DBT-Informed Art Therapy in Practice

Skillful Means in Action

EDITED BY SUSAN M. CLARK

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Susan M. Clark
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1

Front cover image source: A painted jigsaw puzzle by Muneca (pseudonym), whose drawings appear in Chapter 9 "DBT Case Conceptualization Featuring Art Therapy and Poetry Interventions" (Yvette Duarte).

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Contents

Part 2: Multi-Modal DBT-Informed Approaches

Introduction

This volume builds upon the foundation of *DBT-Informed Art Therapy: Mindfulness, Cognitive Behavior Therapy, and the Creative Process* (Clark 2017). My goal for that book was to provide readers with strong overviews of both dialectical behavior therapy (DBT) and art therapy, as well as describe how such differing interventions might come together to assist in the treatment and recovery of individuals with significant emotional and behavioral instability. *DBT-Informed Art Therapy* contains plentiful theoretical information, as well as creative visual exercises for developing competency with DBT's four skills training modules: core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance (Linehan 2015a, 2015b).

The art therapy activities in *DBT-Informed Art Therapy* are suitable for both adult and adolescent clients, and I wrote at length about my experiences working in varied treatment settings (including a community mental health agency, a residential center for addictions, and an intensive outpatient eating disorder program). However, I was also aware of my natural limitations as one individual clinician, which is why I actively sought out other DBT-informed creative arts therapy practitioners. A few of those individuals, who were kind enough to answer my questions and/or donate intervention(s) for the first book, have written chapters in this one.

DBT-Informed Art Therapy in Practice: Skillful Means in Action describes practical applications of the DBT-informed arts therapies within a wide range of settings. The authors hail from the United Kingdom (England), Canada, Australia, New Zealand, Denmark, and the United States. Many possess decades of clinical experience. Some are accomplished instructors, trainers, and presenters. All have great enthusiasm for this novel approach and contribute valuable perspectives resulting from their diverse interests and backgrounds. My hope is that readers become inspired to apply what they learn to their own work. Perhaps some will even pursue opportunities to formally

research the efficacy of DBT-informed art therapy (and, ideally, publish their findings in peer-reviewed journals).

What is "skillful means in action"?

According to DBT's developer, Marsha Linehan, PhD, *skillful means* comes from Zen Buddhism and "refers to any effective method that aids a person to experience reality as it is, or, in DBT terms, to enter fully into wise mind" (Linehan 2015a, p.223). It is the heart and spirit of *participating effectively*, that is, throwing oneself into the present moment and acting as skillfully as possible in order to pursue one's goals: "Do what is needed for the situation you are in," Linehan explains, "not the situation you wish you were in; not the one that is fair; not the one that is more comfortable" (2015b, p.60). By integrating their own unique versions of DBT-informed arts therapy into their respective clinical environments, the authors demonstrate how to assist individuals in acquiring, deepening their understanding of, and applying these important cognitive and behavioral strategies across all aspects of their lives. Such a process is, essentially, *skillful means in action*.

How this book is organized

The book is divided into two parts. The first, "DBT-Informed Visual Art Therapy in Practice," contains eight chapters that emphasize more traditional one- and two-dimensional visual art therapy approaches. In Chapter 1, I illustrate the *Three Ms* of DBT-informed art therapy (mindfulness, metaphor, and mastery) through a fictionalized portrayal of a therapy participant. The *Three Ms* are discussed at length in my first book, but in a much more instructional style. This piece intends to *show*, rather than merely *tell* (i.e., describe), these concepts as they might play out in real clinical situations. In Chapter 2, Heidi Larew considers the chronic internal emptiness that plagues many individuals who struggle with borderline personality disorder (BPD). She encourages therapists to reconsider emptiness as a potential source of strength and/or wisdom, and suggests some creative activities to help both clients and therapists view the phenomenon from an alternate perspective. Jane DeSouza writes about her efforts with combining art therapy and DBT within managed care settings in Chapter 3.

She explains how motivated creative arts-based therapists might integrate their experiential methods with empirically founded practices. Chapter 4 highlights Megan Shiell's decision to re-career as an art therapist at age 50. Within a handful of years she became a highly respected DBT therapist, skills trainer, and pioneer in DBT-informed art therapy who had designed a novel online skills training program for use by both clients and treatment providers.

Chapter 5, Jane DeSouza's second offering, presents the unique aspects of DBT-informed art therapy that may contribute to its observed strengths when applied to the treatment of persistently suicidal individuals. In Chapter 6, I describe an art therapy-based DBT skills training curriculum for individuals with eating disorders. A version of this chapter first appeared in the 2016 Jessica Kingsley Publishers (JKP) book *Creative Arts Therapies and Clients with Eating Disorders* (A. Heiderscheidt, editor). Art therapist and ceramic artist Shelley Kavanagh writes about her ceramic-based DBT-informed art therapy groups for young survivors of sexual abuse in Chapter 7. Housed in a museum, these groups empower participants to become social activists as they prepare to publicly exhibit their creative works. In Chapter 8, co-authors Emma Allen and Anthony Webster share their work with a troubled young man living in long-term seclusion within a high secure treatment unit for mental illnesses and learning disabilities. This hands-on, collaborative intervention proved essential to his development of emotion regulation skills and, ultimately, an ability to achieve and maintain appropriate and rewarding relationships with others.

Part 2, "Multi-Modal DBT-Informed Approaches," comprises six chapters that feature unique fusions of DBT-informed visual art therapy and one or more other modalities (e.g., creative writing, movement, drama). Chapter 9 highlights Yvette Duarte's work with a client who used poetry, drawing, and painting to both deepen their grasp of the DBT skills they learned in program and foster their identity as a person in recovering from mental illness. Duarte presents this individual's story in a DBT case conceptualization-style format. In Chapter 10 we are introduced to "Group InCircle," a creative arts-based intervention that showed promise with helping military veterans acquire, retain, and generalize the DBT skills they received in an outpatient mental health treatment program. This piece's primary author, Jeremy Steglitz, was a postdoctoral fellow at the Veterans Administration Medical Center (VAMC) in Washington, DC. Next, in Chapter 11,

Karin von Daler reintroduces the "creative mindfulness" approach, which she and colleague Lori Schwanbeck first wrote about in JKP's *Mindfulness and the Arts Therapies: Theory and Practice* (2014; Laury Rappaport, editor).

In Chapter 12, Chloe Sekouri describes her work in an urban drop-in center, where she provided short-term—often single-session—DBT-informed creative therapy interventions to a particularly vulnerable clientele. Art therapist Mary Weir introduces readers to her concept of "Queering DBT" with the LGBTQIA+ population in Chapter 13, and challenges us to expand our understanding of, and appreciation for, the myriad manifestations of gender identity and sexuality. And, finally, in Chapter 14 art therapist Penelope James explores one effective approach for implementing a visual journaling (combined art and writing) technique to enhance participants' experiences in a psychoeducational day treatment program.

How to use this book

As in the previous volume, I urge readers who are less familiar with DBT to (at minimum) read the second edition of the *DBT Skills Training Manual* (Linehan 2015a) and *DBT Skills Training Manual: Handouts and Worksheets* (Linehan 2015b). For those who wish to go a bit deeper, the original treatment manual, *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (Linehan 1993), is essential. Newer offerings from experts in the field include *Doing Dialectical Behavior Therapy: A Practical Guide* (2012) by Kelly Koerner, and *DBT Principles in Action: Acceptance, Change, and Dialectics* (2016) by Charles Swenson.

This volume is not a substitute for proper training in a mental health treatment discipline (e.g., professional counseling, clinical psychology, social work, and so on), one or more creative art therapy modalities, and/or DBT. The information contained within each chapter is meant to provide ideas and inspiration around the use of DBT-informed art therapy; however, please exercise discretion with implementing any of the described interventions. Even fully credentialed treatment providers may seek out additional training, consultation, and/or supervision prior to using some of the techniques presented here.

A word about language

Each chapter contributor possesses their own beliefs and preferences regarding how they refer to the people with whom they work. Depending upon an author's educational and professional background, as well as the clinical setting described in their chapter, identifiers such as "clients," "patients," and "participants" typically appear. Gender pronouns vary from feminine to gender-neutral (e.g., they, them, their). In this age of expanding understanding of, and sensitivity toward, the rich range of human identities, my colleagues and I made every effort to balance the many practical aspects of writing for publication with a heartfelt desire to validate and affirm others. Although the results are no doubt imperfect, we offer this book in the spirit of inclusion and respect.

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Part 1

DBT-Informed Visual Art Therapy in Practice

Chapter 1

The *Three Ms* of DBT-Informed Art Therapy (Mindfulness, Metaphor, and Mastery) As Translated Through the Wisdom of a Dog

SUSAN M. CLARK

This chapter illustrates DBT-informed art therapy's *Three Ms* (mindfulness, metaphor, and mastery) through a fictionalized portrayal of an adult therapy participant. Its intention is to suggest how these somewhat abstract concepts might play out within actual clinical situations. Rather than simply describe each concept/practice in the typical academic manner, I show how the *Three Ms* could manifest and develop throughout an individual person's unique recovery journey.

Mindfulness

The artist inhales and runs his palms over the watercolor paper. Its surface is rough and somewhat bumpy. He enjoys looking at the many irregularities, especially the edges, which are uneven, almost ragged. This is a large piece of paper (18 × 24 in.). It is quite thick, as well, and rather heavy. The artist picks it up with both hands, feels the heft, shakes it slightly, and listens to the sound produced, a rustling…no, a *ruffling*, of sorts. Soothing. He shakes it again, this time with a bit more force. He smiles. Before returning it to the table, the artist brings the paper close to his face. He breathes in again, more deeply, enjoying the faint cottony odor. Since no one is around to see, the artist turns his head slightly and allows the paper to rest against his left cheek. He is perfectly still for a moment. All that exists is the silence of the room, the paper's scent, and its faint, flat pressure against his skin.

Once the sheet of watercolor paper is back resting on the table, the artist takes in its crisp white surface once more. It will never again look this way: unmarked, blank, somehow limitless. He reaches for his sponge, which he dips into the small pan of water. Intentionally not squeezing out any excess, he wets the paper's surface thoroughly. Now, it is *glistening*. He clears his throat, puts down the sponge, and immediately takes his favorite brush, touching its tip to the small dollop of blue pigment—then places it against a spot near the sheet's center. Vibrant blue practically leaps from the brush onto the paper, carried effortlessly by vibrating water molecules. It is beautiful. The artist observes how the color feathers out for several inches beyond the original point of contact. He notices that there is a subtle migration toward the right, which means that his table (or the floor) is slightly uneven. He chuckles. So much for perfection.

There was a time when this kind of thing would challenge his patience until he'd slam his fist onto the paper (or tear it into several pieces before crumpling everything up and hurling it all into the trash can). He is not certain why he continued to experiment with art. It would have been easier to just quit. But he kept coming back. Especially to the watercolor.

What *is it* about this stuff? The crap's not easy to work with. It so rarely does what he wants it to do or goes where he intends for it to go. But once he gave up trying to force his will upon the process, things started going much better. It felt a lot better then. He could just do something, *anything* really, and then calmly watch whatever happened. The trick is really in the giving up of control, trusting the process and not freaking out if things don't end up being very pleasing to the eye. After all, this is just a piece of paper and some ordinary tubes of watercolor. Nice enough, but not expensive. There is truly nothing to lose.

The artist scratches his forehead. The room is so quiet that he believes he can hear his heart. He drums a few fingers against the table to break the silence. He coughs once. Then sighs. It's time to add purple. But not the one in the tube. He will make his own, using some ultramarine blue and cadmium red. The artist suddenly becomes aware of feeling eager, kind of excited about mixing colors. It's fun.

Metaphor

About a half an hour has passed, and the artist is truly in the thick of things. He has no idea how it happened, but he finds himself working on

a portrait of a dog, a large, German shepherd-like creature. While the dog itself looks enough like a dog, the coloring isn't realistic because he has been working with blue, purple, and now gray. He is fighting a strange urge to make its eyes bright orange, like autumn pumpkins. "How weird is that?" he whispers to no one in particular, and chuckles again.

The artist has been working with metaphors a lot lately. His therapist says that they are powerful because they can be so deeply personal, especially when they appear in one's artwork. So far, he has found this to be true. A single image can mean many different things, but sometimes it has no meaning at all, which is also sort of meaningful. He regards the dog and has an interesting thought: *My dog is not a fighter*. Okay, so perhaps this one does have meaning, but does this mean that it's meaningful because of what it *isn't*? Hmm.

The artist gives in to temptation and applies a thin, translucent orange glaze over one of the eyeballs. He is careful to allow some white paper to remain and show through, mimicking reflected light. He pauses, takes in his work. It may appear strange, but it feels good and right. The artist turns to the other eye. A moment later, when he is finished, the dog suddenly seems animated. Almost as if he is real and has a soul. The artist feels something like trepidation. *What the hell kind of dog is this?*

Again: *My dog is not a fighter*. All right. Why not, then? The artist sniffs, regards the canine's prominent head, scowls a little. This dog is certainly big. Masculine. Extremely strong looking. If he existed, he could tear someone apart if he wanted to.

Why doesn't he want to?

That is the question, it seems. The artist's eyes are filling up with hot tears. *Oh…shit.* Not this again. Great. He awkwardly wipes his face on a shirt sleeve and then reaches for paper towels. Blows his nose. Wonders if he should wait on this, save it for next time he is with the art therapist. That dog is staring at him, though. *My dog. Who isn't a fighter.*

At least not *that* kind of fighter.

What do you WANT?

The artist places his brush into the soaking water and takes out his notebook and pen. He opens to a blank page and adds the day's date to the top. For the next few minutes, he writes, stream-of-consciousness style.

Again: *My dog is not a fighter*.

And then, a slew of metaphors:

My dog is a rose. A butterfly. A cloud. A secret.

My dog is a song. A dance. A beginning. And an ending…

Oh, good grief. Here we go. He continues to write.

The artist finally closes its front cover with a decisive *snap* and tosses his book onto the far end of the table. He looks down at the orange-eyed dog, who seems to be gazing back at him…almost daringly.

Daring what?

And again: *Not a fighter*.

He remembers the dog he had had as a child, Rusty. What a typical name. But that animal was unique. Rusty was…

It is difficult—*very* difficult—to think about this. He doesn't want to, but he knows well enough about the consequences of not allowing oneself to "feel the feels," as his art therapist likes to say. He sighs. And then, another thought:

This dog does not want to be a fighter. He is what he is. I'm gonna quit trying to make him into something he isn't and never will be. Need to stop now. Stop fighting. Stop fighting reality.

Radical acceptance. Ugh.

After he gets home, he takes out a box of old photos and finds Rusty.

Mastery

The artist started to call himself an artist, at least in his own mind, several months ago. This was after realizing that he had drawn or painted nearly every day for over an entire year. He wasn't supposed to focus on the quality of his artwork; however, over time it became impossible not to notice how much he had improved. He was building up skill. He started to feel something that might have been pride.

Since then, the artist has consistently thought of himself as an artist and allows other people to refer to him as such, if they wish to. Sometimes he works for pure enjoyment. Occasionally his intention is to experiment with new techniques and further develop his abilities. Most of the time, though, he is doing inner work. The nice thing about having skill is that you are more able to make an image close to whatever is in your head (or your heart). Instead of speaking a language but only possessing a minimal number of words to express himself with, the artist's vocabulary has expanded to the point where he is quite articulate. So, if one day his loneliness feels like an empty hand, he'll draw that hand and it will look as desolate and as lost as can be.

There is power in making our selves known, even if just to ourselves.

* * *

It took quite a while before the artist realized that the dog with the orange eyes was his own wise mind. Frankly, wise mind had never made much sense. He wasn't even really sure it existed. His therapist argued about how we can know that we have lungs, kidneys, or whatever without seeing them. Wise mind is there, somewhere, too, whether we have directly experienced it or not. The artist just shook his head and went on about his work.

Gradually, however, the idea began to sink in, especially as he grew less tense and more at peace with himself and his life. The anger was no longer constantly around, and its increasing absence left space, and energy, for other things. He found himself with a desire to explore what this wise mind concept might mean to him (if anything).

The artist began drawing, painting, and sculpting dogs of all breeds and sizes. Some arrived with names, while others did not. But they were all unique, just as Rusty had been. Another commonality was an essential *dog-ness*: loyal, faithful, protective, instinctual, pure. Dogs are themselves. They know what (and whom) they like, as well as what (and whom) they *do not* like. The artist believed the saying that if your dog appears to mistrust someone, you should take it to heart.

He sensed that he needed to start trusting himself. For as long as he could remember, he had rejected his hunches and intuitions. That sort of tripe was just for girls and women. Truth was, he did not know what to think or feel. His parents had constantly said that he shouldn't feel the way he felt (or at least refrain from talking about it). He was overly sensitive. Everything bothered him too much. Basically, he was weak. He needed to toughen the hell up.

The dog with the orange eyes, however, did not seem even slightly concerned about any of that. The dog with the orange eyes simply was. He quietly held whatever he knew and waited. Weeks passed uneventfully. The artist continued to live his life. He even tried a few new things.

* * *

One day the artist mounts the watercolor on some foam board and later, on a whim, hangs it up in his kitchen. At first, he is uncomfortable with

how the dog seems to watch him. He can almost feel those autumnal-hued orbs resting their gaze upon the back of his head as he boils water or fries eggs. The man knows that it's merely flattened wood pulp stained by various mixtures of pigment and gum arabic (and perhaps some glycerine or honey). He isn't going mad; the dog is not real. And, yet.

A couple of months later the artist suddenly realizes that he is happy. This strange recognition arrives as some sort of epiphany just as he finishes his morning coffee. Things aren't *bad* anymore. He had been so busy for so long, working hard trying to build what the DBT people called "a life worth living," that it virtually snuck up behind him. He is okay. Finally. This existence no longer appears to be just about *existing*.

The artist's breath catches in his chest. He recognizes the accompanying emotion as fear. *Can I trust this?* he asks himself, and reflexively glances over at the dog (whose eyes glow with an odd but comforting warmth). *YES*, he says. *Trust in this.*

Chapter 2

The Pause

Borderline Personality Disorder, DBT-Informed Art Therapy, and the Construct of Emptiness

HEIDI LAREW

Emptiness enveloped her like blankets of white snow,
embracing and comforting her in familiarity.
She sat in quiet stillness and felt gratitude for emptiness.
It was quiet and pleasant and safe,
unlike the emptiness
that had consumed her during the in-between years.
There were the first years: Zero, one, two, three, four.
Sunlight poured over her in year four.

She felt the warm breeze, the wide-open space,
the emptiness,
and something of safety,
so safe that there was no need for the word safe.
This was before her tender ways
and her tragic awareness of human suffering collided.
There were the in-between years.
The overwhelm, the loud, the clutter, the emotion,
and words all coming at her
and meanings and sounds
flooding.

And then the unlearning, finally.

And now,
The present. Again, with emptiness,
She could feel it and treasure it,

Be in this moment
With no extra meaning.
Just emptiness.
Just as it was.
—H. Larew

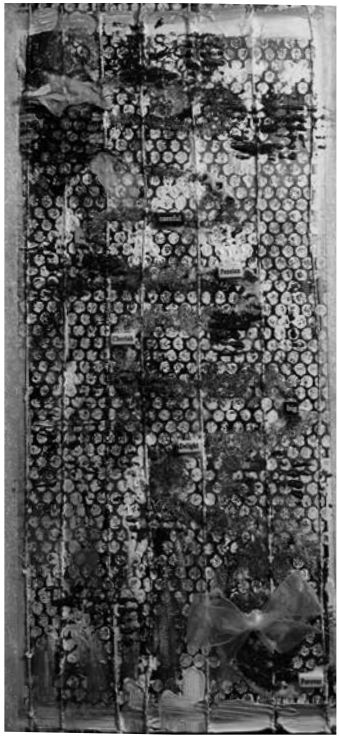

FIGURE 2.1 CONTENTMENT (ACRYLIC PAINTING BY THE AUTHOR)[1]

Introduction

Emptiness in the context of borderline personality disorder (BPD)

Feeling *empty* is a uniquely human phenomenon, one that many have experienced on occasion. Like loneliness and isolation, emptiness is uncomfortable—even painful. It implies a container that lacks fullness, something incomplete. For most people, a sense of emptiness only occurs during difficult periods and may accompany emotional states such as sadness and/or grief. However, emptiness can be more persistent for those who suffer from BPD, a mental illness characterized by severe emotion regulation problems (American Psychiatric Association 2013).

Emptiness is highly subjective and therefore difficult to measure; it has not been the focus of extensive quantitative research. Clinicians and clients alike struggle to adequately describe this experience, although Widiger *et al*. (1995) offer the definition "without meaning, purpose, or substance" (p.99). Gunderson and Links (2008) note that emptiness may include "a visceral feeling, usually in the abdomen or chest" (p.12). Klonsky's (2008) study found a close relationship between emptiness and "pathologically low positive affect and significant psychiatric distress," specifically hopelessness, loneliness, isolation, depression, and suicidal thoughts (p.418).

A defining characteristic of BPD is "chronic feelings of emptiness" (American Psychiatric Association 2013), and the diagnostic criteria also include "frantic efforts to avoid real or imagined abandonment" (p.663). Most individuals with BPD have intense and unstable interpersonal relationships. They tend to view other people in extremes, vacillating between idealization and devaluation. The intensity of their emotions can be overwhelming (Mason and Kreger 2010). Mood lability, an unstable sense of self, difficulty regulating anger, self-harm behaviors, suicidal gestures, suicide attempts, and highly impulsive acts can create distress for others as well. At times, those closest to these individuals may pull away, thereby reinforcing fears of abandonment (and furthering the potential for deeply painful experiences of emptiness).

Coping with emptiness can seem overwhelming, an insurmountable task. Its chronic presence frequently contributes to other BPD symptoms as individuals attempt to distract themselves or fill the sense of inner void with compensatory and "potentially self-damaging" behaviors (American Psychiatric Association 2013, p.663). These could include substance abuse, binge eating, overspending, sexual activities, and reckless driving.

This chapter reflects on the construct of emptiness and explores alternative responses, including radical acceptance (Linehan 1993, 2015a, 2015b), which might involve regarding emptiness from a variety of creative angles and contemplating other, nonjudgmental, viewpoints. It is entitled "The Pause" because emptiness itself is a form of a pause, a space *between*. My intention is to allow readers to reflect on, and perhaps, consider a different understanding of the cumulative effect of BPD symptoms. Just as negative experiences and interpretations can multiply in a downward trend, so also positive experiences and

interpretations can have an upward propulsion, an overall movement toward a more rewarding life.

The chapter also describes dialectical behavior therapy (DBT) and explains how a dialectical view of emptiness (as well as several other traits associated with BPD) can help reduce shame and stigma in the people we treat. Using language that conveys respect as well as a desire to understand and support these individuals may alleviate their suffering. Word choice should focus on validation of emotional pain as well as communicating clearly, with precision and compassion. The chapter includes a brief introduction to art therapy as a potential valuable method for exploring emptiness dialectically. To this end, I offer ten creative exercises for the reader's consideration.

A domino effect

According to DBT developer Marsha Linehan's *biosocial theory* (1993), persons with BPD often possess an inherently sensitive emotional temperament as well as a history of having experienced at least emotional invalidation, if not trauma/abuse, during childhood. Validation communicates that the individual's "responses make sense and are understandable within their current life context or situation" (Linehan 2015a, p.88). In the case of invalidation, such responses are *not* accepted as reasonable, and may even be discounted or trivialized. The message one receives from others, through direct feedback and/or nonverbal signals, communicates that one's perspective is inaccurate or inappropriate. When a person is repeatedly distanced from others through invalidation, feelings of alienation can occur. Social isolation and social rejection contribute to depression (Matthews *et al.* 2016).

An accumulation of problematic factors may result in other undesirable outcomes. For example, if an individual has already experienced recurrent invalidation, and then also contends with substance use and relationship issues during adulthood, there can be a chain reaction type of impact. Just as one domino tips onto another, causing a cascade of falling tiles, so one emotional problem occurs, then other factors are added, and consequences become exponentially more troublesome.

Broken relationships can result in a gradual decline in self-confidence. Chronic environmental invalidation reinforces the idea that the individual is alone (which, again, may contribute to feelings of emptiness). However, while dominos can tumble in negative directions, a positive accrual of

life-affirming and healing experiences is also possible. The key is patience. Individuals in therapy must be willing to consider their experiences from other vantage points. It is also important to develop adaptive coping skills, which often do not provide as much immediate relief as unhealthy choices. Given that impulsivity is such a salient aspect of BPD, developing mindful restraint, while not impossible, is challenging.

DBT

DBT, a familiar evidence-based intervention for BPD, can reduce suicidal ideation, suicide attempts, psychiatric hospitalizations, self-injury, and other destructive acts (Linehan 1993, 2015a, 2015b). DBT is a form of cognitive behavior therapy (CBT) that incorporates concepts from Zen Buddhism and dialectical philosophy. It emphasizes meeting the client wherever they are while working toward the behavioral changes necessary for safety and an improved quality of life. DBT's psychoeducational component includes four modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance (Linehan 2015a, 2015b). Through skills training clients learn to cultivate mindful awareness of their own emotions and/or other internal experiential states (like emptiness). DBT participants also develop capabilities for asserting their personal needs in relationships and effectively managing intense emotions, as well as accepting and tolerating occasions when they are not able to immediately experience emotional relief, resolve pressing problems, and so on.

Emptiness viewed from other perspectives

One can conceptualize emptiness in various ways. The person may experience shame for being lonely while surrounded by loved ones, or for not feeling full, complete, whole. Further, given the persistence and degree of emptiness in individuals with BPD, any encouragement to reframe it as a positive experience could feel like more invalidation. Individuals who suffer from chronic emptiness can perceive other views as *Pollyanna-ish* (i.e., excessively or blindly cheerful/optimistic).

DBT, with its focus on dialectics (described below), strives to balance "the tension between seeking change in a person and encouraging them to embrace acceptance" (Linehan 2020, p.226). In the case of distressing sensations like anxiety, depressed mood, identity disturbance, and

feelings of emptiness, this is no small feat. Individuals understandably wish to push away and/or anesthetize themselves from such experiences. However, the dialectical approach asks that both client and therapist entertain a novel idea:

> Dialectics allows opposites to coexist: you can be weak and you can be strong, you can be happy and you can be sad. In the dialectical worldview, everything is in a constant state of change. There is no absolute truth, and no relative truth, either; no absolute right or wrong. Truth evolves over time. Values that were held in the past might not be held in the present. Dialectics is the process of seeking truth in the moment, drawing on a synthesis of opposites. (Linehan 2020, p.227)

Reconsidering words and meanings

To balance considering emptiness through a less pejorative lens while attempting to avoid unnecessary invalidation, we might examine other words that commonly describe aspects of the BPD experience: *manipulative*, *anxious*, *attention-seeking*, *avoidant*, *impulsive*, *isolative*, *ruminating*, and *numb*. These adjectives, while at times accurate and even productive, are potentially hurtful, as well. I again advise taking a dialectical view. From one perspective, an attribute is seemingly unbecoming; however, from another angle one may see that same quality as functional.

> The case can be made that in the minds of professional caregivers, these terms are not pejorative; indeed, that might be true. However, it seems to me that such…terms do not themselves increase compassion, understanding, and a caring attitude for borderline patients. Instead, for many therapists such terms create emotional distance from and anger at borderline individuals. At other times, such terms reflect already rising emotional distance, anger, and frustration. One of the main goals of my theoretical endeavors has been to develop a theory of BPD that is both scientifically sound and nonjudgmental and nonpejorative in tone. The idea here is that such a theory should lead to effective treatment techniques as well as to a compassionate attitude. Such an attitude is needed, especially with this population: Our tools to help them are limited; their misery is intense and vocal; and the success or failure of our attempts to help can have extreme outcomes. (Linehan 1993, p.18)

- *Manipulative* versus *resourceful*: A manipulative person finds ways to exert control over others without communicating directly. The individual is resourceful but not forthright. This behavior is understandably unsettling to those who feel deceived. However, Linehan (1993) contends that the assumption that individuals with BPD attempt to affect the people around them "by indirect, insidious, or devious means" (i.e., manipulation) is misleading: "Indeed, when they are trying to influence someone, borderline individuals are typically direct, forceful, and, if anything, unartful" (p.16). DBT's interpersonal effectiveness/assertiveness training module teaches them how to express their wants and needs more skillfully (Linehan 2015a, 2015b)—in other words, how to be resourceful in ways that do not negatively impact important relationships.

- *Anxious* versus *eager*: My experience as a treatment provider has been that mental health services clients often pathologize themselves. As they recover, however, they sometimes continue to express feeling difficult emotions such as anxiety (when it may, in fact, not be the case). Hence, one might ask whether they are, instead, *eager*. For example, the person may be excited about a job interview or enthusiastic about a new relationship—two emotional states that can feel like anxiety. It is important to consider this possibility, rather than immediately assume the negative.

- *Attention-seeking* versus *human and in need of connection*: An attention-seeking individual may pursue their goal in ways that are upsetting to others. They could even require more attention than others can give. The desire itself should not be a source of embarrassment; humans need to receive recognition and care. And yet those with BPD may unintentionally deplete the resources of their support systems. Perhaps the attention-seeking individual is in fact searching for connection. The observer's critical assumption is not helpful. What *is* beneficial is helping the individual to identify their need, meet it (if possible), or tolerate times when they cannot obtain the degree of attention that they so strongly desire.

- *Avoidance* versus *intentional diversion*: People make countless choices each day: "Should I plan my commute intentionally to

avoid traffic?" Yet what if I were to take this further, and work to prevent spending time with someone whose ways do not enhance my life? The word *avoidance* itself, like the others noted here, is not completely problematic. However, its tone implies a fearful skirting away when an individual may be making highly proactive decisions. Intentional diversion indicates mindful and empowered choice. Someone with a strong sense of their own independence, or those who are more introverted, may redirect away from people and situations that deplete their energies. This choice to change course can be quite healthy and powerful.

- *Impulsivity* versus *choice*: Impulsive decisions lack forethought—for example, suddenly buying a candy bar in the grocery store line for a screaming toddler (or for oneself). It is the spontaneity and absence of attention to probable consequences that make said behaviors impulsive. Likewise, an unpremeditated leap from a vacation spot's skyline viewing area is an impulsive decision, unlike pondering suicide for days and creating an organized plan to kill oneself. It is important for the person with BPD to be honest with themselves (as well as with their treatment providers and any other trusted individuals) about the potential for destructive behaviors. Justifying such acts as impulsive when they are *not* is disempowering and erodes one's sense of mastery over time.

- *Isolation* versus *choice of solitude*: The term *isolation* describes lack of contact with others. Individuals who have been warned against isolating may require encouragement to remain socially involved, supported, and able to contribute to their communities. Isolation is both a potential trigger for depression and one of its symptoms. However, individuals with a history of isolation can feel shame around preferring time to themselves. They may be people who do not require as much daily interpersonal contact. Given the opportunity to reconsider their conceptualization of this, they may identify as introverted. It is not maladaptive to possess a deep sense of one's own independence and personal dignity without a need to conform to others' expectations. For such individuals, time alone is spent treasuring solitude.

- *Ruminating* versus *problem-solving or engaging in a creative process*: A common feature of both anxiety and depression is

rumination, a pattern of obsessively and repetitively dwelling on the causes, circumstances, and/or outcomes of one's negative emotional experiences (Nolen-Hoeksema and Morrow 1993). The propensity for viewing an obstacle from various angles and considering numerous possibilities for overcoming it is not necessarily undesirable. Creative thinkers often mull over many approaches before tackling an issue head-on. However, rumination lacks focus. It is important for the individual to consider his or her manner of thinking and problem solving. External processers are verbal thinkers (Williams and Tappan 1995); therefore, it may be most effective for them to brainstorm aloud with similarly inclined people. Problem solving can be a stimulating exercise for a group that enjoys open-minded collaboration.

- *Numb* versus *content*: Individuals participating in DBT record their emotions and other internal subjective experiences on preprinted tracking tools called diary cards, which typically include some general emotion terms such as *joy*, *anger*, *anxiety*, and *depression*. *Numbness* is often an option, as well. But what about more subtle affective experiences, such as contentment? Given only a few basic choices, the individual may inappropriately check off numbness. Individuals with BPD, who tend to think in black-and-white/all-or-nothing terms, frequently struggle with this. However, most diary cards do allow clients to fill in items and add numerical ratings to better capture their subjective states. Each person must identify for herself exactly which terminology to use and how to measure progress. As one can never completely understand another's experience (e.g., a headache that stings versus one that feels dull), these must be individually described and defined.

DBT-informed art therapy

DBT's focus on acceptance of emotions is present in art therapy (Abbing *et al*. 2019), a mental health treatment intervention that allows clients to identify and process their feelings through various forms of visual media (i.e., the materials/tools used to make an art product). Examples of media include drawing paper, pencils, paint, oil pastels, and clay.

Clients use these as vehicles for expressing themselves in a symbolic manner. They may then observe the resulting art product and reflect on the conveyed emotions.

DBT concepts and skills may be combined with art therapy in numerous ways (Clark 2017). While experimenting with a range of techniques, clients cultivate mindfulness of the chosen materials (e.g., paying close attention to tactile sensations, colors, and so on). They can create objects with visual symbolic reminders of interpersonal effectiveness skills, as well as written words of encouragement and assertiveness statements. DBT-informed art therapists combine psychoeducation about emotions with artistic expression, allowing clients to paint, draw, or sculpt their feeling states. Techniques and media that are difficult to control (such as watercolor) allow for practice of distress tolerance.

Empty space, positive and negative space, and emptiness in experience and in art

Feeling empty, as we have established, is a deeply troublesome BPD symptom. However, it is possible to broaden one's view of this phenomenon by exploring it in novel ways. For example, Linehan (2015a) states that mindfulness can, over time, elicit a shift in experiencing emptiness "as liberating and joyful rather than painful and constricted" (p.215). An idea for consideration:

The therapist places rocks or other items such as cotton balls into a jar until these objects reach the rim. She then asks the client: "Is the jar full?" Next, the therapist adds much smaller items into the jar (e.g., gravel, tiny seeds) and asks again: "Is the jar full?" Finally, the therapist adds water and asks one last time: "Is the jar full?"

The jar and its contents are a reminder of the empty spaces that exist between everything. Consider the tiny grain of sand, or the spaces between and within particles of matter. Consider the atom—a millionth the size of a grain of sand—as well as subatomic particles, an electron, a proton, a nucleus. The quark, a subatomic particle carrying a fraction of an electrical charge, has a radius smaller than 43 billion-billionths of a centimeter.

> That's 2,000 times smaller than a proton radius, which is about 60,000 times smaller than the radius of a hydrogen atom, which is about forty times smaller than the radius of a DNA double-helix, which is

> about a million times smaller than a grain of sand. Quarks (along with electrons) remain the smallest things we know, and as far as we can tell, they could still be infinitely small. (Butterworth 2016)

While quarks are too small to be directly observed, scientists have proven that they exist. The *spaces between* seem endless. The empty areas separating objects touch each object, and therefore, bridge them. Throughout our daily lives we experience times when we are busy and productive, as well as moments during which we are still…when we pause. The pause is necessary emptiness. In art, *positive space* refers to the solid area on which the eye focuses. It is the mass of the depicted object. *Negative space* is the remaining area, the emptiness that surrounds the object or that rests between objects (Edwards 2012). Without negative space, there is clutter; lines, shapes, colors, and objects would run together chaotically. Our minds require such in-between places to discern an image.

In terms of mental health, the human mind needs something similar. It must occasionally pause, rest, experience solitude and quiet. For those diagnosed with BPD, however, such still, empty spaces can feel all-consuming. In being present alongside clients during therapy sessions, we can pause and allow for these necessary silences. We can model a tolerance of, and respect for, emptiness.

Music, like visual art, offers powerful analogies for emptiness. *Rests* are intervals of silence. With no rests, no occasional absence of sound, cacophony occurs. Emptiness, silence, is of great importance. Consider these words attributed to French composer Claude Debussy: "[M]usic is the space between the notes" (Barton 2014). A pause brings vitality to the sounds surrounding it. A rest of just a beat or two allows for a suspenseful build-up of energy. At the close of a piece of music, the instruments recede momentarily, which accentuates the climax, following as it does this brief quietness.

DBT-informed art therapy and other creative emptiness-related interventions

Clients may engage with the following ten exercises on their own or with a therapist.

1. *Subjective emptiness artwork*: The directive is simply to create an image of what emptiness feels like. By using art materials

to depict this individual and somewhat vague experience, the person may gain better understanding. Research suggests that the act of identifying an affective state helps to reduce its intensity (Lieberman *et al*. 2007). The resulting two-dimensional image can be a visual container for improved emotional regulation.

2. "*Dear Emptiness" letter*: This therapeutic journaling exercise can be particularly effective for increasing distress tolerance. It involves personifying the experience and expressing thoughts and feelings directly to the character of Emptiness. The letter facilitates externalization of difficult emotional content.

3. *Mindful music experience*: The individual carefully listens to a song that she enjoys and is especially mindful of the musical rests/pauses. Possible prompts for writing and reflection include: "What do the rests/pauses communicate to you?"; "What are your thoughts and emotions in response to the rests/pauses?"; and "What specific bodily sensations do you notice while listening to this music?"

4. *Opening the Space*[2]: This is an imaginative technique for exploring the concepts of space, emptiness, and fullness. Provide the client with a sheet of black paper as well as a sheet of white paper of the same size, a glue stick, some colored pencils, and scissors. She will first cut a circular hole (i.e., empty space) into the middle of the black sheet of paper. The client then glues the black sheet over the white sheet. Encourage her to imagine that the resulting white space is her experience of emptiness. Instruct the client to use colored pencils to draw and/or write healthy ways of feeling full. This intervention facilitates a concrete, physical act of creating that helps the client to accept emptiness while, at the same time, consider strategies for changing the internal subjective state.

5. *Mindfulness of darkness and light*: This therapeutic approach allows the client to be present with her experience of emptiness, to depict it on the paper, and to reflect about her own emotional resilience. The therapist encourages the client to gaze upon a sheet of black construction paper and imagine the feeling of emptiness. Next: "Draw a tiny speck of light and then use your pencil to physically expand the drawing out from that, using shading. Symbolize your source of strength. Where do you get

that strength? Even if this seems unreachable, allow yourself to consider that even though you may not feel it, you do have strength that has gotten you this far."

6. *Box of hope*: The therapist provides the client with a small box to decorate in a pleasing manner. Inside this container the client places a note of self-encouragement. When feeling empty, she may open the box and re-read and reflect upon her words. This is an example of the DBT distress tolerance "IMPROVE the Moment" skill "With Self-Encouragement and Rethinking the Situation" (Linehan 2015b, p.336). Similarly, the person can identify someone else who needs support. She could send an uplifting greeting card or postcard to that individual. This is an example of the distress tolerance "With Contributing" strategy, part of the "Wise Mind ACCEPTS" distraction skills (Linehan 2015b, p.333).

7. *M.C. Escher/tessellations*: Invite the individual to consider Escher's artwork (Locher 2013) as well as other examples of tessellations (Stephens and McNeill 2001). A tessellation is a repeated pattern/arrangement of flat shapes, such as polygons, that interlock with no overlapping or gaps between them. Mindful observation of the positive and negative spaces ("How do they work together?") allows the client to engage in a delightful experience of curiosity and reflection.

8. *Georges Seurat*: Invite the individual to view some of Seurat's art (Düchting 2017). Provide a small piece of canvas or art paper (even just 4–6 in. in size) and some fine-tipped markers of various colors. The client may make their own pointillistic drawing after which the clinician can ask: "Consider the spaces between the dots and the sense of connection that those spaces convey. In what ways are we connected to one another?"

9. *Interconnectedness artwork*: This artistic therapeutic intervention allows the client to both explore interpersonal effectiveness in relationships and consider concepts of emptiness and space. The therapist teaches the client to make folded cut-out shapes such as hearts and chains of united people (i.e., paper dolls). These one-dimensional creatures can then be used as is, or the therapist may teach the client how to produce prints using rollers and paint.

The therapist points out the positive and negative spaces and asks thought-provoking questions such as "How do the negative spaces add to the composition?" The client and therapist also may explore concepts such as emptiness and space—as well as connection and boundaries in both artwork and in relationships.

10. *Values mountain*[3]: DBT highlights the importance of integrating one's personal values into mental health recovery. Linehan calls this process *building a life worth living* (2015a, 2015b, 2020). The therapist directs the individual to draw a simple image of a mountain. At its peak, the client adds a symbol representing a current high-priority value. For example, she may create a symbol for valuing family; she will also draw a path up the mountain on which she adds both potential obstacles and potential tools. The therapist can help the client to consider this in the context of finding meaning and purpose in life. They may discuss how working toward *a life worth living* might help to ameliorate and/or reconceptualize emptiness.

Conclusion

The subjective experience of emptiness can be intensely painful, so much so that individuals with BPD often react with behaviors that are disruptive to their quality of life and relationships. As therapists it is important that we consider clients' experiences and respond with supportive and validating actions, including the language we use. Their pain and resilience deserve our respect. It is challenging for clients to consider other perspectives regarding emptiness; however, alternative viewpoints may prove beneficial, especially over the course of long-term treatment. DBT-informed art therapy and other expressive modalities offer potential ways to reach clients and assist them in finding peace. My hope is that readers will be inspired to explore, and perhaps expand upon, these ideas in the spirit of strength-based mental health recovery and wellness.

Endnotes

1 Figure 2.1 depicts Contentment (12 × 24 in. canvas, acrylic paint, and minor assemblage materials). During the Covid-19 pandemic, I painted an initial image to submit for this text. I was pleased with the painting, as I had used the opportunity to focus on the

concept of emptiness in art making. However, I was unsure whether it would have the visual distinction needed for publication in black and white. I began this second piece by using the same size canvas, black and white acrylics, and print making objects around my home. At that time, having been home for eight weeks providing teletherapy, I was profoundly aware of my own experiences of solitude and isolation, as well as gratitude for my well-being.

I began by wrapping the canvas in twine to create a slight rise in texture; I then added tissue paper and layered paint. As I explored the media, I initially intended to duplicate the first art piece, but instead, I adapted. I thought of the black and white paint, and the years of work I had done with clients addressing their "black and white thinking." I reflected on the world news—hearing one set of public health guidelines one day and another set the next. I was aware of the intensity of emotion, the desire of many people to support one another, and simultaneously the chaotic relationships and emotions I observed through television, the radio, and the internet. Crisis had become a source of human divisiveness, and, also, a source of human connection.

In the first painting I had embraced, explored, and expressed the concept of emptiness. But now, in working on this piece, my thoughts and feelings took off in many directions. Despite awareness of the pandemic, I found myself experiencing acceptance of the moment and contentment in this one day. The creative process brought me an opportunity to fully experience my internal processes in a new way. I had a heightened awareness of gratitude for my health and for those I cherish.

2 The author would like to credit Nancy Nierman-Baker for this intervention.

3 The author would like to credit Vicki Lynn Milnark for this intervention.

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Chapter 3

Utilizing DBT, Mindfulness, and Art Therapy in Today's Healthcare Environment

JANE DESOUZA

Introduction

In their efforts to lower the considerable costs of treatment, regulating and reimbursement bodies have increasingly scrutinized mental health services. As a result, interventions with proven beneficial outcomes, that is, *evidence-based practices* (EBPs), are now the norm. EBPs offer significantly more dependable methods of facilitating improved functioning and long-term recovery than do their non-empirically founded counterparts, which "typically rely on tradition, convenience, clinicians' preferences, political correctness, marketing, and clinical wisdom—none of which is consistently related to improving outcomes" (Drake *et al*. 2001, p.181). Hence, to receive financial compensation, providers must demonstrate that the treatments they offer to their clients result in necessary skill acquisition as well as measurable progress toward greater self-sufficiency. This is sometimes called *outcome-based reimbursement* (Kilbourne *et al*. 2018, p.33), or *value-based payment* (p.34). EBPs, many of which involve comprehensive approaches for achieving and maintaining psychiatric stability and well-being, are today among the interventions of choice in managed care settings.

It is challenging to ensure that behavioral health services engage recipients while also consistently producing desirable outcomes. What treatments are most effective for moving clients toward recovery? Over the past 40 years I, the author, have worked primarily in one psychiatric hospital setting where I provided clinical art therapy—an intervention that (at the time of this writing) does not enjoy a strong research base in

spite of its observed strengths. This chapter describes my experience as an art therapist who possesses competence with some EBPs, dialectical behavior therapy (DBT) in particular. I present art therapy as not merely a supportive or supplemental service, but as a useful method for delivering DBT's psychoeducational skills training component (itself a proven tool for promoting client self-efficacy and wellness).

What is EBP?

Sackett *et al.* (1996) define EBP as an "integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care" (p.71). Rather than relying solely on individual instinct or judgment, practitioners balance solid empirical data with a knowledge of clients' unique characteristics (e.g., personal preferences, values, environment, culture, and so on) for the purpose of achieving the best possible outcomes. Treatment responses include measurable results based on the goals and expectations of therapy while taking into consideration a client's level of engagement (Sackett *et al.* 1996).

DBT as EBP

Research on DBT goes back nearly three decades in the form of multiple randomized, controlled studies (Linehan *et al.* 1991; Stoffers *et al.* 2012). This adapted, mindfulness-based cognitive behavior therapy (CBT) is a gold-standard treatment for borderline personality disorder (BPD) (Chapman 2006). BPD is a complex psychiatric condition characterized by "a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (DSM-5; American Psychiatric Association 2013, p.663). Its diagnostic criteria include enduring feelings of emptiness; recurrent suicidal thoughts, attempts, gestures, and/or threats; nonsuicidal self-injurious behaviors (NSSI); and extreme fears of abandonment (actual or imagined) (DSM-5; American Psychiatric Association 2013).

Individuals who suffer from BPD require a high level of care for such intense symptoms, and therefore tend to consume substantial mental health resources in their communities. Problems/limitations include the length of time necessary for adequate treatment, significant expense, and a lack of availability of specialized programs (Parker,

Boldero, and Bell 2006). The instability and unpredictability of this disorder make treatment difficult to manage (Paris 2008), and clients often need interventions from a variety of modalities (Paris 1994).

DBT builds clients' emotion regulation capacities so as to reduce suicidal ideation and self-injurious behaviors (Paris 2008), which, in turn, decreases emergency room visits and the need for costly inpatient hospital admissions (Linehan *et al*. 1991). In a journal article reviewing five separate studies, Panos *et al.* (2013) concluded that DBT is effective in improving patient treatment compliance, as well as in stabilizing and managing self-destructive behaviors. Although most early research focused exclusively on BPD, the addressed symptoms exist within a variety of clinical populations where children and adults struggle with significant affect dysregulation and negative thought patterns. Indeed, DBT has shown promise in treating individuals with comorbid substance abuse disorders, eating disorders, depression, and anxiety disorders (Chapman 2006).

DBT's comprehensive treatment approach emphasizes the acquisition of psychiatric and emotional/behavioral stability through *mindfulness*, or "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn 1994, p.4). Mindfulness originated from ancient Buddhist practices, and over the past two decades has shown efficacy in alleviating a variety of physical and mental conditions (Brown, Cresswell, and Ryan 2015). DBT teaches strategies to replace impulsive, mood-dependent behaviors with mindful awareness, leading to options for alternative, more adaptive responses. Skills trainers utilize a detailed instruction manual (Linehan 2015a, 2015b). The curriculum is organized into four psychoeducational modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. However, the skills comprise only one component of a true DBT approach to recovery. Comprehensive DBT, the form shown most effective in numerous randomized clinical research trials, also includes weekly individual therapy sessions and outside-of-treatment skills coaching calls. Perhaps the most crucial component is support for DBT clinicians themselves: the peer consultation team, where practitioners discuss progress, brainstorm interventions, obtain help with maintaining treatment fidelity, and address their emotional reactions to clients (thus preventing therapist burn-out) (Linehan 1993).

Without all four components—individual psychotherapy, skills training, phone coaching, and peer consultation—DBT would likely

be less effective. Clients may find it easier to avoid full engagement, and they often struggle to grasp the benefits given their habitual maladaptive ways of viewing and interacting with the world around them. Further, clinicians are less able to sustain an appropriate therapeutic stance if they lack necessary professional structure and support. The intensity and drama of DBT clients' lives can be exhausting to everyone around them (including the clients themselves).

DBT skills training as an EBT

There is, however, some evidence that DBT skills training can be a valuable sole/stand-alone or primary intervention (Linehan 2015a; Linehan *et al*. 2015). The people I work with often make comments such as *Why didn't I learn these skills before?* and *They should teach these skills in school!* Age does not seem to be a factor. Older clients are often highly motivated to find a way out of lifelong distress, and young adults respond well to skills training because it is empowering. The psychoeducational materials do not dictate specific responses, but rather emphasize personal choice and effectiveness.

My program has adapted DBT for clients with developmental disorders who must have a slower, more concrete learning process. In other departments, modifications exist to meet the needs of the various milieus (e.g., inpatient units providing introductory skills training as an engagement tool, DBT-informed intensive day program curriculums, and follow-up groups for reinforcing and encouraging clients' long-term use of skills). Most relevant for creative arts therapists, some clinicians have integrated nonverbal expressive modalities into skills training as a means of increasing participants' understanding and application of DBT concepts/strategies into their daily lives (DeSouza *et al*. 2015).

DBT core concepts

DBT is grounded in dialectics, mindfulness, validation, and acceptance (Linehan 1993).

- *Dialectics* refers to the countless opposing forces that are a part of life and features the notion that two highly different ideas or positions can be true *at the same time*. Individuals with distorted cognitive processes and ineffective behavioral styles are in constant conflict with themselves and their environments. On one hand, it is often clients' polarized (all-or-nothing, black-

or-white, right-or-wrong) thinking that creates such chaos. On the other, their "extreme life problems and unstable emotions result in cognitive rigidity at the exact times when clear, balanced thinking is most needed" (Clark 2017, p.32). This is an example of a *dialectical dilemma*.

A life worth living contains positive *and* negative aspects, joy *and* pain. It is important for clients to grasp that avoiding the negative and undesirable aspects also restricts the positive and rewarding elements. The recovery process will not prevent or remove hurtful events, change the people around us, or make up for a traumatic past. However, it does provide tools for better managing each new moment as it arises, as well as tolerating the imperfections of that moment, of ourselves, and others.

Dialectics allows for a balance between acceptance and change, both of which are necessary for establishing fulfilling lives. A dialectical stance does not seek compromise; rather, it looks for the truth in all points of view. It asks: *How do these things go together?*; as well as: *What is being left out of my understanding of what is happening?* Marsha Linehan (2015c) explains that dialectical thinking would perceive the combination of black and white not as gray (i.e., compromise), but as plaid, an interweaving of the two that eliminates neither (Linehan 2015c). Further, it is interested in any transactions occurring between them—because this is where change takes place.

- *Mindfulness* provides the foundation where other DBT skills are built. Mindfulness is a deliberate and nonjudgmental awareness of what takes place in the present. Both internal and external stimuli tend to distract us from full awareness of *now*. DBT is based on the idea that our feelings, thoughts, behaviors (as well as the environmental cues that trigger them) often go unrecognized (Linehan 1993), and this ignorance can precipitate crises. For example, when a person is not paying attention to their escalating emotions, impulsive behaviors such as self-harm may result.

The ability to objectively observe oneself in the world is challenging because it requires the conscious interruption of countless habitual impulsive reactions. I liken this to attempting to turn off an automatic pilot system without knowing the location of the control button. My clients have reported that once they truly grasped the concept of mindfulness, however, the other skills became much easier to understand and operationalize.

- *Validation* is conveying to a person that their "responses make sense and are understandable within their current life context or situation" (Linehan 2015a, p.88). One assumes that all behaviors have a reason/purpose and are not wrong, per se (although they could have harmful consequences, or simply be ineffective in achieving a goal). Validation of emotional responses in the context of a given situation requires the therapist to identify when the client's maladaptive behavioral choices are based on appropriate emotional responses.

DBT's emphasis on validation addresses the fact that many individuals experience standard CBT, which is highly change-focused, as invalidating. Individuals with BPD frequently perceive their treatment providers' feedback and/or recommendations as harshly negative and judgmental, which can lead to resistance (and, sometimes, even withdrawal from therapy). I highlight to my clients that, while maladaptive behaviors were once helpful for survival during difficult times, they are no longer appropriate and may even be quite destructive. Another important dialectical dilemma: *I am doing the best that I can, AND I need to do better, do more, or do something different.*

- *Acceptance* is an essential DBT skill. *Radical* (i.e., total) *acceptance* means letting go of all resistance to reality (Linehan 2015a). It does not involve agreeing with, or liking, or approving of the way things are; rather, it simply means to stop fighting against what cannot be changed. Acceptance is the alternative to denying reality, wishing that it were different, or fixating on how it *should* be. Pain is inevitable, but misery is not. Suffering results from how we respond to pain. The more we hold onto the *should*, the more likely we are to experience negative emotions over a prolonged period, and the more difficult it becomes to determine how to process and move through life's unavoidable hurts and discomforts.

Where does art therapy fit into the EBP model?

As previously mentioned, art therapy is not currently an EBP. Hence its reimbursement is restricted by many managed care companies. While I have seen some art therapists thrive within certain treatment settings, regulatory and financial bodies typically relegate us to very narrowly defined roles across the spectrum of behavioral health services. Because

outpatient community mental health agencies are dependent on third-party payment, the types of clinicians these providers are willing to hire are contingent on financial compensation.

A possible solution to this predicament would be to collect empirical data supporting art therapy. However, in the introduction to her 2006 book *Art Therapy, Research and Evidence-Based Practice*, Andrea Gilroy notes a problematic "tension in the process of art therapy becoming evidence based…(that is) between the discipline and the systems in which it operates" (p.2). Some art therapists believe that rigorous research demands conformity and rigidly followed interventions (Dean 2010).

Fast-forwarding to 2015, Bauer *et al*. state that "Despite its widespread coverage in general literature, EBP is barely addressed by the art therapy field. It is only recently that art therapists have begun to address the controversies, and much of the literature originates from the UK and Australia" (p.17). With regard to any available documented evidence base for art therapy's efficacy, the authors comment: "The few articles that do exist lack cohesion, and the research methodologies did not appear to build upon previous work" (p.43)—the latter of which, replicability, is crucial for determining an EBP (Sackett *et al*. 1996).

My experience

During the early 1990s, at which time I had already practiced art therapy for ten years in New York State, a new psychiatrist brought DBT to the hospital where I worked and trained the entire inpatient unit staff. I integrated what I learned into my groups and immediately saw increased client engagement. Further, the combination of art therapy and DBT seemed natural to me and suited my therapeutic style.

While change is often anxiety provoking, I, unlike some of my colleagues, have experienced the evolution of New York's services for the mentally ill as positive overall. The focus on EBPs strives to constantly improve clients' potential for recovery while juggling the need to meet those third-party reimbursement requirements (a challenge I sometimes refer to as contending with a *multi-headed monster*). I also became familiar with other EBPs by participating in substance abuse trainings, as well through my work with the New York State Office of Mental Health's initiative for Personalized Recovery Oriented Services (PROS).

The incorporation of empirically founded approaches has felt neither restrictive nor devaluing of my art therapist identity; rather, I believe that it has enhanced my expertise in providing high-quality treatment. In addition, fluency in the language of EBPs augments my ability to communicate with clinicians from other disciplines, document in a more concise manner, work collaboratively with clients, and effectively advocate for the creative arts therapies within such an increasingly managed care setting.

Over the course of many years I have seen our job titles evolve in prestige from activity leaders to activity therapists, then to rehabilitation therapists—to, now, creative arts therapists. In the hospital's day treatment program creative arts therapists are primary clinicians, along with social workers and mental health counselors. I became the director of the outpatient program in 2011 and, in the clinic, accommodations were made to utilize me for DBT services despite reimbursement restrictions. Art therapists have even been hired for team leader positions! These accomplishments resulted from clear, consistent demonstrations of art therapy's effectiveness and versatility. To this end, I applied the following strategies:

1. Obtained formal training in EBPs.
2. Carefully integrated art therapy into the use of those EBPs.
3. Displayed professional value based on client engagement (as measured by their attendance/participation as well as via standardized satisfaction surveys).
4. Developed relationships with other clinicians and agencies by communicating in the common language of EBP, i.e., via written documentation as well as verbal communication (e.g., rounds meetings, in-services, case presentations, and so on).

To prevent or reduce professional resistance created by fears of conformity, art therapists must believe that good research offers an effective method for demonstrating their discipline's capacity to promote positive outcomes *while not rigidly dictating its practice*. I propose that art therapy is no more of an EBP than are social work, mental health counseling, nursing, and psychiatry. However, all techniques should be directly informed by existing empirical evidence. EBP ensures that clinicians "are practicing to the best of their abilities through constantly reviewing, updating

and adjusting…according to the latest research findings" (Sackett *et al*. 1996, p.71). EBP creates the groundwork upon which an art therapist's interventions can best meet clients' needs, values, and treatment plans. While nothing will replace the necessity for sound research, I feel that, in the meantime, carefully combining an EBP with one's art therapy skill set is an avenue for gaining recognition as a value-based treatment.

Art therapy as a component of the DBT skills training curriculum

This section describes how I have integrated art therapy into my teaching of the four DBT skills modules.

Mindfulness skills

The mindfulness module starts with introducing states of mind that we all experience at different times and to varying degrees. *Reasonable mind* involves the cool, logical process of doing math, following directions, and using only facts or an end-goal to guide decision making. Values and feelings are irrelevant. In the extreme, this would be a robotic approach that never allows for flexibility based on interests, enjoyment, or spontaneous opportunities. It could also involve being so engrossed in one's objective that one fails to consider the wants and needs of others. *Emotion mind*, reasonable mind's dialectical opposite, is a state in which thought processes and actions are overly influenced by extreme emotions. It includes a loss of control to the point that intense, dysregulated affects "crowd out reason and effectiveness" (Linehan 2015a, p.168) as well as a reduced appreciation for possible undesirable consequences. Emotion mind results in the impulsive/reactive, mood-dependent, and maladaptive actions typical of BPD (American Psychiatric Association 2013; Linehan 1993). One should stress, however, that feelings are essential; they motivate us to do important, often difficult things. Further, our creativity, passions, and empathy are inextricably linked with strong emotions.

Wise mind is a dynamic integration, a synthesis, of reasonable mind and emotion mind. This state is flexible, intuitive, and allows us to attend to the needs of the current moment. Wise mind is the ideal place from which to make important choices and decisions because it fosters "consider[ation of] both emotional and rational/logical options for responding, as well as novel…solutions" (Clark 2017, p.86).

Participating effectively, or *using skillful means*, is mindfulness of the present moment while doing just what is needed in that moment. Skillful means refers to "any effective method that aids a person in experiencing reality as it is, or, in DBT terms, to enter fully into wise mind" (Linehan 2015a, p.223).

My introduction to one art therapy directive compares the recovery process to a road trip. Mindfulness requires that we slow down so we can remember our goals while we identify available choices. If we always use cruise control we risk blowing past stop signs, running into dangerous intersections, and colliding with other drivers. I further explain that, when we neglect to keep our destination at the forefront of attention, we are much more likely to get lost. Because the roads of life are often winding and indirect, decision making is difficult without a map. Figure 3.1 shows a client's response to imagining her *recovery journey on a road map*. Notice how she identified specific "obstacles" and "positive pit stops." The client shared how she was beginning to visualize her change process (as seen in the review mirror) while also staying aware of and looking out for potential problems. This is the essence of using skillful means.

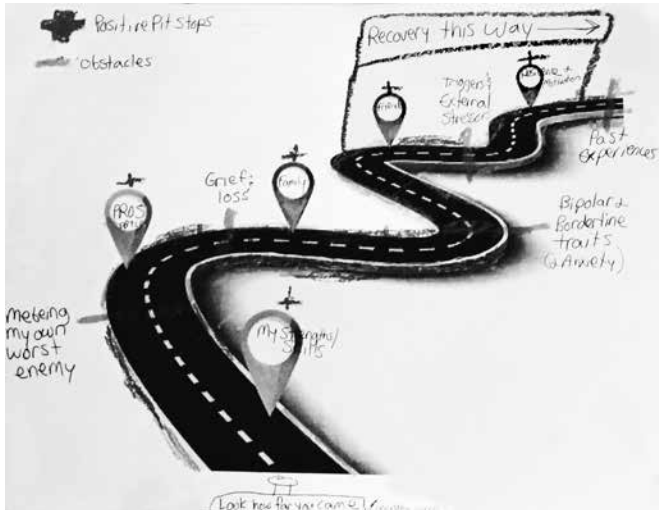

FIGURE 3.1 RECOVERY ROAD MAP WITH "POSITIVE PIT STOPS" AND "OBSTACLES"

Art therapy promotes moving away from intellectualization and toward a more holistic view of one's experiences. Commencing each skills training

session with a mindfulness exercise allows clinicians to customize their directives around that particular lesson (as well as the needs of both the group and its individual members). I always provide a structured activity, for example a simple game such as throwing around a nerf ball or asking each person to name an object they see in the classroom without repeating anything that was previously identified by others. Sometimes I have participants color in a simple preprinted design, for example a mandala, a shield, or—in the case of Figure 3.2—a bird.

The instruction is always to observe and rate one's anxiety level (on a scale of 1–10, 10 being the worst anxiety ever felt) both before and after the mindfulness activity. I encourage clients to practice suspending any judgments and/or resistance with the assurance that it is *just an exercise*: "Be in the moment for the next ten minutes and also try to notice your inner experiences." After the activity ends and they have rated their anxiety levels, group members share observations. Regarding the image in Figure 3.2, the participant stated that he was able to completely focus on coloring. In fact, he found the process so relaxing that his anxiety rating decreased by several points.

FIGURE 3.2 STRUCTURED MINDFULNESS EXERCISE (COLORING)

Clients are usually quite apprehensive at first; in many cases, their anxiety ratings actually go up! However, after a few additional sessions, they tend to relax. At that point participants can describe positive changes (such as feeling calmer or better able to let go of any distress that they had brought with them into the session).

Interpersonal effectiveness skills

These skills involve asking for what one wants, as well as declining undesired requests. The client ranks the relative priority of each: the objective (accomplishing her goal), the relationship (how she would like the other person to feel about her after the interaction), and self-respect (how she wants to feel about herself afterward). As lessons progress through this module, the art therapy directives become less structured and sometimes last for an entire session. These directives are designed to assist participants with conceptualizing how their internal precepts impact social interactions and relationships (and also lay the foundation for role playing activities through which clients practice assertiveness strategies in simulated real-life interactions). Examples of some directives include:

- Create images exploring what it feels like to be *angry and still impulsive* versus *angry but able to use skills*.
- Make a symbolic self-portrait of what one would feel like after being interpersonally effective, even if the other person responds negatively.
- Collaborative group activity: Without drawing any human figures, all group members illustrate one of their important relationships. Participants then pass the papers around and add to each original image. The artists will observe/describe their experience seeing others work on the drawing they started or feel some attachment to.
- Collaborative group activity: Participants plan a supportive community as a mural (once, when I had an art therapy student to help, we actually built a village with clay).

Emotion regulation skills

Although all modules require substantial effort to master (and many report that mindfulness is the most difficult), I consistently observe how clients struggle to grasp, as well as understand how to appropriately use, emotion regulation skills. The idea that they could experience any intense emotions in a controlled, tolerable manner seems too overwhelming—even terrifying—at first. This module commences with a discussion about emotions as a communication system and how each emotion's message helps to organize a valuable behavioral response. It is

important to explain how such messages can be distorted because this validates clients' current functioning. The emotion regulation module includes a model for how emotions work. It is crucial that clients learn how to examine the connections between their thoughts and action urges, as well as ultimately identify the resulting emotion. This skill leads to the identification of methods for changing and/or replacing maladaptive behaviors (i.e., by learning how to conduct a behavioral chain analysis) (Linehan 2015b).

Many of the creative directives I employ involve participants exploring their personal experience of emotions and connecting each, as well as any related thoughts, to a particular trigger/prompting event. Guided imagery exercises that evoke an emotional response can help clients identify their internal sensory experience of that feeling, which they are later asked to illustrate. Sometimes this leads to an ability to catch cognitive distortions in the moment and better appreciate how all-or-nothing thinking perpetuates emotional dysregulation. Figure 3.3 shows one person's experience of learning to manage anger. The directive was: *Pick an emotion that you are beginning to learn to regulate, and then illustrate how that has changed things for you*. This client was constantly wracked with intense anger that resulted in suicidal urges and frequent explosive outbursts. After having learned and practiced emotion regulation skills for a while, she felt less and less overwhelmed. Further, she was no longer as self-destructive and could express frustration without exploding. At the time of this image, the client was not yet satisfied with her progress; however, she acknowledged that stomping her feet or yelling was preferable to trying to kill herself or raging and scaring everyone away.

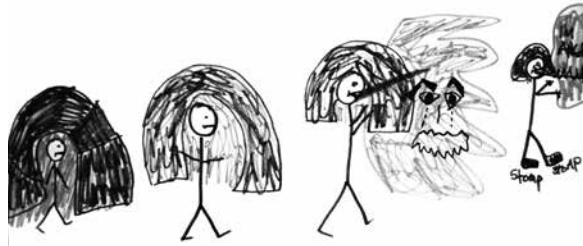

FIGURE 3.3 USING SKILLS TO MANAGE ANGER MORE EFFECTIVELY

Distress tolerance skills

This final skills module focuses on learning to endure painful events and emotions without making things worse by reacting with

impulsive, destructive actions. Its crisis survival strategies include various distraction and self-soothing behaviors. Later lessons involve the importance of reality acceptance and willingness in successfully navigating distressing situations.

We do a variety of fun activities for this module, including playing Jenga, sharing music with one another, and decorating distress tolerance kit toolboxes. This is also where the more long-term projects take place. DBT skills training sessions have significant time constraints, but we talk about what can be done and how to get involved. I encourage clients to take other groups that support skills practice. Some of the group choices include a (separate) art therapy group, DBT-informed movement therapy, understanding anxiety and depression, exercise, sports, nutrition, and building self-esteem. There are various mindfulness-based activity groups, as well (e.g., gardening, arts and crafts, journaling, musical jam session).

At this phase therapists review their clients' treatment goals with them, and staff members reinforce the value of using the program to practice positive experiences. Related art therapy directives include: *Imagine what it will be like to achieve one's long-term goals* and *Visualize building/rebuilding one's motivating hopes and dreams*. This is also a time for normalizing clients' emotions and encouraging them to believe they can take control of their choices, behaviors, and lives. In addition, sharing relevant quotes, poems, and song lyrics reminds everyone that life struggles are universal and bad things do happen to good people. At the end of the four modules clients use art to depict how far they have traveled on their recovery paths.

DBT-informed art therapy

Why art?

DBT encourages wellness, self-management, exploration of one's own values, and a "big picture" view of life (while simultaneously paying attention to the details—yet another dialectic). *Generalization* of DBT skills, that is, the ability to use them independently outside of the classroom, is a key to recovery. Clients often ask me, "What do I do when _____?" I am a sports fan, and so I utilize the analogy of preparing for a sporting event to illustrate this: Although we cannot foresee the best/perfect action to take in any given situation, as the game develops we need to feel prepared to handle unpredictable events

with confidence, flexibility, and spontaneity. Like athletes, clients must practice every day to be ready for whatever challenges they encounter.

The art therapy studio provides bountiful opportunities to use DBT skills in the moment. Involvement with lengthier projects allows clients to plan, make aesthetic choices, and alter or revise their artwork—all of which require skillful behavior (Huckvale and Learmonth 2009). Many individuals with BPD do not possess an ability to soothe themselves and are therefore vulnerable to self-mutilation and other impulsive acts (Linehan 1993). Art making can aid in self-regulation, particularly through repetitive motions, exposure to pleasing colors, and mindful attention. Art therapy might also help clients to develop an internal sense of self-soothing that can be translated to situations outside of therapy (Huckvale and Learmonth 2009; Lamont, Brunero, and Sutton 2009; van Lith 2008).

I frequently emphasize preparation through practicing—that is, "repetition, repetition, repetition." Recovery is not linear; rather, it is a process of experimentation followed by numerous failures as well as successes. I argue that this journey is more akin to rock climbing than an escalator ride: sometimes the best way to move up involves first finding a firm hold that is perhaps slightly lower and to the side. DBT-informed art therapy allows for an alternative perspective that personalizes recovery while accepting the dialectical phenomena of acceptance/change, trial/error, and so on.

Although the DBT skills training modules include homework assignments, my experience has been that only already highly engaged clients—and/or those more advanced in the curriculum—are willing to practice outside of treatment. Including creative activities as part of lessons provides another means for skills generalization because they promote engaged participation in a nonthreatening arena, with extra opportunities to learn self-monitoring techniques, practice consequential thinking, etc.

Creative engagement

The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies ten principles as essential components of mental health recovery: self-direction, individualized and person centered, empowerment, holistic, nonlinear, strengths-based, peer support, respect, responsibility, and hope (SAMHSA 2012). For many individuals

entering a recovery-oriented setting, these concepts are foreign. Clients with serious mental illness (SMI) often have long histories within medical model-based behavioral health systems (where treatment was done *to* them rather than *in collaboration with* them). Hence, they may have grown dependent on providers to make decisions because they were considered noncompliant if they failed to follow recommendations or respond in a positive manner. Some clients might even present as disheartened, passive, or rebellious, making it difficult to enter a new treatment setting with expectations of anything being different.

The first task in engaging clients may be to disrupt their assumptions concerning mental health care and educate them about the recovery process, thus reigniting their imagination and ability to consider new dreams and goals. Marsha Linehan (1993) refers to the therapist's role in this disruption as *irreverence*. DBT-informed art therapy puts the client in an active and empowered position that promotes more effective learning than does just listening to yet another person tell her what to do:

> Over the years I have always thought the important contribution I brought…was being creative, spontaneous, thought-provoking, and consistent. I have been practicing being the "irreverent therapist," openly telling clients [when] it is time to turn over the apple cart. Surprising clients, creating the experience that moves them out of their comfort zone, has been challenging and invigorating. Marsha Linehan encourages therapists to use metaphors and stories to help clients grasp the concepts of the skills. This has required creativity and risk-taking but has become a rewarding aspect of the treatment because clients respond and more easily connect to the skills. My expressive therapy groups utilize many varied modalities to stimulate clients' ability to communicate more effectively and imaging a different way to respond to their illness, trauma, and painful emotional experiences. Mindfulness has become the core of the groups, requiring clients to practice being "conscious" in their own lives. (DeSouza, in Clark 2017, p.136)

Since clients with severe emotion dysregulation often exhibit extreme thoughts and behaviors, using creative expression to bring these out into the open can be surprising enough to get them to pay attention. Emphasizing the drama in life can make them laugh and ease self-judgment. Art therapy is particularly effective in satisfying clients' need for attention by providing a safe space to look at their inner beliefs and myths as well as to create bigger-than-life projects. Art therapy affords

the ability to explore at one's own pace. It allows for self-discovery, and bypasses resistance or the embarrassment of being told by others that change is needed. In addition, the group provides opportunities to normalize participants' thoughts and fears by connecting with peers who have had similar experiences.

It may feel like a dangerous leap of faith to attempt something new, to be vulnerable and open to the unknown in the hope that it will result in positive change. Integrating creativity into skills training gives clients the space to explore what it could be like to take a more self-directed approach to their recovery. Because hope is a difficult concept for many seriously mentally ill individuals, this can be the most challenging and labor-intensive phase. Any small disappointment or perceived threat might cause a client to regress to old habits. The experience of learning skills and exploring the relationship between thinking, physical sensations, emotions, and behaviors is new and can be confusing. Art interventions facilitate this process by helping clients to visualize how skills could practically apply to their own lives.

In dialectical thinking and mindfulness, there is a conscious intent to build awareness of one's behavioral choices. Systems (whether families, work organizations, or social circles) are resistant to change. A balancing of acceptance and change is important not only during therapeutic interactions, but outside of the clinical environment where life may still feel invalidating. Clients also come to appreciate that each movement can have ripple effects that are not always positive.

Within the individual therapy sessions DBT clinicians employ validation strategies as their clients struggle to learn self-acceptance and skillfulness. However, specifically to group art therapy, validation becomes broader as cohesion develops and clients' witnessing of each other's artwork promotes the capacity to challenge invalidating experiences among themselves. For example, a client can practice self-validation by processing with the group when feedback is difficult to hear. She may come to realize that she has the power to decide how much to share at any given time, which in itself cultivates a sense of self-efficacy and mastery.

Art therapy experientials can help participants appreciate that seeing the world from different angles results in multiple viewpoints—and none of these perspectives are incorrect or invalidating of the others. Such realizations may open discussions about the pros and cons of their rigid, nondialectical thinking, as well as how to challenge these patterns if desired.

Conclusion

This chapter introduced readers to EBPs such as DBT and described their significant role in today's managed care mental health treatment environment. Although art therapy is not at present an EBP, I have found over the course of many years that its thoughtful integration with DBT skills training frequently results in more active client participation. Within my treatment setting, better engagement is demonstrated by higher attendance and retention rates; further, clients report satisfaction with their progress in both verbal remarks to staff and standardized surveys.

Additionally, other clinicians convey recognition of the effectiveness of the integrated approach through their increased referrals to skills training as well as via requests for consultation and/or supervision with DBT-informed art therapists. While it is clearly essential that we pursue solid research evidence for the efficacy of art therapy in supporting—and, perhaps, even enhancing—DBT's skills training protocol, I suggest that, in the meantime, a thoughtful combination of the two interventions is an avenue for art therapy's recognition as a value-based treatment.

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Chapter 4

My Journey as an Art Therapist Focusing on DBT and Art Making

MEGAN SHIELL

Introduction

This chapter explores the notion that certain art therapy interventions, when combined with the skills training component of dialectical behavior therapy (DBT), can assist clients who experience emotional regulation problems. I, the author, describe how I was first exposed to DBT while studying to become an art psychotherapist. During a student internship placement, I developed an introductory DBT-informed program that included specialized art making activities. My curiosity was awoken as I witnessed how many individuals with borderline personality disorder (BPD) became more engaged with the skills training process; further, they appeared to better understand/retain DBT concepts and techniques after participating in the creative exercises.

As I continued my career in the northeast corner of New South Wales, Australia, I became aware of the dearth of local empirically founded treatment services for BPD (and for mental health consumers, in general). I resolved to become a DBT trainer and educate as many therapists as possible about this model. The frustration I felt as a helping professional with scarce treatment resources and inconsistent care led to my development of the online *ME* (*Managing Emotions*) self-study DBT program. *ME*, which includes several art projects, is a popular aspect of the services I offer and consists of two versions: one designed for clinicians' continuing education, the other for clients' skills training needs.

The chapter describes how I discovered my interest in DBT-informed art therapy and ultimately developed the virtual *ME* program. I explain how I incorporate therapeutic art interventions into both individual

DBT sessions and skills training. Further, I present two brief case examples to provide readers with an understanding of how creative expression through visual art activities may assist clients with their learning, retention, and implementation of DBT skills. The chapter concludes with suggestions for further inquiry.

Background

My journey began with a visit to Perth, Western Australia, in 2003. Over a weekend with a wise friend, I explored career options as a person approaching 50 years of age. We discussed the fact that I had long gained satisfaction from engaging in my own creative processes. I also very much enjoyed listening to other people's stories. This conversation ultimately led me to the local library, where I strolled through aisles of art books, then sat at a computer station and did a combined internet search using the key words *art* and *therapy*. Among the results was information about the University of Western Sydney's graduate art therapy program. This was an exciting discovery. As I investigated the prerequisites for matriculation, however, self-doubt crept in.

How realistic was this dream? I had only completed year ten in secondary school, and most of my employment experience was in the corporate world! However, I had, over the course of more than 30 years, consistently made art. The resulting creative pieces represented various aspects of my life: working, having a family, and all the related emotional and psychological experiences. Hence, I already had a portfolio of around 30 pieces (an admission requirement of the art therapy program). Additionally, while rearing my children I had held down several volunteer positions; each involved facilitating workshops in which I taught individuals of all ages how to make art for their personal self-expression. And, so, I decided to submit an enrollment application.

After completing the interview process, I was accepted to pursue the University of Western Sydney's graduate diploma in expressive therapies. I eventually obtained admission into its masters of art therapy degree program, which included two student internship placements. The first was in a residential service for differently abled individuals. During this experience I learned to deeply appreciate the value of art therapy, particularly in my work with one client who contended with a serious brain injury. The second internship site was a private psychiatric hospital in Sydney. This facility contained an outpatient *comprehensive*

DBT program (i.e., adherent to the evidence-based model of DBT designed and researched by Marsha Linehan, PhD). I was involved in all facets of the program.

The efficacy of DBT for BPD and other disorders of emotion regulation

The most effective treatments for BPD are highly structured (Paris 2008), and DBT has proven to be the gold standard. Sneed *et al.* (2012) write that,

> [b]ecause DBT has been shown to be efficacious by three independent groups […] it is the only treatment meeting criteria for a well-established treatment for BPD… DBT has the most consistent support in reducing suicidality and parasuicidality compared to other leading BPD treatments. (p.9)

Numerous randomized controlled trials (RCTs) have established that DBT, compared with treatment-as-usual, is more effective not only for BPD but also for some eating disorders (Courbasson, Nishikawa, and Dixon 2012; Safer and Jo 2010), substance abuse (Dimeff and Linehan 2008), depression (Harley *et al.* 2008), bipolar disorder (Van Dijk, Jeffrey, and Katz 2013), attention deficit hyperactivity disorder (Hirvikoski *et al.* 2011), and posttraumatic stress disorder (Bohus *et al.* 2013). Any of the conditions mentioned above share diagnostic criteria with BPD, such as impulsivity, suicidal behavior, and interpersonal difficulties. Perhaps this explains how DBT's efficacy spans such a wide range of conditions (May, Richardi, and Barth 2016).

DBT treatment structure

Comprehensive DBT includes four treatment arms (Linehan 1993, 2015a): individual therapy sessions, DBT skills training (usually delivered in a group format), *in vivo* phone coaching, and peer consultation team meetings for providers. The DBT skills training curriculum consists of four modules (Linehan 2015a, 2015b).

Mindfulness

This core skill set of DBT involves an intentional, nonjudgmental awareness of the present moment, which includes observing one's own reactions to events and situations.

Distress tolerance

These skills assist clients in surviving emotional crises without making them even worse by engaging in impulsive, mood-driven acts. Distress tolerance skills are designed to effectively manage urges to use maladaptive behaviors.

Emotion regulation

These skills enable clients to better understand and modulate their emotional responses. They also assist in teaching how to improve resilience to stressors.

Interpersonal effectiveness

These skills help clients increase the likelihood that their own wants and needs will be met by making assertive requests. They also instruct how to say "no" when necessary.

Art therapy and DBT

During my internship in the private psychiatric hospital I noticed how many clients engaged in creative expression and shared their work with their peers and individual therapists. The DBT program coordinator asked me to develop some art therapy interventions to incorporate into the skills groups. Clients had commented that, at times, it was difficult for them to concentrate on the standard didactic skills training curriculum. Some felt that another form of instruction might help maintain their attention and interest.

In response, I designed several structured art making exercises. The outpatient clients were enthusiastic about the addition of creativity to their DBT skills training groups. I noticed that when they shared at the end of a session, they were better able to communicate how their artwork reminded them of the skill they had just learned. It was paramount to ensure that clients felt emotionally contained and comfortable during this verbal processing time. The theme-focused art therapy approach achieved and maintained a sense of safety. Huckvale and Learmonth (2009) write that "working with chaos, deep distress, acute disturbance and imminent life-threatening danger to the person demands containing structures" (p.62). Further, the art therapist, working

> in conjunction with the place itself, can offer a unique setting […] where battles may be fought in a contained therapeutic space. Boundaries of time, and the use of materials, can offer a structured space to a client with BPD wherein the Art Psychotherapist can make observations of behaviour and anxiety levels in a non-judgmental environment. (Shiell 2008, p.59)

After years of academic study and the many challenges that came with it, I was finally an art therapist. Following graduation from the University of Western Sydney in 2006, the journey continued through my work in private practice as well as for numerous hospitals. I became increasingly intrigued by the combination of concrete DBT skills and artistic expression, and I wanted to continue to pursue its possibilities. DBT-informed art therapy seemed to build a sense of connection, a verbal and nonverbal bridge of sorts, toward what the skills could potentially mean for clients. By creating original artwork in response to the formal psychoeducation-based lessons, they could more fully articulate DBT concepts in ways that made personal sense to them.

In 2007 I was hired by The Sydney Clinic (in Bronte, New South Wales) to co-facilitate its DBT programs; by 2008, I had become coordinator of DBT there. Every member of the treatment team, including myself, had completed intensive training with Dr. Linehan's company, Behavioral Tech. We developed, as closely as possible, a comprehensive four-armed model. The demand for adherent DBT was high, and waiting lists were long; this necessitated the creation of two identical 12-month DBT programs that both met two days each week (for five hours per day).

The Sydney Clinic also offered two eight-week introductory DBT programs conducted for three hours on two separate days. The shorter curriculum assisted staff in assessing whether clients were suitable for groups or ready to commit to the 12-month program. Wishing to build upon the work I had started during my graduate internship, I asked management if we could incorporate art making.

It became a requirement that all participants complete the eight-week DBT course prior to entering the 12-month program. Outcome data revealed that 76 percent of those clients who had finished the introductory course completed the longer program, as well. However, the 12-month DBT program did not include any art making groups (and many clients had expressed the wish that it had).

Individual DBT sessions including art making in private practice

During the time that I worked at The Sydney Clinic I also offered DBT within my private psychotherapy practice. The individual therapy sessions were highly structured via the evidence-based DBT protocol, including diary cards (DCs) and behavior chain analysis (BCA) (Linehan 1993). Clients use DCs to record any problematic behaviors that occurred during the previous week, as well as the intensity of their behavioral urges and various emotional states. DBT's hierarchy prioritizes target one/life-threatening behaviors (e.g., serious suicidal ideation and/or attempts, self-injurious behaviors), followed by target two/therapy-interfering behaviors (e.g., missing individual therapy and/or skills group, failure to complete DCs), and, finally, target three/quality of life-interfering behaviors (e.g., co-occurring mental health and/or substance abuse conditions, financial issues, serious relationship problems). If the individual engages in a behavior that was identified during the initial assessment, the next step is to conduct a BCA, which explores the sequence of events, thoughts, emotions, and actions leading up to said behavior.

After completing a BCA, I teach the client a DBT skill that might help her to avoid a similar behavior in the future. I then allow approximately 20 minutes for the client to create an object or image that directly relates to the skill. She shares the resulting image; then we engage in a grounding exercise and verbally commit to continue working together. I believe that this structured format creates a safe, contained therapeutic environment within which many clients are better able to process highly emotional material. Further, the method of discussing art images metaphorically—a less threatening approach for some—seems to increase clients' willingness to share their distress more openly. Huckvale and Learmonth (2009) posit that making art allows clients to experience a variety of behaviors, and therefore feelings and emotions, within a very particular container. They also discuss that the right kind of therapeutic relationship is crucial and allows clients to take appropriate risks: "Acceptance was embraced in the session structure and the relationship. The possibility of change was explored through the art materials. A dialectic between them was opened up for reflection" (p.56).

> It will be in the moving between being contained and being uncontained in the therapeutic relationship that the client's confidence will grow.

> This replicates the philosophy of DBT, the constant moving between acceptance and change through all the modules of skills training. (Shiell 2008, p.62)

Although the pieces that clients made during their individual therapy sessions directly related to a DBT skill, they could bring to the artwork whatever they wished. Art was a way to enlarge their emotional and psychological sense of self. As I witnessed my clients' creative processes, I became very aware of the struggles and difficulties individuals with BPD face every day.

MIRANDA

Miranda was a 42-year-old single Australian woman who had been diagnosed with BPD. She struggled with extreme, chronic emotional instability (the result of a series of sexual abuse incidents during early childhood to age 12). At the time of her initial interview for admission into an outpatient DBT program, Miranda could maintain neither steady employment nor trusting interpersonal relationships. And, owing to significant social anxiety, she was not considered group-ready. However, given my extensive training and experience as a DBT clinician and skills trainer, I could offer her alternative options for participating. Miranda chose to work with me in individual therapy. She was extremely dedicated to the recovery process, and diligent with completing DCs and homework assignments. She would even write up her own BCAs and bring them to our sessions.

Miranda greatly enjoyed making art while learning the DBT skills. She once commented that having an image to reflect on afterward assisted her with retaining the information. She mentioned how she referred to some of her earlier pieces during times of overwhelming stress and explained that the process allowed her to reconnect with DBT skills she had explored through those previous artworks.

During one of our sessions Miranda shared confusion about whether she should continue to attend Bible study meetings. Miranda's abuse history included sexual molestation by her father. As a result, she possessed a great deal of anger toward her religion because it had not protected her from harm.

In response to Miranda's confusion issue (which was accompanied by significant emotional dysregulation), I taught her the distress tolerance/

crisis survival strategy "*pushing away*" (Linehan 2015b, p.333). This skill is applicable when the individual cannot immediately solve a problem situation and wishes to reduce their current level of emotional intensity. It involves mentally placing the issue "in a box…on a shelf" (Linehan 2015a, p.441) to address at a later, more appropriate time, and therefore temporarily distancing themselves from worries and negative ruminations.

The collage below (Figure 4.1) expresses Miranda's feelings about attending Bible study during that time in her life: "I feel like a battered bulldog and I am not going to get pulled into the fishing pond. I say 'Stop!' with my hands up, in front of the church; I say 'No, I will not go to Bible study anymore.'"

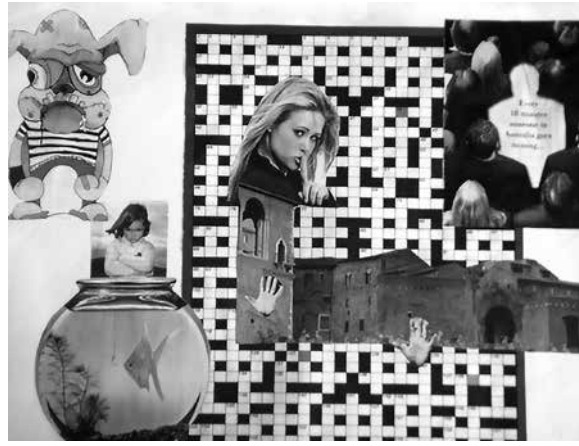

FIGURE 4.1 COLLAGE EXPRESSING THE DBT "PUSHING AWAY" SKILL

Miranda said that the empty crossword puzzle conveyed how she "just does not get the meaning of the words that people speak sometimes." A featureless human figure in the top right-hand corner symbolized her desire "to stay invisible in the crowd." Miranda explained that the collage reflected how, if she made decisions based on the problems and issues she could actually solve/change, she would not return to Bible study. She might then become capable of accepting and moving past the anger she felt, and continued to feel, concerning her childhood trauma. Miranda reported that the process of making this collage helped her to recognize that she could use *pushing away* without growing more dysregulated until she could solve her problem.

Figure 4.2 is a painted mask created by Miranda around four years later in therapy. As I was preparing to move interstate, our work together had

to come to an end. Over the course of the treatment I witnessed Miranda's sense of identity and confidence gradually develop. By the end of DBT she reported that she had greater self-awareness and could see when issues were brewing. She also made more effective choices concerning work, her relationships, and communicating wants and needs to others. Miranda believed that the combined art psychotherapy and DBT approach allowed her to gain better insight into her behaviors, as well as develop the inner strength and courage necessary for overcoming BPD.

FIGURE 4.2 MIRANDA'S PAINTED MASK: WHAT IT'S LIKE TO BE ME

> The left side of my face is painted blue, as some days I see a blue sky with clouds passing by. But even though I can sometimes feel calm (green representing calm on the lower left side of my face), I often have emotions (yellow tears) that I cannot control. The right side of my face represents the deep fears and confusion I experience. It is often terror one minute (the red and black lines crossing my eye), then a feeling of emptiness in the next (blank blue on the lower right side of my face).

These experiences with Miranda had piqued my interest around how art therapy might be applied to DBT skills training. The combined interventions seemed to help her to better understand, retain, and apply the skills to her life outside of therapy.

> Art psychotherapy can offer another dimension to the skills-based DBT program since the making of objects and images can substantially support the understanding of the strategies and techniques offered by DBT in supporting clients… It enables clients to find their observer-self

> and repair the chronic feelings of emptiness that they often felt in their lives. (Shiell 2008, p.51)

The concept of an *observer-self* mirrors the first of DBT's mindfulness "what" skills, *observe* (Linehan 2015b, p.53). Rathus and Miller (2014) describe *observe* as "[w]atch[ing] wordlessly. Just notic[ing] your experience in the present moment" (p.106). Rappaport (2014) states that to *observe* is to cultivate an "awareness of one's moment-by-moment internal and external experience" (p.242). Further, she suggests that movement and visual art activities may allow clients to experience the *observe* skill more readily.

Sea change

In 2011 my family and I moved from Sydney to the northern coast of New South Wales. Here I have continued to pursue my passion of working with DBT and art psychotherapy in private practice. However, I was shocked to learn that, in this new location, many mental health care professionals had never heard of DBT. Others provided the treatment without appropriate training. I took it upon myself to develop a two-day DBT-informed workshop for clinicians. My goal was to offer the course throughout Australia to educate providers about DBT and explain how its comprehensive model is conducted.

On the first day I introduce the theory and components of DBT as well as the delivery of both individual therapy and skills training. The second day involves a more extensive lesson on how DBT skills training sessions should be structured/delivered, and I teach as many of the skills as possible. I also describe the value of combining art making with DBT skills instruction and provide participants with an opportunity to create an image of their own to experience that process.

As of March 2021 I have trained over 2500 clinicians in Australia. This number includes the online programs I developed due to the Covid-19 pandemic. Many of my workshop attendees have described a general lack of knowledge of DBT among their colleagues. They shared that, if DBT was offered in their places of employment (and/or within the larger service areas), it was usually only skills training. Living in a regional area of Australia myself, I became frustrated by the fact that many individuals who suffer with severe emotional dysregulation are unable to access DBT and other effective treatments.

Australia's public sector only occasionally offers DBT (and not always the research-validated version). Existing programs, typically in major cities, have extremely long waiting lists. Approximately one quarter of emergency mental health presentations and inpatient psychiatric admissions are for individuals with personality disorders and associated problems including self-harm and substance dependence (Grenyer 2014). A few comprehensive DBT programs operate within nongovernment organizations and private health care providers; however, these are difficult to access. In the private sector, free-standing DBT skills training groups are typically the only available option.

Developing the *ME* online skills program with an art component

In 2017, in response to my professional concern with the lack of DBT knowledge and training for DBT in Australia's health sector, I created a ten-session virtual self-study DBT-informed skills training curriculum for local and global health care professionals. The *ME* program includes a summary of DBT's theory and techniques. It also contains guidelines for structuring individual DBT sessions.

I created a similar ten-session *ME* self-study program specifically tailored for clients that can serve as an introduction to DBT or as a refresher for those who have completed a comprehensive program. The curriculum consists of ten skills training videos, each around 20–30 minutes in length. Session nine shows how to complete a DC as well as how to conduct a BCA. I produced a 59-page manual to accompany each of the *ME* sessions. It is recommended that individuals view one video per week, which allows for ample skills practice time in between sessions. This mirrors standard DBT skills training groups, which typically introduce one skill per week. Art making is optional. One of the *ME* program's strengths is that users maintain permanent access to the online curriculum after completion. Hence, they can go back and refresh their DBT skills knowledge at any time.

I suggest that if clinicians are going to work through the self-study online program with clients face to face, and the client wishes to create an image, they ask two questions:

- What did it feel like to create this image?

- How does the image relate to the skill you have just been taught?

It is essential to explain that, while there is certainly a strong therapeutic element involved in talking with clients about their art images, the process I describe is not art psychotherapy as practiced by trained, experienced art therapists. My goal is to make it possible for all mental health clinicians to use creativity as part of their DBT-informed work. However, there is no profound exploration into visual symbolism and emotional content. This is described with somewhat greater detail later in the chapter.

DBT-informed art therapy interventions in action: Exploring the *wise mind*

The first session of the *ME* program explains DBT's *wise mind*, an "inherent wisdom that each person has within" (Linehan 2015a, p.166), "the part of each person that can know and experience truth. It is where a person knows something to be true or valid. It is where the person knows something in a centered way" (Linehan 2015a, p.170).

> …When teaching about the Wise Mind (Linehan 1993b) we found that many clients understood the concept but did not have access to the state. We hypothesized that the experiential and imaginal realms needed to be involved in order for clients to access such resources. (von Daler and Schwanbeck 2014, p.238)

Direct the client with a positive instruction; for example, "What could wise mind look like for you? Would it be a place where you may feel calm or a color you associate with a sense of being grounded?" It is important that the instruction to create an image or object directly relates to the skill being taught that day.

The suggestion for the artwork is to create an image using crayons, colored markers, or colored pencils that could represent wise mind. I purposely choose the materials for each art exercise to provide an opportunity for the client to simply create without feeling pressure to decide on a specific medium. I want them to feel especially comfortable in the art making by allowing them to freely experiment with self-expression using the given materials. We do not necessarily even process the resulting image(s).

BARBARA'S WISE MIND

Barbara was a 35-year-old Australian woman diagnosed with BPD. Figure 4.3 shows her representation of her wise mind.

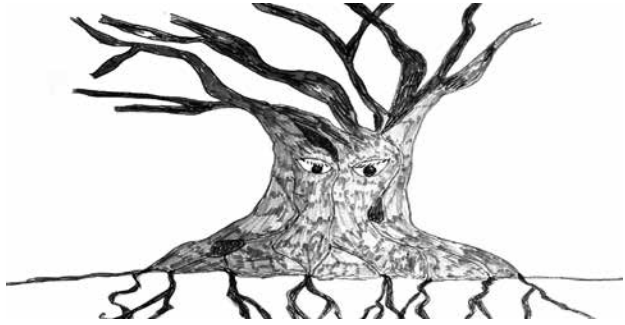

FIGURE 4.3 MY WISE MIND IMAGE, BY BARBARA

I always ask the following two core questions after the art piece is completed (Barbara's responses are in italics):

1. What did it feel like to make that image?

   At the beginning I was stumped and scared of the white page. I had to really think hard.

2. How does this image represent wise mind for you?

   Well I always look at old huge trees in the rainforest. They have been there for so long that they are huge, wide, and must have a big root system. I put the eyes on the tree to show that a wise tree is always looking around, taking information in. There are many roots to the tree so that it is solid underground and will not fall over. That is how I want to be—solid, aware, and wise.

It is interesting to note that over many years I have seen numerous similar images (trees) and descriptions in response to this prompt.

Art in the *ME* program

For eight of the video sessions I suggest an art exercise that can mirror the skill that has been taught in any particular week. Table 4.1 describes the artwork themes and materials:

Table 4.1 *ME* program DBT skills/art activities

DBT skill topic	Related art activity	Materials provided
"What is Wise Mind?" (Video session 1)	*What could wise mind look like for you?*	Drawing paper and colored pencils (a simple, nonthreatening medium)
"Mindfulness" (Video session 2)	*What does it feel like when you are in the present moment?*	Watercolor paper/ watercolors (because a mindful state often feels uncontrolled and flowing)
"The Distress Tolerance *Wise Mind ACCEPTS* and *Self-Soothing* Skills" (Video session 3)	*Try to identify what kind of distress tolerance strategies may help you*	Collage images/ magazines, paper, pens, scissors, and glue (to create a concrete visual list of distraction and self-soothe ideas)
"The Distress Tolerance *IMPROVE the Moment/Self-Encouragement ('Cheerleading')* Skill" (Video session 4)	*Create an object or image representing your inner cheerleader to encourage yourself during difficult moments*	Found objects and glue, for building/constructing a tangible representation of your own cheerleader
"Radical Acceptance *Willingness-vs-Willfulness/'Willing Hands'* Skill" (Video session 5)	*Create representations of a* willing *hand and a* willful *hand*	Drawing paper and colored pens. Trace around both one's closed and open hand, then write/draw on the hands to describe how willing and/or willful you are (this can reveal the client's inner values)
"How Can You Become Emotionally Strong?" (Video session 7)	*Create a collage to describe all the tools you can use to become/stay emotionally well. Sleep, exercise, diet, staying away from "drama," and so on*	Collage images/ magazines, paper, pens, scissors, glue, and crayons

Cont.

DBT skill topic	Related art activity	Materials provided
"Communication Skills" (Video session 8)	*"How do you look?" (when you are communicating effectively)* Decorate a mask to convey a facial expression that communicates a certain emotion	Papier-mâché masks and oil pastels
Walking the middle path. Review all skills and develop a list of the best skill for you to use (Video session 10)	*Build a skills box*	Glue, scissors, cardboard boxes, objects, pens. Provide clients with a list of DBT skills learned in program

A caveat

The sole function of art making in the *ME* program is to reinforce the learning and retention of DBT skills. An art object provides the client with a succinct nonverbal reminder of the value of the related skill, as well as its general application. This is not art psychotherapy, which is a specialized discipline. Individuals in treatment will often try to express their deep feelings in response to any suggestions from a clinician. Only credentialed art therapists can appropriately witness and safely contain the dysregulation that can occur if the creative process provokes a strong emotional reaction.

Conclusion

My professional journey—from brainstorming with a friend about later-in-life career possibilities, to becoming a credentialed art psychotherapist and DBT specialist—has been an extremely fulfilling endeavor. Who would have guessed that a student internship in a DBT treatment milieu would ultimately inspire me to develop two online self-study programs, one to inform clinicians on how to use DBT, and the other tailored to provide clients with DBT skills (both with an optional art making component)?

The joining of a manualized verbal therapy and an experiential, creative approach provides clients with opportunities to experience DBT in a novel manner. Making artwork not only summarizes the didactic material, it also facilitates a unique, personal connection. The clients can quickly refer to their image(s) regarding how to proceed with managing difficult emotion(s). In addition, they receive opportunities to identify what skills they find most helpful by discussing and exploring the metaphors present in their artwork.

The journey started with an internet search and evolved into an online course to help clients reach their potential in coping with emotion dysregulation. I remain driven to make DBT more accessible to anyone who wishes to attain or improve mental wellness. A lack of adequate training for clinicians fueled my resolve to offer education to professionals both face to face and within a virtual domain. Among my future goals is to explore methodologies for evaluating the efficacy of the art making components in both versions of the *ME* online DBT-informed skills course.

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Chapter 5

Inspiring and Sustaining Hope

Treating Suicidal Behavior with DBT-Informed Art Therapy

JANE DESOUZA

> *Crisis hotlines can save lives; so can psychiatric treatment. But suicide is such an unpredictable, often impulsive act that no single intervention has proved sufficient.*
>
> Benedict Carey (journalist, *The New York Times*), 2018

Introduction

Dialectical behavior therapy (DBT)-informed art therapy may assist suicidal individuals in developing the capabilities and motivation necessary to build what DBT's inventor, Marsha Linehan, calls *a life worth living* (2015a, 2020). This chapter describes some common problematic thought patterns experienced by people struggling with suicidal ideation and explores how such beliefs can be effectively challenged and replaced. In addition, it highlights the importance of cultivating a *dialectical stance*, "which holds that reality is dynamic and ever-changing—a complex system of countless interrelated yet polarized elements" (Clark 2017, p.32). Through two case studies illustrating art therapy within an intensive DBT day treatment program, I, the author, demonstrate how a dialectics-based creative approach might help to reduce our most vulnerable clients' severe emotion dysregulation and support them in creating an enduring sense of hope.

The problem of suicide

Suicide is a controversial and often taboo area of human behavior. It is also a significant public health concern. According to the most recent reports from the National Institute of Mental Health (NIMH) (2017) and the Center for Disease Control (CDC) (2018), suicide was the tenth leading cause of death in the United States, and there were more than twice as many suicides as homicides. The first center for suicide prevention was established in California during the 1950s (UDHHS 2012); in the years that followed, substantial literature was published with recommendations for reducing suicide rates. Yet, despite such efforts, its prevalence continues to rise. The latest statistics report that since 2001 the total suicide rate increased by 31 percent, and 47,000 Americans died in 2017 by suicide (CDC 2018; NIMH 2017).

The NIMH and CDC data also indicate that suicide is the second most frequent cause of death in individuals aged 10–34 years old. The highest rates are for men over 65 years old. Although women attempt suicide twice as often as men, men succeed in killing themselves twice as often as women (NIMH 2017). Other high-risk groups include American Indian and Alaskan Native youth and middle-aged individuals (followed closely by non-Hispanic white middle-aged and older adult males), those in the justice and child welfare systems, those who identify as LGBTQIA+, members of the armed forces, military veterans, individuals struggling with mental illness and/or substance use disorders, and people with certain medical conditions. Risk factors include a family history of suicide, maltreatment during childhood or other interpersonal trauma, previous suicide attempts, bereavement due to another person's suicide, intentional nonsuicidal self-injury (NSSI), substance abuse, frequent impulsive behaviors, irrational thinking, insufficient social support, the presence of an organized suicide plan, access to lethal means (especially firearms), and diminished optimism for the future (CDC 2018).

> If you think about the cost society pays due to undiagnosed mental-health conditions, due to emotional crises and stressors leading to loss of function and ultimately to suicide and how many lives are directly affected by suicide…when you think about all that, this is a public health crisis. (Healthcare News 2018, p.2)

Understanding suicidal thinking and assessing for risk

It is not enough just to provide clients with empathy and support; we must identify their underlying thought patterns to assist with changing their approach to solving painful life realities. An individual considering suicide typically suffers from a pervasive sense of being trapped and despairing. Further, they may not possess the necessary skills to effectively contend with difficult situations. Rudd, Joiner, and Rajab (2001, p.29) identify three common suicidogenic beliefs:

- unlovability (I don't deserve to live)
- helplessness (I can't solve my problems)
- poor distress tolerance (I can't stand the pain anymore).

Over the years while treating suicidal individuals, I have repeatedly observed an assumption that there is no other option. Killing oneself becomes *the* solution when distress increases to a certain level. A crucial clinical skill is assessing for immediate suicide risk. One must ascertain the level of danger to self, which includes distinguishing between true suicidal intent and destructive and/or self-mutilating behaviors (i.e., NSSI). Risk factors themselves are not determinants of imminent suicide; however, the number of risk factors, combinations of risk factors, and the current status of each must be considered when determining potential lethality. Therefore, assessment is three-pronged: evaluating the client's risk factors, their current attitude toward suicide (intent/plan), and professional judgment based on one's knowledge and experience with the client (Shea 2002).

Clinicians should differentiate between true suicidality and parasuicidal ideation. The latter involves apparent suicidal behaviors or attempts *without* the goal of death (and may include NSSI). When a person is going down the dark tunnel of suicidal thinking, they can easily become stuck and see no benefit to resisting their urges, even when they don't really want to die. Indicators of possible parasuicidal ideation include comments such as *I'll show them*; *They'll be sorry*; *Nobody cares*; *It's their fault*; *Nobody ever listens to me*. However, clinicians must keep in mind that impulsivity, impaired judgment, and intense emotional dysregulation increases the danger of the person going too far with suicidal gestures, perhaps resulting in unintentional death. Authentic suicidal ideation may be accompanied by thoughts or

comments including *This is the best way*; *I just want to get away from the pain*; *I don't have any choice*; *There is no reason to go on*.

When clients are guarded and/or have difficulty communicating, simple art therapy prompts can offer opportunities to assess intent. One does this by discussing the resulting imagery. Asking clients to illustrate how they are feeling right in that moment, or to draw the present distressing situation, may elicit important information that they are unable (or unwilling) to verbalize. Scribbling/doodling can also serve as a self-soothing or grounding activity.

If the person is deemed to be in imminent danger, crisis intervention must follow, the goals of which are "immediate symptom relief, ensuring the person's safety, and active problem solving" (Rudd *et al.* 2001, p.150). In order to achieve these, it is essential to establish basic rapport with the person (or, if possible, bring in someone with whom they already have a relationship). Attempt to defuse the crisis by reviewing their ability to regulate their cognitive, behavioral, physiological, and affective systems. Identify relevant skills, create a lucid crisis plan, and, finally, assess for a need for supervision.

Once physical safety is ensured, art therapy can provide an objective space for exploring what may be triggering symptoms. Creative activities allow the time and distance for individuals to re-regulate and reframe their thinking by identifying alternative interpretations of events, as well as other possible solutions. Two directives that are helpful when safety planning include making a crisis survival toolbox (containing various skills card reminders, distracting activities, and/or self-soothing products) and drawing one thing that, if changed, would allow the individual to consider staying alive.

What happens after the crisis of imminent danger has passed? Until both therapist and client can fully trust the client to not kill themselves, treatment must revolve around *decreasing* factors that lead to risk for suicidal thoughts and behaviors and *increasing* factors that help strengthen, support, and protect the individuals from acting on future suicidal urges (Rudd *et al.* 2001). DBT skills training and DBT-informed art therapy interventions address these goals by identifying maladaptive cognitions and behavioral patterns, as well as providing effective replacement strategies.

DBT

DBT, an empirically founded cognitive behavioral treatment, reduces suicidal ideation and behavior in many individuals (Linehan 1993). It was originally developed for women who met the diagnostic criteria for borderline personality disorder (BPD). DBT has five functions (Chapman 2006): (1) to enhance the client's capability through increasing their skillful behavior; (2) to improve and maintain the client's motivation to change and to engage in the treatment; (3) to ensure generalization of change; (4) to enhance the therapist's motivation and capability to deliver effective treatment; and (5) to help the client change or restructure their environment "in such a way that it supports and maintains progress and advancement toward goals" (Linehan 2015a, p.13).

DBT is a highly structured, language-based treatment model. Some clinicians believe that combining creative arts therapies with its didactic skills training component can expand certain individuals' capabilities more than standard DBT alone—and better help them to identify erroneous thought patterns, replace maladaptive behaviors with healthy ones, and design a *life worth living* that is congruent with their important personal values (von Daler and Schwanbeck 2014). This may especially be the case for clients with nonverbal learning styles (Clark 2017).

According to Rudd *et al.* (2001), three areas for effective suicide treatment are symptom management, skill building, and personality development. Symptom management and skill building interventions occur within a time-limited framework. The process of personality development is a much lengthier and more arduous journey, although I believe that it is possible to achieve through the mastery of the DBT skills. Effective long-term symptom management is contingent upon the client's improved self-awareness, and skills development requires knowledge of (and insight regarding) one's symptoms. Art therapy can play a role in all three aspects; however, the following case studies focus primarily on skill building (specifically, DBT skills).

Case studies

The following clinical case studies come from my work in a long-term DBT day treatment program for severely mentally ill individuals (pseudonyms protect client confidentiality).

MARY

Mary's story illustrates how cognitive distortions can have a profound negative impact on a person's functioning and hope for a future. She was 37 years old when she entered the intensive DBT day program. Suffering from posttraumatic stress disorder (PTSD), the result of extensive childhood physical and sexual abuse, Mary had not been in contact with her family since age 14 (she spent several years in a detention center for adolescents). Her suicidal thoughts emerged quite early. At one point, after breaking up with a girlfriend, Mary had stood on the edge of a bridge with the intention of jumping off. As an adult she exhibited all the symptoms of depression yet tried very much to present a tough exterior to the world.

However, Mary also recognized that it was becoming increasingly difficult to tolerate her emotional distress and dissociative episodes. She had never attended group treatment before and she had only started individual counseling one year prior to entering this five-day-a-week program. Mary requested DBT because she was making little progress with her therapist; further, her functioning was significantly impacted by the PTSD symptoms. Some people she knew who experienced similar problems had said that they benefited from DBT.

At the time of Mary's admission, I taught DBT skills groups every day and facilitated an accompanying weekly art therapy session. I was assigned as Mary's primary program therapist. Because of her intense distrust of others, nearly a year passed before she would participate to any significant degree in group discussions (or even engage with doing artwork). Yet she was consistently alert and attentive. Only in individual therapy would Mary share about her difficulties tolerating treatment, the group living situation she was in, and so on. She expressed feeling as if she was always in danger; her early experiences had taught her that there was no one she could trust.

Mary believed that things would never get better because she was defective in some essential way. Her thinking was consistently rigid and all-or-nothing. She assumed, since she was so competent at walling off painful feelings, that there was no good reason to risk trying something different. Anger was the only emotion she expressed, which understandably resulted in frequent altercations at the group home. Mary also had a low tolerance for the company of others and chose to keep to herself most of the time. Aggression was an effective way to hold people at a distance.

Slowly, however, Mary began to understand that these behavioral patterns were in reaction to her fears of being hurt by relationships. As she became more engaged in DBT she struggled to navigate the *dialectical*

dilemma of an intense desire for safety versus the growing emotional connection between herself and her therapists (as well as with other program participants). Dialectics tells us that everything in existence has its opposite and that even highly "opposing points of view can both be true" (Linehan 2015a, p.286). Many people—those with severe emotional dysregulation problems, in particular—perceive the world around them in an extreme, dichotomous manner that creates inflexible, ineffective thoughts and behaviors. DBT's goal of cultivating a dialectical stance isn't to teach clients "to view reality as a series of grays, but rather to help them see both black and white, and to achieve a synthesis of the two that does not negate the reality of either" (Linehan 2015a, p.291).

> DBT conceptualizes the client's difficulties as a series of dialectical dilemmas wherein the client and the therapist struggle to reconcile opposing forces. Borderline Personality Disorder…can be viewed as stemming from failure to integrate opposing views. In DBT, the therapist helps the client to recognize these conflicting forces and helps the client to reconcile these into a more balanced view. (Chapman, Turner, and Dixon-Gordon 2011, p.172)

Timing is everything and, at just the right moment, a graduate art therapy student joined the intensive day program's treatment team. Because of this increase in staff Mary received more individualized attention than she otherwise would have, and it seemed to make a difference. Eventually she began to make art. Mary's first piece, created during a private session, was in response to the directive to express what she was feeling in that moment. The painting ("I HATE ART!") was Mary's statement about her attitude toward treatment, her use of anger for self-protection, and the trepidation she felt around sharing her inner world. This was her first attempt at communication through a means other than the typical aggressive acting out. Mary took a risk to see what kind of reaction she would provoke in the clinical team. I used the opportunity to validate how hard it must have been to express herself so honestly considering the abuse she had experienced over the years. Both the art therapy student and I strongly reinforced Mary's willingness to convey such intense emotions despite the possibility of offending us. This marked a significant turning point: She chose to participate actively in treatment going forward.

Mary reported that she had started practicing DBT skills outside of program but was frustrated with the outcomes. She blamed other people when things did not go well rather than acknowledge that she needed to make more of an effort to master the behavioral techniques. In response, I

would refer to the "Model for Describing Emotions" handout (Linehan 2015b, p.213) and ask her to consider alternative (i.e., neutral) interpretations whenever results were less than satisfactory. I also pointed out specific times when she *had been* effective in using the skills during treatment. As Mary became more competent, she grew more trusting of the program. She could view other people's reactions from different perspectives, as well. This also increased her anxiety somewhat as she began to identify, and allow herself to experience, a variety of emotions instead of avoiding them with angry outbursts.

As the months passed Mary's engagement in group discussions evolved, as well. However, her most significant progress took place through the artwork she made during individual sessions. I witnessed her become much more open about her emotional distress. Figure 5.1 shows a large painting that she described as "original pain." The directive was to illustrate what being in relationships felt like. During our discussion, I challenged Mary's rigid belief that closeness with others always results in suffering by identifying ones she had recently developed that were healthy and rewarding.

FIGURE 5.1 MARY'S DEPICTION OF HER ORIGINAL PAIN

Mary struggled with profound guilt and remorse over some of her past behaviors. She eventually disclosed that she had been engaging in cutting and other self-destructive acts since entering the DBT program. However, at that point she was able to verbalize how a negative self-image and sense of worthlessness triggered those urges. During her second round in the

mindfulness skills module, the core theme in art therapy was illustrating one's mindful observations of thoughts and feelings (as an alternative to maladaptive, impulsive outbursts). In response to the directive *Show what it feels like when you are experiencing an intense emotion*, Mary built a volcano to express how she felt like exploding whenever she was angry. Our discussion explored the consequences of erupting with out-of-control behaviors versus dealing with emotions skillfully as they arise.

During another individual session, as we were practicing some reality acceptance exercises to help her to make peace with her past, I asked Mary to consider why she was given such a beautiful name with so much potential for good (i.e., Mary, the mother of Christ). She was stunned that I would compare her to a religious figure—and, for a moment, she experienced a radically different view of herself. Someone might have given her a beautiful name because there was love that could not be expressed any other way. Mary was making room for hope and self-tolerance. She realized that change could be positive rather than always a threat.

During the distress tolerance skills training module art therapy participants construct their own crisis survival toolboxes. Mary was still not doing much work in groups; however, one of her first directives around that time within individual therapy sessions was to illustrate how she presently reacted to distress, and identify what helped her to cope effectively (versus what made things worse). Mary built a concrete container, which she covered with black industrial plastic bags and heavy-gauge wire. She explained that she had no intention of letting anything in *or* out because she believed that this protected her from emotional pain.

In our post-art making discussion, Mary reported she was growing increasingly satisfied with her ability to express herself—and she felt a new sense of optimism that she *could* change. She was also able to acknowledge the following dialectical dilemma: the container not only blocked her pain; it also separated her from any possible pleasant experiences. Mary verbalized an insight that she had never developed her own identity because she was always worrying about protecting herself. She could not name any interests and goals.

Over the months that followed I witnessed Mary discover that she was lovable, that she was strong, and that she could solve her own problems. She was cutting less frequently and had started to take care of her medical issues. She reported that her depressive symptoms were gradually decreasing. She even found it a bit easier to interact with her peers. Mary was building a new approach to the world. She cultivated the

willingness and skill to appreciate other people's differing perspectives *without* absorbing their emotions.

Mary attended the intensive day treatment program for nearly two years. Over that time DBT and art therapy helped her to trust herself and others, explore and change patterns of rigid thinking, and safely communicate overwhelming emotions. Mary was ultimately able to generalize skills outside of the therapeutic environment, make new friends, and enjoy activities. During her final months in the program Mary talked about wanting to share her story. She saw this not just as a way to connect with others, but also as a means of accepting and resolving her past. Mary created her final piece in response to the art therapy group's directive *Illustrate your progress made so far*. Mary presented a bright-colored poster, made for the program itself, which stated her belief that "DBT WORKS!"

It has been many years since Mary's discharge from the day treatment program, yet she continues with individual trauma-informed therapy at our agency's outpatient clinic. When we pass each other in the hallways she greets me with a smile and reports that she is doing good work. Mary has neither made any suicide attempts nor been psychiatrically hospitalized since completing DBT. She sustains hope by trusting in her skills and with the support of ongoing treatment.

TANDY

Tandy, a 43-year-old woman whose primary diagnosis was BPD, entered the DBT day treatment program after her most recent inpatient hospitalization. During our initial individual therapy session, she reported that she had been hospitalized at least 15 times over the years due to recurrent suicidal ideation and attempts. Further, she habitually used self-injury (cutting) to relieve anxiety. Tandy had difficulty tolerating change. The fact that she was not able to return to her previous agency and therapist made her very distraught, even though she had only worked with the therapist for a few months.

Tandy reported feeling different from other people at a young age. She had been in therapy most of her life and spent 13 years in a residential treatment facility (where she reportedly endured both physical and sexual abuse). Despite having received some DBT skills training prior to entering the day treatment program, Tandy was ambivalent about the change process, and, like Mary, avoided considering how her own behavior had impacted her life. However, during the initial evaluation Tandy agreed

that, in order to reduce the frequency of psychiatric hospitalizations, our treatment plan should focus on emotion regulation skills.

Tandy had a very conflictual relationship with her mother, who also struggled with psychiatric issues. She lived in a group home at the time of her admission and believed that it was preferable to staying with family. Tandy's father had been a successful businessman prior to his retirement. Since that time, her parents traveled a great deal. Tandy always became more anxious when they went on extended trips.

Tandy's suicidal behavior was driven by an intense emotional vulnerability. At the beginning of DBT she required daily individual attention (in particular, right before the weekend when she needed coaching around how to implement self-soothing skills). Although she was highly intelligent, Tandy had a childlike demeanor, especially when relating to female clinicians. She would often stand outside of my office door and wait for me to come out.

Tandy was isolative in groups and wanted to interact only with the therapists. She rejected constructive feedback but was apologetic when others became frustrated with her. In contrast, during art therapy sessions she was very expressive. It was there that she began to communicate her emotional pain and internal struggles. In response to the directive *Illustrate opposing (dialectical) emotional forces*, Tandy produced two images: a human baby crying for love, and a large open mouth spewing out a wave of black and red material. Together, the drawings convey how Tandy vacillated between infantile desperation for emotional nourishment and anger so intense that it felt as if she was expelling explosive vomitus of rage.

Although Tandy had some additional psychiatric hospitalizations during her time in the DBT program, such episodes became less frequent. I, as her individual clinician, worked hard to maintain therapeutic consistency as well as manage my reactions to her *help me/I don't want to change* approach to treatment. Tandy was eventually better able to consider how her behaviors impacted other people and this sometimes resulted in negative responses (which, in turn, triggered more self-destructive urges). At one point she portrayed her internal struggle concerning her ambivalence about recovery: "If I change and become more self-sufficient, will I be alone or will life be better?" The directive was to *Draw the likely pros and cons of implementing DBT skills* (Figure 5.2). Tandy appreciated the ineffectiveness of her current coping strategies. Further, by illustrating nascent hope for the future, she could affirm the possibility of a rewarding life.

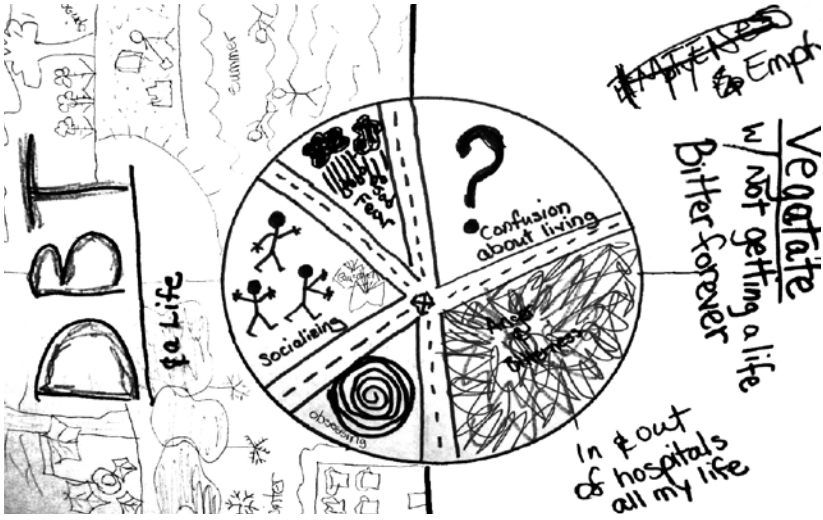

FIGURE 5.2 TANDY: THE PROS AND CONS OF USING DBT SKILLS

Tandy continued to experience emotional overwhelm whenever I went on vacation or her parents left for/returned from one of their seasonal trips. But she *was* doing better, and during our individual sessions she could finally accept feedback concerning her progress. I encouraged Tandy to utilize the groups by talking more about ambivalence. She worked with me on a crisis survival skills toolbox for the weekends yet remained unwilling to give up cutting (as she believed that it was the only way to relieve anxiety/tension). She conceptualized the purpose of self-injury around her belief that she could tolerate physical pain but *not* emotional pain.

As described by Southwick *et al.* (2008), lack of resiliency is a major component of rigid or repetitive behavioral reactions, and adequate supports are necessary to maintain it in the face of trauma. The creative process allows clients to express a sense of hopelessness and helplessness without re-enacting traumatic cycles via maladaptive behaviors. Thus, they are more capable of problem-solving, which ultimately reduces the factors that contribute to suicidal thinking.

During the mindfulness module Tandy also explored *walking the middle path* in art therapy. This skill teaches dialectical thinking—in particular, balancing acceptance and change (Linehan 2015a, 2015b). For Tandy, the middle path meant rejecting suicide as a solution, although she still was not ready to give up cutting. Walking the middle path also involved being more present as a group member, even as she remained quite impulsive in her interactions with peers. During our individual sessions I often pointed

out my observations of Tandy's various dialectic dilemmas while the art therapy component explored what might happen if she fully committed to using the DBT skills. Figure 5.3 shows her response to the directive to visualize a skill that could help put her on the middle path. Tandy chose the distress tolerance module's STOP skill: *Stop, Take a step back, Observe, and Proceed mindfully* (Linehan 2015b, p.327). STOP was effective for slowing her mind down and making more thoughtful decisions (instead of just reacting impulsively).

FIGURE 5.3 TANDY: VISUALIZATION OF WALKING THE MIDDLE PATH (STOP SKILL)

While she was never able to make friends in the DBT day treatment program, Tandy became significantly more interactive during groups; further, she could accept her peers' positive comments on how she used art to communicate concepts. Tandy had also developed a more objective perspective regarding her relationship with her mother, although she still very much wanted approval and was deeply hurt whenever she received criticism from her.

Art making was a powerful avenue for Tandy to communciate her emotions and distress. With the addition of DBT-informed art therapy to the treatment-as-usual, Tandy could better generalize the skills she learned into her daily life (which eventally reduced the frequency of cutting episodes and hospitalizations).

Tandy began to talk about leaving the DBT program because she felt too attached. This was the first time she had made a thoughtful decision. She finally felt hopeful that she would no longer need to be taken care

of on a daily basis. After considerable discussion about how to continue progressing with the skills, Tandy stated that she was ready to step down to weekly individual sessions. She also asked me to refer her to a DBT therapist. Figure 5.4 is her final art project before discharge. Tandy at last could visualize herself as a competent person with a hopeful future. She continues to make art and often brings drawings into therapy sessions. When I see her in the hallways she is able to say hello and only keeps me in conversation for a few minutes.

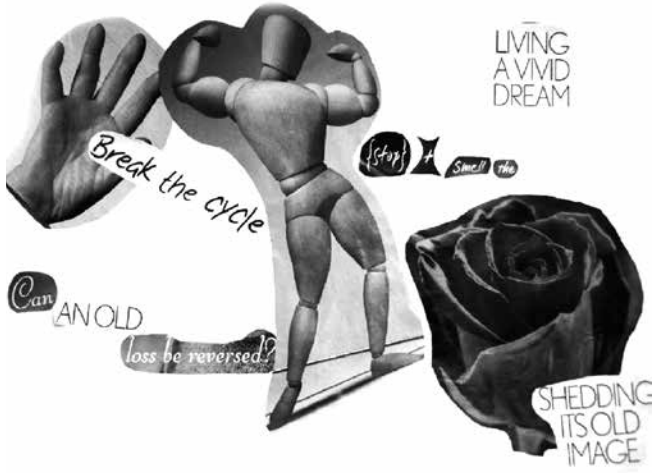

FIGURE 5.4 TANDY'S FINAL ART BEFORE DISCHARGE

Conclusion

There are many DBT-informed art therapy interventions to match any given client's needs and level of functioning. Within the case studies I presented directives designed to allow individuals to practice their skills in a safe environment while they consider the possibility of a *life worth living*. The DBT-informed art therapist must possess an understanding of suicidal thinking, accurately perceive the individual's capacity for taking risks, and be knowledgeable of DBT skills training and art therapy techniques.

Mary required time, patience, and consistent validation through a gentle approach. The directives I implemented in her therapy were simple and meant to only do two things: promote discussion about how the DBT skills might help her to tolerate exposing her repressed emotional pain, and to express those feelings without self-destructive

behaviors. For Tandy, art therapy facilitated the complex task of illustrating the client's observations of her profound ambivalence concerning positive change and recovery. Further, some of the resulting drawings confronted Tandy with challenging dialectics.

Both individuals practiced new behavioral strategies in the art therapy studio while their strengths as survivors were validated. Developing a sense of competence through mastering art materials allowed them to work on challenging ineffective thought patterns and accept the present as it is: imperfect. Practicing mindfulness and self-soothing skills in the studio promotes greater willingness for adaptive risk-taking, as well.

Neither Mary nor Tandy could articulate emotions when they first came to the DBT program. Creativity allowed them to express their internal experiences symbolically. By examining their drawings' content, both women could better understand the negative consequences of impulsive, mood-dependent behaviors. DBT-informed art therapy enhanced ability to use skills for tolerating their pain, fear, amotivation, and dysfunctional response patterns at their own pace. This led to a belief that staying alive would result in desirable change—thus, they could at last reject suicide as a solution. It is also important to note that both Mary and Tandy identified when they were ready to discharge from the DBT program. We agreed that they possessed the skills needed to make better decisions regarding whatever life offered.

While I have focused specifically on DBT skills acquisition, the two case studies also demonstrated more effective symptom management and the beginning of personality development, which are the other two components of effective treatment for suicidal behavior described by Rudd *et al.* (2001). DBT-informed art therapy enhances one's ability to integrate and utilize the DBT skills outside of treatment. It offers the visualization of choices, avenues for accepting and tolerating the dialectics of life, and greater understanding of the unpredictable impulsive urges for suicide. The case study subjects exhibited decreased acting on such urges, and, consequentially, fewer hospitalizations along with enhanced quality of life.

This chapter opened with the statement that "no single intervention has proved sufficient" in solving the problem of suicide (*The New York Times* 2018, p.A17). For individuals who struggle with chronic suicidal ideation, ample time and resources are necessary to achieve enduring cognitive and behavioral change. Mary and Tandy's case

studies demonstrate how combined DBT-informed day treatment programming and art therapy might offer a valuable means of reducing suicidal behaviors while allowing participants to develop their own vision of hope. Next steps should include efforts to obtain empirical support for the value of such interventions.

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Chapter 6

DBT in Action

Art Therapy and DBT Skills Training in Treating Eating Disorders

SUSAN M. CLARK

Introduction

This chapter presents the rationale for providing art therapy in conjunction with the skills training curriculum of dialectical behavior therapy (DBT), an evidence-based treatment for emotion regulation problems that are often issues for patients struggling with binge eating disorder (BED) and bulimia nervosa (BN) (Safer, Telch, and Chen 2009). It describes challenges with teaching DBT skills via the manualized format and posits how specific art activities might enhance comprehension and generalization. One group intervention, "DBT in Action," was a successful addition to several partial-hospitalization programs at a private eating disorder (ED) treatment center. I, the author, suggest how clinicians can practice DBT-informed art therapy and call for research testing the efficacy of this approach.

Art therapy and EDs

Many ED programs offer art therapy in adjunct to standard treatment protocols owing to its observed effectiveness in helping patients tolerate and express intense emotions while ameliorating defense responses frequently triggered by verbal interventions (Dokter 1994; Hinz 2006; Levens 2002). Literature concerning art therapy and EDs is typically psychodynamic (Makin 2002) and describes the reparation of unconscious conflicts through working with artistic images. Patients often seem more receptive to their artworks' insights, perhaps because

"the art is something that the individual has created and is thus an extension of self" (Blake 2006, p.28). Art making allows patients to symbolically convey what they cannot explain with words by acting as "shortcuts" for expressing difficult content (Hinz 2006, p.12). Images may represent multiple (even contradictory) realities, such as being in treatment *and* feeling ambivalent about ED recovery. Because each art object portrays its maker's internal experience at a given moment in time, patients accumulate valuable pictorial records of their therapeutic progress.

While quantitative research is scarce, mindfulness-based art therapy (MBAT), the subject of two randomized controlled studies, appears to improve the mental health of breast cancer patients (Monti *et al.* 2006, 2012). In both experiments patients reported significant post-intervention reductions in stress/anxiety. The latter utilized functional magnetic resonance imaging (fMRI), which revealed blood flow changes in the left insula, amygdala, and hippocampus—the brain's emotional centers. Impaired insula functioning may play a role in the development and maintenance of anorexia nervosa (AN) (Lask 2011; Nunn *et al.* 2008). Art therapy has also garnered recognition as a promising posttraumatic stress disorder (PTSD) treatment (Chapman *et al.* 2001; Collie *et al.* 2006). People with EDs frequently report trauma histories and/or have co-occurring PTSD (Brewerton 2007).

DBT and EDs

DBT was developed for women who exhibited suicidal and nonsuicidal self-injurious behaviors (Linehan 1993) and commonly met diagnostic criteria for borderline personality disorder (BPD) (American Psychiatric Association 2013). DBT synthesizes change strategies from cognitive behavior therapy (CBT) with acceptance concepts from both Eastern and Western contemplative spiritual traditions. Comprehensive DBT features individual psychotherapy, group skills training, and telephone coaching to assist with performing effective behaviors outside the clinical milieu. Practitioners attend peer consultation meetings for professional support and as a means of ensuring treatment fidelity (Dimeff and Koerner 2007).

According to DBT's biosocial theory, pervasive dysregulation results from repeated transactions between biologically based emotional vulnerabilities and invalidating social environments (through which

children learn that their private experiences, i.e., what they believe or feel to be true, are incorrect or unreasonable). Over time, individuals develop behavioral strategies such as cutting, purging, and substance abuse, which, although maladaptive, reduce the intensity of a negative affective state by avoiding its full experience. Paradoxically, emotion regulation, DBT's overarching goal, is facilitated through mindfulness, an increased and/or enhanced awareness of one's experiences of oneself and one's surroundings (Linehan 2015a).

Mindfulness-based interventions have proliferated in medical and mental health care during the past two decades (McCown, Reibel, and Micozzi 2011). Jon Kabat-Zinn, developer of the respected mindfulness-based stress reduction (MBSR) program, defines mindfulness as intentionally attending to the present moment, rather than "reacting automatically and unconsciously to the outside world and to our own inner experiences" (Kabat-Zinn 1990, p.11). DBT teaches mindfulness through sets of interlocking skills. Important concepts include *emotion mind*, a state in which individuals are controlled by emotional dysregulation/reactivity, and *reasonable mind*, where they can access logic and critical thinking (Linehan 2015a). DBT assumes that patients spend most waking hours in emotion mind, resulting in significant distress and behavioral dysfunction. The desired state, *wise mind*, is an "intuitive blend of emotion and reason that radically accepts and responds to the moment just as it is" (Koerner 2012, p.20).

DBT actively targets problematic behaviors; however, this is balanced with accepting patients as they currently function. Unique to DBT are dialectical strategies based on an assumption that any position (thesis) contains its opposite (antithesis) (Linehan 1993). For example, a suicidal person can simultaneously want to live and die; similarly, someone with AN might genuinely desire recovery *and* be loath to relinquish their ED. DBT synthesizes opposite stances by accepting patients and pushing for change: "In a dialectical approach the therapist agrees that the client's life is unbearable and that the client needs a way out, and offers another route, using therapy to build a life that is generally worth living" (Koerner 2012, p.16).

DBT effectively treats several challenging clinical populations and issues, especially those involving emotional dyscontrol: substance abuse/dependence, complex PTSD, suicidal/self-injuring adolescents, high-conflict couples and families, developmental disabilities, and certain EDs. Adaptations of the standard outpatient model include

DBT for inpatient psychiatric units, residential forensic settings, and assertive community treatment (ACT) teams (Dimeff and Koerner 2007). DBT consists of five treatment stages (Linehan 1993):

- Pretreatment reduces the likelihood of premature termination. Orientation/commitment is ongoing because recurrent dysregulation negatively impacts patients' ability and/or willingness to engage with therapy tasks.
- Stage 1 treats patients with the most severe symptomology. Life-threatening (target 1) behaviors are prioritized according to lethality. Therapy-interfering/target 2 behaviors include those that negatively impact the therapy relationship and/or DBT's effectiveness. Patients commonly experience multiple simultaneous quality-of-life-interfering/target 3 issues (e.g., co-occurring psychiatric conditions; substance abuse; non-life-threatening ED behaviors; chaotic/abusive interpersonal relationships). The objective is to replace targeted behaviors with adaptive responses. Patients commit to a year of stage 1 DBT.
- Stages 2–4 are briefly discussed later in this chapter.

Eating-disordered behaviors can be maladaptive attempts to regulate intense emotional states (McCabe, La Via, and Marcus 2004). While CBT and interpersonal psychotherapy (IPT) are the most empirically founded treatments for primary EDs (Fairburn 2008; Garner and Garfinkle 1997), these approaches are ineffective with at least 50 percent of individuals, particularly those with AN and/or co-occurring mental illnesses and personality disorders (Wisniewski, Safer, and Chen 2007). Research suggests that standard or modified/abbreviated DBT is most helpful for less complicated clinical situations, such as the binge eating and/or purging associated with BN and BED; this could relate to the behavioral impulsivity that DBT targets and improves (Blake 2006; Safer *et al.* 2009). According to preliminary findings, patients with severe EDs and comorbidities may require intensive interventions, including full-model DBT in addition to standard outpatient ED treatment (Federici, Wisniewski, and Ben-Porath 2012).

One exciting new development is radically open DBT (RO-DBT) (Lynch 2018a) for problems of emotional overcontrol (OC). Unlike disorders of severe emotional under-control/dysregulation that respond so well to standard DBT, OC disorders are characterized by

extreme perfectionism, aversion to novelty and risk, reduced affective expression, difficulty recognizing the emotional cues of others, and social aloofness. Examples include anorexia nervosa, restricting type (AN-R), obsessive-compulsive personality disorder, and refractory major depression (Lynch *et al.* 2013).

Lynch hypothesizes that OC individuals possess an inherent threat-sensitivity that, when it occurs with family/environmental experiences "emphasizing mistakes as intolerable and self-control as imperative" (Lynch *et al.* 2013, p.3), may eventually result in chronic activation of the sympathetic nervous system. Rather than focusing on cognitive restructuring and affect regulation strategies, RO-DBT directly treats neurophysiological arousal mechanisms so that patients become at ease and are thus able to participate in more spontaneous and genuine social interactions. RO-DBT interventions activate the ventral–vagal-mediated parasympathetic nervous system (the *social-safety system*) (Lynch *et al.* 2013) by having individuals deliberately change their body postures and facial expressions. Once patients feel safe, they can better tolerate interventions directly targeting OC symptoms.

One article described an RO-DBT-informed treatment program for AN-R at an inpatient ED hospital unit located in southwest England (Lynch *et al.* 2013). It contains several ancillary interventions including art therapy groups designed to provide exposure to novelty and opportunities for practicing letting go of perfectionism. Other expressive modalities come into play during the "Themed Applications Skills Week," which occurs every two months when the unit's normal schedule is suspended so that staff and patients may "join together to practice radical openness skills, share community meals, and practice playful spontaneity (e.g., Taiko Drumming, Film Making, Fancy Dress, Pantomime)" (p.6).

RO-DBT's skills curriculum (Lynch 2018b) includes some standard DBT concepts and skills as well as many unique ones. During participation in an intensive training (Lynch 2015), I discovered that many of the challenges I experienced providing art therapy to patients with AN-R were described and explained in the model. This chapter introduces an intervention that explores *radical openness*, RO-DBT's core skill, through combined loose and controlled artistic media. Because they directly address the excessive inhibitory control so characteristic of AN-R, RO-DBT-specific art therapy interventions might become valuable to the application of art therapy for EDs.

DBT skills training

Skills remedy emotion regulation deficits. Standard DBT skills instruction follows a group-based psychoeducational format (Linehan 2015a, 2015b). Three of the four modules—interpersonal effectiveness, distress tolerance, and emotion regulation—appear in consecutive multi-week cycles. Two mindfulness lessons separate them, resulting in 24 weekly sessions. Patients are exposed to each module twice during their stage 1 treatment year.

DBT skills teach either acceptance (mindfulness/distress tolerance) or change (emotion regulation/interpersonal effectiveness). Acceptance skills are appropriate when current stressors or emotions cannot be significantly reduced/eliminated. Change skills help to achieve goals such as solving problems, decreasing susceptibility to emotion mind, and building and/or maintaining relationships.

My experience has been that many patients dislike DBT's handout and worksheet-based curriculum. Although skills training employs metaphor, storytelling, and brief experiential mindfulness activities, patients frequently complain of confusion or boredom to even the more experienced and dynamic group leaders. While the revised manual (Linehan 2015a, 2015b) includes expanded teaching notes, the model remains highly didactic and therefore may not be as helpful to those with nontraditional learning styles. Participant feedback concerning a DBT partial-hospitalization program for EDs included these suggestions: make groups more interesting and include additional opportunities for mindfulness practice (Federici and Wisniewski 2013).

DBT-informed art therapy

DBT-informed art therapy involves the strategic use of creative visual exercises to teach stage 1 DBT concepts and skills. Although no formal evidence-based protocol yet exists, several art therapists have written about their interventions. Most published material hails from English-speaking countries other than the United States (Huckvale and Learmonth 2009; Rothwell and Hutchinson 2011; Shiell 2008). However, one journal article (Lebowitz and Reber 2011) describes a DBT-informed expressive arts curriculum at McLean Hospital's renowned inpatient adolescent unit (Belmont, Massachusetts). Another explores psychodynamically oriented art therapy coordinated with skills training

in a Baltimore, Maryland residential psychiatric treatment facility for adults (Heckwolf, Bergland, and Mouratidis 2014).

DBT-informed art therapy engages the mindfulness *participating* skill (Linehan 2015b). Some clinicians believe that making art slows down learning while activating and exposing patients to positive emotions. The novelty of engaging in creative activities may facilitate mindful attention, as well. This phenomenon could be related to bilateral integration, in which the left and right brain hemispheres are trained to communicate more effectively, resulting in improved emotion regulation and stress management (Hass-Cohen and Carr 2008; Siegel 2012). Group members often describe coming away with a deeper understanding of the skills; furthermore, resulting art products can be helpful reminders of important work long after therapy sessions have concluded.

A unique challenge of teaching DBT skills to acute ED patients involves the cognitive consequences of malnutrition. It is not unusual for individuals, once the refeeding process is complete or well underway, to have forgotten many details of their early weeks in treatment. I have encountered patients who, when asked to recall the name of a certain skill and idea, were not able to do so; however, they remembered the corresponding experiential exercise and also accurately described its general learning objective(s).

Models of DBT-informed art therapy

Stage 1 DBT skills training incorporates art therapy in several possible ways. Note that each of the following models might include individual- or group-based interventions.

- Combined: One standard DBT skills session containing a related art activity.
- Sequential: Two weekly sessions. The first teaches the skill(s) in the usual didactic format. A subsequent session features a related art activity.
- Art-based/parallel process: These DBT-themed sessions do not follow a set modular progression, although patients may simultaneously receive comprehensive DBT or attend a skills group. Examples from an inpatient adolescent program (Lebowitz and Reber 2011):

  - Visual journaling groups with skills-based prompts.
  - Goal-setting groups using expressive arts to help patients structure their time and balance priorities.
  - Self-esteem workshops with projects completed over extended time periods (themes include values, identity, building a *life worth living*).

- Interdisciplinary: Skills training and art therapy services existing within a highly coordinated and collaborative team milieu (e.g., a residential treatment program) (Heckwolf *et al.* 2014) and incorporating a few or several modalities and theoretical frameworks.
- Free-standing: Experiential sessions that utilize DBT language and assist participants in enhancing their grasp of previously learned skills. Clinicians might design interventions for stage 1 DBT graduates (Dyer 2008) on topics such as advanced mindfulness and emotional expression techniques.

Characteristics of the DBT-informed art therapist/art therapy process

Over the course of my career, I have identified several characteristics/qualities that I believe are vital to the integrity of DBT-informed art therapists and the therapy process. Below are some of the most important (Clark 2017):

- Knowledgeable.

  Clinicians should achieve basic competency in both art therapy and DBT. Solid understanding of their theoretical underpinnings, objectives, and protocols is essential, as is general skill with their applications to EDs.

- Radically nonjudgmental.

  It is important to consistently emphasize the nonjudgmental nature of DBT-informed art therapy. Individuals struggling with EDs tend to exhibit perfectionism (Cassin and von Ranson 2005) and approach art therapy with significant performance anxiety. Many denigrate their abilities yet are quick to offer complimentary critiques of peers' artistic products: "That's so pretty," "You are such a good artist," etc. The therapist can gently

note such comments, then invite rephrasing in an observe-and-describe manner. This may involve simply owning the judgment (e.g., "I like it" or "I think the combination of blue and yellow is striking here"), therefore accentuating the differences between fact and opinion. If patients tolerate that level of intervention, therapists might then introduce emotional responding: "If you didn't know anything about the image and who made it, what might you guess the artist may have been feeling? Why?"

It is equally important to validate patients' fears around not being competent at something *and* encourage them to risk joining the process, anyway. Such a gamble holds great potential for new learning, perhaps even reparative experiences. Many associate drawing and painting with emotional wounds originating from their elementary school classrooms:

> Art is often an area where people have experienced shaming, humiliation, and invalidation. Fear makes us stupid, and trauma is completely paralyzing. Ways through and beyond this paralysis and terror can only be achieved by gentle but strategic and challenging interventions. When overwhelmed… to be able to think even one thought or notice one real thing is the beginning of breaking up the cycle. (Huckvale and Learmonth 2009, p.61)

Art therapists offer predictably nonjudgmental environments where patients can experiment with nonverbal self-expression: "Persons with eating disorders need to understand that there are no expectations of beauty… They need to be free to create whatever best embodies their feelings and thoughts at the time" (Hinz 2006, p.18). Coping with the *less-than-perfect* requires patience and practice. One woman's enthusiasm for art eventually became greater than her worry about making a mess. "The latex gloves came off because it was easier and more precise to blend chalk pastels with a bare finger. Engaging with the materials led the way" (Huckvale and Learmonth 2009, p.55). This is cognitive restructuring in action. Lebowitz and Reber (2011) described how, when orienting new residents to the art therapy group, one young woman stated that it was a place where she challenged her need for perfection.

- Validating.

  Clinicians provide validation by conveying that an individual's point of view and behavior "make sense and are understandable within her current life context or situation… The therapist takes the patient's responses seriously and does not discount or trivialize them" (Linehan 1993, p.223). Assuming that behavior is adaptive to the context in which it occurs, the therapist actively looks for, identifies, and describes reasonable aspect(s) of the patient's response to events. Validation supports DBT's change strategies and teaches patients to validate themselves over time (Koerner 2012).

  Model validation by appreciating all creative products as examples of genuine self-expression. Every image possesses value unrelated to appearance or the level of technical skill required for its creation, simply because it exists and reflects the unique characteristics of its maker, who, through the therapy process, gradually discovers that they, too, are essentially valid. This is the kernel of truth, the metaphorical golden nugget lying behind the dross of ineffective behaviors and cognitive distortions (or, perhaps, unpleasant color combinations and skewed perspective). The goal is to encourage patients to discover their "personal expressive style" (McNiff 1981, p.38). The art therapist, who by the nature of the work communicates greater interest in the person and their creative process than in the ED itself, conveys an acceptance that might ultimately translate into self-acceptance (Hinz 2006).

  Group art therapy facilitates exploration of personal issues within a nonthreatening environment. Patients validate each other's realities by exchanging visual and verbal feedback. Experiential groups, by acknowledging and accommodating the needs of those with nontraditional cognitive styles, assist kinesthetic and tactile learners to absorb didactic concepts. Furthermore, "the ability to frame clinical material in a personal and creative way offers an opportunity for self-validation as well as the development of identity through the creation of personal imagery" (Lebowitz and Reber 2011, p.339).

- Dialectical.

  Art therapists design opportunities for patients to practice

dialectical thinking, through which "contradictory truths do not necessarily cancel each other out or dominate each other, but stand side by side, inviting participation and experimentation" (Miller, Rathus, and Linehan 2007, p.39). I enjoy introducing patients to "raw" (Rhodes 2004, p.7) or "outsider" (Rexter 2005, p.11) works by self-taught artists, many of whom have mental illnesses or other disabilities (Maizels 1996). Patients are usually quite impressed, if not inspired, by their emotional power and artistic integrity, despite lack of technical sophistication. Similarly, when patients struggle with materials and harshly judge themselves for failing to create "perfect" products, therapists can reframe this as a learning experience (Makin 2002). As Lebowitz and Reber (2011) explain:

> We also modeled and talked residents through experiences of "mistakes" using them as opportunities to practice self-validation and to recognize that each time we attempt something new and do not reach our original concept of success, we have either opened ourselves to a new definition of success or at least we have uncovered new information about what does not work, therefore bringing us closer to what does work. (p.342)

In the treatment of Elaine (Huckvale and Learmonth 2009), a chronically suicidal and self-harming woman, the clinician designed a practical approach in which she could explore her strong interest in art, and eventually make significant therapeutic progress, through structured exploration of media and techniques. The clinician was careful not to push a change agenda, as this can be invalidating and sometimes results in producing more—or worse—symptoms/behaviors (Linehan 1993). Elaine viewed the sessions as a chance to "have a rest from her problems, not…where she would confront, work on, or change them. It was an attempt to create a space uncontaminated by previous failed attempts to change" (Huckvale and Learmonth 2009, p.55). Art therapy as *constructive diversion* is occasionally "the only effective way to develop the therapeutic relationship enough to stay out of the destructive emotional whirlpools long enough for change to become possible" (Huckvale and Learmonth 2009, p.56).

> Here, the art therapist was…also being directly "behaviorist" (the art therapist would ask, "I wonder how it would be if you try doing the same thing but in charcoal?" Or, "painting seems to be going really well; how about trying to paint a new 'subject'?"). Making art is a physical "doing," an action in the here-and-now. The art therapist was working with Elaine to make different behaviors, and thus feelings, possible within a very particular container. Crucial to the container, of course, was the emphasis on building the right kind of therapeutic relationship to make the risk feel possible. Acceptance was embraced in the session structure and the relationship. The possibility was explored through the art materials. A dialectic between them was opened up for reflection. (p.56)

Rothwell and Hutchinson (2011) describe the parallel-process partnership of an art therapist and a clinical psychologist in helping Elizabeth, who had survived extensive childhood sexual abuse. The therapists viewed their eventual collaboration as akin to a parental couple—one acting as "the thinking father (DBT)" (p.19) who taught skills for change, the other "the emotional containing mother (Art Therapy)" (p.20) who provided acceptance, validation, and a safe environment where Elizabeth could symbolically express her intense feelings and destructive impulses. This allowed Elizabeth to simultaneously experience the present, learn and practice skills, and begin working through traumatic memories.

- Safe.

  The art therapist of popular imagination possesses an almost mystical ability to perceive symptoms, conflicts, and secrets in patient artwork. Individuals diagnosed with EDs seem to believe and fear this myth, and therefore may require repeated assurances that their images will not be *psychoanalyzed*. Stage 1 DBT participants typically experience interpretation as excruciatingly intrusive/controlling. By not assuming to know any ultimate meaning, the art therapist creates an environment conducive to self-awareness, such as when a patient in the process of talking about a drawing suddenly realized that "his words didn't match his picture" (Rabin 2003, p.24).

> Throughout their parallel-process art therapy/DBT work with Elizabeth, Rothwell and Hutchinson (2011) composed two validating environments, both of which encouraged her "to experience her emotional world without pathologizing her or seeking to directly investigate the root causes" of her issues (p.24). In many cases, it is better to work on containing feelings instead of attempting to understand and transform them (Dokter 1994; Levens 2002), an empathetic "building up rather than uncovering" (Shiell 2008, p.61). I have noticed that structured art directives reduce the likelihood of regression and acting-out behaviors. However, DBT-informed art therapy provides opportunities for spontaneity, as well, and this synthesis is essential for managing ED patients' coexisting terror of losing control and need for cognitive flexibility: "The challenge is to present the individual with tasks that require focus but also permit freedom within the art task… This provides a balance: freedom within form; I call it a safe haven" (Rabin 2003, pp.27–28).

Over the course of approximately 4 years, I designed and implemented weekly 60-minute sequential art therapy groups in my facility's CBT- and DBT-adherent adult and adolescent partial-hospitalization programs. These "DBT in Action" groups were generally well-received; however, as might be expected, they were significantly less popular with patients suffering from AN-R (especially those with comorbid personality disorders) whose profound perfectionism and rigidity persist within even the most nonjudgmental experiential group environments. Clinicians should practice accepting these patients' limitations by allowing them to participate as much or as little as they are able, while balancing an expectation that they attend to the process (i.e., remain alert) and offer appropriate verbal feedback to peers.

STAGES OF DBT-INFORMED ART THERAPY

Stage 1 DBT-informed art therapy

The number and variety of effective DBT-informed art therapy activities is limited only by a clinician's creativity, skill, and enthusiasm. Most naturally facilitate mindfulness practice, effective emotional expression,

and mastery. One can also design projects to help teach and reinforce specific skills. What follows is an abbreviated selection of experientials that I devised for my clinical practice.

Mindfulness

Therapists can transform practically any visual art exercise into a mindfulness lesson. The following are two ways of experiencing and practicing mindfulness.

UPSIDE-DOWN DRAWING (ADAPTED FROM EDWARDS 2012, PP.17–26)

Collect various coloring pages from books and the internet—ones sufficiently complex to hold the interest of adolescents and adults, but not so detailed that they would be extremely difficult or time-consuming to copy by hand. Briefly demonstrate how to start by placing unlined paper beside an upside-down coloring page of the same or similar size and beginning to copy the image (no erasing). Encourage participants to refrain from verbally labeling features along the way (e.g., "that's an upside-down ear"), but rather observe the lines and their relationships to one another. Once they complete and view drawings right side up, they are often pleasantly surprised by their technical accuracy. Patients may then color/embellish images to create original works of art.

STATES OF MIND SYMBOLS

Participants make mandalas (circle drawings) representing their experiences of the three states of mind. Advise against resorting to written words and/or common symbols (hearts, smiley faces); rather, encourage artists to convey the essence of each through color, shape, and form. Another option is to replace, or elaborate upon, the wise mind mandala by painting a papier-mâché mask form to depict what one's wise mind might look like if personified. Lebowitz and Reber (2011) describe an experiential where patients identify one or more women they view as particularly wise-minded and come up with some colors and images to represent her/them: "We invite the residents to think of women they admire and the qualities that inspire their admiration, and challenge them to think about how they might embody these qualities themselves" (p.340). Patients write for about 10 minutes, and then make visual representations of their "inner wise woman" using drawing media and magazine images.

Interpersonal effectiveness

In this module, patients learn how to pursue personal objectives by saying "no" and/or asking for what they want while preserving important relationships and maintaining self-respect (Linehan 2015b). The activities consist primarily of role play exercises for practicing assertive communication. However, I designed a brief drawing sequence to enhance participants' understanding of presented skill sets (one of which appears below).

INTERPERSONAL-STYLE SKETCHES

After brainstorming definitions and examples of passive, aggressive, passive-aggressive, and assertive/interpersonally effective behaviors, participants create representations of the first three by portraying each person as a stick figure, symbol, or abstract representation. Urge group members to *show*, not tell (i.e., suggest behaviors through images rather than written words). Patients then share their pictures, guessing and describing behaviors. This usually prompts discussion around how it feels to be on both the giving and receiving ends, as well as possible motivating factors (e.g., aggression/anger may be secondary to fear). The next step is to similarly portray a current important relationship. Patients then create larger drawings illustrating what those relationships might be like if they, at least, behaved in more interpersonally effective ways.

Emotion regulation

Emotion regulation skills help patients identify and understand the purpose of emotions, reduce vulnerability to emotion mind, and decrease the frequency of unwanted emotions and emotional suffering (Linehan 2015a, 2015b). The following activity facilitates this by exposing patients to their feelings in a safe, contained manner.

DRAWING YOUR EMOTIONAL HURRICANE, ROLLERCOASTER, OR WAVE

Mehl (1997) asked patients to draw their dysregulated emotions as hurricanes. I provide comparable prompts; for example: *Draw or paint a feeling in landscape form or as a real or imaginary nonhuman creature (and then respond to some written questions concerning the creature's personality, natural habitat, what it would say to the viewer if it could speak, and so on)*. These allow for sufficient objectivity to observe, describe, and better understand emotional experiences. In

the rollercoaster assignment, the emotional crisis cycle becomes the twisting and turning rail upon which the patient-as-coaster-car travels. Participants label their thoughts, feelings, and behaviors leading up to a crisis, the crisis itself, and what happens on the way down (as the crisis abates and eventually concludes). The result is, essentially, an illustrated behavior chain analysis (BCA). BCAs are painstaking, step-by-step/cause-and-effect descriptions of events leading up to, during, and following maladaptive behaviors (Linehan 1993).

In Figure 6.1, the person symbolizes her anxiety's life cycle as a wave that begins, increases in intensity, reaches maximum power, and gradually declines. She included a numeric scale to identify the level of distress, as well as a *skills breakdown point* where her emotion is so extreme that she can no longer problem-solve and/or use complex coping strategies. Notice how she listed appropriate behavioral responses for all phases of the emotional experience. The wave drawing activity can also teach *urge surfing*, which involves riding out a strong desire to engage in ED behavior(s) (Safer *et al.* 2009).

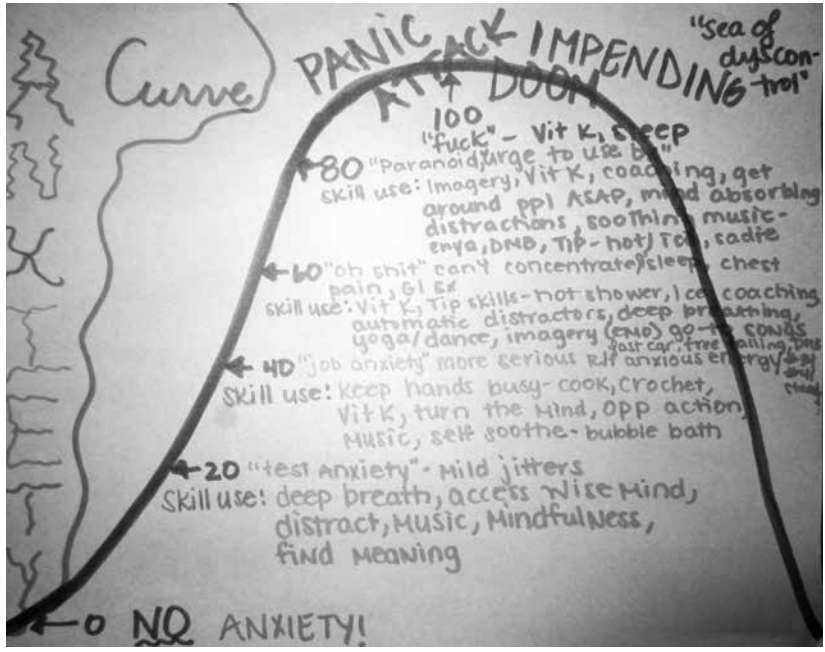

FIGURE 6.1 DRAWING OF AN EMOTIONAL WAVE

Distress tolerance

Many distress tolerance activities are specific to skills retrieval and generalization. For example, since patients are apt to forget potentially helpful skills during periods of intense emotional arousal, they make/decorate portable booklets in which they list various crisis survival and reality acceptance strategies (Linehan 2015a, 2015b). They also might assemble kits for distraction and self-soothing (e.g., puzzle books, silly putty or clay, aromatherapy products) and have each for specific situation(s) or environment(s) (e.g., automobile, purse, office, locker). One adolescent patient used his *pet rock and habitat* (Clark 2017) to help him get through difficult therapeutic meals in a day treatment program; he would place it on the table beside his eating utensils.

PERSONAL ZEN GARDENS

The therapist introduces the Zen garden, explains its role in mindful contemplation, and demonstrates how patients will construct their own using inexpensive photo frames, foam board, and sand (Figure 6.2). Twigs, seashells, stones, smooth pieces of colored glass, acorn caps, small wooden craft sticks, and toothpicks are available for decoration and to build rakes and other "gardening" tools. Patients seem to obtain great enjoyment from creating unique Zen gardens. Several have reported keeping them in their bedrooms or other convenient locations and rearranging the contents and/or sand designs (as a way to focus their thoughts and self-soothe).

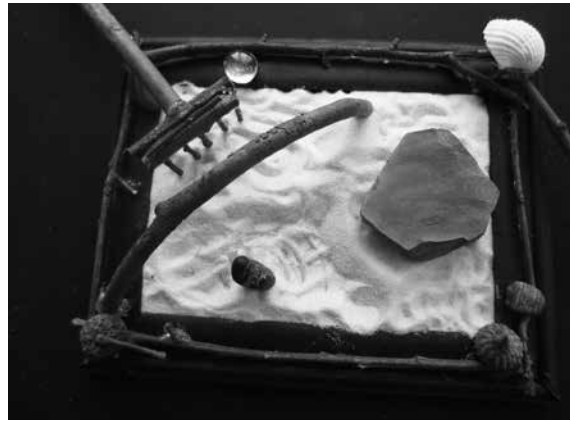

FIGURE 6.2 A ZEN GARDEN

Radical openness (RO)

RO is the key skill in RO-DBT. Lynch defines it as a willingness to consider new (and perhaps personally disconfirming) information and feedback, as well as an ability to respond flexibly to the current moment. RO is often extremely challenging, since it involves "actively seeking out those areas of one's life that one wants to avoid, or may find uncomfortable, in order to learn" (Lynch 2015). Patients may practice by acting opposite to the typical OC desire to rigidly control the creative process and art product.

SMUGGLING WATERCOLOR

Smuggling is a therapeutic strategy of gently suggesting the possibility of a reality different from what the individual believes to be absolute truth. Lynch (2015) calls this "getting new information under the barbed-wire" of a patient's defenses. Individuals with AN-R and other OC conditions usually despise watercolor due to the medium's loose, unpredictable nature. However, art therapists can smuggle the potential value of letting go of some control by mentioning that the final product will likely be more desirable if, during the first part of the activity, one allows the watercolor to *do what it wants* on the dampened paper. It is also helpful to assure them that, during the second part, they will receive opportunities to *take back* some control. Instruct patients to experiment with applying a variety of watercolor pigments onto dampened paper, allowing them to freely bleed and intermingle over the entire surface. After the piece has dried, either naturally or with a hairdryer, patients can add to it as desired with high-control media (e.g., markers, pens, watercolor pencils, and/or oil pastels). The paper may also be cropped or cut into other shapes. I have observed that those who allowed themselves to participate as directed were often thrilled with aesthetically pleasing results. And, perhaps most importantly, afterward they seemed somewhat less convinced that controlling everything is always an effective habit (at least when engaging in art).

Stage 2 DBT-informed art therapy

Stage 2 assists those who have achieved stability to address PTSD-related issues, including intrusive symptoms (e.g., flashbacks, nightmares), situational avoidance, and self-invalidation. Patients who enjoy and benefit from stage 1 DBT-informed art therapy might choose

to continue as they enter stage 2. PTSD treatment pioneer Bessel van der Kolk (1996) advocates the creative therapies in treating traumatized individuals who have lost the ability to verbally communicate their internal experiences:

> Prone to action, and deficient in words, these patients can often express their internal states more articulately in physical movements or in pictures than in words. Utilizing drawings and psychodrama may help them develop a language that is essential for effective communication and for the symbolic transformation that can occur in psychotherapy. (p.195)

Another option is a graduate group designed to assist individuals with reinforcing and generalizing previously learned DBT skills (Dyer 2008). Interventions focus on practicing mindfulness through image making and other creative activities with the intention of more deeply integrating skills acquired during stage 1.

Stage 3 DBT-informed art therapy

Because stage 3's goal is to build a *life worth living*—one of ordinary happiness and unhappiness (Linehan 1993)—and patients are now presumably skilled enough to manage any resulting emotional dysregulation, body image work might be indicated here. Rabin (2003) and Hunter (2012) describe compelling art therapy interventions for body image problems. There is also a plethora of qualitative literature concerning art therapy for other quality-of-life-interfering conditions (e.g., depression, chemical dependence, debilitating physical illness) (Malchiodi 2003); theoretical frameworks include psychodynamic, humanistic, and cognitive behavioral (Rubin 2001).

Stage 4 DBT-informed art therapy

Stage 4 addresses the incompleteness some patients experience after problems in living are resolved. Individuals seeking a sense of connectedness to a greater whole might explore spiritual traditions or contemplative practices. Renowned psychiatrist James F. Masterson (1990) made a case for the arts in resolving personality disorders and went so far as to say that creativity is the birthright of all fully functioning human beings. Masterson believed that individuals with a healthy sense of self possess the "potential for leading a creative

life and dealing with problems and challenges in new ways" (p.208). Those who deeply value artistic endeavors might pursue stage 4 with a transpersonal and/or explicitly spiritual art therapy practice (Allen 2005; Farrelly-Hansen 2009; Horovitz 2002).

Conclusion

What might the future hold for this approach? Other creative arts therapists are beginning to work in a DBT-informed manner: some music therapists integrate their techniques with skills training (Plener *et al*. 2009; Spiegel, Makary, and Bonavitacola 2020), and a drama therapist has written about her experiential method of teaching skills to women with EDs (Rubin 2008). Additionally, recent neurobiological research suggests benefits from applying multi-sensory interventions to learning (Shams and Seitz 2008) and the treatment of complex PTSD (Hass-Cohen and Carr 2008); to this end, certain art therapists have explored multi-modal processes combining visual art, music, movement, drama, and creative writing (von Daler and Schwanbeck 2014).

Perhaps DBT skills training featuring expressive arts interventions will one day become an evidence-based treatment. Unfortunately, many art therapists lack the necessary background and/or interest in quantitative methodologies, which may warrant collaboration with colleagues versed in conducting research. Such joint efforts could help build the body of research and foster the use of DBT-informed art therapy. Lebowitz and Reber (2011) suggest starting with following patients as they enter a combined DBT/art therapy model through at least six months post-discharge. The results of such a qualitative project might then facilitate small randomized studies comparing DBT-informed art therapy with "treatment-as-usual": skills instruction through the standard didactic model.

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Chapter 7

DBT-Informed Ceramic-Based Art Therapy Groups for Adolescents

Educating the Community About the Impacts of Sexual Abuse Through Public Exhibition and Social Activism

SHELLEY KAVANAGH

Introduction

My first exposure to dialectical behavior therapy (DBT) was close to 20 years ago, not long after I had begun my career as an art therapist. It took place during a camping trip with my children and some family friends. We were all seated around the campfire when, suddenly, a pager went off. The pager in question belonged to Dr. Shelley McMain, a friend who had recently started working with Marsha Linehan, clinical psychologist and the developer of DBT. I watched as Shelley rummaged for her pager, then called someone back on what would now be considered a prehistoric cell phone. While Shelley attended to the emergency I was struck by the calm and direct manner she used with her distressed client (who needed help managing high urges to engage in self-injury). I soon learned how this form of therapeutic communication, *phone coaching*, provides support outside of traditional office hours—particularly for individuals struggling with borderline personality disorder (BPD) (Linehan 1993).

DBT evolved from Linehan's efforts to create a treatment that directly targeted suicidality. Initially, her interventions were so focused on changing problematic cognitions and behaviors that many recipients felt misunderstood, invalidated, and criticized (and, consequently, often dropped out of treatment). As the research developed, however, Linehan added techniques intended to convey validation and help clients accept themselves, their thoughts, and intense emotions. DBT

eventually came to rest on a foundation of dialectical philosophy (Marx and Engels 1970), whereby therapists strive to continually balance/synthesize acceptance and change-oriented stances (Linehan 2020). DBT relies heavily on the use of validation and metaphor (Koerner 2012). Further, it combines standard cognitive behavior therapy (CBT) with mindfulness concepts and skills largely derived from Buddhist meditation practices (Linehan 1993).

During the years that followed I built a career as a DBT-informed art therapist and, in 2009, began formal DBT training that included a two-year practicum at the Centre for Addiction and Mental Health (CAMH). My educational activities eventually led to the development of a ceramic-based art therapy group for child and adolescent sexual abuse survivors. Now in its 17th year, the program invites participants to gather and sculpt their experiences of trauma and healing into clay. This form of expression has helped many of my clients to reduce often longstanding self-harming behaviors. In addition, they receive opportunities to share their stories with the public through exhibits at The Gardiner Museum of Ceramic Arts. Children and youth between 6 and 19 years old are supported by the expertise of a distinguished ceramic artist (Lynn Fisher) and a credentialed art therapist (me), as well as a supportive group of co-facilitators that changes from year to year for education and training purposes.

This chapter highlights how clay-based DBT-informed art therapy groups integrate safety, self-regulation skills, resilience enhancement, and body-based mindful awareness practices. An essential component is social activism, which plays a key role in helping young artists to identify themselves as "thrivers" (Dinsmore 1991, p.46). *Thriving* is the recovery stage in which a trauma survivor has healed to the point where she enjoys general life satisfaction and is forward-focused. Thanks to collaborations between Radius Child and Youth Services (formerly the Sexual Abuse Family Education Treatment/"SAFE-T" program) and The Gardiner Museum, projects spanning almost two decades have raised awareness about mental health issues. To help adolescents who self-injure cope with the trauma of sexual abuse, this program bridges what begins as a private and individual recovery process to a collective, political one. Communal exhibits support these young people in finding their creative voices, challenging histories that previously oppressed/silenced them, authoring alternative stories of hope, and experiencing themselves as artists who actively contribute to social change.

The foundation

My desire to provide young people with the skills necessary to reduce or eliminate impulsive and self-harming behaviors emerged when I was little more than an adolescent myself. I first volunteered, at age 18, to teach art in an open custody facility for youth convicted of criminal offenses. Open custody facilities are small, highly supervised residences generally located within the community. The individuals I encountered struggled with significant emotion regulation problems; as a result, they often behaved impetuously and came into conflict with house staff (authority figures the youth sometimes viewed as akin to their abuse perpetrators). According to the Crisis and Trauma Resource Institute, most youth who break the law are trauma survivors (Oudshoorn 2016). Research consistently shows that as many as 90 percent of offenders between the ages of 12 and 17 years old have experienced some sort of childhood trauma (Abram *et al*. 2004; Oudshoorn 2020).

Creating art relaxed the young residents; as a result, they were more willing to talk about personal experiences. During moments of calm self-reflection they often commented about how art helped connect them to the present. They could step away from their usual patterns of ruminating about the past and/or worrying about future unknowns. Only years later would I fully understand that the art making activities cultivated mindfulness, the core skill in DBT (Linehan 2015a, 2015b). This would profoundly shape my life and work.

In my early 20s I became a counselor for Street Outreach Services (SOS), a Toronto agency serving adolescents who had been trafficked into prostitution. Self-harm was common among the clients. Many also used various substances in their efforts to avoid the unbearable emotional pain of childhood physical and sexual abuse. During this same time period I was also employed with an Etobicoke senior high school (in Toronto's west end) for teens with similar risky behaviors and unique learning styles. Like their counterparts at SOS, most of my students disclosed significant trauma histories. While participating in the expressive arts program they shared stories about witnessing and being subjected to violence or abuse. They, too, typically engaged in self-harm to numb the intensity of their internal chaos.

Another commonality between the youth at SOS and the Etobicoke students was a drive to channel emotional suffering through visual self-expression. They did this by drawing or spray-painting on public walls and bathroom stalls (as well as anything else they viewed as a potential

canvas). I also noticed that, just as the youth in the open custody facility developed a greater capacity to attend to the present moment through art therapy, many of the students with learning disabilities seemed to become better able to focus and process new material. I believe that that was a direct result of the arts-based trauma therapy they received.

ALICE'S STORY

This was particularly true for one 16-year-old girl receiving therapy for intrafamilial sexual abuse at the SAFE-T program. A prominent adolescent psychologist had diagnosed Alice with cognitive delays, and she was not expected to ever function independently. Alice attended my ceramic-based art therapy group as part of her treatment plan. This group, co-facilitated at that time by my brilliant colleague Karen Holladay, comprised ten young women between the ages of 13 and 18.

For Alice, creating, and then verbally processing, her sculptures provided the structure and safety she needed to eventually talk about being drugged and then molested, which she described as feeling "like falling down the rabbit hole" in Lewis Carroll's famous novel *Alice in Wonderland* (2001). Alice had previously talked about experiencing the world around her as if "in a fog"—that is, nothing ever seemed real, tangible, or hopeful. However, once she had established herself as part of the art therapy group's community, Alice felt comfortable enough to begin disclosing further details of her abuse history within individual psychotherapy sessions. Over time she also grew more aware, focused, and capable of attending to the present moment rather than continuously feeling "stuck in the past" as before. After 18 months of therapy, Alice went on to study at a community college. She even published a poem about her trauma recovery.

Working through trauma with one's hands

Given the medium's unique properties, sculpting with natural clay may be well suited for trauma-informed art therapy:

> Clay work is a body-based psychotherapy that can be used in healing grief, depressed mood, anger, and fear (Sherwood 2004). As a form of clay work, Clay Art Therapy (CAT) combines nonverbal and verbal elements in the psychotherapeutic processes. The processes of clay work integrates the experience and of multi-sensory modalities (tactile, visual,

> proprioception (Elbrecht 2013), auditory), and kinesthetic activities in interacting with clay that range from gentle touch…to intense input of physical energy (e.g., pounding, rolling, molding clay slump). The processes of creating personally meaningful clay products require intense participation of perceptual skills, affective expression, creating symbolically meaningful clay works, cognitive functions (e.g., memory, decision making, organizational skills), and creative ability. These various processes can help raise the ability to properly understand emotion and better control of emotional expression. Through these processes, distorted thoughts and emotions can also be progressively restored and organized into a holistic piece (Carr 2008). Verbal expression of emotions will eventually become easier in psychotherapeutic process that can potentially benefit improvement of alexithymia (Nan and Ho 2014). (Nan and Ho 2017, p.238)

According to author and trauma specialist Noah Hass-Cohen (Hass-Cohen and Carr 2008), making art together in a group environment fosters healthy interactions, connectedness, and a sense of belonging that transcends language. Further, I suspect that our particular art therapy group, featuring as it does a profoundly sensory-based modality, supports growth in the brain areas where previously only trauma resided. Clay is indeed a unique medium. A recent randomized controlled trial (RTC) study showed that a clay/sculpture intervention was more effective in reducing depression and improving general mental health (and a sense of well-being) than was a nondirective two-dimensional visual art intervention (Nan and Ho 2017). Similarities exist between the sculpting process and interpersonal relationships, as well. There is a constant flow of conversation; when the artist pushes the clay, the clay pushes back. This heavily tactile material responds, reacts, and often must be wrestled with, in the same manner that relationships require if they are to fully develop.

Clay begins as a shapeless piece of earth. However, the art therapy group participants transform it into astonishing symbolic representations. Clay provides a conduit for emotional expression. It leaves an imprint; feelings move through one's hands and into its substance, and the unseen becomes visible. This process allows exposure to inner traumas and wounds, documented in a manner that can facilitate healing. Like the course of therapy itself, the firing process (which entirely changes the material substance of the clay) has inherent

vulnerabilities. For example, a sculpture may be shattered. Yet the artist, with the group's support and encouragement, can find ways to make the piece whole again.

Clay sculpture as a specifically DBT-informed practice

All projects emphasize dialectics, acceptance, validation, and compassion. DBT recognizes that, for healing to occur, full acceptance of current realities must balance every quest for change. Representing one's trauma history with clay in a manner that includes past struggles, current coping patterns, and future hopes offers an effective method of addressing all four of the DBT skills modules (core mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness). Additionally, ceramics making fosters self-validation and other achievable treatment goals including personal mastery and developing a more flexible, adaptive sense of self.

Distress tolerance skills—ACCEPTS

Incorporated within the intention of the ceramic therapy groups is the DBT distress tolerance ACCEPTS skill (Linehan 2015a, 2015b). This is a group of distraction strategies; its purpose is to cope effectively with difficult feelings and situations by tolerating what one cannot immediately change. ACCEPTS helps us navigate crisis-level emotional states, such as when the mind is flooded with negative thoughts and/or when the body feels extremely activated.

ACCEPTS comprises distracting with *Activities*, *Contributing*, *Comparisons*, opposite *Emotion(s)*, *Pushing away*, other *Thoughts*, and other *Sensations* (Linehan 2015b, p.166). In terms of the group's therapeutic sculpture/clay work, ACCEPTS plays out as follows:

A—Activity: Creating with art materials is an excellent distracting activity!

C—Contributing: When strong emotions take over, it can seem as though our problems and worries are all-encompassing. During such moments it is important to step outside of ourselves. Being part of a group that displays artwork for the purposes of teaching the public about the impacts of abuse/trauma—with a focus on contributing to a collaborative ceramic piece—is a way of *paying it forward*: the sculpture is left behind as a gift to new clients coming into the art therapy group.

C—Comparisons: If we observe ourselves getting caught up in our issues and emotions, we may take a step back and express gratitude for what we *do* have. In addition, group members can compare how they are currently functioning with when the abuse was first disclosed (and/or during an earlier point in their trauma recovery process).

E—(opposite) Emotions: We may use opposite-to-emotion action as a tool to bring balance and return to a neutral ground. This technique invites us to engage in behaviors that are directly opposite to the intense emotion's action urge. For example, if feeling sad, then participate in the group art project (instead of isolating and/or doing nothing).

P—Pushing away: It may be necessary to take a break from a distressing situation by leaving it mentally for a while. Within the ceramic studio one might engage in a conversation with a peer. Over time, we demonstrate to ourselves that we can distract from the thoughts/feelings that do not serve a positive purpose in the moment (while still validating their existence).

T—(other) Thoughts: This can be done in a ceramics group by looking at artwork in the gallery, practicing a mindfulness technique, or using the provided journal for drawing or writing poetry.

S—(other) Sensations: Physical sensations can give great relief when we are overcome with intense emotions. Clay possesses an interesting texture and odor that some find soothing. In addition, pounding, slapping, and roughly kneading it is a good way to channel strong, agitated physical energy.

Distress tolerance skills—radical acceptance

Radical acceptance, an important distress tolerance skill (Linehan 2015a, 2015b), encourages us to fully explore the notion of self-acceptance. Marsha Linehan claims that "acceptance may lead to sadness, but deep calmness usually follows" (2015a, p.342). In other words, radical acceptance eventually results in a sense of freedom and peace. Clients' personal narratives, reformed into ceramic sculptures, provide opportunities to represent metaphorically their inner experiences.

Metaphors are powerful because they convey abstract thoughts or feelings. They also help to facilitate a dialectical stance of accepting our present circumstances while simultaneously moving us toward necessary growth. When clients work with clay while holding an

openness and curiosity as to what form it will take, they are essentially practicing acceptance. They own their hurtful past experiences, allow for the present moment to be what it is, *and* imagine potential future healing landscapes. More precisely, this activity facilitates emotional pain tolerance to ensure the possibility of positive change.

The clay-firing process embodies the dialectic of establishing control as necessary while *also* letting go. In a shared kiln one must trust that the other pieces were hollowed carefully. If not scored well, they can easily break. Firing tests the artist's willingness to relinquish ultimate control over the product; this is another powerful analogy for radical acceptance. Because accepting reality requires fully acknowledging life on life's own terms, it also follows that one must learn how to let go.

Transforming raw clay into a ceramic piece explores this idea on multiple levels. The client, in choosing what emotional material to process, personalizes the experience from the very beginning. Sculpting calls for delicate and careful control. This offers a potentially meditative and grounding experience that invites her to be present in her body. Finally, as mentioned earlier, there is a great degree of uncertainty involved with firing clay, which necessitates the client's ability to accept the end result of her piece, just as it is, after the transformation of the firing process is complete.

The role of mindfulness

One method for building and supporting group participants' coping skills is a brief mindfulness activity at the beginning and close of each art therapy session. These exercises, intended for both personal practice and the group's benefit, can take many forms (mindfulness might involve working with clay or could be a guided visualization). Mindfulness is at the core of DBT. This foundational tool helps participants practice being in the present moment, bringing awareness to judgmental thoughts with the aim of reducing judgments of self and others, and letting go of any attachment to how things "should" be. Mindfulness supports group members to progress with their art making, and to transition out of the ceramic studio when the session comes to a close.

A mentorship and profound friendship with Toronto-based art therapist and Rinzai Zen practitioner Suzanne Thomson has deepened my understanding of *self-compassion centered mindfulness*, which has recently become integral to the work I share with clients. What grew most apparent to me over time is that those individuals who engaged in

cutting reduced their frequency of self-injury as they learned to tolerate emotional discomfort during the art therapy group. I also believe that connecting with other participants was key. As relationships among group members grow, self-harm behaviors usually decline. The experience of being part of a community, and a corresponding decrease in isolation, seems to help clients commit to a life worth living. The building of the group is equivalent to the development of hope.

One of the artists, age 13, describes their artwork (Figure 7.1):

> My sculpture represents my journey. It began in a rough way; someone who I thought was my friend ended up not being the case—they broke my trust. Now I am on a great path. Before (prior to the start of the group) I wasn't myself; I was down. Since the group, I feel like I am not alone, there are people there for me. Working with art has helped with this. Just know there is always hope and people there for you.

FIGURE 7.1 "MY SCULPTURE REPRESENTS MY JOURNEY… JUST KNOW THAT THERE IS ALWAYS HOPE AND PEOPLE THERE FOR YOU."

Art therapy, community building, and social activism

The partnership between The Gardiner Museum and the SAFE-T program began in 2004. Its goal was to provide young sexual abuse survivors with opportunities to create their personal trauma narratives in clay. The trauma narrative is a cognitive behavior therapy (CBT)

technique used to help individuals who have suffered from abuse express and make sense of those events. The trauma narrative also serves as a form of exposure to painful memories (Deblinger *et al*. 2011). The client shares the story of her traumatic experience(s) through verbal, written, and/or artistic means.

Additional goals of creating a trauma narrative are to incorporate unspoken aspects of the person's past into their life story, explore difficult emotions, and recreate this story through the construction of a new meaning. Group participants share with the intention of releasing unresolved pain to make room for new, healthy experiences. Clay is a particularly safe and effective material for trauma work. It allows the participant/artist to maintain distance and gain mastery at the same time. Creating distance from one's trauma, a trait inherent to working with clay via its long-form creation period, allows the artist time to process unforeseen emotional responses that may arise during group. Further, given the long-form creation period, artists may work through their traumas and build resilience.

As evidenced by Alice's story, ceramic-based art therapy groups provide opportunities for children and adolescents to interact with peers with similar backgrounds. When a young artist meets others who have also endured sexual abuse, her realization that she is not alone reduces the typical sense of isolation. Ceramic art projects are designed to combine the wisdom of reflection, the beauty of compassion, and the science of creativity into a unique source of support for trauma survivors. The group process itself allows participants to come together and empower one another, as well as develop a sense of agency in their individual lives.

Every year features a metaphor-focused project such as "Bridge to Resiliency." Another, entitled "Our Piece of the Sky," was a response to *Half the Sky: Turning Oppression into Opportunity for Women Worldwide* (Kristof and WuDunn 2008). This book portrays courageous women who experienced adversity and took great risks to contribute to their communities. We shared these stories with the 2012 ceramic group participants in the hope that they would identify with them.

A continuous theme throughout every annual project is acknowledging and building community. Our 2014 project was inspired by Maya Angelou's wise words: "There is no greater agony than bearing an untold story inside you" (Angelou 2009, p.114). This quote supported the idea that group members create their trauma narratives for their

own recovery while also using art to inform the public about the impact of sexual abuse.

At the close of every project, group members come forward to share their personal experiences and artwork in a public exhibition at The Gardiner Museum. By this time they are usually not just determined to break the silence of sexual abuse; they also feel confident in their role as agents of change. This self-assurance starts with developing personal creativity and results in championing the values of social justice and community engagement.

A group I worked with in 2013 coined the term "One Together" in honor of children who lived halfway around the world and had similar trauma backgrounds. That year's theme was an artistic response to the 160 Girls Project, a legal initiative led by attorneys and social workers from Kenya and Toronto. The 160 Girls Project compelled the enforcement of existing Kenyan laws prohibiting sexual assault, where previously rape was systemically perpetuated and went unprosecuted. The all-female ceramic group felt a kinship with these girls on another continent and wanted to lend their support through raising awareness in a public exhibit at The Gardiner Museum: a clay sculpture consisting of over 160 hands and figures wrapped around the United Nations Convention on the Rights of the Child. One year later, Toronto's first Child and Youth Advocacy Centre opened its doors (and provided referrals to the ceramic group). The legal crusade in Kenya continued to receive ongoing exposure, as well.

In 2015 a ceramic project entitled "Forging New Paths" took shape. The SAFE-T program had transitioned into a community-based agency, Radius Child and Family Services. Radius joined with The Gardiner Museum to continue to break the silence that often shrouds sexual exploitation. Participants sculpted their symbolic footsteps and placed them on a clay "journey" to represent how traveling with others makes the passage more accessible and less burdensome. These trailblazers were inspired by a quote found on Pinterest (attributed to Tom Hiddleston): "You keep putting one foot in front of the other, and then one day you look back and you've climbed a mountain" (Aniban 2017) (Figure 7.2).

As one client identified within her artist statement:

> My first piece was inspired by another group member: a mountain with large obstacles and supports to help me overcome. Large rocks blocking a clear/positive path represent these tough times. A bridge shows the

supports over a waterfall and substance use as a way of coping. I'm shown at the top, celebrating overcoming such difficult times.

My second piece is a book showing negative sides of my life that I use to help cope. It shows strategies that I've used to get me through tough times and how I've stopped self-harming. Although it's still a thought, it's never acted on.

FIGURE 7.2 COLLABORATIVE CERAMIC PIECE INSPIRED BY TOM HIDDLESTON'S WORDS: "YOU KEEP PUTTING ONE FOOT IN FRONT OF THE OTHER, AND THEN ONE DAY YOU LOOK BACK AND YOU'VE CLIMBED A MOUNTAIN."

Another group member shared: "Following repression came expression, as I'd always been paranoid about what I did and didn't say. Art got me out of that habit."

In 2018 a collective ceramic piece entitled "Our Sheros" was an homage to all the powerful women who have helped keep the conversation of sexual abuse in the forefront of many minds and hearts. The artists defined a *shero* as "a female hero, a female that displays strong heroic traits under tremendous pressure and is triumphant over her circumstances." *Sheros* are girls and women who act courageously, especially in times of adversity and uncertainty; *sheros* have been through extraordinary experiences and have proven to be *sheroic*. They exemplify what is possible and inspire people of all ages. The *#MeToo* and *Time's Up* movements, which both emerged during the timeframe of this project, were extremely validating for many of the group participants. #MeToo, founded in 2006 by Tarana Burke, has helped survivors of sexual violence—particularly Black women/girls and

other young women of color from disadvantaged communities—find pathways to healing (Garcia 2017). Time's Up (founded by Hollywood celebrities) shares a similar vision for women's empowerment with #MeToo (Langone 2018): it asserts that everyone deserves to be free of harassment, sexual assault, and discrimination. The "Our Sheros" sculpture was also reminiscent of the words of Maya Angelou (1993): "History, despite its wrenching pain, / Cannot be unlived, but if faced / With courage, need not be lived again."

The most recent ceramic project involved some interesting synchronicity. While the group participants met and worked weekly in The Gardiner Museum's basement studio (called the building's *foundation*), Ai Weiwei, one of the world's most influential living artists and social activists, displayed his show "Unbroken"—a perspective on human rights violations and social justice—on the top floor. While the artworks upstairs reflected boundary-breaking (Davidson 2019), the work being created below expressed freedom from the oppression of sexual abuse.

The large mindfulness bowl shown in Figure 7.3 was created by me as a witness response to the courage, commitment, and creativity each group participant embodies as they reveal their personal experiences of recovery from sexual abuse. In a desire to honor the sharing of pain and healing that occurs in the clay studio, I offer a quote by Thích Nhất Hạnh (2001): "Love is not just the intention to love, but the capacity to reduce suffering, and offer peace."

The bowl embraces the Metta meditation that nourishes loving-kindness as a restorative process (Thích Nhất Hạnh 2020):

May I Be Happy
May I Be Well
May I Be Safe
May I Be Peaceful and at Ease

May You Be Happy
May You Be Well
May You Be Safe
May You Be Peaceful and at Ease

May We All Be Happy
May We All Be Well
May We All Be Safe

May We All Be Peaceful and at Ease

May the experience of community, belonging and interconnectedness always overflow.

FIGURE 7.3 MINDFULNESS BOWL CREATED BY THE AUTHOR IN RESPONSE TO THE GROUP MEMBERS' PROCESS AND ARTWORK

Conclusion

I have, over nearly two decades of providing clay-based art therapy groups, striven to maintain a validating and nonjudgmental clinical environment congruent with DBT's principles. DBT helps individuals to build on their strengths, develop self-confidence, and build mastery. And, like DBT, working with clay encourages clients to identify and appropriately challenge maladaptive beliefs, assumptions, and habitual behaviors that have historically made their lives more difficult. The experience of attending group art therapy sessions, sculpting a narrative indicative of both trauma and healing, and then putting the resulting art work on public display for others to witness and take inspiration from, have all contributed to trauma survivors' capacities for moving forward. My recollection of how Shelley McMain made herself so available to her client during that now long-ago evening left a permanent impact on my own willingness to embrace individuals who have typically not received much validation. I have been honored by the trust of so many

courageous young people, and am grateful for my children, friends, and colleagues that support me as deeply and fully as they do.

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Chapter 8

From Hatch to Handshake

Combined Art Therapy and DBT Skills Training in a High-Security Learning Disability Treatment Unit

EMMA ALLEN AND ANTHONY WEBSTER

Introduction

Tactile stimulation (touch, in particular) is a highly personal and profound method of nonverbal communication as well as an important component in the development and maintenance of physiological, psychological, and emotional regulation throughout the human lifespan. Consensual touch facilitates a calming sense of empathy, safety, and reassurance (Hill 1995); it is perhaps also a powerful mechanism for repairing preverbal or nonverbal developmental disturbances (Zur and Nordmarken 2011).

> Touch is one of the fundamental human experiences: to know loving or unwanted touch, the traumatic rupture of boundaries and their repair. Touch is the basis for secure attachment, linked to earliest body memories, to the ability to handle the world, to sexuality and injury. (Elbrecht and Antcliff 2014, p.19)

Within the helping professions, however, touch is a sensitive and complex topic (Hetherington 1998; Hunter and Struve 1998). The counseling, social work, and psychotherapy fields generally regard physical contact between patients and clinicians as a boundary violation with strong potential for harm (Karbelnig 2000). However, prior to the Covid-19 pandemic, handshakes (now a serious health concern) were relatively commonplace and, at times, unavoidable (Zur and Nordmarken 2011). In high-security forensic psychiatric treatment units, touch is only appropriate and/or acceptable during restraint (i.e.,

restricting movement), pat-down searches (inspecting clothing on the body for concealed items), and routine nursing duties (e.g., delivering medication, completing physical examinations, and so on). Whenever risk levels escalate, forensic unit staff attempt to contain or reduce the patient's potential violence to self/others through *seclusion*, a method of therapeutic isolation and confinement that prevents, limits, or subdues free movement (Bleijlevens *et al*. 2016; Department of Health 2014).

At the National High Secure Learning Disability (NHSLD) men's service,[1] a 54-bed unit where this case study is based, patients live in specialized low-stimulation suites (containing a bedroom and bathroom) with observation windows. Communal areas are carefully monitored via 24-hour closed-circuit television (CCTV) surveillance. Individuals in seclusion receive their nursing and therapeutic care/support exclusively through a hatch window until immediate risk subsides.

Such safety measures, although necessary, preclude any potential benefits from close connections with others. There is strong evidence that people experience significantly limited social contact as dehumanizing (Alty and Mason 2013; Wadeson and Carpenter 1976). Additionally, some patients report that risk management techniques make them feel "institutionalised, deskilled, bored, frustrated, and treated as an object to be managed" (Tomlin 2020, p.2). Restraint may also provoke hostility, depression, and suicidal ideation (Franke *et al.* 2019).

A high proportion of patients in the NHSLD men's service unit have histories of significant childhood neglect as well as physical and/or sexual abuse. Posttraumatic stress disorder symptoms can engender strong fears of touch and close bodily proximity where touch may internally represent aspects of the original trauma; this may precipitate acute emotional dysregulation—even acts of violence (Allen 2018; American Psychiatric Association 2013). Hence, handshakes, such as those occurring at the start or end of many therapeutic relationships, are discouraged with sequestered forensic patients. Allen writes about how these individuals "pose high risks to others, in particular by grabbing staff at the seclusion hatch" (p.142).[2]

The present chapter is a continuation of "The Boy Who Cried Wolf" (Allen 2018), which described a collaborative/cross-disciplinary dialectical behavioral therapy (DBT) skills training and art therapy intervention in the NHSLD men's service unit. Its subject was "Daniel,"

a male in his mid-20s. Daniel presented with a "complex history of anti-social criminal behavior and co-morbidity of bipolar disorder, borderline personality disorder and intellectual developmental disorder (IDD)… [and] trauma relate[d] to…suffering long and extensive family violence and abuse" (Allen 2018, p.140). He was frequently secluded due to recurring threats and/or attacks against female staff. The initial treatment phase took place at a hatch window and slowly progressed to lower-security ward-based sessions.

This chapter reviews the therapeutic process portrayed in "The Boy Who Cried Wolf" and then explores the subsequent, more intensive interventions that followed. Co-author Emma Allen previously suggested that seclusion may have provided a "safe retreat" for Daniel where he could maladaptively "'segregate' his emotions" and thus avoid challenging situations (Allen 2018, p.144). However, the unique triadic therapy relationship (*art therapist/patient/DBT therapist*) created "an alternative sense of containment to that offered by seclusion" (p.150) so that Daniel could tolerate his eventual transition from long-term isolation into general ward life.

We portray the evolution of Daniel's ability to regulate intense emotions as well as authentically engage with us, the authors, through the use of art and DBT skills training. We also posit that by outlining his own hands, as well as ours, Daniel developed healthier attachments (within which he neither feared being left nor maintained urges to *grab* and *hold on*). In the context of his artwork, Daniel was at last *seen* and *heard*; by the end of therapy, he had finally let go of the compulsive need to physically offend and could appropriately shake hands with us. The chapter describes the journey leading from the hatch window to this handshake. We conclude with recommendations for future practice and suggest a combined DBT and art therapy approach that is suited to a forensic learning disability (LD) setting given its physical restrictions.

DBT and its adaptations

DBT is a specialized, multi-modal cognitive behavior therapy (CBT) for extreme affect regulation problems (Linehan 1993). This popular and empirically founded intervention was developed to treat chronically suicidal individuals who frequently met the diagnostic criteria for borderline personality disorder (BPD) (Dimeff and Koerner 2007; Rathus and Miller 2002; Rizvi and Linehan 2001). DBT interventions

and strategies aim to balance standard CBT's emphasis on change with accepting patients as they are in the present moment. The long-term goal is "increasing clients' capabilities in experiencing and managing emotions, interpersonal relationships, and crises" (Swales and Dunkley 2020, p.18).

DBT has been adapted for other diagnoses and clinical situations, including forensic environments (McCann *et al*. 2007) such as prisons and institutions for young offenders (Shelton *et al*. 2009, 2011). DBT demonstrates effectiveness with low patient engagement (Linehan *et al*. 1991; Verheul *et al*. 2003), anger, and aggression (Frazier and Vela 2014). While its impact upon recidivism requires further investigation (Tomlinson 2018), research does support DBT's capacity to reduce risk-related behaviors in those with LDs (Lew *et al*. 2006). Brown, Brown, and Dibiasio (2013) state that DBT's core principles and strategies (e.g., validation, positive reinforcement, the dialectic of acceptance versus change) can address entrenched "patterns of escalating emotions, which are underlying factors associated with challenging behaviors" in IDD patients (pp.284–285).

DBT-informed skills training: *The I Can Feel Good* (*ICFG*) program

A significant component of comprehensive DBT is psychoeducational and contains four didactic modules: core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills (Linehan 2015a, 2015b). Although the skills curriculum is only one piece of DBT's standard evidence-based model, recent studies indicate that it can be a valuable sole and/or primary intervention (Linehan 2015a; Linehan *et al*. 2015). Furthermore, modified skills systems exist for the unique needs of LD and IDD populations (Ashworth *et al*. 2018; Brown 2015). For example, *I Can Feel Good: DBT-Informed Skills Training for People with Intellectual Disabilities and Problems Managing Emotions* (Ashworth *et al*. 2018) is "specifically designed to help those with an intellectual disability and personality disorder to identify emotions, thoughts, and behaviours, increase self-awareness and reduce unwanted impulsive behaviours" (Allen 2018, p.141). The program achieves this, in part, by reducing the number of skills, eliminating complex language and mnemonics, and repeating modules to help improve understanding and retention.

The *I Can Feel Good* (*ICFG*) manual (Ashworth *et al*. 2018) places more of an emphasis upon experiential learning than does standard DBT, with its strong language-based approach (Linehan 2015a, 2015b). *ICFG* encourages patients to become more aware and accepting of their internal cognitive and emotional experiences through practical tasks featuring visual methods, physical teaching tools, and creative activities (Morrissey and Ingamells 2011). A wide range of exercises focus on bodily sensations as well as props to aid in comprehending abstract concepts. An example of the latter is the use of a papier-mâché head filled with colored balls representing thoughts. Because visual learning is essential for this patient group, DBT's handouts and homework materials were redesigned to include more pictures than words (Ashworth *et al*. 2018).

Nontraditional teaching methods such as *ICFG* can help abuse survivors, as well. Even years after the actual event(s), traumatic experiences overstimulate the brain's right hemisphere while shutting down the left hemisphere (which is necessary for higher neurological functions including verbal communication, sequencing, and executive functioning) (van der Kolk 2015). Such processes are crucial to benefiting from psychoeducational programs like DBT. Hence, the effects of posttraumatic stress may pose a significant impediment to both day-to-day functioning and to the optimum acquisition and retention of new cognitive and behavioral skills.

Art therapy

Clinical art therapy is a therapeutic discipline that incorporates visual art-based creative methods such as drawing, painting, collage, and sculpture into mental health treatment. Interventions can range from simple and/or rudimentary activities (where the emphasis is on the creative process) to ones intended to resolve psychological problems by exploring symbolic material within the artworks themselves. The latter approach is often called *art in therapy*, *dynamically oriented art therapy*, or *art psychotherapy* (Malchiodi 2011).

Like DBT, art therapy/art psychotherapy exists in multiple treatment milieus and is adapted for the LD and forensic populations (Bull and O'Farrell 2012; Gussak 2012; Gussak and Cohen-Liebmann 2001). It has also begun to garner interest as a promising brain-based trauma treatment (King 2016). For Daniel, a nonverbal approach was ideal

because it was "less threatening…due to his communication deficits and avoidance through verbalisation" (Allen 2018, p.140). Art therapy provided an alternative means of accessing emotions in ways that were effective with past traumatic experiences, while keeping the patient grounded in the present.

Although our work with Daniel had deep roots in psychodynamic processes (and was *art psychotherapy* to a large degree), for the purposes of this chapter we center on its more cognitive behavioral and humanistic elements. That said, certain schema therapy-informed principles (Rafaeli, Bernstein, and Young 2011), as well as ideas from attachment theory (Solomon and Siegel 2003), appear when relevant. For example, while the DBT skills were invaluable for Daniel's treatment and recovery, we maintain that "[o]verall…it was our joint therapeutic relationship, and our offering of a secure and trusting attachment that helped re-engage Daniel into therapy and out of the seclusion suite" (Allen 2018, p.150).

Combined DBT skills training and art therapy interventions

The merging of DBT skills training and therapeutic art activities is a relatively new treatment method and is not currently supported by quantitative research. DBT-informed art therapy approaches may assist with the delivery, retention, and generalization of the behavioral skills (Clark 2017). The incorporation of art therapy activities into DBT skills training involves *hands-on* experiential directives (finger painting, for example, provides a preverbal expressive language accessible to all learning capabilities). According to Heckwolf, Bergland, and Mouratidis (2014), coordinating them "both in case conceptualization and in therapy sessions can reinforce skills gained within each approach alone and link parts of therapy for the patient, creating a more coherent treatment experience" (p.330). Integrating creative art interventions into the four didactic DBT skills training modules is thought to have greater impact upon recovery and well-being for those specifically identified as suited to both therapies, and can initiate significant changes in therapeutic relationships and psychological presentations (Huckvale and Learmonth 2009).

Another possible benefit of combining these particular interventions relates to DBT's focus on present-day issues as well as current, active behavior, whereas traditional art psychotherapy concerns itself

more with the past and "unconscious and pre conscious material yet to surface" (Rothwell and Hutchinson 2011, p.25). Perhaps these differing approaches allow one therapy to "balance out the other" (p.25). However, both work from the premise that suppression of emotions leads to suffering (Gross and Levenson 1997; Linehan 2015a; Roemer and Borkovec 1994). Thus combined approaches tend to highlight full emotional experiencing and expression (Clark 2017). An example is Huckvale and Learmonth's (2009) integration of DBT's theoretical and practical features (such as synthesizing *acceptance* and *change*, the development of *wise mind*, and so on) with pragmatic image making processes to create a cohesive psychosocial education model.

Clinicians may devise DBT and art therapy sessions to equip patients with new strategies for identifying dysfunctional thoughts/emotions, as well as managing them more effectively, through techniques like problem-solving and changing existing behavioral responses (Clark 2017; Johnson and Thomson 2016). Our approach for increased distress tolerance and emotion regulation capacities revolves around fostering a "here-and-now awareness" (Haeyen, Kleijberg, and Hinz 2018, p.166): the recognition and acceptance of one's own and others' self-expression in order to improve one's mental health, resilience, and flexibility. Our triadic (2:1) combined art therapy/DBT-informed approach described below involves building a sense of agency, exploring the relationships with self and others, and alleviating fears of abandonment. Our rationale considered the importance of touch for emotional, physiological, and interpersonal development (Harlow 1958). The work with Daniel, centered as it was on relationships and collaboration, seemed to naturally result in images of our hands.

Forensic art therapy and DBT with LDs and IDDs: Combined interventions

Art therapy and DBT have been applied to the delivery of LD offender treatment programs/interventions in several settings (Huckvale and Learmonth 2009; Rothwell and Henagulph 2017; Rothwell and Hutchinson 2011). For example, the combined modalities in LD forensic services appeared to increase one's patient's emotional literacy and ability to "bear the pain" of her traumatic past and current psychiatric symptoms (Rothwell and Hutchinson 2011, p.24). Research

has shown that art therapy may assist those with an LD to improve communication, mentalization, and self-reflection—thereby reducing levels of aggression (Hackett 2012). In our work with Daniel, we designed art therapy directives[3] that provided visual metaphors of the DBT-informed psychoeducational concepts (which made them more accessible to him). Clinicians may also modify existing directives to meet the needs, characteristics, and abilities of individuals in forensic settings (Gussak 2012).

DANIEL

Daniel, stage one

Daniel's mother died when he was an infant; shortly thereafter his father began to abuse him both physically and sexually (which continued into adolescence) (Allen 2018). Daniel received treatment within several hospital settings starting in his late teens. However, following an escalation of antisocial and criminal behavior, he was admitted to the NHSLD unit for risk of harm to self and others, and to treat his existing comorbid diagnoses.

Emma, the art therapist, and an assistant psychologist (Richard Short) began to work with Daniel during a period when he "fluctuated from being nursed in seclusion and LTS following assaults and threats to kill female staff" (Allen 2018, p.139). He was isolated after a psychiatric decompensation with psychosis and homicidal ideation, including a physical attack on his female DBT therapist, that took place in the high secure unit. Daniel also exhibited a propensity for "fantasy and exaggeration" (p.140); he had made numerous false claims of abuse and neglect against staff. Richard became his new DBT therapist.

Usually hostile toward females, Daniel "placed [Emma] and art therapy on a pedestal" (p.140). That changed when she disclosed her need to take a planned sick leave for a few months: "Although this was not an ending, Daniel found the prospect of me 'abandoning' him difficult to tolerate, and he became angry and fearful. He pushed me away, and I fell off the pedestal" (p.140). Concerned about his escalating agitation and intimidating manner while in Emma's presence, the multidisciplinary team decided to suspend therapy for an extended period. Unfortunately, the long-term seclusion and lack of contact took a substantial toll on Daniel's mental state, which had "severely deteriorated" (p.141).

After Emma's return, the team recommended that Daniel resume treatment: His Recovery Care Plan "had indicated that he should continue with DBT for emotional regulation and improved problem-solving skills […] and art therapy for the better understanding of feelings and improved behaviours" (p.141). Sessions occurred on a 2:1 basis (two clinicians to a single patient) to decrease the risk of violence. Providing both art therapy and DBT skills training during the same session "prevented Daniel 'splitting' therapists off and making serious allegations" (p.141). In the beginning, the interventions consisted of introducing basic cognitive and behavioral techniques (e.g., mindful breathing and/or visualization exercises, focusing on positive self-talk, squeezing a paper cup in lieu of a stress ball[4]) and DBT-informed concepts:

> During this pre-therapy work, we integrated ICFG Mindfulness Practice Worksheets, repeating exercises that differentiated between a *Hot*, *Cool* and *Wise Mind* to enable learning and reduction of risk, building upon coping skills and self-reflection through "in-the-moment" coaching. This took place through both the seclusion and quiet room hatches. (p.142)

When the time came to introduce art supplies, the clinicians provided Daniel with pastels, "passing his chosen colour through the hatch one at a time… Offering materials felt like providing him food: a form of nourishment and care that was harder for him to reject or attack" (p.146). Daniel learned how to use different colors to describe his emotions (e.g., "suicidal red," p.147), as well as symbolize their related physical sensations and felt locations in his body. Sessions continued to be structured first around mindfulness worksheets (from the *ICFG* manual), and then image making.

> Turn-taking felt similar to the parenting process, giving the other parent a break or a "breather." […] At times, I felt distressed as if unable to comfort an infant. It felt exhausting to endure his tests: we had to prove that we were not the "abandoning mother" and "abusive father." It seemed that the DBT exercises brought a paternal structure, with its focus on behaviour, whilst art therapy offered a more maternal focus upon emotional expression and containment (Rothwell and Hutchinson 2011). (Allen 2018, pp.144–145)

By the time that Richard announced his imminent departure from the ward in order to start doctoral training, Daniel was well enough

to endure some exploration of his feelings concerning endings, grief, and underlying fears of abandonment—that is, being left alone "to die" (p.148). He eventually came to trust that he was not being rejected and agreed to continue joint therapy with another DBT therapist (co-author Anthony Webster).

> Our three-way relationship had offered a unique opportunity to support Daniel with unresolved bereavement and loss: a prominent theme for individuals with learning disabilities, when the patient's existence can be validated by knowing that another cares if they live or die. Offering art materials not only offered hope, but allowed him to feel human again. (pp.148–149)

The final session with Richard, carefully observed by nursing staff sitting nearby, took place out of seclusion with both clinicians and Daniel together in the dining room. It was a successful experience and the patient was able to say goodbye to Richard. In addition, he indicated willingness to continue to work on his issues using art therapy and DBT.

Daniel: At the hatch

This second phase transpired over 13 months and included a more formal combination of art therapy and DBT. The art therapy component was a directive, mindfulness-based approach with joint/combined three-way image making.[5] Over the course of his therapy we witnessed a significant reduction in physical violence from Daniel, who earned transfer to a low-dependency ward prior to being discharged to a medium (lesser) secure unit.

Combined DBT and art therapy with Daniel

The weekly sessions took place in the ward dining room. We provided Daniel with a therapy calendar that noted any upcoming cancelled sessions. The purpose was to ease Daniel's anxiety and support him in retaining information. We also hoped to reduce the likelihood of complaints and/or allegations.

> Applying DBT and art therapy simultaneously provided emotional regulation and reinforcement of practicing, accepting, and changing. DBT strengthens and enhances art therapy by maintaining a structure, while the image making of art therapy provided sensory input,

> mindfulness in action, and a safe container for Daniel's manageable emotions. DBT techniques helped focus on the positive, distracting him from his homicidal expressions and incorporating mindfulness provided an important common ground for us both as practitioners. (Allen 2018, p.150)

Session structure

- Initial check-in (5 minutes): We often used visual methods for identifying emotional states, such as Blob Trees and Men (Wilson and Long 2017).
- DBT skills training/psychoeducation (20 minutes): We used the *ICFG* manual.
- A mindfulness exercise (5 minutes): Examples include a brief watercolor activity, guided imagery and relaxation/breathing script, and progressive muscle relaxation.
- Joint/combined image making (10–15 minutes): These were in response to a specific art therapy directive. For consistency and containment, Daniel worked in a sketchbook provided by us.
- A brief guided breathing exercise (10 minutes): Daniel would squeeze a stress ball in both hands while inhaling/exhaling to feel more balanced.
- Concluding check-out (5 minutes): We summarized the session content and evaluated Daniel's emotional state prior to his re-entering the ward.

Fears of being forgotten: Trauma at hand

Art therapy with forensic patients often uncovers painful emotional states such as fear of abandonment, feelings of inadequacy, and grief/loss (Collier 2016), and can also create "opportunities for mastering trauma from neglected experiences of, and failures in, past emotional containment and boundaries" (Allen 2020, p.36). Internal states are more articulately expressed in pictures than through words; hence, it is crucial to devise a symbolic language for processing and coming to terms with trauma (van der Kolk 2015). Loss, especially difficulty with change, is prominent in those with LDs. Given his terror of "being

forgotten" (Figure 8.1), Daniel required consistent reassurance that we would both return after breaks in therapy (Kuczaj 1998; Stokes and Sinason 1992).

People with LDs are among the most vulnerable and socially excluded client groups and have a greater occurrence of physical and mental health issues (Emerson *et al*. 2011). The trauma Daniel had experienced during childhood drastically impaired his development of boundaries to the point where he had little concept of safety. Daniel's conceptualization of separateness from the environment did not extend much further than his own personal space. The loss of his mother and subsequent paternal physical/sexual abuse had removed any sense of internal security. In its stead was an intense fear of being discarded, forgotten, and/or abused.

Whenever Daniel's physical boundaries were encroached on, it felt like a breach in his tenuous self-concept, which he perceived as a life or death situation (the threat being a potential re-experiencing of childhood abuse). He often reacted with explosive violence and aggression. This served to reaffirm his personal space, and thus create an accurate perception of safety, in relation to the external environment. An example: Daniel not only had profound need for attention and care, as well as a fear of abandonment; he was also extremely averse to touch. The administration of medication was highly distressing for him and he would often become more confrontational with staff at medication time.

To repair the boundaries his father had violated early on, Daniel needed Anthony to build trust and provide reassurance that he would not be mistreated in the absence of Emma. Daniel's recurring allegations of abuse by staff, we felt, resulted from a profound need to be heard, cared for, and affirmed. The presence of both a male and a female therapist emulated adoptive parents. We held in mind the schematic approach of *reparenting* (Kellogg and Young 2006) as we strove (within professional boundaries) to address Daniel's unmet childhood emotional needs while limiting cross-over between the two therapeutic models.[6] Reparenting provided a means through which we could attempt to restore/extend upon boundaries via listening to and validating Daniel whenever appropriate, as well as apologizing for his childhood experiences.

Handprints

During one image making session Daniel spontaneously drew around both of his hands, then added descriptions of his most significant fears: "not having someone to talk to," "being forgotten," "not having somebody close," and "losing a best friend" who was moving on (Figure 8.1). We explored how outlining his hands as part of the artistic process helped focus mindful attention toward his own body as well as validate and release difficult emotions; the words themselves, with our guidance, assisted Daniel in restructuring anxiety-provoking thoughts into affirmations (e.g., the fear of *being forgotten* became *I will be remembered*). This image, made in the center of his sketchbook, seemed to reach out to both therapists. Some of the pieces that followed also included Daniel's hands; these were reminiscent of both M.C. Escher's 1948 lithograph "Drawing Hands" (Escher 2016) and the Cueva de las Manos—that is, the *Cave of Hands*—in Argentina, with its prehistoric, stenciled human handprints (Troncoso, Armstrong, and Nash 2018). Hands are what make us human; they create and give us purpose, but paradoxically, "are precisely what disobey" (Leader 2016, p.4). Daniel's drawings appeared to say: "Here I am."

FIGURE 8.1 FEAR OF BEING FORGOTTEN

Drawing around another person's hands allows for a nonthreatening visual, tactile, and emotional connection, as well as opportunities for exploring boundaries. Through the creation of collaborative art works involving both Emma and Anthony, Daniel gradually appeared to grow more comfortable with closeness. While significant physical contact was obviously not appropriate, this symbolic and imaginal linking of hands became an innovative replacement for touch. It also evidenced the developed therapeutic relationship between the clinicians and this patient. Daniel initially outlined our hands on the same page as his own. Over time, however, he drew them closer and closer together until the fingers slightly overlapped, as seen in Figure 8.2. This piece was created by Daniel drawing around the therapists' hands, and vice versa, a process that involved very minor physical contact to which Daniel responded appropriately (we noticed how he gently touched our hands as he drew around them).

Image making became the medium through which Daniel could access and communicate his thoughts and feelings. Inherent within his IDD were significant cognitive issues (i.e., difficulties with processing, assimilating, and relaying information). Art therapy allowed him a nonverbal means of emotional expression and facilitated in-the-moment practice of distress tolerance skills. The combined art therapy and DBT helped Daniel to assert his sense of personal boundaries without resorting to violence. By effectively managing the physiological impact of traumatic memories (and therefore becoming more grounded in the present), Daniel could better differentiate between past threats and his current surroundings.

Daniel was ultimately able to maintain close proximity to us and interact effectively, something he had never experienced with his own parents. Daniel took the lead, which enabled him to reclaim some control back in his life and build a sense of safety—not only with us, his therapists, but in relation to other people, as well. Over time, pat-down searches and other procedures no longer held the same threat. There was a marked reduction in violence and aggression during searches as well as administration of medication by nursing staff. Daniel shifted from viewing himself as a perpetual victim to a survivor. His growing confidence improved his capacity to engage with others.

Image making focused on expressing and discharging emotions (such as Daniel's fear of abandonment and anger). This provided a foundation for the DBT-informed psychoeducation, which utilized

both the *ICFG* people skills modules and distress tolerance. The latter comprised *body maps*, that is, visual templates of the human body exploring how emotions are physically experienced, the roles they play in communication, and recognizing them in others.[7]

Repeatedly drawing around our hands in our work with Daniel cemented his body awareness into the present therapy (rather than keeping it trapped in past trauma). One half of Figure 8.2 features our joined hands while the other half is a collaborative painting where we all made marks on the page; this piece shows a diverse range of colors and shapes.

FIGURE 8.2 ACTIONS SPEAK LOUDER THAN WORDS

When working with those who have personality disorders, it is important not to overanalyze the past, but, rather, to remain focused on the present. This helps prevent unhelpful repetitive patterns such as self-defeating behaviors. Instead, the objective is to use image making to externalize various states of mind and emotions (Springham *et al.* 2012). Externalization allows patients to notice and witness their internal experiences from a reasonable distance and prevent overidentification

with them. This is essentially mindfulness of current thoughts and emotions (Linehan 2015a, 2015b). For example, we often suggested that Daniel take the lead on the breathing exercises and image making and, if his mind wandered, to simply notice that and gently return to the current moment. Working with thoughts/feelings in this way helps one to experience them as temporary manifestations rather than permanent states.

After completing a series of joint/combined mindful watercolor paintings, Daniel described one as a "happy ending" (and he asked Emma to write this on the image) (Figure 8.3). Over the course of 13 months, Daniel had evolved from hopeless in the face of past traumas to optimistic and hopeful for the future. We watched his relationships improve, along with his developing sense of self and personal boundaries, as he progressed from long-term seclusion and reintegrated into ward life. Imagery allowed Daniel to be seen and heard. Our final handshake at the close of therapy increased an internal sense of calm, empathy, and reassurance, restoring previous disturbances (Hill 1995).

FIGURE 8.3 A HAPPY ENDING

Conclusion

This chapter described the integrated use of art therapy and DBT skills training interventions with a young man residing in a long-term, high-security forensic treatment unit for an LD and psychiatric conditions. Daniel was frequently secluded due to his impaired self-regulation capacities, which were in large part the result of extensive childhood trauma. Although necessary given the high risk of harm to others, this lack of physical contact and human connection had had a negative impact on Daniel's mental and emotional health.

The paired experiential and didactic approach provided containment, grounding, and resolution of emotional experiences; furthermore, it appeared to help empower Daniel through a newly acquired awareness of agency and control, the opposite of *learned helplessness* (Maier and Seligman 2016). The DBT skills themselves were one important component. Creative self-expression was the other. DBT's emotion regulation skills afforded Daniel the means to develop and reinforce healthy separateness from the external world without the need to resort to violence.

The resulting nascent sense of safety is what allowed him to feel confident enough to invite us into his artwork during later sessions. Daniel's act of drawing around his therapists' hands enabled touch to occur safely and appropriately within the high secure setting—making the impossible possible and establishing true human connection. Daniel's personal agency seemed to increase when he returned to drawing around his own hands, grasping and letting go of emotions rather than becoming them.

We suggest adapting joint/combined image making to suit working under extreme physical restrictions. Therapists should consider the active use of the body and hands with those who have been abused or neglected (while also minimizing the risks of exploitation). This may help build a sense of mastery over the physiological effects of trauma through the acquisition and application of DBT skills and creative self-expression. We also suggest that forensic arts psychotherapists consider the use of touch as a basis for secure attachment that is linked to early body trauma, and "the ability to handle the world" (Elbrecht and Antcliff 2014, p.156).

Daniel has transitioned from the NHSLD men's service unit to a less-secure setting. We hope that our work together will inspire other therapists to consider a similar approach for the benefit of patients who

struggle with complex conditions and needs. Combined DBT-informed skills training and art therapy interventions appear to hold promise for helping such individuals as they move forward with their lives.

Acknowledgment

We are grateful to Daniel for consenting to share this work, for all that he has taught us in our practice, and for assisting other clinicians to develop theirs, as well.

Endnotes

1 The National High Secure Learning Disability (NHSLD) men's service unit is part of Rampton Hospital, located in Nottinghamshire, UK, which also provides national high secure treatment for four other patient populations: mental health (male), the deaf (male), personality disorders (male), and women with mental illnesses, personality disorders, and/or learning disabilities. Rampton is one of three high secure hospitals in England and Wales.

2 "This became exceedingly clear at the time of our first joint session with Daniel: Daniel had been asking after us, and was looking forward to seeing us both. The hatch was placed open for us by staff. Daniel greeted us through the window with a smile and offered his hand through the gap to shake our hands. Richard went first, and I followed, but Daniel gripped hard at my hand and wrist, not letting me go. I asked him to let go and he suddenly apologized, saying he 'didn't know what came over' him. I remember feeling a little shaken—by how possessive this felt—and left with a feeling that I couldn't ever let him down. Hyper-sensitive to feeling rejected or abandoned, Daniel often tested boundaries in dangerous ways" (Allen 2018, p.142).

3 Art therapy directives included a variety of drawing games, collaborative mandala paintings, and mindfulness-based watercolors (i.e., watching water drop onto the paper, noticing the merging colors). Others: Draw your emotions and/or locate their related sensations in your body using body map templates (see endnote 7). We also encouraged spontaneous image making in response to each DBT skills module's themes and concepts.

4 As "trust and integration go hand in hand" (Siegel 2010, p.86), we encouraged Daniel to squeeze a stress ball (sometimes referred to as a hand exercise ball) in time with his breathing. This can relieve muscle tension and address the physiological aspects of trauma by assisting individuals with gaining conscious awareness of their physical selves (van der Kolk 2015). Posttraumatic stress disorder (PTSD) has a profound impact on the person's ability to piece sensory information together into a whole, coherent experience (McFarlane 2010). Therefore, it is likely that the stress balls (used during guided mindfulness exercises) allowed Daniel to focus on his bodily sensations and begin to reconnect with brain areas associated with wider self-awareness. These structures are significantly underactive in PTSD cases (e.g., the parietal lobes, which manage physical sensations; the insula, which links physical sensations and emotions; and the anterior cingulate, which links emotions and thought) (van der Kolk 2015). NOTE: Throughout our work with Daniel, we focused a great deal on physical/kinesthetic methods to help him better manage the physiological symptoms of his trauma.

5 *Joint/combined three-way image making* refers to the technique we employed with Daniel in which all three of us collaborated in the creation of a single artwork. Sometimes this

involved taking turns (adding to the piece one person at a time). On other occasions we simultaneously contributed marks, images, etc.

6 An example of this took place when Daniel misinterpreted the intent of a physical examination that had been requested by his specialty doctor. Daniel believed that it would be a genital exam, which, although not the case, triggered a heightened state of agitation (he was anxious and fearful of sexual abuse). Like new parents on the scene, we reassured Daniel of the nature of the exam. This evoked a significant shift in his level of trust toward us both, and afterward the team noticed a marked reduction in the number of aggressive outbursts.

7 *Body maps* are grounded in CBT theory (Rapee *et al*. 2000; Santen 2015; Zandt and Barrett 2017). We used them with Daniel as a psychoeducational exercise. He would draw or color his current internal emotional experience onto a blank template of an androgynous human body. We guided him with prompts about specific emotions (e.g., "When you're angry, where does it sit in your body?"). We coupled this with an exploration of language he could use to effectively describe his emotions and physical experiences. Daniel appeared to find the body map exercises useful for separating out his emotions, which had become enmeshed by the trauma. For instance, Daniel's experience of fear was often heavily entwined with anger and shame. Through this exercise he was not only able to draw them apart from one another but also developed a wider vocabulary for communicating each emotion to others.

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Part 2

Multi-Modal DBT-Informed Approaches

Chapter 9

DBT Case Conceptualization Featuring Art Therapy and Poetry Interventions

YVETTE DUARTE

Introduction

This chapter presents combined dialectical behavior therapy (DBT) and art therapy, a novel intervention that appears particularly effective for some individuals. I, the author, provide the case conceptualization for Muneca (pseudonym), a young adult who completed one year of comprehensive outpatient services at Awake DBT, Inc.[1] in San Jose, California. The client's second six months of treatment featured a weekly skills training group that included DBT-informed art therapy activities, as well as ongoing individual DBT sessions (the latter of which also contained art therapy elements).

I share Muneca's story via a modified DBT case conceptualization format[2] and follow this with some drawings and poems the client created during their participation. The chapter also considers how integrated DBT, art therapy, and poetry may have helped this individual to achieve some of their treatment goals. It concludes with suggestions for researching DBT-informed art therapy interventions and measuring treatment outcomes.

DBT

DBT is a well-known cognitive behavior therapy for severe emotion regulation problems (Koerner 2012; Linehan 1993; Swenson 2016). It was designed to treat borderline personality disorder (BPD), a mental illness marked by impulsive, risky, and/or self-destructive behaviors,

frequent or chronic suicidal ideation (SI) and attempts, self-injury, severe mood instability, relationship difficulties, intense fears of abandonment, and poor treatment response (American Psychiatric Association 2013; Dimeff and Koerner 2007). According to Marsha Linehan, PhD, DBT's developer, "[T]he unrelenting crises and behavioral complexity of a borderline patient often overwhelm both the patient and the therapist" (1993, p.165). Such intense situations and high-risk problems require a very structured, specific, and inclusive intervention with clearly defined, consistent priorities.

> DBT is a behavioral treatment program, not so much an individual psychotherapy approach. It is a combination of individual psychotherapy sessions, group [skills] training, telephone coaching, a therapist consultation team, and the opportunity to help change the client's social or family situation as well. (Linehan 2020, p.9)

Comprehensive treatment at Awake DBT involves a six-month commitment, including one 24-week cycle of skills training. The curriculum contains four modules: core mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation skills (Linehan 2015a, 2015b). DBT consists of five stages: pretreatment[3] and stages 1–4. After a thorough assessment of a client's history and presenting issues, the clinician determines the appropriate treatment stage. For the purposes of this case study, I focus on stage 1 DBT, the typical entry-level intervention for those with problems "so pervasive that they significantly impair quality of life, interfere with therapy, and pose a threat to life" (Koerner 2012, p.27).

Miller, Rathus, and Linehan (2006) state that the focus of Stage 1 DBT is on attaining "a life pattern that is reasonably functional and stable" (p.46). To this end, the therapist and client collaboratively work toward four primary behavioral categories. *Target* behaviors refer to behaviors that are explicitly identified as needing to change. These are addressed within the individual therapy session and "are approached hierarchically and recursively as higher-priority behaviors reappear" (Miller *et al*. 2006, p.46).

Listed in order of importance, the four DBT stage 1 targets are (1) *decreasing* life-threatening behaviors, (2) *decreasing* therapy-interfering behaviors (on the part of the client and/or therapist), (3) *decreasing* quality-of-life-interfering behaviors, and (4) *increasing* behavioral skills. Clients record any occurrence of primary "target" behaviors

(Linehan 1993, p.165) on a *diary card* and bring this monitoring tool with them to every individual therapy and skills training session. Routine review of the diary card assists with keeping both client and therapist focused on the primary targets (Miller *et al*. 2006).

Art therapy

The American Art Therapy Association (AATA) describes art therapy as "an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship" (2017). Although a detailed exploration is outside the scope of this chapter, it is important to note that, as with other mental health disciplines, art therapy "is used to encourage personal growth, increase self-understanding, and assist in emotional reparation" (Malchiodi 2012, p.1). However, unlike DBT, art therapy has not obtained a strong evidence base, as the existing research is mainly qualitative in nature.

DBT-informed art therapy

Some clinicians believe that art therapy can serve as a valuable complement to DBT. Huckvale and Learmonth (2009) found that DBT's dialectical approach[4] to acceptance and change (as well as the concepts of emotion regulation and developing one's *wise mind*[5]) resonates with art making processes both within and outside of formal art therapy environments. Clark (2016) defines DBT-informed art therapy as a "strategic use of creative visual exercises to explore, practice, and generalize stage 1 DBT concepts and skills" (p.190). As such, it introduces novel multi-modal (e.g., visual, kinesthetic) interventions to DBT's primarily language-based skills training protocol (Linehan 2015a, 2015b); these may be more engaging for nontraditional learners. The resulting enhanced mental interest could potentially improve skills retention because participants are more likely to associate personal meaning with the acquired information (through creating artistic metaphors and symbols) (Dyer 2008). Furthermore, such heightened interest/attention may stimulate the core mindfulness skill of *participating effectively*: According to Clark (2016), combined DBT and art therapy clients "often describe coming away with a deeper

understanding of the skills, and the resulting art product can be a helpful presence and reminder of important work long after the actual therapy session has concluded" (p.115).

Art making gives participants an alternative method for discovering and integrating didactic materials through various creative media such as collage, pencils, pastels, paints, and clay. I suspect that this unique application offers a depth not attainable through standard language-centered skills training. Megan Shiell, a DBT-informed art therapist from Australia, points out that "clients are learning in two different ways: one from a skills-based cognitive approach, and one from an experiential, nonverbal style of learning" (personal communication) (Clark 2017, p.111). Along these same lines, von Daler and Schwanbeck (2014) write:

> As efficacious as DBT is in helping clients change behaviors, regulate emotions and create a life worth living, we wanted to integrate the wealth of possibilities that comes from the sensory engagement, imagination, and creativity of expressive arts—that might augment growth and deepen engagement and transformation. (p.237)

The DBT/art therapy skills group at Awake DBT

Only one of Awake DBT's several skills training groups includes art therapy. Individuals who express interest in this advanced group at the time of their intake interview must demonstrate solid familiarity with the DBT skills (and/or have successfully completed a standard skills training group).

I introduced the DBT/art therapy group in 2015. My intention was to help clients better integrate DBT into their daily lives by engaging in creative methods for exploring, expressing, and deepening their comprehension of the DBT concepts/skills. Group members frequently state that they feel that they are "getting" the material on a deeper level. Many also note how they connect with peers in a more intimate, authentic manner than seemed possible while attending the regular didactic DBT skills training group. Additionally, clients report that they feel good about themselves and what they accomplish through DBT/art therapy.

The two-hour-long group commences with a brief mindfulness exercise (20 minutes) followed by a review of the previous week's skills practice homework (30 minutes). After a 5-minute break the session resumes with a DBT skills lesson (25 minutes), then a related art therapy

exercise (40 minutes with sharing/processing time). I end the session with a new skills practice homework assignment.

During their intake Muneca talked about how they wanted to attend the group and shared a belief that they learned best by creating art. Throughout the second half of their DBT tenure, Muneca received art therapy interventions within both DBT individual therapy and skills group. As for the individual sessions, these were woven into target 3 (quality of life) work after we had addressed any target 1 and/or target 2 behaviors. Art therapy provided Muneca with ample opportunities to externalize their inner experiences through the nonverbal language of lines, colors, and textures. The resulting artworks provided concrete evidence of Muneca's journey toward health and wholeness.

CASE CONCEPTUALIZATION—MUNECA

Muneca's DBT case conceptualization consists of the following: client description/presenting problems, biosocial theory, stage 1 primary targeted behaviors, and life worth living goals.

Client description/presenting problems

Muneca, a 21-year-old Mexican American nonbinary person, was referred for comprehensive DBT as part of their discharge plan from an inpatient treatment facility. Muneca reported psychiatric symptoms beginning at age 15 (e.g., "falling behind on homework," "crying and being moody"). At intake they carried the following diagnoses: major depressive disorder, generalized anxiety disorder, and attention deficit hyperactivity disorder (ADHD).

Muneca endorsed a history of self-harming behaviors (e.g., cutting, skin picking) but claimed that their last cutting episode occurred during high school, when they had used a blade to "feel something" and "deal with the emotional pain." Muneca received inpatient psychiatric treatment on at least six occasions for SI when they were under the age of 15, as well as four more times as an adult. Their most recent hospitalization occurred six months prior to entering Awake DBT. Other risk factors included the suicides of a nephew and their best friend.

Muneca displayed significant behavioral impulsivity fueled by emotional dysregulation. During these episodes they might overspend. They also reported "spiraling out of control when bad things happened." Muneca struggled with intense anger (another common BPD symptom), which they often expressed by punching walls. Muneca denied any extreme outbursts

for several months prior to starting DBT. However, they maladaptively controlled their anger by "shutting down"/isolating (which resulted in bouts of sadness). Muneca often chose not to directly communicate their needs for fear of "being a burden."

Other symptoms/behaviors: Muneca had difficulty concentrating and could be quite forgetful. They frequently exhibited paranoia and occasionally dissociated around other people. They sometimes experienced depersonalization, as well. Muneca reported smoking marijuana one to two times a week; however, use increased when they were emotionally dysregulated. During their time in comprehensive DBT, Muneca was prescribed Prozac and Abilify.

Biosocial theory

DBT's biosocial theory posits that BPD is a disorder of the emotion regulation system and that emotion dysregulation "is due to high emotional vulnerability plus an inability to regulate emotions" (Linehan 1993, p.43). Linehan hypothesized the following: first, individuals prone to emotion dysregulation possess high sensitivity to emotional stimuli; they react quickly, and "[e]vents that might not bother many people are likely to bother the emotionally vulnerable person" (Linehan 1993, p.44). Second, they experience emotional intensity—responses are extreme, and such high arousal can dysregulate cognitive processes, too. Third, emotions are long-lasting, with a slow return to baseline. Koerner (2012) states that difficulties managing emotions negatively impacts myriad areas of one's life: "Most of what we do and who we are depends on mood stability and adequate emotion regulation" (p.5).

During their DBT assessment Muneca reported feeling "very sensitive to people's energy." They described many examples of sudden reactions that were out of proportion to the prompting event(s). Muneca concurred that these intense emotions seemed to take much longer to return to normal levels compared with other people's responses.

According to the biosocial theory, BPD develops through repeated transactions between this innate sensitivity and one or more invalidating environments. Koerner (2012) elaborates that pervasive invalidation occurs when "our valid primary emotional responses" are treated by others as though they are "incorrect, inaccurate, inappropriate, pathological or not to be taken seriously. Primary responses of interest are persistently squelched or mocked; normal needs for soothing are regularly neglected or shamed; honest motives consistently doubted and misinterpreted" (p.6).

Muneca reported that their parents failed to validate their emotional experiences. For example, their father apparently responded to their frustration or sadness by yelling. Whenever their mother supported him (or remained neutral), Muneca felt disregarded and invalidated. In addition to conflicts with their parents, Muneca was bullied by other children because they were "different," and quick to tears or anger. Their physical appearance was also quite unlike that of their Christian school classmates: they dyed their hair and dressed in their own unique style. Muneca attended the school from sixth through eleventh grade but was expelled for cutting and threatening to kill themselves shortly after their best friend committed suicide. Although Muneca did not then possess the resources or capacity to manage academic challenges, they eventually graduated from high school.

Interactions between Muneca's inherent sensitivity and invalidating and traumatic environmental factors may have impaired their ability to regulate emotions and moods.

Linehan's biosocial theory holds that emotionally vulnerable children are unlikely to naturally acquire competence with managing intense affect—hence why DBT explicitly teaches emotion regulation skills (Koerner 2012).

Stage 1—Primary targeted behaviors

Muneca and I agreed to collaboratively address the following:

- *Target 1/Life-threatening behaviors*: These are the most serious behaviors and, therefore, prioritized. Target 1 includes suicide attempts, significant SI, and self-harming acts (especially resulting in tissue damage).

Muneca denied current target 1 behaviors, although they had a recent history of psychiatric hospitalizations related to SI. Muneca had once created a plan to jump in front of a train. However, they did not make any attempts. Muneca also reported that they had not cut themselves in several years.

- *Target 2/Therapy-interfering behaviors (TIBs)*: These get in the way of effective DBT and include not completing diary cards and/or skills group homework, as well as treatment absences. The goal is to reduce both client and therapist TIBs and increase behaviors that "enhance the continuation and effectiveness of therapy" (Linehan 1993, p.129). Linehan explains that individuals "who are not in therapy or who, though nominally in therapy, do not engage in or receive therapeutic activities, cannot benefit" (p.129).

In the beginning, Muneca did not consistently complete their diary card and homework assignments. A missing link analysis (a type of behavior analysis for identifying treatment obstacles) indicated that ADHD made it difficult for them to concentrate and, therefore, follow through. This TIB declined as Muneca developed mindfulness skills (and set reminders on their phone).

- *Target 3/Quality-of-life-interfering behaviors*: These are behaviors/problems that create (or are themselves) obstacles to improving overall quality of life. Muneca's target 3 behaviors included difficulties with obtaining housing and with securing employment. They also contended with some financial and academic issues.

Muneca possessed several negative self-judgments that contributed to their overall emotional dysregulation and often precluded them from pursuing and achieving important goals (an example of the secondary target *self-invalidation*[6]). They also lacked appropriate follow-through with tasks such as registering for classes at school and completing job and housing applications. Further, intense emotions reduced Muneca's ability to keep relationships; they did not trust other people and tended to ineffectively confront friends when upset.

Muneca and I collaborated during the intake to identify some initial goals and *targets*. Targets are behaviors that must change (i.e., decrease, stop, or increase) for the client to achieve their goals. Muneca's primary targets were to: (1) decrease punching walls or "shutting down" when angry; and (2) increase motivation (and reduce isolation).

- First target behavior.

Muneca wished to better control anger, which often resulted in SI/psychiatric hospital admissions. The function of their angry behavior, for example punching walls and "shutting down"/withdrawing, was twofold: Muneca wanted their father to stop yelling *and* wanted their mother to validate their emotions. This was sometimes effective when one or both parent(s) showed concern or provided some validation (which unintentionally reinforced the target behavior). However, if Muneca withdrew and ruminated to the point of feeling very depressed (and communicating that they might attempt to kill themselves), they frequently ended up in the hospital for SI.[7]

- Second target behavior.

Muneca exhibited a pattern of isolating from friends, which triggered loneliness and an ever-decreasing motivation to socialize. Withdrawal

was a way to avoid, in the short term, normal but painful feelings of grief/sorrow. For example, on the anniversary of their friend's death, Muneca did not leave their bedroom all day and ruminated on guilt, which, although unpleasant, was not as painful to Muneca as the sadness. The behavior was dysfunctional because it ultimately made Muneca more depressed and probably in need of hospitalization (this is an example of the secondary target *inhibited grieving*[8]).

Life worth living goals (LWLGs)

During the intake process clients also establish LWLGs, specific things they must achieve to create the kind of life they desire. These goals are what drive/motivate treatment (while the target behaviors get in the way of treatment). Muneca's LWLGs were as follows:

- LWLG 1.

Muneca wanted to become more independent from their parents and ultimately move to Oregon with their boyfriend: "I want to be less affected by what my parents are dealing with and be at peace with them. I want to become my own person." However, Muneca also wished to be on good terms with them. Improving their relationship with both their mother and father would strengthen Muneca's support system (which would help them to feel more confident in living independently).

- LWLG 2.

Muneca's second goal was to develop more friendships so that they would not be as lonely.

Comprehensive DBT is a complex treatment model containing numerous and sophisticated assumptions, procedures, and strategies. Although its skills training component is extremely important,[9] skills are not always sufficient (Koerner 2012). Other aspects of DBT that were crucial for Muneca included contingency management, cognitive restructuring, and exposure interventions.

Contingency management utilizes reinforcement principles to increase desirable behaviors and decrease undesirable ones. Because the client/therapist relationship is typically so powerful and positive, these strategies are often "ways to manage the contingent relationships between the patient's behavior and the therapist's responses so that the ultimate outcomes are beneficial instead of iatrogenic" (Linehan 1993, p.297).

Cognitive restructuring procedures assist clients to change both the style and content of their thinking. This was essential for reducing Muneca's negative self-judgments so that they were more able to regulate their emotions. This involved challenging dysfunctional beliefs such as "my anger defines me" and replacing it with a less extreme cognition (i.e., "anger doesn't define me and it's okay to be angry sometimes").

Mindfulness of emotions is an exposure practice. For example, clients are "instructed to 'experience' exactly what is happening in the moment, without either pushing any of it away or grabbing onto it. They are also instructed to 'step back from' and observe judgmental responses to their own behaviors" (Linehan 1993, p.354). Linehan further states that, "[i]n its entirety, mindfulness is an instance of exposure to naturally arising thoughts, feelings and sensations…and may be particularly useful way to encourage exposure to somatic cues associated with emotions" (p.354). This treatment was helpful for Muneca in decreasing emotional/physiological arousal after conflicts with their parents. Exposure work allowed Muneca to fully experience the emotions so that they no longer feared and avoided them.

ART THERAPY AND POETRY: DBT IN ACTION

Art therapy and poetry: DBT in action

This section explores some of the artwork that Muneca created during their DBT participation. These pieces specifically addressed the previously mentioned target behaviors and LWLGs. Although Muneca used a variety of art materials in both their individual DBT sessions and within the art therapy/skills group, this case conceptualization highlights the following: a 8.5 × 11 in. spiral-bound multimedia sketchbook (referred to as "blue spiral"), alcohol ink markers, and thin pens. Muneca preferred to draw with markers and pens, which, as more controlled media options, allowed them to feel more comfortable and secure in their creative expression.

Activity 1: Create a LWLG (Figure 9.1)

Purpose

Explore meaningful treatment goals applicable to the client's personal conceptualization of their *life worth living*.

Materials
The blue spiral sketchbook, markers, and pens.

Procedure
During one of our individual sessions I asked Muneca to create an image representing their LWLGs, which included improving their relationships with their parents and becoming more independent.

Discussion
Muneca stated that the scale illustrated "wanting more balance in [their] life" so that anger and anxiety would not continue to overwhelm them: "The moon represents the dark night of the soul and dealing with emotions. The sun represents when things go well and [are] lit up. I could stay balanced whether it's the day or night." The title indicated that "Hopefully, whatever journey I was on, I would reach a balance."

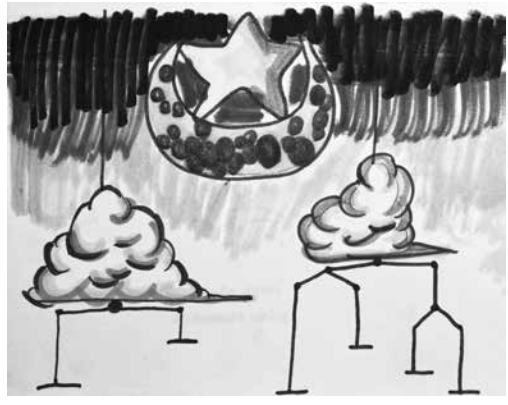

FIGURE 9.1 "THAT'S ALL, FOLKS!" (CREATE A LIFE WORTH LIVING GOAL)

Activity 2: STOP skills diagram (Figure 9.2)
Purpose
Deepen (enhance and reinforce) the client's understanding of the DBT STOP skill (Linehan 2015a, 2015b). STOP is part of the distress tolerance module (crisis survival skills) and comprises four consecutive steps/components: *S*top moving (don't act on impulsive behavior urges); *T*ake a step back and breathe; *O*bserve what is happening both inside and outside of oneself; and *P*roceed mindfully ("Think about your goals. Ask Wise Mind: Which actions will make it better or worse?") (2015b, p.327).

Materials

The blue spiral sketchbook, markers, and pens.

Procedure

This assignment was given in a DBT/art group session. I invited participants to make a diagram of the STOP acronym and draw their own iconography for each of the four steps/components.

Discussion

Muneca wanted to break their pattern of becoming extremely stressed and overwhelmed, then suicidal (which had resulted in numerous hospitalizations). Using STOP decreased their suicidal urges when their father yelled at them and/or did not acknowledge their feelings. Muneca also wished to reduce what they called "shutting down" in response to becoming emotionally upset (i.e., isolating and ruminating about stepping in front of a train). These episodes typically resulted in Muneca calling 911, then being hospitalized for suicidal ideation. Using colored markers in their blue spiral sketchbook, the client made a diagram of a figure demonstrating the STOP skill in its entirety. Muneca reported that drawing all four steps/components in this way helped them to better understand and integrate STOP into their expanding repertoire of effective behaviors. Over time, they became less reactive when they felt angry, and hence made more desirable choices.

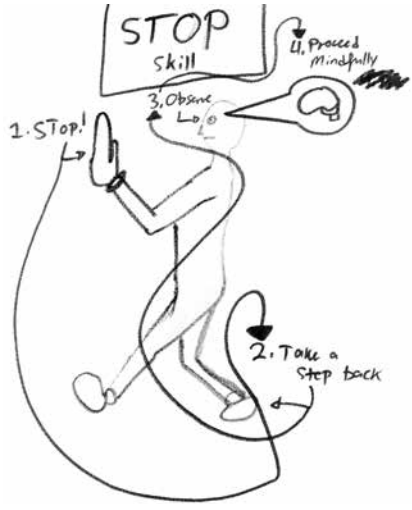

FIGURE 9.2 THE STOP SKILL

Activity 3: Mindfulness of current emotion (Figure 9.3)

Purpose

Deepen (enhance and reinforce) the client's understanding of the mindfulness of current emotion skill by practicing it, and then further exploring the observed affect state through creative expression. Mindfulness of current emotion involves exposing oneself to that emotion by attending to it fully and not pushing it away.

Materials

The blue spiral sketchbook, markers, and pens.

Procedure

During an individual session Muneca struggled with intense anger. I directed them to practice breathing and observing their body sensations until the emotion subsided. Afterward, the client shared that their distress had significantly decreased. Muneca then completed this symbolic artwork.

Discussion

The snake image came to Muneca while practicing mindfulness of their current emotional state. Muneca explained that the snake held divine wisdom; further, it represented transformation and infinity (expressed by the snake eating itself). Muneca added that the fangs depicted anger. However, this snake was controlled and would not strike unless it was in danger. It showed a strong presence but did not *need* to lash out. Muneca reported that they felt more confident after completing this exercise.

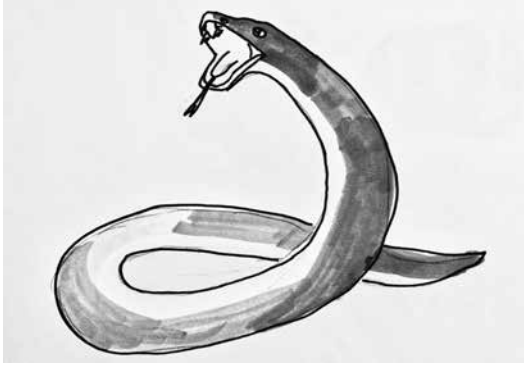

FIGURE 9.3 RIDING THE WAVE OF ANGER—DIVINE WISDOM (MINDFULNESS OF CURRENT EMOTION)

Activity 4: Wise mind (Figure 9.4)

Purpose

Strengthen personal understanding of wise mind (the inherent wisdom in each of us).

Materials

The blue spiral sketchbook, markers, and pens.

Procedure

This exercise was completed during an individual therapy session. The directive was for Muneca to create an image of the wisdom they felt in that moment after reaching their goal of finding housing.

Discussion

Layla was the final artwork that Muneca made around their second LWLG (to develop friendships and decrease loneliness). They had worked on processing unresolved grief in order to build healthier relationships and to feel more connected with other people. One day near the end of treatment, Muneca came to their individual session excited about having just secured an apartment in Oregon. They were looking forward to moving out of their parents' house and becoming more independent. Muneca identified *Layla* as their "wise mind monster" (and smiled as they described this creature as "soft, furry, and warm"). Muneca described how Layla possesses a "third eye"—also symbolic of DBT's "middle path" (Linehan 2015b, p.74)—with which to see things more clearly. It is their "eye of wisdom." Muneca believed that they had grown a great deal and had strengthened their wise mind over the course of the DBT treatment.

FIGURE 9.4 LAYLA THE WISE MIND MONSTER! (PERSONAL CONCEPTUALIZATION OF WISE MIND)

Poetry

Poetry writing was another powerful means of self-expression for this client. Muneca engaged in creative writing on their own. However, they often shared their poems during the skills group homework review.

Muneca's writing changed over the course of their time in the DBT program. The poems appear to reflect a developing sense of self. For example, in several early pieces they described themselves as wounded and "empty." Yet by the time they had graduated from DBT, Muneca came across as more confident as well as capable of empathizing and connecting with others. This following poem describes how they felt at the beginning of their treatment journey.

Vessel
I am but an empty vessel for mental illness to do its dirty work
My body used to house a person, but the demon was always there
Lurking, hiding, waiting, rationalizing its existence away,
Until one day, a coup happened,
And the person became hostage to their own skin and shed itself away.
So, they walked with their demon to the train tracks,
Where the sweet but violent embrace of death was
Supposed to come at 60 miles per hour
With 70 tons of weight behind it to back it up in case speed wasn't enough
It missed.
So even though the train missed, I still manage to hate myself everyday
And have long since left my body rotting for the demon to feast on.
—12/1/17

Although it was composed only four months after "Vessel," the next poem, Muneca said, spoke to the middle phase of treatment and finally being able to "calm down."

Calming Down After a Panic Attack (A Love Letter to Me and All Other Survivors)
Breathe
In
Out
In again
Out again

You made it to here, the now
The you in this present moment
A present to yourself from you

A beautiful soul so deep with words
That haven't even been invented yet
Used to describe you and your every feature
Indescribable
So, beautiful
Mind body and soul
You're wonderful
Give yourself some credit
Because you deserve it
Anxiety is an unwanted guest
Even when you do your best
Coming when least expected
Leaving you affected
Trashing the living room of your mind
And leaving you pieces of garbage to find
Even when you try to make it feel most unwelcome…
…But you have survived this abuse
before, and you have survived it now.
You did your best
And that's all that matters.
—12/1/17

Muneca wrote the final poem, "Prayer," nearly two years after "Vessel." They describe it as "represent[ing] how far along I have come."

Prayer
I'm living life to the fullest, choosing to be ever present in this moment. Yeah I'm skipping rope by landmines and treading ever so carefully by crossroads, where the steel demon ravages on rails at 60 miles per hour, taking souls where they need to travel for a small fee, but I am free! More free than ever! For what is life, if it's not lived freely? Yeah I wear my heart on my cloak of shame, but have since ripped the cloak to pieces in exchange for a peace of mind and have kept the heart safe within me. I'm going to sing my song all through the night 'til the Lord, goddess, whoever the hell is in charge beckons me onwards home. And even though I am preyed upon by the earthly powers that be and the system that is, I pray that I can save

a few lives at least before my time is up. Please to whoever is reading this, don't give up! There is more to see than what meets the eye. Even if you don't believe in you, take it from me who has such faith in you and what you are capable of. Yes, my faith is blind, but that doesn't make it wrong or make me wrong.
—11/15/19

Conclusion

By the end of their participation in the year-long comprehensive DBT program, Muneca had accomplished their goals of becoming more independent, moving to Oregon, and improving their relationship with their parents. They were also starting to make new friends. Muneca believed that DBT art therapy had been especially helpful because it allowed them to work through many life challenges using creative expression. Muneca stated that the combined modalities allowed them to learn most effectively. Writing poetry and doing art on their own would not have been as helpful because they needed the structure of the group (Muneca had a hard time focusing and the group kept them accountable and on track). They also recognized how much they learned about themselves through engaging with others. For example, they were able to make a lot of progress practicing communication and validation with their peers.

While DBT is an evidence-based intervention, as of this writing DBT-informed art therapy has not undergone any rigorous research trials proving its effectiveness. To join the ranks of empirically founded treatments, DBT-informed art therapy requires statistically significant data indicating that it results in tangible reductions of BPD symptoms and behaviors. It is possible to explore outcomes with measurement tools such as the Borderline Symptom List (BSL) self-rating scale (Bohus *et al.* 2007), as well as comparing diary cards before and after treatment. At Awake DBT, Inc., we are currently starting to administer pre- and post-intervention tests to our DBT/art therapy clients.

Endnotes

1 Awake DBT, Inc. is a private psychotherapy practice in San Jose, California that specializes in comprehensive DBT. It was the first program in northern California (and 15th in the entire United States) to receive credentialing through the DBT-Linehan Board of Certification (2014–2020). Certified programs "demonstrate having the necessary components and organization to deliver DBT with fidelity to the model" (www.dbt-lbc.org).

2 In cognitive behavior therapy (CBT), case conceptualization refers to *a detailed hypothesis concerning the cause(s) and maintenance of a person's psychological problems, symptoms, and behaviors* (Kuyken, Padesky, and Dudley 2009; Persons 2008). Case conceptualization is a principle-driven approach that identifies and targets mechanisms from psychological theories such as cognitive theory and behaviorism (e.g., classical conditioning; operant conditioning). Specific to DBT, Manning (2018) notes that a solid case conceptualization

> […] uses the principles and the protocols of the treatment to assess client goals and behaviours, create a treatment plan, and provide accurate interventions that ultimately bring the clients to his/her life worth living goals. It begins with the initial assessment and continues through pretreatment. Throughout treatment specific behavioural targets are conceptualized using a behavioural formulation, including functions, controlling variables, and the behavioural interventions that treat the behaviours. The case conceptualization is organic and changes as needed. Formal case conceptualization can be written or therapists can articulate their conceptualization of a case as they conduct the therapy. (pp.237–258)

3 Linehan (1993) states that "[a]greement on goals of treatment and general treatment procedures is the crucial first step before therapy even begins" (p.97). Pretreatment prepares the prospective DBT client and DBT therapist to work together. Both must commit to working toward the identified treatment goals. This crucial stage "focuses solely on eliciting a commitment that is sufficiently strong, durable, and meaningful to carry the [client] through the challenges of behavioral change" (Swenson 2016, p.204).

4 A unique aspect of DBT is its emphasis on dialectics. Linehan (2020) describes this, in practical terms, as

> […] the dynamic balance between acceptance of oneself and one's situation in life, on the one hand, and embracing change toward a better life, on the other. (That is what "dialectics" means—the balance of opposites and the coming to a synthesis)… This balance between pursuing change strategies and pursuing acceptance strategies is a basis DBT, and unique to DBT. This emphasis on acceptance as counterbalance to change flows directly from the integration of Eastern (Zen) practice, as I experienced it, and Western psychological practice. (pp.7–8)

5 The goal of DBT mindfulness practice is cultivating one's *wise mind*, which Linehan (1993) describes as a "center of calmness" (p.215) that adds intuitive knowing to the other states (*reasonable mind* and *emotion mind*).

6 Muneca's negative self-judgments are examples of a secondary behavioral target called *self-invalidation*. Secondary targets are "rigid, ineffective behavior patterns functionally related to stage 1 primary treatment targets" (Dimeff and Koerner 2007, p.120). Linehan refers to these patterns as *dialectical dilemmas* because of their transactional nature. The antithesis of self-invalidation is *emotional vulnerability*. Emotional vulnerability (and hence the individual's inevitable inability to regulate their emotions) results in increased invalidation from the environment (Koerner 2012; Swenson 2016). Over time, the client tends to adopt the characteristic of the invalidating environment and "invalidate her own affective experiences…look to others for accurate reflections of external reality, and… oversimplify the ease of solving life's problems. Invalidation of affective experiences leads to attempts to inhibit emotional experiences and expression" (Linehan 1993, p.72).

Muneca was initially quite susceptible to emotional triggers and, as a result, had frequent psychiatric hospitalizations (inpatient stays decreased over the course of their DBT participation). Their oversimplification of life's difficulties led to extreme shame and self-criticism/punishment when goals were not met. Muneca often put themselves down by saying "I am stupid" and ruminating on their mistakes. Muneca also habitually apologized for actions that did not warrant an apology (these behaviors also reduced during treatment).

7 This is an example of *operant conditioning*, which Heard and Swales (2016) define as the process whereby animals learn to associate a behavior with specific consequences and those consequences of the behavior then significantly control the probability of that behavior reoccurring. Skinner (1953, 1976) used the term "operant" as he viewed many behaviors as "operating" on the environment in ways that produced certain consequences. A contingent relationship thus exists between the operant behavior and its consequences. Consistent with many forms of behavior therapy, DBT therapists use behavioral analysis to assess and describe the contingent relationships related to the target behaviors. Therapist and clients can then apply contingency management…to change problematic contingent relationships (p.9). Heard and Swales (2016) describe how operant conditioning includes *reinforcement* and *punishment*: "These processes contribute both to the development and maintenance of a client's problematic behaviors. Reinforcement occurs when a consequence of a behavior increases the likelihood that the behavior will occur again" (p.9).

8 The secondary behavioral target *inhibited grieving* "refers to attempts to avoid or escape emotional experiences related to sadness and loss" and is "heavily influenced by the invalidating environment" (Swenson 2016, p.170). Muneca reported experiencing survivor's guilt after the suicides of both their nephew and best friend. They avoided feeling their grief by isolating themselves and ruminating about suicide, which resulted in several hospitalizations.

The antithesis of inhibited grieving is *unrelenting crises* (Linehan 1993). The individual's high emotional reactivity, along with chronic highly stressful life events, triggers a strong, automatic avoidance response. Suicidal thoughts can be maladaptive efforts to problem solve by momentarily reducing emotional distress. However, the individual becomes "engaged in a constant effort to block awareness and extinguish memory of negative events" (Swenson 2016, p.170). Swensen (2016) adds that inhibited grieving may ultimately create "a level of suppression and detachment that lends itself to extreme loneliness, despair, and suicide" (p.170). As with Muneca's self-invalidation, this pattern of inhibited grieving reduced over time and treatment. Muneca is now able to fully experience their emotions.

9 Below are some examples of how DBT skills (Linehan 2015a, 2015b) helped Muneca.

Core mindfulness skills were designed by Marsha Linehan as secular and behavioral versions of ancient meditation practices. She (2020) states that: "The second aspect of DBT that makes it unique is the inclusion of mindfulness practice as a therapeutic skill, a first in psychotherapy. This, too, came from my experience with Zen…" (p.8). Mindfulness skills decreased Muneca's low motivation and tendency to isolate. They developed an ability to tolerate and fully experience difficult emotions like sadness without resorting to problematic behaviors for relief. They developed a strong personal understanding of their *wise mind* (Activity 4/Figure 9.4).

Emotion regulation skills enabled Muneca to work through intense emotions without becoming overwhelmed. The skill *mindfulness of current emotion* (Activity 3/Figure 9.3) strengthened their ability to experience grief over the deaths of loved ones. They also implemented *opposite action* to combat low motivation and isolation, so that they could look for a job, explore housing options, and connect with friends. Muneca subsequently reported more frequent experiences of joy.

Distress tolerance skills assisted Muneca in managing dysregulation so that they could interact with their parents without becoming aggressive and/or suicidal. Crisis survival strategies such as STOP (Activity 2/Figure 9.2) helped Muneca handle overwhelming emotions so that they could improve family relationships and avoid additional psychiatric hospitalizations.

Interpersonal effectiveness skills taught Muneca to assert themselves much more competently. Over time they could directly communicate their wants and needs. This allowed Muneca to achieve their objective(s) and, more often than not, simultaneously improve important relationships and maintain their self-respect.

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Chapter 10

Group InCircle

Development and Implementation of a Novel DBT-Informed Creative Arts Therapy Group for Veterans with Serious Mental Illness in a Large Hospital Setting

JEREMY STEGLITZ, SCOTT LEVSON, MELANIE PACI, AND TRACELA M. ZAPATA

Introduction

Serious mental illness (SMI) is a significant problem in the United States and affects nearly 13.1 million adults (National Institute of Mental Health 2019). American military Veterans are disproportionately impacted by SMI (Trivedi *et al.* 2015). Dialectical behavior therapy (DBT) is a cognitive behavioral approach that has shown significant promise in reducing high-risk behaviors (e.g., self-harm) and improving overall quality of life among this population (Goodman *et al.* 2016). However, DBT's primarily group-based skills training format may not be an ideal treatment for Veterans with SMI. While group therapy is often a useful and cost-effective method of addressing mental health problems, such individuals (particularly those in a hospital setting) possess unique cognitive impairments that may interfere with learning via traditional instructional methods (Twamley *et al.* 2019). Veterans have reported consistent challenges with acquiring DBT skills due to group-related anxieties as well as the density of the curriculum's didactic content (Barnicot *et al.* 2015).

Art therapy, an "integrative mental health and human services profession that enriches…lives…through active art-making, creative process, [and] applied psychological theory" (American Art Therapy Association 2017), could overcome some of the major barriers to DBT skills acquisition among Veterans contending with SMI. Art therapy

can reduce anxiety (Cho 2016; Tang *et al.* 2019); further, it may facilitate and/or enhance the comprehension of new learning by recruiting neuroanatomical brain structures not involved in traditional didactic skills training models (Havsteen-Franklin and Altamirano 2015). Active art making, more so than usual language-based instruction, requires the integration of higher cortical cognitive processes—such as planning, attention, and mindful problem-solving—that play significant roles in learning (Hass-Cohen and Carr 2008). Sub-cortical centers involved in implicit motivation (e.g., the limbic system and brainstem) are also activated by art therapy interventions (Rubin 2016). Grounded in affective-sensory experiences, art therapy comprises repeated experiences that directly contribute to the formation and strengthening of complex information associated with the consolidation of new material (Chancellor, Duncan, and Chatterjee 2012).

This chapter describes the development and implementation of a DBT-informed creative arts therapy group within an outpatient mental health treatment program for Veterans. The 23-week intervention, named Group InCircle, is an alternative to the standard DBT skills training model that delivers educational material through a manualized protocol featuring highly structured lesson plans, handouts, and worksheets (Linehan 2015a, 2015b). We, the authors, adapted lessons from Susan M. Clark (2017), and also created novel lessons during weekly brainstorming sessions.

A challenge (and a possible solution)

The Psychosocial Rehabilitation and Recovery Center (PRRC), a voluntary intensive outpatient program of the Washington DC Veterans Administration Medical Center (DCVAMC), provides support and treatment to Veterans with SMI diagnoses. The PRRC utilizes a strengths-based approach to promoting psychosocial rehabilitation and assisting patients in enhancing their adaptive and social skills, self-care, employment satisfaction, crisis resolution skills, problem-solving abilities, and overall quality of life. A major priority of the Veterans Health Administration (VHA), one of the largest hospital systems in the United States, is to "empower [patients] to improve their well-being" and to provide "both patient-centered and evidence-based" services that support "learning, discovery, and continuous improvement" (VHA 2017). With that in mind, the PRRC offers a myriad of recovery-oriented

treatment options geared toward helping Veterans optimize their symptom management while engaging in meaningful self-exploration and skills acquisition.

The PRRC utilizes an interdisciplinary team approach consisting of clinical social workers, psychologists, recreational therapists, chaplains, vocational rehabilitation specialists, nurse case managers, and peer support specialists. The census varies; however, approximately 200 Veterans are enrolled in programming each month. The PRRC's hours of operation are 7:30 AM to 4:00 PM, Monday through Friday. Treatment is multi-modal and patients may elect to participate in individual psychotherapy, recovery coaching, and peer support services, as well as a wide array of groups.

During an average week the PRRC offers nearly 50 groups. The daily schedule, including groups, workshops, orientation sessions, and community meetings, is posted in the facility's hallway; each morning, Veterans elect what they will attend that day. Groups are facilitated by nurse case managers, psychologists, social workers, peer support specialists, and student trainees. Topics include acceptance and commitment therapy (ACT), spirituality, and health and wellness (to name a few).

When Group InCircle was first developed and integrated into the PRRC's program, two of the four authors (who were completing postdoctoral fellowships in severe mental illness) co-facilitated it. Another worked as a staff psychologist at that time and provided clinical supervision to the above-mentioned authors, while the fourth served as the program manager. Although each clinician possessed some familiarity with both DBT skills training and art therapy, this was their first attempt to combine the approaches.

The genesis of Group InCircle

DBT skills is a well-liked group within the PRRC and multiple iterations took place throughout the week. There were also some art therapy groups (albeit less ubiquitous than DBT skills training). However, we soon realized that, despite its popularity, many Veterans struggled with DBT's highly language-based concepts and acronyms. Such barriers precluded many patients' retention and application of the skills—and prompted some to attend multiple DBT groups each week (rather than explore other PRRC offerings) in the hope that repetition would enhance their understanding.

The difficulties that many Veterans experienced with conventional DBT skills training were highlighted within one early Group InCircle session. During the prelude to a lesson on the interpersonal effectiveness (IE) module's GIVE (relationship-centered) behavioral strategies, Veterans received a handout explaining each item in the skills set. This was intended to orient them to these ideas prior to engaging in a related art activity. While both authors took the information for granted, most patients expressed significant confusion and unfamiliarity with *validation*, an essential component of GIVE (Linehan 2015a, 2015b). Although the authors attempted explanations (primarily using synonyms for the word itself), only after participating in the art therapy activity did the patients fully understand the concept.

This anecdote illustrates the inspiration for Group InCircle. We came to appreciate that, far too often, DBT skills were not being adequately metabolized by our Veterans owing to a variety of barriers. Using a creative medium to help enliven and enrich the content made it more accessible for some. Based on previous research suggesting that art therapy can synergistically enhance traditional skills-based therapeutic approaches such as cognitive behavior therapy (CBT) (Cho 2016; Rubin 2016), Group InCircle's goal, in alignment with the missions of the VHA and PRRC, was to integrate DBT and art therapy interventions to improve skills acquisition among PRRC Veterans.

Identifying stakeholders and seeking buy-in

An important step in Group InCircle's development was to determine the stakeholders—that is, any individuals, groups, or organizations who would be impacted by project outcomes. This included the group members themselves, group facilitators, PRRC leadership, administrative staff, and other clinicians. In order to obtain necessary buy-in, it was imperative to convey the rationale for Group InCircle as well as how the new program offering might benefit each stakeholder (Appendix 10.1, "Strategic Statement of Need").

Needs assessment

The authors conducted a multi-level needs assessment to demonstrate Group InCircle's potential value for stakeholders. The initial level involved a review of the current literature on DBT, art therapy, and SMI. Its purpose was to identify any clinical challenges that might require

further attention and/or research. During the second level the authors conducted informal interviews with the PRRC's leadership, staff, and clinicians. Our aim was to better understand these stakeholders' perspectives and opinions concerning ongoing program needs.

The third and final level focused on better understanding the Veterans' clinical priorities. The authors developed a 10-item/5-point Likert scale self-report survey (from 1 = Strongly Disagree to 5 = Strongly Agree) to anonymously assess patient attitudes toward traditional didactic group therapy, as well as their perceived obstacles to skills acquisition (Appendix 10.2, "Veterans Needs Assessment"). For example, items on the scale included the statements "I don't understand the therapy skills" and "I'm interested in practicing skills in a new, creative way." The results (Table 10.1) were synopsized in a Strategic Statement of Need that we presented to PRRC staff, clinicians, and leadership to assist with buy-in.

Table 10.1 Results of Veterans Needs Assessment (n = 9)

Item	Average response (1 = Strongly Disagree, 5 = Strongly Agree)
1. I don't have time to practice therapy skills.	2.25
2. I don't understand the therapy skills.	2.33
3. Practicing new therapy skills is not part of therapy.	2.25
4. It's hard for me to focus in group to learn the therapy skills.	2.67
5. Practice is not assigned in the groups I attend.	2.63
6. I'm interested in practicing skills in a new, creative way.	4.22
7. Practicing therapy skills takes too much time.	2.25
8. It's not clear to me how to practice therapy skills.	3.00
9. The therapy skills aren't useful in my life.	2.50
10. The lessons in group are too wordy or have too many handouts.	2.38

Responses suggested that the PRRC patients were, in general, strongly interested in "practicing skills in a new, creative way." Veterans seemed

to deny that time management issues precluded learning new skills; indeed, they reported having ample opportunities to practice what was covered in group. However, it is also noteworthy that the Veterans were neutral about whether they understood how to practice these skills, which perhaps suggests obstacles to traditional, classroom-based ways of teaching psychoeducational material with text-heavy handouts.

Identifying deliverables

Once investment was established among stakeholders, the authors moved on to Group InCircle's *deliverables*. In other words, we determined the components that would comprise the final product (e.g., participant evaluations/surveys, the therapist manual, posters for professional presentations). These were integral parts of the development and implementation process.

Formative and summative evaluations

After each group session the facilitators administered a two-item qualitative survey that assessed the participants' experiences with, and the perceived effectiveness of, that week's art therapy exercise. We collected formative evaluations throughout the implementation process to optimize, in real time, the structure and delivery of Group InCircle.

Summative evaluations were longer assessments administered at the end of each module (mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance). Our goal was to collect patients' self-reported behavioral outcomes associated with the four skills sets. These 22-item 5-point Likert scale surveys were anonymous in order to protect the Veterans' confidentiality (Appendix 10.3, "Summative Evaluation").

Sustainability and dissemination

The therapist manual consisted of lesson plans outlining the agenda and structure for every session (Appendix 10.4, "Lesson from the Therapist Manual"). It comprises 23 weekly 50-minute lessons. The first 10 minutes are dedicated to reviewing homework; the middle 30 minutes is devoted to the new art therapy exercise; and the final 10 minutes is used to process the new art therapy exercise and assign homework. The manual provides current group leaders with a solid framework for facilitating Group InCircle. The manual is also instrumental in supporting sustainability because it contains all the information needed

to train future facilitators. Other deliverables associated with project sustainability and dissemination included informal reports in PRRC staff meetings and the published posters and articles.

The authors regularly shared process and outcome results during staff meetings to maintain buy-in as well as to seek feedback for optimizing the group process. We disseminated results via poster sessions at the DCVAMC; these also attracted Veterans who might benefit from Group InCircle. Given the novelty of a DBT-informed creative arts therapy intervention within such a setting, we sought out opportunities to disseminate process articles.

Determine procedures and timeline

High- and low-level planning

There were three main strategies in facilitating the development, implementation, and sustainability of Group InCircle.

First, the authors executed a high-level project plan to organize deliverables into three major phases: (1) Planning, (2) Implementation and Monitoring, and (3) Project Close. Under *Planning*, which lasted from October through November of 2017, we included the following deliverables: completion of the strategic statement of need, completion of the needs assessment survey, completion of the summative and formative evaluations, recruitment of group members (see recruitment procedures, below), attending staff meetings/obtaining stakeholder buy-in, and drafting the therapist manual. *Implementation and Monitoring* spanned December 2017 through April 2018 and included the completion of the therapist manual, launching Group InCircle in the PRRC, the administration of summative and formative evaluations, attending weekly meetings with the group co-leader, attending monthly meetings with key stakeholders, ongoing patient recruitment as needed, and the analysis of formative evaluations. *Project Close* took place from May through August 2018 and included disseminating results, training new group co-leaders, and optimizing the therapist manual.

Second, the authors employed a Gantt chart to organize the high-level deliverables into a detailed timeline (broken down by the weeks of each month). The Gantt chart specified when each deliverable would be initiated and completed.

Third, the authors used a work breakdown structure (WBS) for low-level planning. The WBS was a dynamic document that facilitated

communication between the project leads and stakeholders. It consisted of a detailed table that outlined the following: specific tasks associated with each deliverable, a description of each task, the name of the person leading the task(s), the anticipated duration to completion, the deadlines to completion, the actual completion dates, and current status (e.g., *In Progress*, *Completed*).

Patient recruitment

Recruitment of potential Group InCircle members took place during the planning stages and continued throughout project implementation on an as-needed basis. It comprised different modalities, including (1) emails to PRRC staff/clinicians, (2) flyers (posted on PRRC community boards and distributed in staff and community meetings), (3) announcements in weekly PRRC staff meetings as well as monthly community meetings attended by PRRC staff and patients, (4) within one-on-one meetings with clinical case managers (who were in charge of Veterans' treatment plans), and (5) during hospital-based research presentations where hospital staff and patients could inquire about the project.

Project implementation

Information and data gathering

After each weekly group the facilitators administered brief two-item questionnaires (i.e., the previously mentioned formative evaluations) to attendees. These qualitative measures assessed the patients' general experiences in Group InCircle that day, as well as the perceived impact of the creative arts therapy exercise on their acquisition of the new DBT skill. In this manner, group leaders collected timely formative feedback (i.e., self-reported level of learning and attitudes toward the intervention) that could be used to optimize the group throughout its implementation phase.

To quantitatively assess the learning of DBT skills, an outcome-based 22-item 5-point Likert scale measure (from 1 = Strongly Disagree to 5 = Strongly Agree) was administered before and after each of the four skills modules. The authors adapted the 22-item scale from validated measures that independently assessed skill-learning

related to *mindfulness* (e.g., "I am open to the experience of the present moment"), *emotion regulation* (e.g., "When I'm upset, I believe there is nothing I can do to make myself feel better"), *interpersonal effectiveness* (e.g., "I allow friends to see who I really am"), and *distress tolerance* (e.g., "I'll do anything to stop feeling upset"). Unfortunately, given several methodological and organizational limitations, the quantitative data collection was not completed.

Maintaining stakeholder engagement

PRRC staff and leadership

Group InCircle's two facilitators met monthly with PRRC staff and leadership to discuss implementation and qualitative outcomes. During these meetings the co-leaders solicited feedback concerning manual development, art therapy exercises, and clinical challenges.

Veterans

Veteran responses concerning their experiences in Group InCircle were shared weekly to empower them throughout the group implementation process. Depending on the group's size, co-leaders also conducted ongoing recruitment efforts.

Creative arts therapy exercises

As a multi-modal group therapy, Group InCircle included nonvisual art elements to provide a range of creative learning exercises. For example, the second lesson in the interpersonal effectiveness module was *GIVE Sculpt*. Inspired by Virginia Satir's (1978) family therapy interventions, this exercise invited pairs of group members to each use their body to "sculpt" a particular skill within the GIVE skillset (e.g., "I," or "act Interested") (Linehan 2015a, 2015b). There would be a "giver" and a "receiver." The giver would be the person who sculpts their body, while the receiver would use mindfulness skills to observe the sculpt and then guess which skill the giver was embodying (see Appendix 10.5, "Lesson from the Therapist Manual (GIVE Sculpt)"). Figure 10.1 shows a patient's personal conceptualization of two of DBT's states of mind (Linehan 2015a, 2015b).

FIGURE 10.1 CLIENT ARTWORK: DBT STATES OF MIND

Project optimization and sustainability

Formative data analysis: Qualitative surveys and artwork

After every session the group facilitators collected and analyzed the anonymous formative evaluations. Overall, patients reported positive experiences with the creative arts therapy exercises (in terms of focus and engagement with the concepts/skills taught that day). For example, one commented: "[Collage] helped me to focus on my values and what is important to me." Another veteran reported that creative activities could be "fun" and assisted her with emotion regulation skills: "It helped me to see how I feel about stuff."

Complete deliverables

Manual and publications

The Group InCircle therapist manual, which ultimately included 23 weekly sessions across four different clinical skills modules, was completed after the group's first cycle. Its main purpose was to provide a framework for future co-leaders to implement and optimize the

group. The authors disseminated qualitative findings on both a formal and informal basis within the DCVAMC. We also presented a research poster to Veterans, staff, and hospital leadership.

Develop transition plan

The transition plan helped ensure Group InCircle's sustainability after its original facilitators transitioned out of the PRRC. In addition to the therapist manual, the authors created an archival system on the hospital share drive so that PRRC staff could access group documents and procedures. Given that the DCVAMC is a training hospital, we were able to recruit clinical psychology trainees who had an interest in DBT and art therapy. We invited the new co-leaders to observe several weeks' worth of sessions in order to become familiar with group processes, format, and members. They then transitioned to facilitating the group (while the authors observed and provided feedback, real-time support). In addition, all four clinicians met regularly before the final transition to review group processes as well as the organization of the archival folder.

Lessons learned

To the best of the authors' knowledge, Group InCircle was the first combined DBT skills training and creative arts therapy intervention ever launched at a VA hospital. While there were many successes, Group InCircle's first iteration also presented some important challenges. Because the PRRC groups were open-entry, a number of patients joined and exited Group InCircle every week. Benefits to this policy included the ability of the Veterans to easily access groups they had an interest in and/or felt they needed; it also provided flexibility for those who struggled with executive functioning and, therefore, traditional language-based types of learning.

Unfortunately, the resulting inconsistent attendance precluded our collection of longitudinal data for tracking individual patients' progress over time. Second, we did not have a control group to directly compare formative and summative outcomes. It would be beneficial to conduct a randomized controlled trial in which Veterans are recruited and placed into one of two separate treatment modalities (a traditional DBT skills training group or Group InCircle) to accurately assess the added value of a creative arts therapy component.

Conclusion

Group InCircle proved to be an enjoyable and enriching group within the PRRC of the Washington DC VAMC. Its development was inspired by the authors' realization that, while DBT skills training delivered through a traditional didactic group format is highly sought-after, the content was frequently not fully understood or retained by Veterans struggling with SMI. Our solution, to combine psychoeducational instruction with carefully designed creative interventions, was appreciated by PRRC staff and patients alike for its apparent potential for facilitating the latter's overall comprehension and generalization of necessary behavioral strategies. We view DBT-informed arts therapy as a promising method of reinforcing skills training and welcome future research investigating its efficacy.

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Appendices

Appendix 10.1: Strategic Statement of Need

GroupInCircle
A novel group psychotherapy to augment DBT skills acquisition in PRRC Veterans

Strategic Statement of Need

A major goal of the VA is to "empower Veterans to improve their well-being," while the VHA's vision is to provide "both patient-centered and evidence-based" services that support "learning, discovery, and continuous improvement." Specifically, it strives to "partner with each Veteran to create a personalized, proactive strategy to optimize health and well-being." The Psychosocial Rehabilitation and Recovery Center (PRRC) of the Washington DC VA Medical Center (DCVAMC) is a mental health clinic that serves Veterans with serious mental illness (SMI). It is a recovery-oriented center that aims to use evidence-based psychological treatments to help Veterans with SMI develop skills that are needed to achieve their goals and reintegrate into the community.

Dialectical Behavior Therapy (DBT) is an evidence-based skills-oriented approach that has shown promise in improving the well-being and psychological health of Veterans. However, Veterans in the PRRC have demonstrated difficulties in learning DBT skills. Recent studies have found that two of the most common patient-reported barriers, in general, are group-related anxiety and difficulty understanding the material. Furthermore, SMI has been associated with cognitive deficits that directly impair Veterans' capacity to retain new skills via traditional, didactic approaches.

Art therapy has the potential to overcome some of the major barriers to DBT skills acquisition in the PRRC. Art therapy can reduce anxiety and enhance understanding of new skills by recruiting neuroanatomical structures not involved in traditional didactic training. It requires the

integration of higher cortical thinking, such as planning, attention, and mindful problem-solving, that play significant roles in the learning process. Sub-cortical centers that are involved in implicit motivation, such as the limbic system and brainstem, have also been activated by art therapy interventions. Grounded in affective-sensory experiences, art therapy comprises repeated experiences that directly contribute to the formation and strengthening of complex information associated with consolidation of new material.

Some evidence-based treatments, such as Cognitive Behavior Therapy, have begun integrating art therapy into their protocols with promising effects, suggesting that art therapy can synergistically enhance traditional didactic skills-based therapeutic approaches. Therefore, we propose to develop and implement a novel group psychotherapy that integrates DBT and art therapy to enhance DBT skills acquisition among PRRC Veterans. The specific objectives of the proposal include:

Goals

1. To improve Veterans' learning and retention of DBT skills.
2. To increase the frequency of DBT skills practice between sessions.
3. To enhance Veterans' self-efficacy and recovery.

Appendix 10.2: Veterans Needs Assessment

G r o u p I n C i r c l e :: DBT + Art Therapy

In January 2018, we are beginning a new psychotherapy group in the PRRC called **Group InCircle**. It's a DBT-informed art therapy group that is open to all Veterans who are interested in learning the core DBT skills in a new way. As with most groups, Group InCircle will include practicing new skills between sessions. We are interested in your experience with practicing new skills. There are no right or wrong answers, and all of your responses will be kept confidential. Please circle the response that feels most accurate for your current experience, using this scale:

1. = Strongly Disagree
2. = Disagree
3. = Neutral

4. = Agree
5. = Strongly Agree

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I don't have time to practice therapy skills.	1	2	3	4	5
2. I don't understand the therapy skills.	1	2	3	4	5
3. Practicing new therapy skills is not part of therapy.	1	2	3	4	5
4. It's hard for me to focus in group to learn the therapy skills.	1	2	3	4	5
5. Practice is not assigned in the groups I attend.	1	2	3	4	5
6. I'm interested in practicing skills in a new, creative way.	1	2	3	4	5
7. Practicing therapy skills takes too much time.	1	2	3	4	5
8. It's not clear to me how to practice therapy skills.	1	2	3	4	5
9. The therapy skills aren't useful in my life.	1	2	3	4	5
10. The lessons in group are too wordy or have too many handouts.	1	2	3	4	5

Please share any other thoughts or reactions you might have about practicing new therapy skills:

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Thank you!

Appendix 10.3: Summative Evaluation

G r o u p I n C i r c l e :: Creating a Life Worth Living

Group InCircle is a DBT-informed art therapy group that is open to all Veterans who are interested in learning the core DBT skills in a new way. As with most groups, Group InCircle will include practicing new skills between sessions. As a way to measure the effectiveness of the group and to ensure we are meeting your needs, we are interested in your current experience with DBT therapy skills as well as your overall recovery. There are no right or wrong answers, and all of your responses will be kept confidential. Please circle the response that feels most accurate for you right now, using this scale:

1. = Strongly Disagree
2. = Disagree
3. = Neutral
4. = Agree
5. = Strongly Agree

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I am open to the experience of the present moment.	1	2	3	4	5
2. I sense my body, whether eating, cooking, cleaning, or talking.	1	2	3	4	5
3. I see my mistakes and difficulties without judging them.	1	2	3	4	5
4. I feel connected to my experience in the here-and-now.	1	2	3	4	5
5. I can put myself in others' shoes.	1	2	3	4	5
6. When I've been wronged, I confront the person who wronged me.	1	2	3	4	5
7. I allow friends to see who I really am.	1	2	3	4	5

Cont.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
8. I am comfortable in social situations.	1	2	3	4	5
9. When I'm upset, I have difficulty focusing on other things.	1	2	3	4	5
10. I am confused about how I feel.	1	2	3	4	5
11. When I'm upset, I have difficulty getting anything done.	1	2	3	4	5
12. When I'm upset, I believe there is nothing I can do to make myself feel better.	1	2	3	4	5
13. Feeling upset is unbearable to me.	1	2	3	4	5
14. When I feel upset, all I can think about is how bad I feel.	1	2	3	4	5
15. Other people seem to be able to tolerate feeling upset better than I can.	1	2	3	4	5
16. I'll do anything to stop feeling upset.	1	2	3	4	5
17. I can always manage to solve difficult problems if I try hard enough.	1	2	3	4	5
18. It is easy for me to stick to my aims and accomplish my goals.	1	2	3	4	5
19. I can usually handle whatever comes my way.	1	2	3	4	5
20. I engage in work or activities that enrich myself and the world around me.	1	2	3	4	5
21. I am making progress towards my goals.	1	2	3	4	5
22. I have control over my mental health problems.	1	2	3	4	5

Thank you!

Appendix 10.4: Lesson from the Therapist Manual
Agenda

9.1. Review of Action Plan

9.2. Brief review of FAST skills

9.3. FAST Collage (Part 1 of 2)

9.4. Process art therapy exercise

9.5. Action Plan

9.1. Review of Action Plan

- Practice at least one GIVE skill between now and next group
- Review successes and obstacles

9.2. Brief review of FAST skills

- FAST is a way to remember self-respect effectiveness skills
- Self-respect effectiveness means acting in a way that maintains or increases your self-respect after an interaction with someone. The key question here is how to ask for what you want or say no in a way that you will still respect yourself afterward
- Distribute *Interpersonal Effectiveness Handout 7* (Linehan 2015b) if needed, depending on skill-level of members
- FAST stands for Fair, (no) Apologies, Stick to values, Truthful
  - *(Be) Fair: Be fair to yourself and the other person when you try to get what you want*
  - *(No) Apologies: Do not over-apologize. When apologies are warranted, of course, they are appropriate. But no apologizing for being alive, for making a request, for having an opinion, or for disagreeing*
  - *Stick to values: Avoid selling out your values or integrity to get your objective or to keep a person liking you*
  - *(Be) Truthful: Don't lie, act helpless when you are not, or exaggerate. A pattern of dishonesty over time can erode your self-respect*

9.3. FAST Collage (Part 1 of 2)

- Skills/concepts
  - *General mindfulness*
  - *FAST skills (relationship effectiveness)*
- Materials
  - *Magazines*
  - *Scissors (if allowed by clinic)*
  - *Folder for the selected magazine clippings*
- Procedure
  - *Invite group members to brainstorm their current values (i.e., the "S" of FAST)*
  - *Lay out magazines on table(s)*
  - *Ask group members to select several magazines and select images and words that represent their values*
  - *Also inform group members that some images and words might inspire or help identify their current values*
  - *Place cut-out images and words in folder for Session 10 FAST Collage (Part 2)*

9.4. Process art therapy exercise

- Invite group members to share their experience of identifying magazines, flipping through pages, and identifying images and words that are values-based
- Provide feedback on accuracy of FAST skills and conceptualization of values, if needed

9.5. Action Plan

- Do at least one thing that is in line with a current value
- Notice how you feel after living in line with your value
- Notice how you feel when you do not live in line with your value

Keeping Respect for Yourself :: FAST h a n d o u t (Linehan 2015b, p.130)

- (Be) **F**air by being fair to yourself and to the other person. Remember to validate your own feelings and wishes, as well as the other person's.
- (No) **A**pologies by not over-apologizing. No apologizing for being alive or for making a request at all. No apologies for having an opinion, for disagreeing. No looking ashamed, with eyes and head down or body slumped. No invalidating the valid.
- **S**tick to values by not selling out your values or integrity for reasons that aren't very important. Be clear on what you believe is the moral or valued way of thinking and acting, and "stick to your guns."
- (Be) **T**ruthful by not lying. Don't act helpless when you are not. Don't exaggerate or make up excuses.

Appendix 10.5: Lesson from the Therapist Manual (GIVE Sculpt)

Agenda

8.1. Review of Action Plan

8.2. Brief review of GIVE skills

8.3. GIVE Sculpt

8.4. Process art therapy exercise

8.5. Action Plan

8.1. Review of Action Plan

- Practice at least one DEAR MAN skill between now and next group
- Review successes and obstacles

8.2. Brief review of GIVE skills

- GIVE is a way to remember relationship effectiveness skills

- Relationship effectiveness means maintaining or improving your relationship with another person while trying to get your needs met in the interaction
- Distribute *Interpersonal Effectiveness Handout 6* if needed, depending on skill-level of members
- GIVE stands for Gentle, Interested, Validate, and Easy manner
  - *(Be) Gentle: Being gentle means being kind and respectful in your approach. People in general respond to gentleness more than they do to harshness. Gentleness means: no attacks, no threats, no judging, and no disrespect.*
  - *(Act) Interested: Listen to the other person's point of view, reasons for saying no, or reasons for making a request of you. Don't interrupt or try to talk over. There are times when you're not actually interested in what they want to talk about. Choosing to listen means deliberately choosing to be effective in achieving your goal of helping them have a positive experience with you.*
  - *Validate: This means communicating that the other person's feelings, thoughts, and actions are understandable to you, given his or her past and current situation. We can validate without agreeing.*
  - *(Use an) Easy manner: Try to be lighthearted if appropriate. Use a little humor if that's your style. Smile if appropriate. Ease the other person along.*

8.3. GIVE Sculpt

- Skills/concepts
  - *General mindfulness*
  - *GIVE skills (relationship effectiveness)*
  - *Mindfulness of others*
- Materials
  - *None*

- Procedure
  - *A sculpt is a way to use your body as a sculpture*
  - *In general, select a specific pose to represent or communicate something and hold that pose*
  - *Ask two group members to volunteer*
  - *Have one of the group members be the "giver" (i.e., the one doing the sculpt) and the other be the "receiver"*
  - *The "giver" silently selects a specific GIVE skill (e.g., act Interested) and "sculpts" that skill (i.e., form his/her body and face to suggest that s/he is acting interested)*
  - *The "receiver" mindfully observes the "giver" and (a) tries to guess which GIVE skill the "giver" is sculpting, and (b) pays attention to the "receiver's" internal experience*
  - *There is no specific time-limit to this exercise, so use your clinical judgment*

8.4. Process art therapy exercise

- Invite group members to share their experience
  - *Guess which GIVE skill the "giver" was sculpting*
  - *What was it like to be the "giver"?*
  - *What was it like to be the "receiver"?*
- Provide feedback on accuracy of GIVE skills

8.5. Action Plan

- Practice at least one GIVE skill between now and next group

Keeping the Relationship :: GIVE h a n d o u t (Linehan 2015b, p.128)

- (Be) **G**entle by being kind and respectful. No attacks: No verbal or physical attacks. No harassment of any kind. Express anger directly with words. No threats: If you have to describe painful consequences for not getting what you want, describe them

calmly and without exaggerating. No "manipulative" statements, no hidden threats. Tolerate a "no." Stay in the discussion even if it gets painful. Exit gracefully. No judging: No moralizing. No "If you were a good person, you would…" No "You should…" or "You shouldn't…" Abandon blame. No sneering: No smirking, eye rolling, sucking teeth. No cutting off or walking away. No saying, "That's stupid, don't be sad," "I don't care what you say."

- (Act) **I**nterested by listening and appearing interested in the other person. Listen to the other person's point of view. Face the person; maintain eye contact; lean toward the person rather than away. Don't interrupt or talk over the person. Be sensitive to the person's wish to have the discussion at a later time. Be patient.
- **V**alidate with words and actions, show that you understand the other person's feelings and thoughts about the situation. See the world from the other person's point of view, and then say or act on what you see. "I realize this is hard for you, and…", "I see that you are busy, and…" Go to a private place when the person is uncomfortable talking in a public place.
- (Use an) **E**asy manner by using a little humor. Smile. Ease the person along. Be light-hearted. Sweet-talk. Use a "soft sell" over a "hard sell." Be "political." Leave your attitude at the door.

Chapter 11

Creative Mindfulness

DBT Skills-Oriented Intermodal Expressive Arts Therapy for Populations with Severe Emotion Dysregulation

KARIN VON DALER

Introduction

Severe, chronic emotion dysregulation can lead to self-harm behaviors, impaired relationships, substance abuse, and a general lowered quality of life (Linehan 1993, 2015a). It is often the subjective experience of intense emotional distress that brings people into therapy, regardless of whether said dysregulation is later identified as stemming from one or more specific diagnoses (e.g., borderline personality disorder (BPD), major depression, bipolar disorder, eating disorders, posttraumatic stress disorder, and so on) (Kass and Trantham 2014). Many arts therapies-oriented clinicians find that working with these individuals via their usual methods is challenging, and, at times, outright ineffective. Some expressive interventions are not sufficiently directive and/or structured to contain intense affect—and risk overwhelming clinicians and clients alike (Huckvale and Learmonth 2009; von Daler and Schwanbeck 2014).

Even when arts therapies facilitate appropriate emotional expression, there may not be adequate integration of new skilled behaviors for improved regulation outside of the treatment setting. This can prompt therapists to look to cognitive behavioral approaches for solutions; however, these are not designed to provide clients with the experiences of creativity and play that could give them access to previously unknown perspectives and resources. Ultimately, the dilemma of feeling ineffective versus abandoning the desired "organic, non-directive, and spontaneous elements of art-making" (Huckvale and Learmonth 2009, p.62) can leave practitioners feeling helpless or burnt out (von Daler and Schwanbeck 2014).

This chapter presents a method for developing healthy emotion regulation capacities that balances sensory experiences and fun with a cohesive, skills-based framework. Creative Mindfulness (CM) is an embodied, multi-modal expressive arts and dialectical behavior therapy (DBT)-informed intervention. *Embodiment* means centered on the felt sensory experiences within, and outside of, the physical body. My (the author's) primary goal is to describe how CM might foster lasting emotional wellness in those who contend with the chronic suffering of emotional chaos. A secondary aim is to suggest a way of addressing such extreme dysregulation that is both playful and effective, thus lessening the risk of therapist burn-out and/or abandonment of attempts to work with this challenging population.

The chapter draws on theories from the expressive arts therapies and DBT; however, it also refers to relevant supporting tenets from clinical neuroscience. Further, it provides concrete suggestions for facilitating enduring change in clients' abilities to regulate emotions through safe, structured, and collaborative engagement with their therapists. The reader will come to understand how core elements of DBT and expressive arts therapy can comprise a simple and immediately applicable model for working with severe emotional distress.

Emotion regulation and dysregulation

DBT's developer, Marsha Linehan, states that emotion regulation is "the ability to control or influence which emotions you have, when you have them, and how you experience and express them" (2015a, p.323). It is an individual's capacity for modulating his or her emotional intensity in order to respond with flexibility to the needs/demands of the current environment and circumstances. According to Pavuluri, Herbener, and Sweeney (2005), "[V]oluntary self-regulation of negative affect is essential to a healthy psyche" (p.2). Individuals with a solid repertoire of emotion regulation strategies can adapt to a broad range of stressful situations. Further, they are more likely to respond in a manner that aligns with their own needs, values, and intentions.

Emotion *dysregulation*, conversely, refers to a response that is neither well-modulated nor contained, that causes significant distress, and is not within the range of adaptive emotional responses. Pavuluri *et al.* (2005) elaborate that deficits in regulating affect are "commonly associated with major mood disorders like depression and bipolar

disorder. Numerous behavioral and cognitive models implicate poor negative affect regulation as a major factor contributing to vulnerability in bipolar and unipolar disorders" (p.2).

Chronic emotion dysregulation has a variety of possible manifestations, such as low behavioral inhibition (which can result in verbal threats and/or aggressive or destructive acts), mood swings, profound yet undefined emotional pain, anxiety, and/or loss of interest in social contact. Vulnerable individuals tend to experience marked hypersensitivity to stimuli, more frequent intense feeling states (compared with less sensitive people), and slower return to a baseline/normal level of emotional experiencing (Linehan 2015a).

Causes of emotion dysregulation

DBT suggests that emotion dysregulation has bio-psycho-social origins related to transactions between an individual's innate sensitivity and invalidating (sometimes outright traumatic) family, social, and/or cultural environments (Linehan 2015a). In addition, there is growing consensus that emotion dysregulation manifests physiologically through the stress response as *fight*, *flight*, *freeze*, or *fold* (Levine 2010).

The brain areas most associated with affect regulation are the prefrontal cortex and the amygdala. The hypothalamus (which controls certain functions of the autonomic nervous system and affects the endocrine system) and the anterior cingulate (which also plays a role in the autonomic system and in certain higher-level functions, such as decision making and impulse control) are involved, as well (Kass and Trantham 2014; Pavuluri *et al*. 2005). Finally, although the popular *serotonin hypothesis* has been criticized in recent literature, it is well established that brain chemistry has a marked impact on emotion dysregulation and regulation (Brogan 2016; Linehan 2015a).

Emotional dysregulation as addressed in CM

DBT's emotion regulation skills training module is designed to help clients understand the purpose of emotions, lower their vulnerability to painful feeling states, and decrease suffering:

> Emotions can be viewed as problematic, mysterious, and dangerous by those who have experienced intense emotional invalidation. Teaching

> that emotions are natural responses to stimuli, affect our body, mind, and behaviors, and are functional in getting us to respond to situations, is essential. The goal of emotion regulation is not to eliminate negative and unpleasant emotions, but to reduce suffering that arises from either denying emotions, being too reactive or unable to regulate emotions once they arise. (von Daler and Schwanbeck 2014, p.237)

CM identifies four significant challenges faced by those who struggle with emotion regulation deficits, then presents a corresponding objective or intervention(s) for each:

1. The first challenge is a basic inability to identify and name one's own emotions (Linehan 2015a). CM exercises feature the DBT core mindfulness "observe" and "describe" skills (Linehan 2015b, p.53) to help the client notice and accurately label what they are feeling.

2. Another challenge involves difficulties with experiencing, and appropriately containing, painful affect. CM's multi-sensory, structured approach may help develop or strengthen an individual's capacity for full emotional experiencing.

3. A third challenge is that dysregulation impairs the ability to *choose* when, how (and whether) to express feelings. CM implements multi-modal creative methods for inhibiting or reducing emotional reactivity, as well as developing a wider variety of adaptive behavioral options.

4. The final challenge arises from a limited capacity for intentionally generating positive emotions. CM's multi-sensory and embodied format encourages the client to devise healthy methods of prompting joy, pleasure, and connection.

Background

CM was developed by me and my colleague, Lori Schwanbeck (von Daler and Schwanbeck 2014). In 2004 Lori and I were both student interns at a low-fee psychotherapy training clinic in San Francisco. There, we learned to run DBT skills groups for women diagnosed with BPD and other psychiatric disorders. All of the group members contended with extreme emotion regulation problems that often resulted in serious

(and, occasionally, life-threatening) self-harm impulses. For several years after we became licensed clinicians, Lori and I also co-facilitated a weekly group for women with eating disorders.

I was fascinated by DBT's effectiveness, yet (as an expressive arts therapist) also felt somewhat frustrated with the skills training protocol's limited opportunities for play and embodiment. However, Lori and I had, independently of each other, made the following important observation: whenever we used the more experiential exercises suggested in the manual (e.g., guided mindfulness meditations, role plays for interpersonal effectiveness) (Linehan 2015a), the participants became more engaged. They exhibited improved skills retention, as well.

Our first attempts at integrating DBT skills with expressive arts therapy interventions quickly showed the potential of this combination. Skills group sessions immediately became more dynamic. Further, many clients reported that these new immersive activities allowed them to directly *experience* the skills' effects, in the here-and-now (rather than just talking about them).

The CM protocol initially consisted of the 20 exercises we used when teaching the most popular DBT skills in our groups. Lori and I also shared the curriculum with other practitioners who were interested in using this intervention with their own clients. Nine more exercises were added for our chapter in *Mindfulness and the Arts Therapies: Theory and Practice* (von Daler and Schwanbeck 2014).

CM can be used in group settings as well as individual therapy. This chapter presents modified versions of most of the exercises from the 2014 chapter. I have also added seven new activities designed to support the development of healthy emotion regulation.

Perspectives from clinical neuroscience

CM is inspired by neuroscientific research from the past two decades. Several theories are at the core of our intervention as it relates to emotion regulation. The emphasis on *mindful presence* is based on growing evidence that such approaches can strengthen emotion regulation by supporting regulatory functions in the central nervous system (Kass and Trantham 2014; van der Kolk 2014). In addition, CM aims to engage the whole brain in a combined *bottom-up* and *top-down* approach (Siegel 2007): Mindfulness alone can be seen as

a primarily top-down approach, meaning that it aims to affect higher functions of the brain, such as cognition and awareness, and activates the frontal lobes through self-reflection, insight, and witnessing (Kass and Trantham 2014).

However, persistent emotion dysregulation is a full-body experience that may originate from early, preverbal traumas. Memories of such events are often not consciously recalled (*implicit*). They imprint as disorganized sensory impressions—for example, fragmented sounds, odors, visual images, and somatic sensations. In such cases, a *bottom-up* approach, meaning an intervention that directly engages the body and senses, is necessary (van der Kolk 2014). CM's combined strategy aims to access the deeper sensory imprints while tapping into the regulatory benefits of mindful attention.

CM is based on an assumption of *neuroplasticity*: that the brain is malleable, and all neural events, such as actions, thoughts, sensations, memories, and emotions, directly impact its structure and function. Every experience shapes one's brain and, consequently, one's behavior and way of being (Doidge 2007). When a person engages in healthy, skillful responses to emotional distress, with sufficient repetition her brain will gradually rewire itself and retain this new learning (thus replacing the original maladaptive behaviors). These interventions allow adaptive emotional experiences to be integrated in the nervous system. They also provide the necessary elements for novel behavioral responses to become as accessible as the original, less adaptive ones (Hanson and Mendius 2009).

Trauma research suggests that multi-sensory memories are more accessible than abstract/cognitive ones, as they offer deeper reminders of the imprint (van der Kolk 2014). Hence, Lori Schwanbeck and I (2014) hypothesized that an event will have a more enduring impression on the brain whenever multiple sensory centers (e.g., the somato-sensory, visual, and olfactory cortices) are engaged *as* the new experience/learning takes place. Such sensory and experience-based impressions may create broader, better anchored neural networks (Chatterjee and Hannan 2016).

According to psychologist Stephen Porges' polyvagal theory (2009), the vagus nerve comprises two distinct branches, which trigger their own unique relaxation response via the parasympathetic nervous system. The dorsal/back branch elicits primitive, pervasive shut-down states (*freeze* and *fold*/collapse). The ventral/front branch, in contrast,

is more highly developed and supports emotional well-being. Ventral–vagal responses are activated by play and positive social interactions, as well as singing, visual imagery, dramatization, and other types of embodied self-expression (Kass and Trantham 2014; Porges 2009).

Finally, neuroscientific research on psychotherapy outcomes notes the importance of *right brain* to *right brain* hemispheric communication: the unconscious, wordless interactions that occur within healthy contact between parent and child (and can be employed within therapeutic encounters to optimize emotion regulation) (Schore 2005). For example, a clinician might intuit their client's unexpressed emotional state and communicate it back to her in a more regulated, tolerable manner. This type of contact cannot be accomplished through verbal dialogue alone; rather, it must arise from an attunement to facial expression, voice tone, and bodily movement (Schore 2005), elements of communication that are actively fostered in the expressive arts approach.

The clinical model of CM

Factors to consider

CM adapts to particular clinical need(s) according to the following factors:

- Taste and aptitude for art modality (e.g., dance, painting, drama, music, poetry, and so on). For example, if a client loves to draw but is uncomfortable with movement, simply emphasize drawing as the primary option when planning and suggesting interventions.
- Severity of dysregulation. CM teaches mindfulness through focused attention on the art making process (rather than on the internal sensory experiences or the emotions themselves) to reduce the risk of flooding the nervous system. According to some trauma-informed theories, an ability to attend to the external environment is a prerequisite for full *embodiment*, a phenomenon of complete emotional/physical attunement (Levine 1997; Rothschild 2000). Such externally oriented activities lay the sensory groundwork for fully experiencing internal states in the form of emotions and bodily sensations. This first stage will take as long as the client requires.

- Treatment stage. In the early phases of therapy, CM employs highly structured activities and exercises. As the process moves forward, however, more improvisational and self-directed work ensues.

Stages of the CM intervention

CM sessions generally transition through three stages of learning and change. Each draws from both DBT concepts and expressive arts therapy tenets.

Distancing (distraction)/decentering

The initial step in building more regulated emotional responses to stress and pain involves intentionally separating from habitual patterns of negative thoughts/behaviors. In DBT, distraction skills turn one's attention away from a distressing experience. This mindful refocusing helps break rumination cycles that might otherwise result in cascades of emotional reactivity.

Distancing is similar to *decentering* in the expressive arts therapies (Knill, Levine, and Levine 2005). Decentering invites focus *away* from emotions related to the presenting issue and *toward* playful creation (which sometimes leads to new possibilities in the here-and-now of the creative process): "…[D]ecentering activities can open the door to unexpected surprises and often emerge with spontaneity or intuition. They point in the direction of an alternative world experience through a distancing effect" (Knill *et al.* 2005, p.64).

We first offer validation and nonjudgmental witnessing of the problem represented in the client's artwork, then encourage exploration of its other aspects. For example, the client may draw an image of her depression, which the therapist acknowledges. However, the therapist then comments on and/or inquires about aspects (lines, colors, and so on) that the client had not mentioned. This stage broadens the individual's imagination to consider previously unconscious or unknown possibilities—thus making room for new skills and ways of acting.

Creating a new experience/range of play

The client's attention is now focused on more regulated, adaptive emotional experiences, with an emphasis on sensory immersion

and *creating* something. In DBT, building a new positive experience works to deliberately increase and solidify positive emotions. In the expressive arts therapies, the strategy of expanding the "range of play" (Knill *et al*. 2005, p.64) offers a wider aesthetic repertoire and sparks the imagination, thereby increasing access to resources such as flexibility, creativity, new perspectives, and ways of responding (von Daler and Schwanbeck 2014). To continue with the previous example, the therapist might advise the client to familiarize herself with those heretofore unexplored lines and colors via the creation of a second art piece (such as a clay figure).

Application of the new skill in the client's life/rehearsal and performance

To fully anchor and integrate a new response (and to make it as compelling and effective as older, less adaptive ones), the client must repeatedly apply and practice it. DBT refers to this as generalization, where the behavior is accessible in many situations and circumstances (Linehan 2015a). The resulting artwork is a tangible manifestation of the learning that occurred during a particular therapy session. Performing, touching, hearing, or viewing the art piece outside of session reminds its creator of associated feelings and cognitions, and can act as a sort of talisman or reminder of the healing experience (Rothaus 2014). For example, I had a client choose a beautiful gray rock to take home and hold during a difficult phone conversation she planned on having. This stone was part of a sculpture that she had made during session that represented a state of calm and balance that arose from *observing* and *describing*. The client returned the following week and reported that, even though the phone conversation had been difficult, her rock had "kept [her] on track so [she] did not spin out" into emotional dyscontrol. It reminded her of the skills she had connected to during the previous session.

Examples of CM exercises

Although the following selected activities are categorized within DBT's four skills training modules, each supports emotion regulation in a general sense. They are appropriate for both group and individual sessions. Depending on need, such exercises can range from 15 minutes in length to most of the therapy hour.

Core mindfulness skills

Mindfulness creates a framework for the emotion regulation module's more direct work with affect. These foundational skills help clients access their ability to observe and describe current emotions and remain present while avoiding the judgments and ruminations that often trigger episodes of dysregulation (Linehan 2015a, 2015b).

"Wise mind" is central to mindfulness and DBT. This concept refers to the meeting/synthesis of our rational and emotional faculties. Wise mind balances pure emotion with logical thought; further, it includes a sense of intuition that expands beyond both.

- Sculpture/drama: Ask the client to imagine what her wise mind might look like if it were physically present. What kind of body posture would it have? How would it move? How would it sound when it talked? Invite her to shape its form with clay and feel it with her hands. Then suggest a role play exploring how wise mind might respond in an emotionally charged situation.

Observing is the awareness of one's moment-by-moment internal and external emotional experience.

- Movement: Bring awareness to the sensation of an emotion in the body as the client gives it expression by moving about the room. Ask her to watch for any changes in her emotional state.
- Visual art: Observe the client's (or fellow group members') emotion-based image—slowly, one color and shape at a time.

Describing entails putting words to one's emotional experience, using sensory and factual language.

- Painting/sculpture: The client makes art describing an observation from a previous exercise. This could be a sensation in one's belly, a shape in a painted image, a specific movement. Emphasize naming the emotions experienced in the exercise and repeating back the client's words.

A *nonjudgmental stance* involves open receptivity. One refrains from evaluating anything as *good* or *bad*.

- Visual art: Ask the client to close her eyes and paint with her fingers. Next, with eyes open, she will practice speaking

nonjudgmentally about the piece. Outline the client's figure on a large piece of paper. She then draws or paints symbolic representations of where in her body she experiences various emotional sensations.

One-mindfully means doing one thing at a time with full awareness.

- Sculpture: Ask the client to explore a lump of clay with as many senses as possible, practicing immersing herself in the here-and-now of the experience.
- Music: Play various pieces of music. Invite the client to stay fully present (and return to listening whenever the music prompts an emotion, or if her mind wanders).

Effectively is responding to the reality of a given moment, keeping in mind one's long-term goals rather than what one may judge to be *right* or *fair*.

- Visual art: Create a group (or dyad) painting. Begin with one person and pass the painting around, instructing each client to add to the piece. If/when strong emotions arise, guide participants to return to the idea of present-moment effectiveness.
- Sculpture: Divide art materials (paper, glue, clay, fabric, popsicle sticks, etc.) unevenly among group participants (i.e., one person gets most of the fabric, and so on). Everyone builds a tower (or another shape) using *only* the materials they received.

Emotion regulation skills

These skills aim to reduce emotional vulnerability, identify and modulate negative emotions, and deliberately create positive ones (Linehan 2015a, 2015b). Clients develop emotional balance by exploring a more spacious, self-compassionate relationship with their affective states.

Accumulating positive emotions involves an intentional pursuit of enjoyable activities and experiences to this end.

- Multiple art forms: Co-create a weekly ritual of engaging in the creative processes the client most enjoys. Ask the client to journal about the impact on her mood (being sure to name each positive emotion that arises, employing the mindfulness *observe* and *describe* skills).

- Receptive music therapy: The client listens to pieces of music deliberately chosen for the desired emotional valence.

Building mastery involves doing things that make one feel competent.

- Multiple art forms: Ask the client to choose a form of self-expression she feels good at and engage with it both inside and outside of therapy sessions. Help the client to notice how practicing something that she has mastered can positively impact her mood.

Coping ahead is planning for how to effectively handle emotionally challenging future situations.

- Drama: Brainstorm and role play acting skillfully and practicing good self-care in difficult circumstances.
- Visual art/writing: Ask the client to write and/or illustrate how she would like the situation to occur in a story format, setting the new scene with as much detail as possible.

Opposite-to-emotion action is a skill for decreasing the presence or intensity of an emotion by engaging in a manner that is opposite to its action urge.

- Movement: Instruct the client to find and hold a body position that represents a difficult emotion they are experiencing. Then shift into a position that represents a positive emotion—the opposite of the negative emotion. Invite the client to use *observe* and *describe* to notice the differences in mood and energy between each body position.
- Visual art: Ask the client to paint an image of a difficult negative emotion. Notice what colors and shapes best express the emotion and allow plenty of time until there is nothing more to express. Then ask her to deliberately choose colors and shapes that represent the opposite emotions and paint with those. Notice any judgments and/or shifts in mood and feeling state. At the end, *observe* and *describe* both images nonjudgmentally and notice what feelings, states, and action urges are evoked from each image.
- Writing: Compose a story that includes all the current feelings and action urges. Use *observe* and *describe* to give as much detail as possible. Then imagine the opposite feeling state and write

multiple new endings with solutions and behaviors that spring from this state.

Distress tolerance skills

Distress tolerance skills help create emotional balance because they prevent the downward behavioral and emotional spiraling that often accompanies, and in turn exacerbates, emotional dysregulation. These strategies can also assist clients with improving their current emotional state (Linehan 2015a, 2015b).

Distracting is shifting attention away from distressing emotions in order to prevent emotional flooding.

- Movement: Move (alone or together) energetically to music that invites dancing *and* shifting awareness away from negative emotions and toward pleasurable bodily sensations.

Self-soothing with the five senses involves intentionally engaging in acts of comfort, nurturance, and kindness toward oneself.

- Movement: Invite the client to move gently and rhythmically (perhaps with slow rocking, gentle patting, or by giving their own body a hug).
- Drama: Invite the client to imagine and then role play what a warm, caring friend might say if they were here. The therapist can then portray that friend, repeating what the client had said in a similar tone of voice, as the client plays herself. Encourage the client to focus on how she feels when hearing those words.

Improving the moment is a set of skills for getting through an emotionally difficult time by deliberately making it better.

- Visual arts: Ask the client to practice working with what is available in the moment. Complete a quick imperfect drawing, and then ask what else the image "needs" in terms of colors or shapes.
- Guided imagery with all senses: Lead clients through imagining personally pleasing colors, images, shapes, body sensations, and sounds.

Pros and cons lists involve assessing both the desirable and undesirable consequences of a potential emotion-fueled action (the intent is to curb impulsive, reactive behaviors).

- Movement/sculpture: Invite the client to reflect on the consequences and effects of making several specific life choices, such as taking a new job or not, initiating a new relationship, and so on, by experiencing each choice within the body. Make "islands" around the room with colored scarves to represent different choices. Step onto the first island; then observe and describe how it is to have taken the choice this represents. Then step onto another and notice the difference between them. After the client has visited all the islands of choices, ask her to step aside and reflect on what she noticed.

Radical acceptance means accepting one's emotions and circumstances as they are, regardless of whether one likes them or agrees with them.

- Visual arts: Have clients draw or paint an experience including their related emotions and exactly how it is for them, but without any added value judgments—such as how bad it is, how things should be instead, and so on—and allow themselves to become immersed in reality and express that in colors and shapes.

Interpersonal effectiveness skills

Interpersonal relationships are deeply connected and intertwined with emotion regulation. Attunement and secure attachment are at the root of affect regulation, and affect regulation is often impaired by poor attachment. Our ability to self-regulate is founded within our first relationship(s) (Schore 2003). Healthy adult relationships are essential because of their potential to engender good emotional regulation, and because less adaptive ones are common triggers for dysregulation. Interpersonal effectiveness skills increase the likelihood of achieving one's goals by asking for what one wants or setting appropriate boundaries (saying *no*) while maintaining self-respect and the integrity of important relationships. These skills also support emotion regulation because they counter the reactive emotional expressions that often result from dysregulation—and can trigger or worsen relationship problems.

The *DEAR MAN* skills are steps to effectively communicate and address a problem with another person.

- Drama: Have clients role play in dyads to practice communicating ineffectively—and then effectively—in an imagined and

somewhat challenging interaction (in which they might normally become emotionally dysregulated and have difficulty *expressing and asserting* themselves). They will experiment with finding the appropriate tones of voice, body postures, and facial expressions as they go through the steps of *D*escribing the facts, *E*xpressing how they feel, *A*sking for what they want, *R*einforcing the benefits to the other person, staying *M*indful, *A*ppearing confident, and, finally, *N*egotiating a good solution for both parties (Linehan 2015b, pp.125–126). Ask them to track how each feels in their body. Additionally, you can have a third group member help by directing the scene and providing feedback.

GIVE skills are helpful when keeping the relationship is a higher priority than getting what one wants.

- Drama: Ask clients to role play making a request. Invite them to play with finding the right voice and body stance for them, practicing how to express emotions as they appear *G*entle, *I*nterested, *V*alidating, and *E*asy in their manner (regardless of the emotional pressure they may feel inside) (Linehan 2015b, p.128). Encourage clients to be cognizant of how their inner states change as they practice.

FAST is a skills set that aims to support healthy self-respect.

- Drama: Clients role play in dyads, holding to their positions when challenged and not reacting or collapsing for emotional reasons. For example, person A wants a favor from person B; however, person B does not want to give it them. Person B's job is to insist on saying "no" to the request regardless of what person A says. Coach clients to hold a somatic awareness of their center, observing boundaries as they go through the four letters/steps: (be) *F*air, non-*A*pologetic, *S*tick to their values, and be *T*ruthful (Linehan 2015b, p.130).

CASE STUDY: LINA

Lina is a 51-year-old Danish woman. She has seen me in my Copenhagen clinic every few weeks for the past year. She suffers from debilitating mood swings, alternating between fits of rage and crushing sadness. Her emotion regulation problems had previously led to self-harm behaviors and suicidal

thoughts. Lina experienced a tumultuous and chaotic childhood with parents who loved her, but were "unable to really connect [with me] and [were] basically just stuck in their heads."

Lina recently went through a divorce. She is understandably sad and angry given that her former husband had suddenly left her for a new relationship. Lina is highly gifted, creative, and intelligent; however, she has struggled to find a career that suits her. She never completed any formal education past her high school diploma.

Lina's moods and strong emotions make it difficult for her to stick with plans. We agree that she has improved a lot since beginning therapy, and I always notice that she is very engaged when learning how to find more emotional balance. She finds it liberating to focus on concrete behavioral skills after years of participating in analytical and depth-oriented psychotherapy. Today Lina is very upset about a recent email interaction with her former husband, and she is visibly distraught as she walks in. She quickly recounts the story as she takes off her winter coat with fast, jerking movements. She begins to cry as soon as she sits down.

Lina's emotions seem to intensify as she leans over and pounds her legs with her fists. I want to validate and support her, perhaps communicate that I can see and understand her distress. I am not sure that she can hear this, however, and so I wait until she comes to a natural pause. I then gently ask if she can *observe* and *describe* what she is feeling. Lina grows more upset in response to this perhaps overly skills-focused query. "I don't know, I really don't, except I just don't want to feel this way any longer…" Noticing that my invitation for Lina to be mindful of her internal state seemed to exacerbate her dysregulation, I decide to simply be empathically present with her in the moment. I again validate her emotional response.

Lina eventually stops crying and looks up at me. I then ask, "Would you be willing to draw how this feels to you?" Lina says "Sure," and begins to make large, rapid marks (in black, purple, and blue) across the paper. Next, she writes the word "help" in Danish, as well as the letters *A-A-A-A-A-A-H*. I gently support Lina in continuing to express her current experience by "Let[ting] it all just come out onto the paper." Her movements slow somewhat after a few minutes. Although verbalizing her emotional state is at first too difficult given the intensity of her dysregulation, Lina *is* able to draw.

As time goes by Lina add a few words, and, finally, can speak with me about her artwork. Lina seems a bit calmer and is now very involved in

her process. I ask whether she can identify a body posture that fits the feeling state in her drawing. She confirms this with a "yes," then slumps into her chair, grabs her hair at the roots with both fists, and shakes her head vigorously from side to side. I remark that that looks very painful, to which she replies "Well, yeah…it is."

I go on: "I know what I am about to say may be challenging right now, but could you show me what you sense might be the *opposite emotion* to this, I mean, what that opposite feeling might look like in a body posture?" Lina nods and starts to move around, searching for the right one. At last she sits up, arches her back a little, lifts both arms into the air, and looks up at me. She then breathes out in a big sigh, lowers her arms, and settles into a more neutral stance. "What was the feeling you showed me there?" I ask. Lina hesitates, then says "Relief, maybe? Calm?" I then invite her to mindfully move back and forth between the two poses a few times, and really notice how that feels.

I do this to help Lina appreciate that it is possible to shift in and out of emotional states, and that accessing the emotion opposite to the one we feel stuck in can sometimes pull us out of it. As Lina starts moving again, I remind her to *observe and describe* her experience *in the moment* and to notice *nonjudgmentally* if/when the body movements seem to affect her mood. Lina and I talk some more about her process. She is now rather calm and focused; her eye contact has improved, as well. I ask her to brainstorm with me how she can deliberately repeat the exercises from today to shift out of any overwhelming moods that might come up during the week—if, for example, she receives another email from her ex. Further, I ask about how she might create some *positive emotions* by recalling today's experience. We talk about what DBT skills and pleasant feelings were at play during the exercise and consider activities that might remind her of them. She decides to anchor her learning from today with another drawing. Lina quickly sketches what appears to be a bouquet of several red, pink, and orange flowers. She then draws a carrot-like figure that she calls "the chief." This figure often comes up as a kind of representation for her wise mind. I ask Lina if she can tell me more about "the chief" and what it stands for here, and she says: "That's the *wise* and strong part of me that I showed you before in the movement when I sat up." She adds, "It's a feeling that I want to hold onto…even if he writes me again. I can look at the drawing and remind myself before I write back…but I *do* need to keep reminding myself."

Discussion of case study

In this case study we met Lina, who has a long history of struggling with emotion regulation and yet is very open to learning new, adaptive behaviors. DBT skills she and I work with in the session are *opposite to emotion action*, *observe and describe*, *one-mindfully, nonjudgmental stance*, *and accumulating positive emotions.* By exploring them through drawing and movement, Lina can feel and experience each skill in a profound way. We have discovered during our work together that this creative and embodied approach allows her faster and more enduring access to the skills, and to her own inner resources, than do the traditional cognitive, verbal modalities.

Conclusion

Emotion dysregulation is at the core of many of the most painful states of suffering and psychiatric diagnoses. Art therapy-oriented clinicians are often uncertain about how to work effectively with highly emotionally reactive individuals. The DBT-informed CM approach teaches emotion regulation skills in a playful, engaging manner while reducing the risk of overwhelming sensitive nervous systems.

This intervention also works to support integration of new emotional learning by anchoring and repeating the experience through the senses. CM is readily adaptable to the needs of various client issues and treament environments. Further, it serves as a foundation for less structured expressive arts interventions, which clients may explore during later therapy stages.

Over the course of several years of implementing and teaching this approach, we have been encouraged by observations that our clients achieve lasting improvements in their emotion regulation capacities. However, empirical qualitative research is needed to assess more solidly CM's efficacy and usefulness.

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Chapter 12

Toward a Distress Tolerance-Informed Expressive Arts Therapy Protocol with Vulnerable Populations Experiencing Multiple, Persistent Barriers

CHLOE SEKOURI

Introduction

The expressive arts offer rich opportunities for valuable therapeutic experiences. By attending to insights afforded by dialectical behavior therapy (DBT)—and DBT's distress tolerance skills module, in particular (Linehan 1993, 2015a, 2015b)—expressive arts-based clinicians are uniquely positioned to teach, model, and support the use of creative activities in managing overwhelming emotions and developing healthy self-care practices. This is especially critical for individuals experiencing multiple, persistent problems and barriers in their psychosocial functioning.

This chapter presents one method for incorporating a DBT-informed artmaking practice into one's clinical work. It describes my, the author's, protocol for a combined visual art/poetry/psychoeducational technique via the case example of Cathy (pseudonym), a 28-year-old sex trade worker contending with chronic homelessness/housing insecurity, substance abuse, and mental illness. This chapter concludes with suggestions for effectively delivering such an intervention to similarly vulnerable clients.

Who am I and what am I doing?

While this chapter describes a cognitive behavioral model, DBT, I am influenced by several therapeutic traditions. For example, the school I attended, the Vancouver Art Therapy Institute (VATI), was, at the time I studied there, a traditional psychodynamic training program that emphasized object relations and depth psychotherapies. Exposure to other approaches brought me to the work of art therapist and clinical psychologist Mala Gitlin Betensky. I practice her phenomenological inquiry method (1995) in almost every expressive arts therapy session I conduct. My work is also grounded in insights from Gestalt therapy (Perls 1969a, 1969b), solution-focused brief therapy (Berg 1989; de Shazer and Dolan 2012), motivational interviewing (Miller and Rollnick 2012), and anti-oppressive social work practice (Dominelli and Campling 2002). My only formal clinical training is in expressive arts therapy. Regarding foundational social work and counseling skills, I am self-educated (or, rather, I have been taught by my clients through trial and error).

People come and people go

Many of my clinical experiences took place in a drop-in center in Vancouver's infamous Downtown Eastside (DTES). Such environments present therapists with challenges around choosing an appropriate framework for their goals as helpers (Bloom 2001; Cameron 2007; Campbell 2012). As the name indicates, it is the nature of drop-in services for people to come and go. The interaction you are having in any moment with any client may be the *only* interaction you will ever share, so it is worth considering a single-session treatment approach (Slive and Bobele 2011).

I was mindful to round off each exchange so that, if I did not work with the person again, there was no blatant unfinished business. Some individuals engaged with me one time only, never to return; others tried art making but did not continue with it despite being frequent drop-in center users. Some wanted to regularly spend time in conversation with me, but consistently declined art. Committed art therapy clients were rare. Hence, I frequently employed the solution-focused brief therapy (SFBT) model. Rather than maintaining a focus on the problems that bring clients to therapy, SFBT encourages us to remain future-oriented,

goal-directed, and working on solutions. In the SFBT framework every therapy participant is a *visitor*, a *complainant*, or a *customer* (Berg 1989).

On one end of the engagement/commitment spectrum, there are visitors and complainants. *Visitors* typically come at another person's request. They are willing to attend therapy, but usually only to please the other individual. A visitor is not personally invested in change (Berg 1989). *Complainants* desire to talk about their difficulties, air frustrations, and/or analyze or criticize other persons involved. However, a complainant typically lacks the ability to see how their own behavior may contribute to their problem(s) (Berg 1989).

On the other end are the *customers* who are ready to problem-solve. Therefore, they go beyond mere compliance; they are active participants and collaborators (Berg 1989). Customers appreciate that they might have contributed to the issue(s) at hand and know that they must author any solutions. This echoes DBT's assumption (Linehan 1993) that individuals in treatment "may not have caused all of their own problems, but they have to solve them anyway" (p.107). The customer will consider novel ideas and is open to different methods for approaching the problem (Berg 1989).

Whether visitors, complainants, or customers, individuals seeking services at the drop-in center rather consistently expressed profound skepticism toward the idea of psychotherapeutic change. As one put it, "The power of positive thinking has never un-raped anybody." She certainly had a point.

Even if my clients had been willing, both the drop-in context itself and the difficult life conditions they experienced outside the center suggested that psychodynamic-oriented modalities would be inappropriate. People require a certain baseline level of stability and safety for such deep interventions to be productive, ethical, and pointful (Bloom 2011; Cameron 2007; Campbell 2012; Watson 2007). This realization has dripped from the helping professions and infused the overculture—such that I recently saw a t-shirt printed with the slogan "Stop looking at the past; that's not where you are headed." But if it isn't necessarily helpful to dig into the past, what can we do instead?

DBT

Developed during the 1980s by psychologist Marsha Linehan, DBT is a behavior therapy designed to treat borderline personality disorder

(BPD) (Linehan 1993). It has since been applied to a wide range of other mental health concerns (Gross 2015; Newhill and Mulvey 2002). The model is particularly efficacious for problems that include emotion and mood dysregulation elements such as substance abuse/dependence, unresolved trauma, and attachment issues (Feigenbaum 2007; Hayes *et al*. 2004; Welch, Rizvi, and Dimidjian 2006).

DBT's psychoeducational skills training curriculum, just one component of this comprehensive evidence-based intervention, consists of four interlocking modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance skills (Linehan 2015a, 2015b). Each module circles back to, and informs, the others. While it makes sense to speak of them as separate entities, in the context of teaching customers one may find that all four skills sets are present (and needed) in any given moment. This is analogous to some organic biological processes. For example, the seeds of future apples are present in apple blossoms, within the juicy just-ripe fruit, as well as in every decomposing core.

While the principal uses we have for the blossoms, whole fruit, and core are different and varied, apple seeds are, by necessity, present in all states. And so it is with DBT: seeds of mindfulness are present within the distress tolerance skills. Similarly, emotional regulation must be present for a customer to improve their interpersonal effectiveness capabilities. Thus it is with some trepidation that I attempt to discuss the distress tolerance skills in isolation from the other modules.

Distress tolerance skills

Many people believe that the point of seeking out helping services is to change or eliminate undesirable circumstances. Troubled marriage? *Divorce or try couples counseling*. Abusive boss? *Quit or speak with HR for mediation*. Low self-esteem? *Engage in personal work that builds confidence as well as a realistic sense of one's self.* Another assumption is simply that some problems have no real-world solutions. Many drop-in center participants, at some point during our interactions, have voiced serious doubt that psychotherapeutic treatment "actually works."

On one hand, they are correct: psychotherapy cannot reanimate the dead, eliminate all trauma sequelae, or return the sufferer to a state of pristine wholeness (should such a thing exist). On the other, I believe they are mistaken: the point and the power of DBT lies within

its acknowledgment that some issues and situations are inherently unfixable—and that we must accept their existence in order to avoid unnecessary suffering (Linehan 1993, 2015a, 2015b). When we discard fantasies of *closure*, what remains is our human capacity to live, as best we can, despite the unavoidable pain involved. DBT aims to help customers accept, construct meaning for, and endure distress without relying on coping behaviors that place them at additional risk for injury. In other words, the essence of the distress tolerance module is learning to bear pain skillfully, using methods that do no further harm.

The vehicle for this is mindfulness. In a nutshell, DBT's mindfulness skills center on the ability to accept, without judgment, oneself as well as the current situation. Note that accepting reality is not the same as approval. For example, acknowledgment of inequality is not tantamount to desiring or condoning it. The distress tolerance module leverages the customer's use of mindfulness to survive crisis and upset while refraining from making things worse (no matter how unintentionally).

Who is the expressive arts therapy participant?

CATHY

Cathy was a 28-year-old woman of mixed indigenous Canadian and white settler ancestry. We worked together intermittently at the drop-in center for a period of six months in 2007. I should mention that not all of our clinical encounters involved art therapy or DBT. However, those interactions are not relevant here and therefore were not included.

Cathy grew up in Alberta with her six younger siblings. Their mother struggled with substance abuse problems that resulted in significant child welfare involvement. When not in foster care placements, Cathy and her sisters and brothers resided with a variety of extended family members. Cathy ran away from her last foster home at age 16 and eventually made her way to Vancouver. Like many young people who come to the city alone and lacking a support network, she found community, fellowship, danger, and exploitation within the infamous Downtown Eastside (DTES). By the time she was 17 years old, Cathy was supporting herself through sex work.

If it were possible for me, writing today, to ask Cathy to describe herself, I suspect that she would include several other facts. For example, she

might tell you how much she loved to read. I believe that Cathy would also talk about her volunteer work in the public library, for a local women's center, and with a community garden initiative. Employees of mental health and social service systems are subtly, and sometimes not-so-subtly, conditioned to see client narratives that support certain paradigms. One cannot include case study information without implying that the subject is a *case*. I am in a quandary because I know I must tell you something about Cathy, but I also appreciate that I will inevitably fail to do her justice. I have tried to resolve this (at least partially) by disrupting the narrative before you with reflexivity as well as with an acknowledgment of my limitations and personal biases.

Procedural overview: A DBT-informed art therapy intervention

In the expressive arts therapies, the creative process (as well as any resulting artistic products) functions as a safe container for overwhelming feelings. It is therefore unsurprising that some practitioners resonate with DBT's distress tolerance component. Creating art helps us bear pain skillfully.

After completing a DBT-informed art therapy activity I supported Cathy's use of worksheets and journaling, taking care to point out any connections between her experiences/insights and the following crisis survival strategies (Linehan 2015a, 2015b):

- mindful distraction activities
- self-soothing practices
- improving the moment skills
- examining pros and cons (i.e., the likely desirable/undesirable consequences of both using DBT skills *and* of resorting to maladaptive behaviors).

These strategies were, by necessity, combined with instruction in mindfulness and how to turn one's attention toward accepting reality.

Objective

To develop and/or improve an individual's distress tolerance skills using directive, experiential art-based methods.

Duration

There is no ideal format for this protocol given that the nature of my drop-in center work was fluid, situational, and highly individualized. In this instance, Cathy and I met one-to-one for 120 minutes (which was inclusive of some participant-initiated cigarette breaks).

Art materials and equipment

I keep on hand the following basic items: paper of various sizes and colors, bound notebooks of lined paper (used as participant journals), canvases, pre-cut collage images, acrylic paints, fluid paint medium, molding paste, chalk pastels, conté pencils, assorted plastic/rubber toys and other found items, spray adhesive, glitter glue, scissors, paintbrushes, spatulas, a small kitchen torch, and a hairdryer (for quick-drying paint, glue, and so on). If space and budget allow, I include additional materials.

NOTE: My experience has been that agencies serving vulnerable populations with multiple barriers typically lack the budget and infrastructure for sculpting work. Potentially one of the wettest visual mediums, clay might not be a good fit for customers in need of significant emotional containment. I believe that such individuals tend to become easily overwhelmed when using clay.

The session—Understanding DBT's states of mind

The purpose of this session is to familiarize the participant with the art making space and supplies, as well as offer basic information about three unique *states of mind* as understood in DBT: *emotion mind*, *reasonable mind*, and *wise mind* (Linehan 2015b, p.50).

When emotion mind predominates, our behavior is controlled by our affective state (Linehan 1993, 2015a, 2015b). It is difficult (or impossible) to think in a logical manner. Emotion mind's dialectical opposite, reasonable mind, is intellectual, rational, and excels at identifying cause–effect relationships. In reasonable mind we can plan how to navigate difficult situations. We possess the capacity to respond based on evidence and facts (Linehan 1993, 2015a, 2015b).

The third state, wise mind, integrates/synthesizes emotions with rational thought. It also adds a dimension of intuitive knowing. Wise mind is greater than the sum of its parts; here we see more clearly and can grasp the bigger picture (Linehan 1993, 2015a, 2015b). Further,

wise mind ensures that the needs of both emotion and reasonable minds are met: it validates intellectual processes and allows for the soothing/regulation of intense emotions.

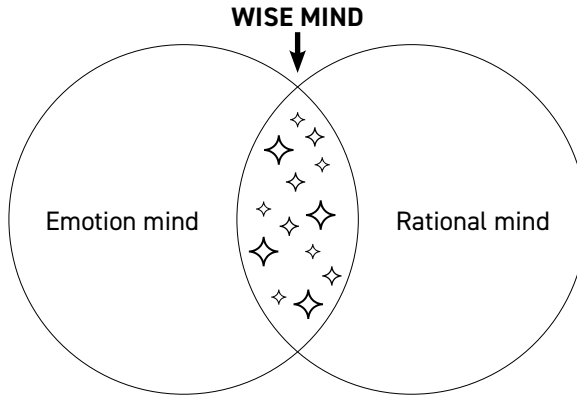

FIGURE 12.1 THERAPIST'S DIAGRAM: DBT STATES OF MIND

Protocol

Below are the sequential steps for implementing the intervention:

1. First I introduce the participant to available supplies via pre-art play. This consisted of the participant experimenting with the materials to gain familiarity with them.
2. Next I draw the DBT states of mind diagram (Figure 12.1) on paper while noting verbally that "Wise mind is our sweet spot, the place where we are balanced and make our best choices."
3. I then invite the participant to collage her/his personal conceptualization of each state of mind.
4. I hold the space while the participant makes art. Holding the space involves being with someone without judgment, putting one's own needs and opinions aside, and allowing the client to just be (Gafner 2013).
5. I witness the participant's finished artwork and attend to any commentary.
6. I invite the participant to journal about this experience (if desired).

Discussion (Cathy's process)

After warming up with some pre-art play using the collage materials on hand, Cathy created her own DBT states of mind diagram (Figure 12.2).

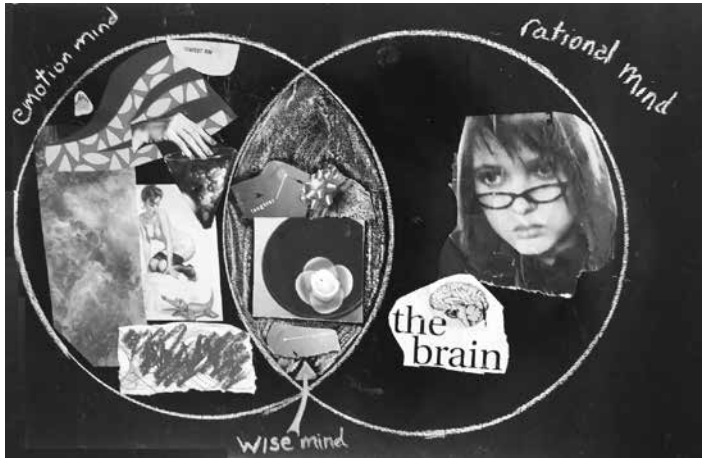

FIGURE 12.2 PARTICIPANT IMAGE: "MY MINDS" (COLLAGE, CONTÉ, CHALK PASTEL)

When sharing the states of mind diagram from Figure 12.1 with Cathy, I sketched it onto the back of a used envelope with a ballpoint pen. Experience has taught me that many individuals who are new to art therapy flounder when presented with nondirective art making prompts. Further, those lacking a formal visual art background often express feeling anxious and/or intimidated (usually resulting from perfectionism and negative judgments), which has a chilling effect on their ability to relax into a creative process. By using materials of perceived low value (e.g., dollar store pen, scrap paper fished from the recycling bin), I communicated to Cathy that she should not worry about her piece needing to be perfect, special, or precious.

We had had sufficient verbal interactions prior to this first art making session for me to know that Cathy would not take risks without a sense of reciprocity. My intuition told me that, by providing a simple handmade visual example, she would more readily accept my invitation to make art. A selection from our discussion about her piece follows:

CS: Can you tell me the story of how you made this?
C: Okay, so in the emotions section, the first thing I put down was the words "Tempest Rim" because when I saw it in with all the collage

stuff, it made me think of that Shakespeare play *The Tempest*, you know that one with the storm and the creepy magician?

CS: Uh huh.

C: So, when I saw that, I thought about the storm. That's kinda how my emotions feel, like a wild storm at sea, right? Then I looked for a water picture and I found a perfect one—it's all stormy—so I put that one down, too. (pause) The next thing I put down was the green and blue swoop thing. I like both those colors. I'm not sure why I picked it. I just like green and blue together.

CS: Right.

C: It's funny, though, because looking at it now, it looks like an ocean wave to me.

CS: Yes, it looks like that to me, too.

C: Freaky how that works, hey?

(both laugh)

C: So, then the next thing I put down was the girl in her underwear…

CS: Any thoughts on that?

C: Well, I liked it just because I liked her old-time underwear. (laughs) (pause) As I look at it, it's a sorta ridiculous picture. I'm like, "Bitch, why you afraid of a toy alligator?" (laughs) (pause) Seriously, though, I think that it's about manipulation. She's playin' at being afraid, but she's not really afraid. She's all like, "Oh, I'm so cute and sexy and scared. You gotta help me."

CS: You make anything of that?

C: (sighs) (pause) Well, that's life, right?

CS: Like, all of life, or life in the game?

C: (laughs) Well, I meant it as life in the game. That's how you are with a date, right? Keep him happy, play along, make your money, get out. But just now, when you asked me that, maybe it is all of life—like most of us playing somebody sometime for something.

CS: Huh. (pause) Anything else?

C: Yeah. (pause) I saw that little house and wanted it on there. After I stuck it on, I drew in the flames because some emotions are like being on fire, right?

CS: Yes.

C: Fire and water at the same time somehow. Then when I found that scrap of paper with the doodle on it, it looked too perfect, I wanted to wreck it, just cross it out, get rid of it.

CS: Uh huh.

C: So, I used that skinny chalk to scribble on it. Take that, you damn doodle!
(both laugh)
C: And then the last thing was the hand with the candy bowl. (pause)
CS: Okay, what's happening there?
C: Well, I like how her nail polish matches the jellybean colors.
CS: Anything else?
C: (sighs) It makes me think about when I was a teenager, I had bulimia, right, I told you that, didn't I?
CS: Yes.
C: So if I got stressed out, which was all the time, I'd eat my feelings… and I was starting to get fat.
CS: Uh huh.
C: And I didn't wanna be fat, and I had seen about bulimia on TV—on *Maury* or some shit. And I thought "Okay, let's give that a try."
CS: Right.
C: I don't do that anymore, though.
CS: Oh?
C: (laughs) Crack keeps me nice and skinny now.

At this point in the session Cathy excused herself to go outside to smoke a cigarette. We resumed our work after she returned.

CS: Do you want to say more about your collage, or do you want to do something else?
C: Let's talk about the collage.
CS: Sounds good.
C: So, the overlap in the circles…
CS: Wise mind.
C: Yeah, the wise mind. The first thing I put down was the bowl with the floating candles. I liked how the candle looks like a flower. The picture is very simple. I liked that.
CS: I wonder why you were drawn to it.
C: (pause) I think it makes me feel peaceful, relaxed. Is that part of wisdom?
CS: What do you think?
C: (pause) Yes. (pause) Then I saw that picture of the present, and I started to think that wisdom is a kind of gift, right?
CS: Yes.

C: And maybe the point of wise mind is it's the gift you give yourself when you balance emotional and mental things.
CS: Mmmmm.
C: It's like a seesaw, maybe, like on a playground. One end goes up, the other goes down, then the other way. But sometimes it balances out and everything is…level.
CS: Right. (pause) You've said the word *balance* a couple of times and I notice one of the images is a dandelion seed labeled "balance." How important is balance?
C: How do you mean?
CS: Like, in wise mind, is balance always a part of it, or just sometimes?
C: Always.
CS: Okay, good, that's good to know. Anything about the seed labeled "laughter"?
C: Can't get through a day without it, right? I mean, if you don't laugh, I'd say you are pretty much fucked! (laughs)
CS: True that.
(both laugh)
CS: Anything about the fact you colored the overlap in?
C: I just wanted to show that the circles overlap. I wish I hadn't used the chalk. I don't like how it feels on my hands. If I do another one, I think I'd fill it in with felts…are there felts?
CS: I can get some.
C: I'd have to use white paper then, so the felts would show up.
CS: I can get some that show up on black, like some metallic ones or gel felts or something.
C: Metallic ones would be cool! (pause)
CS: Anything to say about the rational mind part of your collage?
C: There's not much there.
CS: How so?
C: Well, there's a cute smart girl in her glasses. That'd be me if I wore glasses. (laughs)
CS: Anything else?
C: Not really, just a great big ol' brain. (long pause)
CS: I have a guess about your collage. Want to hear it?
C: Sure!
CS: My guess is you feel confident about your mind, being smart, so there isn't a ton to say.
C: My brain speaks for itself, huh?

(both laugh)
CS: Meanwhile, the emotion part, it can cause some trouble. Maybe get you unbalanced, so you put more in that circle…
C: Yeah, 'cause I'm trying to figure it out. I'm like, "What is all this feeling shit?"
CS: Right.
C: So why do you think I filled up the wise mind part?
CS: Why do you think you did that?
C: (pause) I'm wishing and hoping for that stuff. Sometimes it seems so close, and sometimes not.
CS: Right.

As our session continued, Cathy and I transitioned from the art-based process to a didactic/psychoeducational lesson involving DBT skills and journaling. The materials were based on contents from *The Dialectical Behavior Therapy Skills Workbook* (McKay, Wood, and Brantley 2007)—specifically, the checklists "Radical Acceptance Coping Statements" (p.11), "Distract Yourself from Self-Destructive Behaviors" (p.13), and "Self-Soothing Using Your Sense of Vision" (pp.24–25), as well as the "Create Your Distraction Plan" worksheet (pp.22–23).

Under other circumstances I might have used the "Big List of Pleasurable Activities" checklist (pp.15–16) as well, but opted not to here because it reflects an economic lifestyle that was outside of Cathy's grasp at the time of this session. I was concerned that the list could be upsetting to her (i.e., owing to a possible perceived implication that feeling better is only for people who have the money to afford it). Instead I gifted Cathy with a blank journal and pen, and together we brainstormed her personal list of pleasurable activities.

As Cathy and I discussed the worksheets and she wrote down her answers, I facilitated making connections between skills she already possessed and the distress tolerance modules. For example, Cathy's self-reflection tied directly into an ability to weigh the pros and cons. In addition, I assisted her in appreciating that making art can function as a distraction from dysphoric states, be used to self-soothe, and improve the moment with an infusion of beauty and creativity.

Within a few sessions of receiving a journal Cathy started to compose poetry and bring her poems to our therapy sessions. When I inquired about how she felt before, during, and after writing poetry, Cathy replied:

> It lets the pressure off. When I feel the emotions building up inside me, I can write down a line or two. I usually feel bad when I start and feel really bad while I'm doing it. It's kind of my wallow time. After the poem comes out, I feel better, lighter, more in control. It's like the poem has absorbed all my negative emotions.

Poetry therapy is a form of expressive arts therapy and involves the use of poems, narratives, and other spoken or written media to promote healing and well-being (Mazza 2017). While I had not initially offered creative writing suggestions or directives to Cathy, I started to do so after she introduced some of her poems into our sessions. Poetry proved a rich vehicle for Cathy to safely explore her emotions and responses to people and life events. For example, Cathy wrote an untitled piece about her involvement with the sex trade:

Open mouths with teeth
Everyone wants a bite
of my juicy ass
fuck that
I'll either be a cannibal or a suicide

While discussing this poem Cathy identified themes that she had not previously given voice to. Interestingly, Cathy never made visual art directly associated with any poems, nor did she write poetry that connected to her visual art. When I mentioned this during one of our sessions, Cathy replied:

> Yes, I notice that, too. I mean, the poems and the art are connected because they are made by the same person, by me, but it's like some things are better dealt with in words, and some in pictures. They are connected because it's all happening in one life, my life, but it's like I want to keep things in separate compartments.

Other ideas for combining DBT skills and art making

Self-soothing through vision is an obvious match for visual art making. However, other sensory elements lend themselves to a distress tolerance-informed art therapy session, such as:

- Playing or listening to music (sound).
- Dance, self-massage, or yoga activities (touch) to supplement the

haptics already embedded in the making of music (e.g., the feel of the ukulele strings, the texture of the drum skin) and visual art (e.g., sensations available when we interact repetitively with paint while finger painting, sculpting with clay, and so on).

Even simple acts such as offering healthy snacks (e.g., herbal teas, fruit) provide clients with specific examples for integrating these skills into daily life.

Art making of any medium can be incorporated into a willing individual's distraction plan or used to improve the moment. If desired, clinicians may develop didactic psychoeducation lessons connecting the principles of distress tolerance to what has just taken place in the therapeutic encounter. My experiences suggest that it is best first to provide the creative intervention, then process the client's response(s) (as well as the artistic product)—and, finally, introduce psychoeducation. It will likely always be the case that some individuals resist didactics and worksheets. This is their right. Roll with the resistance and meet them wherever they are.

Conclusion

This chapter introduced a novel method for using expressive arts techniques to teach select DBT skills to customers of an urban drop-in center. These individuals often experience multiple, persistent barriers to their optimum functioning and tend to harbor skepticism around the potential value of mental health treatment services. Cathy was one such person, a vulnerable young woman who contended with significant psychiatric issues, homelessness, and substance abuse; further, she was employed in the sex trade.

Cathy's engagement with an expressive arts therapy process, along with the resulting creative products (visual art and poetry), facilitated a point of access for valuable conversations concerning her thoughts, feelings, and behaviors, as well as the pros and cons of various choices and options. These discussions connected easily with DBT's distress tolerance skills module; as a result, Cathy could explore her personal experiences of such important concepts as wise mind, crisis survival, and reality acceptance. She ultimately acquired self-regulation skills that had previously been much less accessible to her owing to the standard didactic handout and worksheet-based format.

The presented protocol is certainly not appropriate in all treatment milieus. However, my hope is that it will provide readers with helpful insights around potential applications for combined DBT skills training and creative arts interventions. Cathy's reported feedback suggests that the process of making art, then stepping back to objectively observe and describe her work with a trained expressive therapist, improved this woman's emotion regulation capacity as well as an overall enhanced effectiveness in activating her *wise mind*. Clinicians may find the inspiration to develop this intervention further and test its validity through formal research projects within their places of employment.

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Chapter 13

Queering DBT

Critical DBT-Informed Art Therapy with the LGBTQIA+ Community

MARY WEIR

"I mainly get support from within a personal relationship at the moment," I say.
And has your boyfriend been helpful? my therapist politely inquires.

I pause. You see, I went to get a sexual health check the other day:

Have you had unprotected sex recently?
"No, but my partner has."
Oh dear, is this the first time that they have been unfaithful?
"They weren't unfaithful; we are ethically non-monogamous. This is a routine check-up."
And did he wear a condom?
"They don't have the right genitals for a condom."
Err…ah, okay, and so did she sleep with a man or a woman?

My femme[1]-identified partner, like me, was assigned female at birth but does not identify with binary[2] pronouns. Although I feel guilty, I let this slide for the sake of simplicity.

"Man."
And did he wear a condom?
"Well, he is trans,[3] so he doesn't currently use condoms specifically."
I'm sorry, did they or didn't they have penetrative sex?
"They did have penetrative sex but there was no need for a condom. This is a routine check-u—"
I don't understand…are you saying…

She seems flustered, and so distracted by trying to work out my love life that she starts to insert the speculum without warning me first. I freeze, inhale sharply, and put my hands over my face.

Are you okay?
"Nope," I force out.

She removes the speculum and I remain frozen in place.
"I have had sexual trauma…" I eventually stammer.

Without acknowledging her failure to prepare me for the penetration (or my momentarily unraveling) she moves on with clinical matter-of-factness:

Do you usually have problems with sexual health checks?
"Just the failure to ask for my consent," I growl internally (but remain silent).
I certainly hope you are getting help! Maybe you could see a counselor.
"I'm usually okay as long as there is lots of clarity and preparation."

I'm sad that, in my highly dysregulated state, and fearing her defensiveness, I can only deliver this somewhat passive feedback. I leave, shaken and emotionally drained.

No: I am angry, as well. And I feel dissociated for a long time afterward.

. . . . . .

My therapist is still looking at me.
Is he supportive? they repeat.

I silently run through possible replies, considering the potential outcomes of each:

1. "*He*" assumes heteronormativity.[4]
2. The use of "*he*" is based on my feminine performativity.[5]
3. Both assumptions place me within a binary that is a result of gender policing.[6]
4. They also make similar assumptions of my significant others.

Ugh. It all feels too difficult, having so recently experienced my queer[7] identity and trauma history intersect. After a prolonged pause, I reply: "They are supportive" ("*they*" is another indirect correction that

surreptitiously covers multiple partners *and* nonbinary genders). It goes unnoticed by my therapist, who continues to use masculine pronouns. Eventually I discontinue our sessions, claiming to be "in a much better place." This is a lie. The idea of educating a mental health provider on identity politics simply feels like a waste of expensive therapy time.

* * *

Introduction

A self-authored identity

When I was younger, I saw my queer experience through the lens of the surrounding society: flawed, problematic, and dangerous. Openness felt impossible within a conservative religious family. At 16 years old I spent nearly six months in a day program for adolescents with suicidal ideation and self-harming behaviors. I now imagine that I was considered a *difficult client*—in and out of emergency departments and never really connecting with my therapists.

Today I use dialectical behavior therapy (DBT)-informed arts therapy within my own counseling practice, as well as in partnership with programs serving youth, LGBTQIA+[8] individuals, and sex trade workers. While engaging with DBT-based principles and interventions, therapy participants[9] and I intentionally deconstruct preconceptions that tie our identities to problem-saturated discourses. Psychology has historically viewed divergence from Western cultural norms as maladaptive. It has (and sometimes still does) elevated the expertise of the therapist, who is often privileged by wealth, education, and professional status, over that of the person living out their differences within deeply inequitable cultural milieus. An object of the therapeutic gaze for much of my own youth, I am sensitive to how some providers problematize their clients' behavior in unhelpful ways. I seek to cultivate a vastly different environment for the individuals with whom I work.

DBT's developer, Marsha Linehan (1993), describes how its "dialectical perspective on the nature of reality and human behavior" stresses interrelatedness and wholeness based on the assumption that "identity itself is relational" (p.31). She acknowledges that this perspective conflicts with current cultural/sociological mores around independence as normative behavior: "[A]lthough there is a 'dependent personality disorder'…there is no 'independent personality

disorder'" (p.55). Linehan suggests that entrenched sexist attitudes—in particular, parental devaluation and/or rejection of female children who do not possess typical feminine characteristics, interests, and abilities—might result in the type of corrosive invalidation thought to contribute to the etiology of borderline personality disorder (BPD). Sadly, the world outside of the home is typically little different given overlying cultural values. Hence "[it] is difficult to imagine how such a child could not grow up believing that there must be something wrong with her" (p.56).

Therapists should be cognizant of how we might, through our foundational beliefs and/or treatment models, perpetuate participants' experience of inherent *wrongness*. While aspects of DBT's origins and philosophies contain a "holistic view…compatible with both feminist and contextual views of psychopathology" (p.31), I posit that we must offer much more if we are to become fully inclusive of LGBTQIA+ experience. Considering how "stress stemming from social stigma, discrimination, and the coming out process" may account for significant symptomization (Pelton-Sweet and Sherry 2008, p.170), this is a serious ethical concern. I view the extrication of psychological methods from their histories, power structures, and theories as part of the mindfulness practices advised for DBT-informed practitioners. Linehan describes "compassionate flexibility (i.e., the ability to take in relevant information about the client and modify one's position accordingly, including the ability to admit to and repair one's inevitable mistakes)" (Dimeff and Linehan 2001, p.11) as an essential skill. In treating LGBTQIA+ participants, compassionate flexibility must entertain the active *queering* of DBT.

Queering

Queering, a verb that rainbow (LGBTQIA+) people often use when engaging in critical practices, involves observing the broader culture through an anti-cis[10]-heteronormative lens. Queering dismantles cultural ideals through which heterosexual/binary/genital-based concepts of gender drive what experiences and behaviors are validated (Sedgwick 2012) and reconstructs them in more inclusive ways. Throughout history, diversity of sexual and gender expression has been conflated with criminality, pathology, and deviance (Woods 2018). However, "[q]ueer…does not seek to 'rationalise' difference. It is not interested in simply adding differences to normative structures,

but rather in seeking to disrupt the very idea of normalcy through legitimising differences on their own terms" (Zappa 2016, p.4). As a critical theory it "is suspicious of the very categories of better, useful, appropriate, productive, and valuable as these are understood in the present order" (Horkheimer 1972, pp.206–207).

This chapter considers the oppression of LGBTQIA+ communities within Western psychological models, including their overrepresentation as high-risk mental health clients with inequitable contemporary diagnosis (BPD, in particular). I seek to disentangle DBT from its socially normative frameworks through critical analysis. Further, I intend to be radically explicit regarding my researcher privileges and transparent regarding my own subjectivity/biases. Given that clinical observation has often been covertly, sometimes overtly, the domain of the Western heteronormative man, my engagement with academia is activism. I unashamedly acknowledge my rainbow and feminist viewpoints, as well as the fact that I employ unconventional means for understanding experiences occurring beyond the domain of traditional academic understanding. This approach addresses how

> [M]any people of trans*[11] and queer identities are often not "out" to their service providers and thus we should begin with the simple recognition that providing room for people to tell their own stories facilitates client connection and understanding, both of which are vital for competent mental health care. (Schroeder 2014, p.36)

Recognizing the importance of greater visibility for rainbow people, without co-opting another's experience for my privileged academic purposes, is a delicate balance. Autoethnography (an ethnographic account of the author's own life experiences), a/r/tography (a living inquiry including art making, creative writing, and other activities not traditionally associated with academic research), and fictionalized therapeutic accounts offer "ways to create useful arts therapy session descriptions in contexts where it is unethical to reference recognisable clients" (Green 2015, p.33). Self-revelation is necessary for rainbow therapists/researchers to establish mutual understanding and trust with participants who suffer from queerphobia and discrimination. Therefore, this chapter describes some of my experiences as both therapy participant and provider. It offers a first-person narrative weaving together creativity, activism, and the academic.

Background

My home of Aotearoa, New Zealand has engaged in some recent reflection on the mental health crisis, particularly around how support systems marginalize people of color, women+,[12] and the rainbow community. A report from Victoria University (Fraser 2019) revealed that "the number of people who said their mental health professional required education about sex, sexuality, and gender diversity has increased" (p.12). Although clinicians are less likely to try to force clients to fit their preconceptions (Fraser 2019), psychological discrimination persists.[13] Identity and diversity politics evolve so rapidly that therapists educated several years ago may struggle to respond skillfully to the language and behaviors of today's LGBTQIA+ population. People under age 40 are four times more likely than those over 40 to present fluid, indefinable, gender-nonconforming identities (Schroeder 2014). This challenges Western psychology's highly categorical models and might result in overrepresentation of self-concept pathology among gender/sexually fluid and/or nonbinary individuals.

FIGURE 13.1 POSTERS BY GENDER MINORITIES AOTEAROA (SUPPORTING GENDER DIVERSITY IN AOTEAROA)

Even therapists who strive to transform structural inequity may unintentionally commit discrimination and/or microaggressions[14] toward those who traverse social terrain beyond their own cultural maps. This is particularly true when clinicians possess a primarily binary, cis-heteronormative, and/or monogamous experience. Furthermore, LGBTQIA+ experiences are often entangled with other markers of inequity such as race, socioeconomic status, and neurodiversity.[15] Indeed, gender and sexuality are singular facets of a potentially infinite intersectional multiplicity. I am queer and a survivor of youth homelessness and psychiatric institutionalization, but I am *also* white, self-employed, cis-privileged (at first glance), and use an academic voice. While I cannot speak for all rainbow people, I hope that my work facilitates the self-advocacy and self-determination of those who seek it.

Therapy is a queer situation

We have been sitting here for a while. I feel an expectancy to the silence; however, I just breathe and sink into my center. Suddenly the young man blurts out: "I'm pansexual[16]!" I nod encouragingly. "I didn't feel like I could talk properly about sexuality stuff with my last therapist, but these help" (he indicates the Pride flag sticking out of a potted plant in the corner and the little rainbow-themed heart on the bookshelf). Although Fraser's research (2019) identifies "visual signs of support" as some of the most helpful therapist actions (p.14), I marvel at how often participants remark on them with appreciation.

He is a university student who sought me out after a string of failed relationships with "traditional psychologists," hoping that "something different," like art therapy, might help. My frustration bristles as I recall the language in his treatment reports. The summary concluded that "therapist/patient rapport was not established," and I wonder if professional mythologies about difficult clients (Jones 2012; Lawn and McMahon 2015) influenced the therapist to surmise that he "display[ed] sub-threshold BPD symptomology (DBT models advised)."

While I do not believe in "difficult" participants, I *do* appreciate difficult life circumstances. I also contend that covert structural oppressions can oblige individuals to adapt in creative, unconventional ways. Hence, I determine to cultivate *unknowingness* and deeply listen to each person's narrative (feeling as I do that therapeutic success is mostly determined by a full acceptance of *what is*).

Who decides what defines BPD?

Comprehensive DBT is a team-based model developed by clinical psychologist Marsha Linehan (Linehan 1993, 2015a, 2015b) to support individuals at high risk of self-harm and/or suicide. It is a popular treatment for BPD, a diagnostic label not lacking in controversy:

> BPD became both a female and despised diagnosis. This shift in meaning occurred largely in the 1970s and 1980s, decades in which radical feminists fought to legitimate women's anger and sexual expression, at the same time asserting a right to protection from physical or sexual abuse and launching a sustained critique of psychiatry for its role in women's subjugation. (Cahn 2014, p.3)

Both anger and active sexuality are more acceptable for men (Gavey and Senn 2014), and BPD has undoubtedly contributed to stigmatizing their expression in women+ (Berger 2014): "As long as men hold positions of power it is *their* beliefs that count, and they tend to see women's aggression—because it remains inexplicable in male terms—as comic, hysterical, or insane" (Campbell 1993, p.2). Some argue that the increasing number of men diagnosed with BPD reflects an ironing out of clinical gender bias (Weiderman and Sansone 2009). Perhaps, however, gender policing has merely extended to include men and the rainbow community. Weiderman and Sansone (2009) describe how "when psychologists perceived a male client as gay, they were more likely to diagnose the client as having BPD" (p.280).

Furthermore, there appears to be an illogical conflation of heteronormative divergence with pathology: "The combination of impulsivity and a relatively unstable sense of personal identity may also help explain the elevated rates of homosexual behavior among individuals with BPD" (Weiderman and Sansone 2009, p.280). A cis-heteronormative environment is one in which rainbow identities are undermined, invalidated, demanded to change, and aggressed (and/or microaggressed) against. Invalidating environments, through which chronic emotional dysregulation is likely to develop (Linehan 1993), can be socio-systemic; as previously mentioned, they do not exist only on a personal or familial level. Heteronormative (diagnostic) bias likely contributes to apparent "higher rates of non-heterosexual identity, behavior, or attraction in BPD populations" (Reuter *et al.* 2015, p.3).

I urge clinicians and researchers to consider what differentiates BPD from complex posttraumatic stress disorder (C-PTSD), for "sexually

violent behavior is not as clearly demarcated from 'normal' sexuality as one may like to think" (Gavey and Senn 2014, p.340). A critical lens "helps us to see the ways in which sexual choices are constrained and regulated, and it also forces us to recognize that sometimes these dynamics are actually forms of sexual violence" (Gavey and Senn 2014, p.340). Cultural oppressions/microaggressions against marginalized genders and sexualities are complex, ongoing traumatic experiences that fall upon a spectrum of institutionalized and systemic abuse.

I also believe that any drive toward behavioral change born out of unexamined biases is coercive. I endured a lot of really harmful sex under the belief that I had *an avoidance of physical intimacy* (as posited by therapists and trauma indexes, and perhaps "caused" by sexual trauma, ambivalent attachment, or perversity, according to popular reading). I had the impression that *I* was the problem in a relationship where I felt unsafe; however, with the help of a really awesome queer community, I eventually discovered that I didn't have a fear of intimacy at all, only specific prerequisites—such as trust, deep emotional connection, and a direct welcoming of my diverse and fluid sexuality, which shifts quite happily between very and not so expressive. In other words, I realized that I also belonged to the *A+* part of LGBTQIA+: I am a Gray Ace or demisexual.[17]

DBT and the rainbow: Radical acceptance, radical openness

DBT and DBT-informed treatments involve classic behaviorist interventions such as contingency management (e.g., positive and negative reinforcement, punishment) (Linehan 1993). A usual goal is for "new capabilities [to] generalize to the natural environment" (Dimeff and Linehan 2001, p.10). But how does one address the likelihood that such *natural environments* contain invisible cis-heteronormative assumptions? Thus, I became curious about *mindfulness*, *acceptance*, and *change*—and how therapists could more wisely engage with each.

Mindfulness (and heart-mind-fullness)

Intersectional work demands that I expand my conceptualization of mindfulness. Am I aware of the ways in which my foundational beliefs inform what changes I expect from participants? And, in practicing mindfulness, am I not just cognizant of their personal emotions, but also of the systemic factors influencing them (within the therapeutic

space as well as the world at large)? While DBT's mindfulness module is largely a secular skillset, it is important to acknowledge the Eastern mystical traditions from which Western mindfulness has taken much of its contemporary form. However, translations of *citta*, Pali/Sanskrit for something akin to heart-mind (O'Brien 2020), tend to leave out the *heart*. I propose the term *heart-mind*-fullness: my fusion of a therapeutic manifold awareness with compassionate longing for collective freedom from suffering. This encourages a heart-full systemic view (because self-liberation cannot be achieved apart from the liberation of all) (O'Brien 2020).

Acceptance

Acceptance involves receptivity to, and a nonjudgmental stance toward, what *is*. In working with people of diverse genders and sexualities, acceptance may seem an obvious necessity for socially conscious interventions. Yet I see acceptance as an underachievement. Rather, I ask myself: "Can *I* own that existing power dynamics, foundational beliefs and historical influences inform my own position and affect my ability to be *really* accepting?" In relationships where I have felt safest, there was a *welcoming* element to the other person's behavior that went beyond mere acceptance. They acknowledged their own fallibilities and blind spots and conveyed a willingness to be changed by our encounters. This brings to mind *radical openness*, the core skill of another type of DBT—RO(radically open)-DBT.[18]

> [R]adical openness means developing a passion for going opposite to where you are. It is more than mindful awareness. It means actively seeking those areas of our lives that we want to avoid or may find uncomfortable, in order to learn. It involves purposeful self-enquiry and a willingness to be wrong, with an intention to change if we need to change. It is humility in action. (Lynch 2018, p.187)

Radical openness challenges therapists to explore novel perspectives and ways of being (especially ones quite different from what they are usually drawn to, or even approve of). Compared with standard DBT's radical acceptance skill (Linehan 2015a, 2015b), radical openness is perhaps *even more radical*:

> Radical acceptance means letting go of the *fight with* reality, and turning intolerable suffering into tolerable pain, whereas radical openness

challenges our *perceptions* of reality. Radical openness posits that we are unable to see things as they are but instead see things as *we are*. Thus RO encourages the cultivation of self-enquiry and healthy self-doubt in order to…learn from what the world may have to offer. (Lynch 2018, p.190)

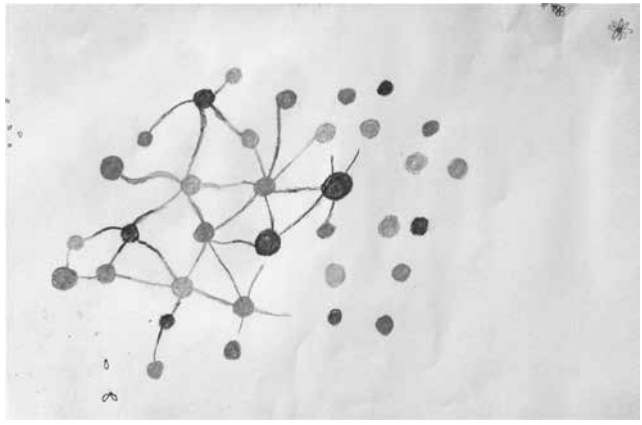

FIGURE 13.2 AN IMAGE BY ART THERAPY PARTICIPANT INDI—MINDFULNESS OF INNER EXPERIENCE (DBT MINDFULNESS OF THOUGHTS AND EMOTIONS; LINEHAN 2015A, 2015B). IT DEPICTS A DIVERSE SELF-CONCEPT WITH MULTIPLE GENDER EXPRESSIONS (SOME OF WHICH THEY DESCRIBED AS "DISCONNECTED" DUE TO TRAUMATIC EXPERIENCES, STIGMA, AND DISCRIMINATION)

Change

DBT necessitates that clinicians carefully "balance [the] use of acceptance and change strategies within each treatment interaction… to inhibit judgmental attitudes and practice radical acceptance of the client in each moment while keeping an eye on the ultimate goal of the treatment" (Dimeff and Linehan 2001, p.11). Traditional cognitive behavior therapy (CBT)'s emphasis on change and outcomes is not effective for individuals with severe emotion regulation difficulties, and DBT developed to remedy that deficit (Linehan 1993). DBT acknowledges the importance of strong validation and acceptance of current functioning (Linehan 2020); however, I believe that DBT and DBT-informed approaches can still overemphasize change for some individuals. While I happily support behavior modification in those intrinsically motivated to pursue it, I feel called to shift my expectation that participants change according to my limited worldview. I believe

that, with absolute validation and acceptance, the right kinds of transformation will naturally emerge.

When working with rainbow (and, in fact, *all*) participants of DBT-informed art therapy, my own self-reflection, and possible self-correction, always precedes the behavioral component. I prioritize my own *unknowing* and curiosity to reduce the likelihood that my clinical training will inadvertently hijack their self-determination. Often the needed change "is not to reduce symptoms or increase emotional regulation skills, but to assist clients in generating narratives that feel truer and more meaningful to them than the problem-saturated account" (Berger 2014, p.4). This requires a deep consciousness of my own blind spots and constant adjustment of treatment models in response to the nuance of an individual's experience.

International research shows that sexual/gender diverse people contend with negative mental health issues resulting from the chronic stress of stigma, discrimination, and violence (Fraser 2019). Gender Minorities Aotearoa (2017) notes that "[a]ttempted suicide amongst trans populations sits at 40%. If healthcare providers refuse assistance, this increases to 61%"—for, in being refused affirmative care, their risk of "harassment, assault, sexual violence, or worse" is increased and/or prolonged. Additionally, "Gay and lesbian adolescents report attempted suicide at rates approximately twice that of their heterosexual counterparts" (Pelton-Sweet and Sherry 2008, p.170). Given DBT's emphasis on "decreasing life-threatening, suicidal behaviors" (Dimeff and Linehan 2001, p.11), it is likely used with rainbow people the world over. While community members may participate in DBT owing to high rates of suicidal ideation and self-harm, and *also* because "diagnostic bias may lead to an overestimation of the prevalence of BPD in gay samples" (Ibáñez *et al.* 2015, p.7), I argue that behavioral targets are not the primary picture for LGBTQIA+. We need support in challenging systems and languages that continue to position us as aberrant *others*. Because my sexuality and gender remained deeply entangled with cultural beliefs about "normality," I spent years feeling *mad* and *bad*. The pathologization of hyper- and hypo-sexuality, and the *othering* experienced through multiple psychological diagnoses, only compounded this. Internalized queerphobia continues to affect me whenever I am confronted by people who cannot accept my unique ways of being.

Fluidity in practice

DBT-informed models alongside different ways of being

LGBTQIA+ individuals may, or may not, bring rainbow issues into therapy. Responsive clinical support involves preparing for the acknowledgment and processing of systemic marginalization, yet not demanding this if participants focus on other challenges. That said, I have observed how many *do* come with internalized invalidating narratives that deeply affect their self-worth.[19] The models I draw from include internal family systems (IFS) (Shwartz and Sweezy 2020), Gestalt (Perls, Hefferline, and Goodman 1994), trauma embodiment (van der Kolk 2014), transpersonal (Rowan 2005), and feminist narrative (Berger 2014)-informed art therapies. As with *queering DBT*, such methods rarely end up looking or sounding precisely like their standard counterparts; I find myself altering frameworks, techniques, and languages to be less prescriptive and better welcoming of diversity/inclusiveness.

* * *

"I want to die," they say.

This is not the first time I have heard this. I've tracked their risk factors for a while: a history of self-harm, no planning involved in past suicidal ideation, but an ongoing dialogue with despair. The participant enjoys a support network of chosen family members (who are aware of these thought patterns).

I gently weave reassessment into the conversation, to which they respond: "I wouldn't act on it, no; I am just feeling so helpless…"

I have noticed that when people feel disempowered, they can be particularly sensitive to input, so I ask for consent before proceeding.

Me: I have a perspective which I find useful. Would you be interested in hearing it?

Participant: Yeah, I'm open to that.

Me: Even if an absolute ending isn't really on the cards right now, I imagine that this statement is still coming from somewhere. And, in my life, it has often been a feeling or a part of my experience that I want to end. It's reasonable to want difficult experiences to go away. I notice feeling quite curious about the part of you that might be directing the "I want to die" thoughts.

We've touched on dialogue territory before, so they sit for a moment, eyes half-closed. I watch as tension in their shoulders builds—and then suddenly drops—with a sigh.

Participant: It's this bit that is always switched on, you know, like it's got to be defending me, explaining that I'm real, that I deserve to exist in the world. That it's not bad or disgusting to be different or whatever. This part is just really fucking exhausted, because it never gets to rest. It feels like the only time it will get to rest is when it's dead.

I pause and breathe that in. We look each other in the eye for a long moment.

Me: It seems to me like this part of your inner community exists in its own right. It has been doing a huge job defending you and it doesn't sound like it had much of a choice, or a voice, in that. I get the sense that, if it felt welcome to speak, it might have a lot more to say than simply "I want to die." Would you be open to extending an invitation to it?

Participant: How?

Me: Well, imagine we're in a drama improvisation. You would be playing the part of Defender, and we could speak to them and ask them about their experience. Interested?

Participant: I could give it a try.

Me: Okay, Defender-Being: I'm really curious about your story. What's been going on for you?

The participant's eyes shift a little to the left, then drop to the mug of chamomile tea sitting on the art table.

Participant: I'm so tired; it's taken me this long to feel safe enough to come out, and all that has meant is I have to work twice as hard to defend my identity, and sometimes the people around me won't even recognize that identity at all, so I feel like I'm bad news and invisible at the same time.

Me: That does sound exhausting! I can see why you really wish you could rest. I wonder if there is something you need or want which could make this burden easier to bear?

Participant: I need support, but it's scary to ask for it. I want to know I'm not alone in this and that I'm not crazy. It makes me feel crazy

when people tell me that I'm making up my identity, or that I'm just doing this for attention.

Me: It's really reasonable to want support—that's a lot to be defending such big stuff on your own. It seems to me that identities are perfectly adapted creatures in highly specialized environments, like olm salamanders or flying lemurs—no one else can decide how they should look because we don't know the unique ways and needs of their particular ecology. I don't think you're crazy at all. I think that the rigid categories of what has become "normal" aren't working anymore, and it's people like you who are creating more flexible ways of being in this world. Flying lemurs don't fly because they're seeking attention, flying lemurs fly because they are flying lemurs!

The uniquely adapted creature sitting in front of me bursts into laughter. We giggle a little more together before I ask: "What is the Defender noticing now?"

Participant: I'm feeling a little bit less crazy, but I kind of feel this big energy inside too, like maybe angry, or just wanting to go "arggghh"—like, let out some frustration.

Me: It sounds like you know what you need best. What if we stand up and make some space for that?

Together, we move away from the chairs; the participant begins to hesitantly shake out their hands and arms (while making some little "grrrrrrrrrrr" sounds under breath). Standing opposite them, I gently mirror—and then amplify—both sound and movement, welcoming fuller expression. Together we build a crescendo; throwing our arms between poses of head-clutching frustration and air-beating challenges, we reach an animalistic roar that feels satisfying and true to the unavoidability of the situation. This quickly turns into sighs of satisfaction and relaxation, which naturally closes with a huge breath in and out.

"Where are we now?" I wonder.

"The Defender sort of feels like they have a bit more energy," comes the reply, "like, I don't know, but maybe the fight could be worth it eventually?"

"I really hope so too, and it's folks like you who are creating change," I say, and smile.

* * *

This dialogue illustrates one example of IFS-informed creative arts therapy (using sound/movement to express inner experiences) combined with a DBT-informed approach toward invalidation and discrimination. Validation involves conveying to participants "that their responses make sense and are understandable within their current life context and situation." Further, the therapist "actively accept[s]…and communicate[s] this acceptance. Clients' responses are taken seriously and…not discounted or trivialized" (Linehan 2015a, p.88). The participant heard me validate their situation, then directly witnessed it through my mirroring and amplification of their movements/sounds. The long-term goal was to support their existing resources for self-validation.

Through autoethnographic Master's research (Weir 2018), I explored how reframing pathology in a strengths-based manner might assist psychotherapy participants to recover from "narratives that have been imposed upon them, exploring collaboratively how power and oppression have shaped their views of themselves" (Berger 2014, pp.6–7). There is nothing wrong with being labeled "maladjusted" in an unjust system; rather, this is *creative maladjustment* (King 1967), a potential catalyst for change. While fictionalized to respect confidentiality and ownership of personal material, the above dialogue illustrates how this plays out in my therapy practice.

Conclusion

Queer differs from what is normal, and rainbow normalizes difference

The reclamation of *queer* by rainbow community elders has helped shift sexual and gender divergence from a source of shame into one of pride. Similarly, the term *rainbow* evokes inclusion as a part of normal human experience. In authentically representing my experience as a sexuality- and gender-fluid human whose identity continues to metamorphose throughout life, I find that I need the wisdom of both. *Queering* confronts cis-heteronormative defaults within the psychology/art therapy domain and presents something a bit unusual: like anything out of the ordinary, it is sometimes asked (perhaps covertly) to get back into

the box, to clean up and be more status quo. Rainbow wisdom, pushing back in a light, cheeky way, says "I am what I am and there is nothing odd or unusual about it, in fact it's *normal* to be different!"

I envision a world that holds personal narratives and creative ways of knowing as valuable as academic research—complementing (i.e., making *more complete*) our understanding of what it means to be human. Through a queer lens, well-being is not expressed through resolved differences. Rainbow is a spectrum that finds strength in variety. This is crucial when working with DBT-informed practices that emphasize finding *synthesis* within paradox and achieving a stable sense of self. As de Bono (2017) states: "Argument is the very essence of dialectic" (p.38), which at times "locks us into dangerous and unproductive polarities" (p.420). I prefer to explore the *unresolved*, where "dichotomy is softened by 'possibility,' overlap and fuzzy edges. Alternative views can lie alongside each other—in parallel" (de Bono 2017, p.35).

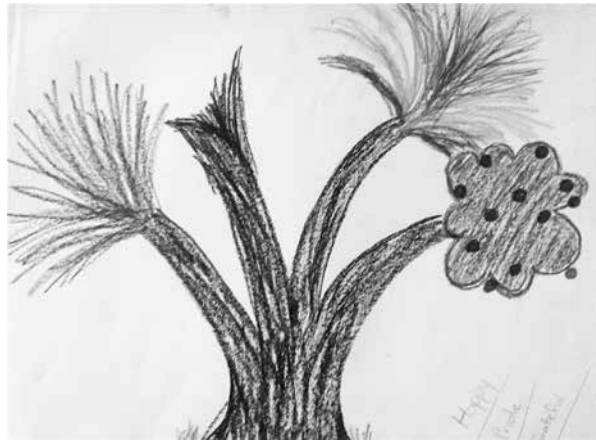

FIGURE 13.3 INDI'S TREE IMAGE. PART OF A "SELF-NARRATIVE" SERIES THAT ILLUSTRATES STRENGTHENED RESOURCES IN OBJECTIVE AND SELF-RESPECT EFFECTIVENESS (DBT INTERPERSONAL EFFECTIVENESS SKILLS; LINEHAN 2015A, 2015B). THEY IMAGINED A WORLD WHERE THEIR RAINBOW IDENTITY, AS WELL AS THEIR "BROKEN" PARTS, AND VARIOUS OTHER SELVES, WERE ALL WELCOME

DBT itself emerged from polarized cultural structures. For example, Western psychological paradigms assumed to be "relatively consistent across cultures" (American Psychiatric Association 2013, p.773) are

presented as oppositional to indigenous or folk health practices, which have been tragically colonized and/or deemed *unscientific*. Therapist-as-expert stands in contrast to patient in need of specialized care. It is only by doing our own self-reflective and paradigm-deconstructing work that we can hope to hold the kind of radically open spaces that will allow participants' diverse gifts to fully develop and express themselves. We might also discover that, as we welcome these practices into the art therapy space, aspects of our own psyches that have felt unaccepted or unloved also may experience a sense of belonging.

I invite readers to engage with deep self-reflection, become more open to alternative perspectives, and explore the self-determined research of diverse communities. There are numerous resources for making therapy/counseling services more affirming and inclusive (accessed through a Google search or by contacting local rainbow organizations that advocate for equitable health care). Through a queer lens we may dismantle pathologizing discourses around our fluid/boundaryless, uncategorizable selves and celebrate them, instead, as valid ways of being. Sometimes it is the therapist who requires the most psychoeducation; hence we, as therapists, are responsible for doing the necessary inner work that can, over time, contribute to collective equality and well-being.

Endnotes

1 *Femme* is a multivalent term that may have emerged from lesbian culture to describe one's relationship to cultural notions of femininity (as in *butch* and *femme* women). Femme can also convey feminine-oriented nonconformity/fluidity. It performs as a noun ("their gender is femme"), adjective ("he's quite a femme guy"), and—my personal favorite—verb ("I'm gonna femme tonight"). I use femme to reclaim what our culture considers "less than" compared with masculinity. One's behavior need not read consistently (or even occasionally) as "feminine" in order for one to *be*, or *do*, femme. Restricting femme to those who display stereotypical femininity is a form of *gender policing*.

2 *Gender binary/binarism*: Classification of gender into two distinct, opposite categories of masculine/man and feminine/woman. *Nonbinary* identities (Richards, Bouman, and Barker 2017) fall outside of this, such that individuals may identify as transgender, or having no gender, or having more than one gender (experienced as fluidity and/or changes in gender over time). Nonbinary individuals possess a variety of sexual orientations as well as gender expressions. *Genderfluid* refers to an identity in flux or moving between genders.

3 *Trans* is popularly used for *transgender*, and sometimes *nonbinary* identity, or gender identity that differs from the one assigned at birth. Like *femme*, *trans* is multivariant; one person's experience can be quite different from another's (see *trans**, endnote 11).

4 *Heteronormativity* is the worldview of heterosexuality as normal or preferred sexual orientation (Warner 1991). Heteronormativity relates to attitudes and behaviors that are consistent with traditional Western gender roles.
5 *Gender performativity*, first proposed by feminist philosopher Judith Butler (1990), posits that identities such as *man* or *woman* are collections of learned cultural behaviors rather than innate, biological aspects of self. My performance of behaviors culturally ascribed to femininity led the therapist to assume I identified as a woman. This was entangled with presumed heterosexuality, causing them also to surmise my partner was male.
6 *Gender policing* describes both individual and cultural enforcement of mandates that (1) one should ascribe to the dominant cultural paradigm of identifying as either a man or a woman, and/or (2) one's gender should be fixed rather than fluid, and/or (3) one's behaviors should match this gender according to dominant cultural ideals.
7 *Queer* reflects divergence from normative models of gender, sexuality, and romantic orientation. Originally a pejorative label for nonheterosexual people and/or behavior (O'Brien 2009), by the 2000s *queer* had increasingly come to describe a spectrum of diverse gender and sexual identities (although not without controversy and criticism).
8 *LGBTQIA+* stands for lesbian, gay, bisexual, trans, queer, intersex, and asexual, *plus* any other identity/orientation/experience diverging from gender-binary heteronormativity.
9 *Participant*: I prefer this to more common terms that seem to convey power hierarchies and active/passive dualities (e.g., *doctor–patient*; *treatment provider–treatment consumer*). While *client* has become a welcome alternative to the pathological-oriented tradition of *patient*, I still find it dry and unrepresentative of the rich reciprocity that often exists in therapeutic relationships. Hence, I use *participant* because it feels more reflective of the active role and personal resourcefulness of the individuals with whom I work.
10 *Cis* (*cisgender*): Individuals whose gender identity is the same as the sex assigned them at birth.
11 *Trans** is a variant of *trans* (see endnote 3). The asterisk borrows from computer-mediated language to "metaphorically…capture all the identities—from drag queen to genderqueer—that fall outside traditional gender norms" (Ryan 2014).
12 *Women+* is sometimes used for inclusion of nonbinary, gender-nonconforming, and transgendered individuals within feminist practice that emphasizes women.
13 Research regarding the rainbow community notes "variability of gender expression over time for all identities" (Schroeder 2014, p.36). However, this is not directive of mainstream practice. In Aotearoa, most individuals seeking mental health services during gender transition have "felt pressure to conform to a dominant narrative during their assessment, e.g. having a binary identity, knowing they were trans from an early age, or feeling 'trapped in the wrong body.' This suggests that though [there are] many individual professionals providing good support to their clients, professionals must still ask outdated questions because of systemic demands" (Fraser 2019, p.15). If such assumptions persist in relation to gender, they may also be notable for sexuality and all manner of minority experiences.
14 *Microaggressions*: Brief and commonplace verbal, behavioral, and/or environmental communications that intentionally or unintentionally communicate derogatory, insensitive, or hostile messages toward a minority, marginalized, and/or stigmatized group. However insignificant such subtle invalidating expressions may seem from the perspective of the culturally privileged, microaggressions have serious and ongoing negative impacts on those who experience them frequently throughout life.
15 *Neurodiversity* refers to a variety of cognitive, emotional, learning, attention, and other differences in human brain and mental functioning. This nonpathological term was coined by Australian psychologist Judy Singer (2017).

16 *Pansexual*: Romantic and/or sexual attraction that is not limited by the other person's gender, genitalia, and sexual orientation.
17 *Gray Ace* includes sexualities falling on a nonpathological spectrum of *asexuality* (experiencing sexuality from *none of the time* to *some of the time*, and under varying conditions). *Demisexual* refers to individuals for whom sexual attraction is contingent upon an initial nonsexual connection (although the required type and depth of connection varies).
18 *RO-DBT* is a transdiagnostic intervention for psychiatric disorders characterized by *excessive self-control* (e.g., refractory depression, anorexia nervosa, avoidant personality disorder, obsessive-compulsive personality disorder) (Lynch 2018). RO-DBT branched off from standard DBT during the early 2000s.
19 A profound, recurrent issue is the incongruence between personal desires to accept *in-betweenness* and social expectations of conformity to binary concepts. I am constantly told, in a thousand subtle (and not-so-subtle) ways, that I must be straight *or* gay, single *or* monogamous, man *or* woman, well *or* unwell—while each polarity is deemed either "good" or "bad."

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Chapter 14

Integrating DBT-Informed Psychoeducation with Visual Journaling

Practical Considerations

PENELOPE JAMES

Introduction

This chapter offers practical guidance to mental health clinicians who wish to build the efficacy of traditional psychoeducation methods through the art therapy technique of visual journaling. Psychoeducation is a therapeutic intervention that provides cognitive and behavioral skills instruction for managing mental illness symptoms; further, it assists individuals in taking personal responsibility for their recovery (Bhattacharjee *et al*. 2011). I, the author, observed that a responsive visual art/reflective writing-based process appeared to assist in building my day treatment program clients' understanding of, and personal connection with, the concepts and skills they learned in a psychoeducational group. This, in turn, may have enhanced these individuals' capacity to implement the skills in their daily lives.

Fundamental aspects of integrating visual journaling with psychoeducation are outlined, in detail, to demonstrate their apparent value in encouraging participation and enriching the therapeutic experience. This description is not intended to provide primary core art therapy training for the therapist or art therapist. Rather, I offer lessons learned from a decade of work combining art therapy with psychoeducation in a clinical mental health setting (specifically, a mood management group that is part of a psychiatric hospital's outpatient day treatment program). The information is structured as

a step-by-step guide for facilitating visual journaling with optimum potential therapeutic outcomes. Please note that these ideas may require modification for different client populations as well as for one's own workplace. Hence, I offer them in the spirit of "take what you need and leave the rest."

The mood management group

It has been a privilege to work with this committed group and witness its members' self-defining recovery over the past five years. Clients are referred to the outpatient adult day program by their psychiatrists. The mood management group, which runs from 9:30 AM to 3:00 PM every Friday, welcomes individuals who enter following a hospital discharge, as well as some who have not previously been hospitalized for mental health issues.

This weekly open group contains many long-term members, some of whom have attended for years (while others, after a period of participation, feel ready and able to leave). Their ages range from 18 to 70 years. Typical diagnoses include major depression, anxiety disorders, schizophrenia, bipolar disorder, and borderline personality disorder (BPD). Comorbid diagnoses can include gambling addiction, substance dependence, and eating disorders.

Group goals

Participants are united by the common experiences of living in the community with mental illness, as well as a motivation to make positive behavioral changes. The mood management group's primary goal is to teach clients psychoeducational skills so that they may pursue more functional lives. A secondary goal is to assist clients in recognizing when their symptoms become overwhelming, and acknowledging if they require additional interventions (e.g., a hospital admission, change in medication(s), and/or individual therapy). The ability and willingness to self-assess and reach out for appropriate help are considered evidence of an individual's developing emotional health and resilience.

The mood management program draws from a variety of approaches, including dialectical behavior therapy (DBT) (Linehan 1993). DBT offers psychoeducational skills to address ineffective cognitive, emotional, and behavioral patterns with the aim of increasing positive

outcomes in clients' daily lives. The four DBT skills training modules are core mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation (Linehan 2015a, 2015b).

The day program schedule, which remains the same from week to week, is written on the group room whiteboard along with the featured psychoeducational skill. This ensures that participants know the general theme and direction of the group. I often ask if there is anything specific that they would like to work on that day. Whenever possible, I facilitate the psychoeducation in response to clients' requests.

It is useful to provide breaks. These allow opportunities for clients to engage in informal social interactions during which "group cohesion, independent of the leaders, is…fostered" (Linehan 1993, p.20). Further, breaks help the group to shift cleanly between check-in, the psychoeducation lesson, and the creative visual journaling portion. I find that the optimal time for the first break (morning tea) is after the check-in session and before the psychoeducation session. The second (lunch) is scheduled between psychoeducation and visual journaling. The full sequence and duration of program events is as follows: check-in (1 hour), meditation (5–10 minutes), morning tea break (30 minutes), psychoeducation (75 minutes), lunch (45 minutes), visual journaling (110 minutes), and group close (10 minutes).

Group positioning

During the check-in and psychoeducation sessions, participants sit together in a semi-circle. This arrangement facilitates their equal and clear viewing of the whiteboard, the facilitator, and each other. It also allows me to easily see and engage with all group members, which is necessary for my proper functioning as therapist: I can address a single member, while, at the same time, assess and respond to the needs of the entire group (Moon 2016). Because the semi-circle helps members to be heard and witnessed by one another, it also encourages group identification, empathy, and bonding.

Group structure

The clinical portions of the mood management group consist of five distinct phases: part 1—check-in (1 hour), part 2—meditation (5–10 minutes), part 3—psychoeducation (75 minutes), part 4—visual journaling (110 minutes), part 5—group ending (10 minutes).

PHASES OF THE GROUP

Part 1: Check-in

The day commences with a one-hour check-in session during which clients have an opportunity to speak. I see this as critical for a successful therapeutic outcome, given that it prepares members for the psychoeducational learning to follow. If a client is sitting on some troubling or exciting news, it may be hard for them to focus on didactic materials. Each person is allotted approximately eight minutes (but this timeframe varies according to the number of attendees and their individual needs). I invite participation with the prompt: "Would you like to share how things are going for you?"

Check-ins typically focus on the difficulties and/or progress that clients have experienced during the previous week. This might include reports on the relative effectiveness of psychoeducational skills practiced outside of therapy. I observe each client's presentation while listening to the content of what they share. When appropriate, I provide validation. I also take note of how their experiences could be applied to the psychoeducational material I will teach that day (or to past lessons).

For example, a client shared that he struggled to get out of bed in the morning due to a depressed mood and overwhelming negative thoughts, including a belief that it was too hard to face the world. The client acknowledged that he felt much worse whenever he followed those thoughts and stayed in bed. I reminded him of opposite action, which the group had recently explored. Opposite action is an emotion regulation (ER) skill. The ER module includes a range of strategies that reduce suffering by changing, or lowering the intensity of, unwanted emotions (Linehan 2015a, 2015b). If, after "checking the facts" (Linehan 2015b, p.228), the individual determines that a behavioral urge (in this case, to give up and remain in bed) would likely perpetuate or increase a difficult emotion (i.e., depression), he might choose to go against this self-destructive pattern by engaging in the direct opposite behavior (i.e., getting up and facing the day).

Over time, opposite action could reduce this client's suffering and help him to stay connected with his long-term goal of building a functional life. However, the strategy must be implemented wholeheartedly—that is, "all the way"—in order to successfully oppose the mind's often compelling negative messages (Linehan 2015b, p.231). In this instance, the client identified that the appropriate *all the way*

steps were to get out of bed, have a shower, and eat breakfast. Opposite action is also an example of behavioral activation, an evidence-based treatment for depression, which can release clients from engaging in self-defeating behaviors such as isolating and rumination (Linehan 2015a).

Part 2: Meditation

A brief meditation exercise is the next step toward readying the group for psychoeducation. Mindfulness meditation assists in setting aside the check-in content so that participants may shift to a calmer and more present-centered stance. Mindfulness is the underlying component for all DBT skills acquisition (Linehan 2015a). Kabat-Zinn (2009) describes it as a process of accepting ourselves in the present. He notes that, in order to improve our health and well-being, "we have to start from where we actually are today, in this moment, not from where we would like to be" (p.280).

Linehan defines mindfulness as "the intentional process of observing, describing and participating in reality nonjudgmentally, in the moment, and with effectiveness" (2015a, p.151). This is not only the primary instruction for sitting meditation, but also in experiencing one's day-to-day life. When increased self-awareness is combined with psychoeducational skills, clients often become less reactive as well as more cognizant of their ability to respond effectively (as opposed to remaining stuck in compulsive problematic behaviors).

Depending on the amount of time available, I facilitate a guided meditation practice either at the end of check-in or at the beginning of the psychoeducation session. Group meditation can include practices such as a body scan, which involves gaining present-centered awareness of one's body, breath, and mind (Dreeben, Mamberg, and Salmon 2013; Linehan 2015a). Another practice, "Stopping the War Within" (Kornfield 1993, p.30) encourages observing rising physical sensations, thoughts, and emotions through an intention of kind attention (kind attention is designed to foster compassionate, nonjudgmental acceptance toward oneself).

At the close of the practice I invite clients to share feedback. This assists the therapist with planning future group meditations. It can also help clients validate and reinforce any of their positive experiences (which could foster the eventual development of a personal practice).

At-home mindfulness activities are encouraged as they can facilitate significant positive behavioral change (Linehan 2015a).

Part 3: Psychoeducation

Individuals with serious psychiatric illnesses often contend with a debilitating sense of isolation. Participation in psychoeducational programs may alleviate this through highlighting the universality of clients' struggles. As group members share their respective lived experiences, empathy and compassion for self and others naturally develops. However, the trust and comfort that results from validating one another's symptoms and issues can at times inadvertently reinforce personal identification with mental health problems (Cruwys and Gunaseelan 2016).

The challenge, then, is to balance nonjudgmentalness and acceptance with recognizing the destructive consequences of symptom-driven behaviors. Linehan (2015a) describes DBT's dialectical philosophy, which asserts that two opposing things can be simultaneously true—in this case, "the need for clients to accept themselves as they are in the moment and the need for them to change" (p.5). Psychoeducation encourages embracing the dialectic of nonjudgmentally acknowledging a mental health diagnosis while, at the same time, working toward effectively managing it. This, in turn, can assist clients in developing a sense of personal responsibility for building a *life worth living* (Linehan 2015a) through positive behavioral change.

The task of the therapist

During the psychoeducation session the therapist provides a safe place for clients to actively participate. I encourage lively but judgment-free discussion and the sharing of personal reflections. My role as the group leader also involves writing relevant pointers on the whiteboard (Figure 14.1), as well as offering feedback and respectful prompting around specific psychoeducation skills and strategies.

My objective in teaching psychoeducation is to give clients a solid understanding of its relevance to their psychiatric issues as well as how to apply it practically in their lives. I have observed that clients are keen to learn a potentially helpful intervention when they are experiencing difficult, and often accelerating, symptomology. Merely possessing this

knowledge can ease distress by counteracting helplessness. This is an example of the DBT emotion regulation skill *building mastery*, which shifts a client's focus from hopeless beliefs toward a sense of competence (Linehan 2015a).

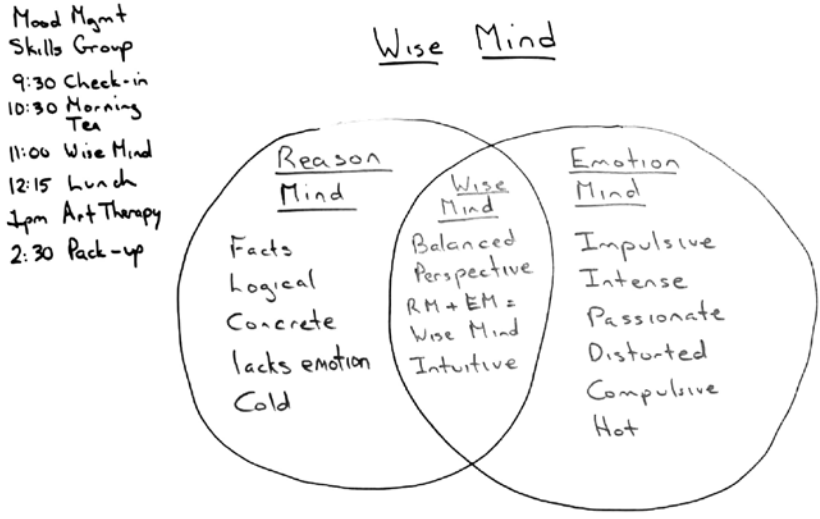

FIGURE 14.1 AN EXAMPLE OF PSYCHOEDUCATION NOTES ON THE WHITEBOARD

Notes

To encourage active notetaking, each participant receives a clipboard, some blank paper, and a ballpoint pen. This hands-on engagement, together with interactive discussion, helps clients gain a clearer understanding of the ideas presented and builds group cohesion (Clanton Harpine 2015). The resulting notes provide a handy reference for reading at home in between sessions.

Part 4: Visual journaling

During the lunch break I set up portable tables for visual journaling. The session begins with reflective writing, followed by art making. Prior to commencing the activities, I encourage clients to write the date and featured psychoeducational skill on their paper to serve as a reminder of past assignments. The psychoeducation notes remain on the whiteboard so that clients can refer to them during their creative explorations.

Provision of art media

I offer a moderate range of options. Too much choice can be overwhelming and thus inhibit engagement (Waller 1993), especially when participants are not familiar with art materials. Yet a certain degree of variety "creates a context for people to find their way to a medium that reflects their particular state of mind" (Ward 1999, p.112). It is important to purchase products of a good usable standard because it signifies respect for the clients and their work. Further, the creative process is much less likely to be hindered by frustrations associated with inferior materials.

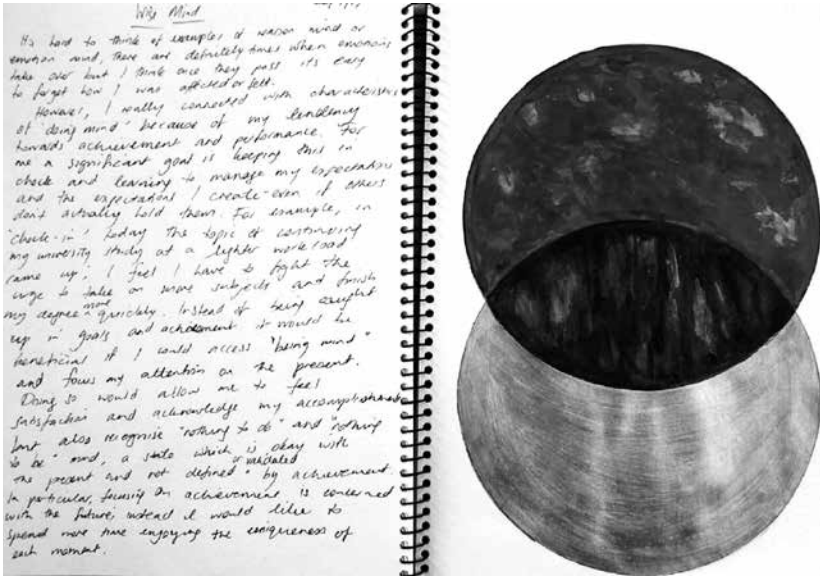

FIGURE 14.2 VISUAL ART JOURNAL

Visual art journal

Some of my clients keep a dedicated art journal in a bound sketch book so that their work is organized and easily accessible. The journal contains psychoeducation notes as well as clients' reflective writing and art making from the visual journaling sessions—a valuable reference when struggling with symptoms or difficult emotions between groups (Figure 14.2). Clients can also continue their visual journaling practice at home as a self-care activity.

- Reflective writing.

The visual journaling session commences with personal reflections regarding the psychoeducational skill. Clients have 20–30 minutes for this activity.

> You are now invited to write for about fifteen to twenty minutes about your responses to the skills learning. You can write as little or as much as you like within the time frame. I encourage you to use "I" statements. The more personal your writing, the more meaningful it can be for you. You might like to write about your blocks to using the skill. You can write about how you think your life might be improved with using the skill. You can write about whatever came up for you during the skills learning.

The role of the therapist

The therapist is a silent witness throughout the visual journaling activities. I am the group's safe container, holding and tolerating whatever arises for participants during their creative explorations. For example, I notice one client pause thoughtfully before she puts pastel to paper. Another client is engrossed and tearful as she writes (I can integrate such observations into the feedback I later provide, with the goal of facilitating deeper exploration). The therapist encourages clients to expound their creativity. As Ward (1999) notes, "It is the relationship with both the therapist and the art process itself that brings about change in art therapy" (p.104).

Therapeutic efficacy of group silence

Silence is a powerful intervention during the visual journaling activities in that it can "help clients to collect and organize their thoughts and to better connect with themselves" (Regev, Chasday, and Snir 2016, p.73). This was highlighted for me during a lesson on the interpersonal effectiveness DEAR MAN skills (Linehan 2015a, 2015b). One participant spoke of feeling devastated by his inability to discuss relationship issues with his partner. He then, in quiet contemplation, wrote about his hope for respectful and effective communication (Figure 14.3). This authentic connection with the skill would likely not have happened without the implementation of group silence.

Effective communication

Communicating a desired result, while maintaining values and self-respect. While you may not get the result you are after, you will have gotten your message across authentically—my truth matters and it's what matters to me. Get clarity and provide clarity by separating the situation, what it means to me, that it matters to me, and how it affects the other, staying true to myself by being mindful, (appearing) confident, and negotiable.

It matters to me and that's why it matters.

FIGURE 14.3 EFFECTIVE COMMUNICATION

I request silence with the prompt: "During your creative process try not to talk as silence gives you the opportunity for self-exploration and the opportunity to notice your thoughts and feelings. This is your time to give attention to your needs."

Voluntary participation

I always invite (rather than require) group members to participate in the visual journaling activities. A balanced approach acknowledges apprehension while gently pulling for engagement (Clark 2017). Clients tend to encourage one another to join in. When someone is particularly reluctant to do so, however, I allow her to simply observe. This is with the understanding that she does not distract other group members. Interestingly, an observer often will eventually pick up a pastel, brush, or pen and either make marks, draw, or write something.

The therapist models participation

Facilitators can join in the visual journaling as a means of modeling the creative activities. Briefly sharing one's reflective writing and/or the meaning of one's artwork within the context of the psychoeducational lesson can be helpful for group members. However, while this should be an authentic practice, it is important that the therapist's participation is done for the benefit of the group rather than as a personal therapeutic experience.

- Sharing of reflective writing.

To communicate that the writing segment is nearing a close, I give a prompt five minutes before its end. I then wait until everyone has finished and put their pens down before inviting them to share. It is vital that no one continues to write while others are reading. Group processing is a time to be present for one another. Listening to fellow participants' stories is always done through an accepting and nonjudgmental lens.

I orient clients to this approach as follows: "You now have an opportunity to share your reflective writing. I encourage those of you who are listening to sit back and listen with an open heart and mind. We can learn from hearing each other's stories."

Responding through an appreciative lens

I invite feedback by simply asking, "Would anyone like to respond?"

Respect and appreciation are central. Every story is validated and gratefully received. There is no critique of writing style, grammar, or content. Frequently, after someone shares, there is not much that I or the other clients need to add; the writing speaks for itself. However, sometimes I encourage the person to elaborate on their reflections as a way of helping them to process a deeply personal issue.

The value of digression from the psychoeducation focus

Occasionally an individual does not choose to engage with the featured skill. Instead, they write or create a visual image about their current emotional state, a personal difficulty, or another source of distress. In such instances I will affirm and validate the resulting creative expressions because I view whatever emerges as valuable. It is better to release an urgent internal experience than repress it in order to adhere faithfully to the directive.

- Art making.

The art making session immediately follows the reflective writing and reading/sharing segments and runs for around 30–45 minutes. The prompt is as follows:

> You are now invited to create an art response to the skills learning. You can create an image exploring the benefits of using the skill, or an image exploring your blocks that stop you from using the skill. You can create a dual image; on one section of your art paper you can represent your

life without the skill, on another section of your art paper your life with the skill. You can create an image of whatever arose for you around the skills learning (Figure 14.4).

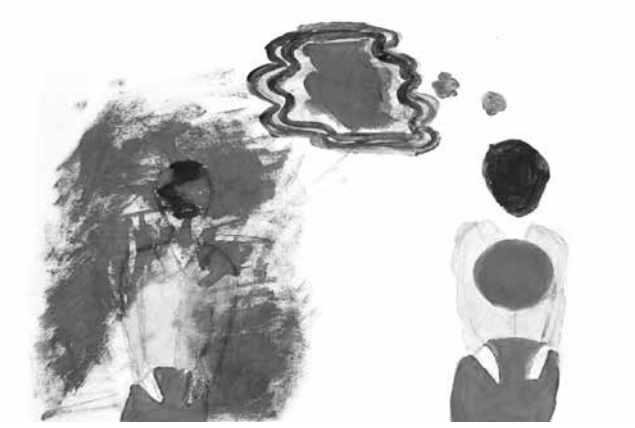

FIGURE 14.4 DUAL IMAGE (CLIENT EXPLORING MINDFULNESS OF THOUGHTS)

Directives as options for client art making

Clients may, either individually or collectively, request ideas for creative responses. Therefore, in preparing for the program day, I not only read up on the planned psychoeducational skill, but also spend time formulating prospective activities for their art making. In order to ensure clients' agency around their creative work, I always frame a directive as an option and not as an order (McNeilly 2006).

Individual directives

Directives that are personalized can provide clients with a secure framework within which to explore their internal experiences. A young woman who joined the group following a discharge from hospital shared, "I don't like non-directive art therapy. I get lost in my emotions. It's like I've got nothing to hold onto." I responded by asking, "Does the directive help you to contain your feelings?" "Yes," the client replied. "When I'm given directives, I feel safer." This was helpful information, and I offered optional art directives each week. I also gave her mandalas to color whenever she completed her artwork before other group members had finished (the structural forms within the mandala patterns provided additional containment and safety). In time, this client was able to come up with her own ideas for her art.

Group directives

An example of the entire group requesting direction for their artwork took place during a cognitive behavior therapy (CBT) skills session, the topic of which was the four communication styles (e.g., passive, aggressive, passive-aggressive, and assertive). CBT's objective is to build positive life-enhancing experiences by restructuring distorted thought patterns into more accurate ones (Hogan 2016). Clients identify their interpersonal strengths and deficits by exploring the communication styles. This forms a foundation on which to build assertiveness skills through psychoeducational models like DBT (DEAR MAN skills as previously discussed). In response to the group's desire for further direction, I drew simple stick figures on the whiteboard, each portraying a different style. I then added adjoining dialogue bubbles, and together as a group we worked out what caption might fit each bubble. The clients used this as a guide to engage in their artwork and create their own figures and captions.

Alleviating fear of art making

Many adult clients have not made art since childhood and can be fearful of the prospect. Fortunately, there are ways to help assuage such anxiety. It is essential to reassure them that the focus is on the creative *experience* rather than an end-product. This can help these clients to feel less pressure:

> It is the process, not the final product, that is important in art therapy. This is an opportunity for self-expression. Whatever you create is appreciated. You don't have to make a pretty picture. You can do an illustrative image, or you can create an image using marks, shapes, and colors. And you can put words in the image.

Words in the image

Often clients with minimal art experience will have ideas that are too difficult to draw. Words can thus be literally included as part of the image. In fact, single words and/or phrases may become an integral aspect of an art piece as well as a natural component of the image within visual journaling (Ganim and Fox 1999).

Collage

Certain art activities help to make for a less daunting experience. Collage is a good starting point as it does not require one to draw anything.

Invite clients to look through magazines and choose images and words representing their responses to the psychoeducation. They then can cut out, position, and paste these onto the paper to create a cohesive piece.

Mandalas

Coloring is another activity that can provide a sense of safety and structure for the apprehensive art therapy participant. Provide a black-and-white mandala design (patterns within a circle) and offer the option of coloring it in a manner that somehow conveys their response to the psychoeducation. Participants may choose from a variety of art media such as watercolors, acrylic paints, oil pastels, colored markers, or pencils. They might also make their own mandala by outlining a circle on blank paper, into which they can then create their own unique patterns.

The therapist as witness to art making

As previously discussed, the facilitator models silent, mindful attention throughout the art making period. The therapist's act of witnessing the group's creative process encourages clients to attend to their own experiences more mindfully (Grosz 2013). I find it compelling to watch the myriad paths that therapeutic creativity can follow: the gradual forming of an image as each mark appears on the blank paper; color combinations evolving, stroke by stroke; the juxtaposing of contrasting textures as each layer of art media is applied; the scraping back to unearth an underlying symbol; and the improvised use of whatever is at hand (such as running a pen through paint to gain an expressive effect or dabbing the artwork with a paper towel as a final finishing touch). Importantly, giving clients feedback on what you observed of their art making process can lead to significant insights.

- Sharing of artwork.

I provide a five-minute notification that the art making period is coming to an end. When the time is up, I clean the whiteboard so that the artwork can be seen without distraction. Viewing begins once everyone has finished. All participants give their full attention to this process. Each client is individually invited to share their piece and describe its meaning. I display artwork in a central position on the whiteboard, using magnets, so that they are easily viewed by everyone.

I introduce this segment with the prompt: "You are now invited to share and, without interruption, speak about the meaning of your artwork."

Options for processing artwork

Verbal processing is encouraged; however, there are times when a client may not want to show their work to the group. They may also not wish to talk about it or have others respond. These desires should be respected. In such instances one can offer various alternative options for participation. For example, they might opt to have their artwork viewed by the group in silence. I also mention that, while they may not want to talk about their artwork, it can be enlightening to receive feedback. Sometimes others' responses to an image can trigger helpful ideas and insights (and this may eventually get the artist talking).

Viewing images with a psychoeducation focus

I encourage participants to frame their expositions in relation to skills training. Through the many different perspectives that clients bring, the group can build a diverse and comprehensive understanding of a given skill. Discussing their image may yield fascinating and insightful explorations around the psychoeducational lesson that would not have happened without this creative element. "You had to be there" is what comes to mind as these dynamic, adventurous, in-the-moment happenings energize, validate, and motivate the clients in their journey of healing through skills-based learning.

I prompt clients to reflect on their artwork as follows: "How does your image relate to the skills learning? What feelings and thoughts about the skill came up for you while creating your artwork?"

Client as expert

I am constantly impressed by how naturally clients, many of whom have not drawn or painted since early childhood, will speak about their artwork's symbolic content. Because art is an expression of the self, the client's own voice is paramount. The meaning that she attributes is accepted and explored. When facilitating sharing of ideas in response to an art piece, the therapist is careful to maintain these respectful guidelines.

The therapist is not an "expert"

The group facilitator neither makes assumptions nor offers diagnostic interpretations of images. Still, it can be helpful to share some of one's observations around an individual's art making process and/or any distinctive aspects of their artwork. This might include simple feedback

such as "You seemed to be soothed by the flow of the water color paints"; "You looked like you were releasing strong feelings as you vigorously applied the oil pastels"; "I notice the deep colors and rough texture of the left side in contrast to the light colors and smoothness of the right side of your artwork."

The therapist maintains a light touch

This stance was instilled in me following a session on anxiety management. I interpreted an image of a large lounge chair beside a window with flowers around the frame as a pleasant scene. The artist then disclosed the emotional pain she experienced when alone at home, immobilized with anxiety: she sat at this window and felt cut off from the world. How much further from the truth could I have been?! This confirmed the necessity of waiting for each participant to speak her truth rather than immediately applying one's assumptions. As McNeilly (2006, p.36) so aptly advises, "It is important to know when to shut up."

Peers respond respectfully

I offer the other group members an opportunity to participate with the prompt: "Would anyone like to respond to the image?"

Group feedback is given with respect for the client, their artwork, and their interpretations (i.e., never as a critique). With these guidelines in place, peers can add significant richness, depth, and insight with their meaningful remarks.

Confidentiality and the safekeeping of visual journaling

According to Ward (1999), "How and where images are kept and who can see them or touch them need to be carefully considered" (p.113). I encourage clients to keep their reflective writing and artwork in a safe, accessible place. I also caution them to be mindful about with whom they share these personal and sensitive materials outside of group. On the one hand, family members and friends can be ignorantly dismissive or even ridicule such creative expressions. On the other, sharing with a trusted and validating person can deepen both parties' understanding of the changes that the client is working toward. In addition, the client may greatly benefit from exploring the artwork and reflective writing, along with the insights that arose during the group process, with their individual therapist.

Occasionally someone will discharge from the program and leave

their work behind. In such cases I advise keeping them in a locked cupboard (assuming this is practical and realistic for one's workplace). Your national art therapy association provides guidelines around the brief and long-term storage of clients' creative materials.

Photographing visual journaling

Owing to their deeply personal and confidential nature, I do not generally support the reproduction of client artwork and reflective writing. The mood management group adheres to the guideline "What you hear and see here: When you leave here, let it stay here." This ensures the safest possible container for therapeutic processes. If there is a necessity for photographing visual journaling responses, one must obtain written permission from the client artist. Again, please refer to your national art therapy association's directives on such matters.

It is important to note that requests for clients to reproduce their visual journaling should be made thoughtfully. Casual and/or spontaneous requests tend to evoke permission given out of perceived pressure from the therapist or fellow participants. Allow the individual ample time to think through and process their authentic needs (rather than quickly acquiescing).

Part 5: Group ending

At the end of the day I briefly check in with each person about how they are feeling and whether they wish to mention anything that had particularly resonated with them. I also encourage clients, in their own time, to write about what it was like to share their creative responses as well as any insights that arose through the processing and exploration. At this point I ask the group if there are any specific issues that they would like to work on during future psychoeducation sessions.

Finally, I express my sincere gratitude for everyone's courage and willingness to participate in this therapeutic experience. Clients often tell me how tired they feel at the end of the day, and it is no wonder: they have listened, discussed, taken notes, reflected through writing, symbolized through art making, shared, identified, interpreted, and explored. The individual inspires the group as the group inspires the individual. As one client remarked, "The visual journaling helps me to connect with the skill on a personal level. It helps me to think about how to apply the skill in my life and how to communicate that learning to the group."

Conclusion

The chapter illustrated how a combined psychoeducation and art therapy intervention may enhance the skills acquisition of adult participants in a DBT-informed mood management group. Psychoeducation builds clients' awareness of their dysfunctional thought and behavior patterns; furthermore, it teaches them to respond in more adaptive ways. The approach acknowledges the client as central to their own recovery—indeed, as the primary source of re-education and wellness.

However, traditional didactic models may inadvertently foster a passive acquisition of knowledge. The active nature of reflective journaling and making art empowers individuals to take a more assertive, engaged role in their skills development. Rather than merely being fed information, they step forward (as the therapist simultaneously steps back somewhat) and make personal, emotional connections with the materials. In so doing, they become the expert in their journey of recovery.

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Author Biographies

Emma Allen, Health and Care Professions Council (HCPC)-registered art psychotherapist, is the professional lead for arts therapies at Rampton Hospital, one of three high secure hospitals in the UK, Nottinghamshire Healthcare NHS Foundation Trust. Emma has worked at Rampton since 2009 as an art psychotherapist, and she is the founder of Forensic Sandplay Therapy (FSPT). Emma also works for Northamptonshire Healthcare NHS Foundation Trust (within the National Offender Personality Disorder Pathway and prison service) assessing and treating young men at risk of developing personality disorders and who struggle with interpersonal relationships related to their trauma histories. During 2017–2019, Emma was a treatment manager for the Aurora Project, the first project in the UK for the prevention of sexual offending. Emma provides clinical supervision. She is also a lecturer for forensic psychology courses at Nottingham Trent University. Emma has authored several book chapters and journal papers.

Susan M. Clark, LPCC-S, ATR-BC, is a registered/board-certified art therapist as well as a licensed professional clinical counselor (supervisor's designation). She has worked in the mental health field for over 20 years with a variety of adult and juvenile client populations, including individuals contending with serious and chronic mental illnesses, substance abuse/dependence, and eating disorders. Susan is the author of *DBT-Informed Art Therapy: Mindfulness, Cognitive Behavior Therapy, and the Creative Process* (JKP 2017). She currently works in private practice at WiseMind Counseling in Kent, Ohio.

Jane DeSouza, ATR-BC, LCAT, received a BFA from the University of Kansas (Painting, Drawing and Theater Design) and an MPS from Pratt Institute (Art Therapy and Creativity Development). She worked at Saint Vincent's Hospital-Westchester in Harrison, NY from 1980 to 2020. During her career Jane held several important positions, including

program director of Personalized Recovery Oriented Services (PROS), a comprehensive recovery-oriented program for adults with severe and persistent mental illness. Jane also provided dialectical behavior therapy (DBT) skills training and clinical supervision in an outpatient mental health clinic. Jane received the 1999 Outstanding Clinician Award from the Westchester Art Therapy Association (WATA). Jane has worked on various committees for the American Art Therapy Association (AATA), including six years as the annual conference chair. Now that Jane is retired, besides staying involved in AATA, she is enjoying community theater, painting, reading, watching sports, and getting together with friends and family.

Yvette Duarte is the owner of Awake DBT, Inc. in San Jose, California. She is a DBT-Linehan Board of Certification Certified Clinician™, a licensed marriage and family therapist (LMFT), and a registered art therapist (ATR). Yvette graduated from Notre Dame de Namur University with an MA in Marriage and Family Therapy/Art Therapy. For over 20 years Yvette has practiced psychotherapy with adults, children, and families in community-based settings such as domestic violence shelters, supported housing, outpatient mental health services, and homeless shelters. She has also provided trainings on DBT and art therapy at several agencies in the Bay Area.

Penelope James is a clinical registrant of PACFA (the Psychotherapy and Counselling Federation of Australia) and a full professional member and registered supervisor with ANZACATA (the Australia, New Zealand, and Asian Creative Arts Therapy Association). She works in a variety of settings, including private practice, community health, and clinical mental health centers. She specializes in the art therapy process of visual journaling, which integrates art therapy with psychoeducation. Penelope has presented at art therapy and counseling symposiums and conferences and for the Western Sydney University Master of Art Therapy clinical training program. Penelope received the Mental Health Matters Consumer Involvement and Engagement Award in recognition of her coordination of the STiGMA Exhibition. This celebratory event engaged community members living with mental illness to explore their recovery journeys through expressive art making. More recently she coordinated the L&L Riverwood Creative Community "We All Are One" sculpture for the Rookwood Cemetery Exhibition.

Shelley Kavanagh, RP, RCAT, is a registered psychotherapist and registered art therapist with over 25 years of experience working with young people challenged by emotional and behavioral dysregulation. She consults to numerous community-based agencies and is a faculty member of the Toronto Art Therapy Institute. For the past several years, Shelley has worked in a supervised practice with DBT expert Dr. Shelley McMain, as well as with Dr. Shari Geller (who has been a great teacher in therapeutic presence through her advancement in the field of emotion focused therapy). Shelley's personal mindfulness practice is greatly enhanced by her adult children, Justine and Ryan, who often model the DBT concept of "wise mind." Lastly, a lifelong friendship with art therapist Suzanne Thomson has helped strengthen, sustain, and reinforce Shelley's trauma-informed practices with clay.

Heidi Larew, LPCC-S, LICDC-CS, ATCS, has worked as an art therapist for 23 years. She specializes in clinical supervision and is experienced in spiritual care, mental health counseling, and chemical dependency counseling. Her professional philosophy emphasizes being present with clients, supervisees, and colleagues in ways that may foster in them a sense of peace and hope. She enjoys the use of creativity, storytelling, and metaphor. Heidi treasures engaging with others and enjoys bringing laughter and kindness to the healing process.

Scott Levson, PsyD, is a staff psychologist in the Polytrauma Clinic of the Washington DC VA Medical Center, where he provides individual, couples, and group psychotherapy to veterans who have experienced traumatic physical and emotional injuries. He is involved in the supervision and training of psychology students at the extern, predoctoral, and postdoctoral levels, and serves as a member of the DC VA's training committee and DBT treatment team. Dr. Levson graduated from Chestnut Hill College in Philadelphia and gained exposure to relational psychoanalysis at the Haverford College CAPS clinic. He completed a predoctoral internship at the Hudson Valley VA in Montrose, NY, as well as a postdoctoral fellowship specializing in severe mental illness at the Washington DC VA. He also enjoys teaching and has held adjunct faculty appointments at Chestnut Hill College. Dr. Levson is certified in cognitive behavior therapy (CBT) for insomnia and cognitive processing therapy (CPT) for posttraumatic stress disorder (PTSD).

Melanie Paci, PsyD, is a clinical psychologist who has provided clinical services and training in the Department of Veterans Affairs for 12 years. Her areas of specialization are recovery-oriented group therapy, suicide prevention, and telemental health. Dr. Paci has also been involved in program development/evaluation initiatives focusing on suicide prevention and integrating creative processes in the delivery of psychotherapy. She is trained and certified in several evidence-based therapies including CPT for PTSD, DBT, acceptance and commitment therapy, CBT for psychosis, and integrative behavioral couples therapy.

Chloe Sekouri worked in the social services as a counselor, art therapist, and social worker in Vancouver, British Columbia, Canada. She was based in women's treatment programs, front-line drop-in centers, and First Nations organizations. She worked in a youth detention facility and as part of the North American Opiate Medication Initiative (NAOMI) clinical trial. She completed her Master's-level diploma in art therapy at Vancouver Art Therapy Institute in 2004. Ms. Sekouri has transitioned out of the helping professions, but continues to make art as a way to explore her inner and outer worlds.

Megan Shiell, AThR, is a DBT specialist, registered art psychotherapist, and a level 4 counselor in Australia. Megan received comprehensive DBT training in 2008 and subsequently developed a two-day intensive DBT workshop which she facilitates around Australia (to date, she has trained approximately 2000 clinicians). Her experience in structuring DBT teams has been extensive, as well. Megan is passionate about assisting clinicians and clients in the use of DBT skills with an added component of art making/creative imagery. In 2018, Megan developed the online "*ME*" (Managing Emotions) ten-session DBT-informed skills training for clinician professional development, as well as a similar program for clients. Megan has assisted many clinicians in developing DBT-informed skills training programs both for groups and individual therapy. Megan's goal is to make DBT skills accessible to as many people as possible.

Jeremy Steglitz, PhD, MPH, is a photographer and licensed clinical psychologist in Washington DC and Virginia. He is currently a staff psychotherapist, lecturer, and supervisor at the Therapy Group of DC. Dr. Steglitz has published numerous articles and book chapters

on evidence-based practice. One of his more recent interests is the integration of structured interventions (e.g., CBT, DBT) with depth-oriented psychotherapies (e.g., psychodynamic psychotherapy, creative arts therapies). Dr. Steglitz has been involved in program development evaluation initiatives at the Washington DC VA Medical Center and Mount Sinai St. Luke's Hospital in New York City that have focused on combining creative arts therapies with CBT or DBT to optimize therapeutic impact.

Karin von Daler, MFT, REAT, is a psychologist, expressive arts therapist, family therapist, and artist. She maintains a private psychotherapy, teaching, and supervision practice in Copenhagen. Trained at the California Institute of Integral Studies, Karin has taught expressive arts therapy around the world and is the co-creator of creative mindfulness. She recently developed the course series "The Art of Self-Healing," as well as "The Heal Keys," a popular online course. Karin paints, dances, and plays the harp.

Anthony Webster, MSc, has worked at Rampton Hospital, Nottinghamshire Healthcare NHS Foundation Trust, since 2011. For the past three years he has served as an assistant psychologist across the National Men's High Secure Learning Disability Service and the Men's Mental Health Service. Throughout that time he received training in, and has supported the delivery of, both DBT and radically open dialectical behavior therapy (RO-DBT). Prior to this, he worked as a nursing assistant on the Personality Disorder Service for five years. Anthony trained at Lincoln University for both his undergraduate degree in Psychology, and MSc in Forensic Psychology. He is currently working toward becoming a qualified psychologist.

Mary Weir, MA, is an Irish-Australian living in Aotearoa, New Zealand. After studying visual arts, anthropology, gender theory, yoga, and adult education (and performing and teaching circus arts for almost a decade), they now provide art therapy for diverse folk in both private practice and through the New Zealand Prostitutes Collective. Mary feels that the most satisfying thing in life is to be fully oneself and hopes for a future world where love and acceptance of diversity is the norm. They also write about gender, sexuality, mental well-being, and the human journey. Mary writes from home on the Kāpati coast, and wishes to

acknowledge local iwi, and the Māori people of Aotearoa, as rightful custodians of this land. Mary offers gratitude and acknowledgment to their loved ones and community, who take the time to read and support their work, because it takes a village to raise consciousness about diversity and inclusion.

Tracela M. Zapata, PhD, is a clinical psychologist and a Booz Allen Hamilton Associate with experience providing subject matter expertise for healthcare initiatives within the Department of Defense (DoD). Dr. Zapata has worked as a clinical psychologist for over 20 years, nine of which were in the Department of Veteran's Affairs. She has been responsible for program development/program evaluation initiatives in the Department of Veteran's Affairs for six years (with a specific focus on access to care, evaluating program effectiveness/efficiency, and patient satisfaction). She has also provided program translation on emerging psychological health issues. Her research experience spans a period of ten years to include Internal Review Board (IRB) membership, research protocol management, monitoring, adherence, and tracking in accordance with human subject requirements and standards. She also has experience creating reports for accrediting bodies, funding agencies, and presenting project results/key findings to local and national conferences.

Subject Index

Author Index