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# Once Upon an Assessment

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## Abstract

For this research Six-Piece Story Making, an assessment created by Mooi Lahad (2006), was used to elicit a more creative way of assessing risk daily with children. After reviewing the literature on the topic of using storytelling as a therapeutic intervention with children, it was found that there is a lack of information around using storytelling within a partial hospitalization environment. This research began to explore the possibilities of using storytelling in a partial hospitalization setting with male and female children aging in range from 6 to 13 years of age. It was found that within a partial hospitalization program using storytelling at the start of the program fostered within the clients the ability to create playful environment that fostered an openness with the children during the risk assessment questions. Another finding was that the participants showed more agency and ownership when creating a treatment goal to focus on during that day of treatment. This was an unexpected benefit that was documented through the research and was evidence to the fact that by implementing Six-Piece Story Making at the partial hospitalization program risk can be assessed in a creative and playful way that encourages the child's involvement in their treatment goals.

Keywords: Storytelling, Six-Piece Story Making, Partial Hospitalization Program, Drama Therapy, Children, Risk Assessment, Six-Piece Story Making.

Once Upon an Assessment

**Introduction**

Storytelling is an age-old tradition of entertainment, but also an age-old form of healing. It is through the act of storytelling that communities can heal from natural disasters, and shared experiences of hardship can be carried, and knowledge passed from one generation to another. Since there has been language, there has been storytelling, a pathway to connect individuals to something bigger then themselves. Storytelling has been used as a means of understanding the grand phenomenon's in life as well as its mundane moments. Cultures around the world have used storytelling to find connection within their community and as a means of explaining the experience of those within the community. It has been viewed as a way of healing and helping communities cope with the things they experienced in their collective lives.

The powers of storytelling have been well documented and explored by many in the healing professions. Healing though storytelling is not a new concept, however, adapting storytelling to fit into a medical model has only become accepted within the last 40 years. Much of the research that has been done with storytelling has been done within inpatient settings or outpatient private work. This research is in hopes to create a bridge between outpatient and inpatient practice, to expand upon the current research that can be found on the topic of using storytelling to assess the safety of an individual daily.

**Literature Review**

The tradition of storytelling is just as powerful today as it was amongst the ancient societies of the world. The potential benefits for those who are ill telling their story has long been recognized in many cultures and is receiving the attention of medical practitioners (Sunwolf et

al., 2005).  There has been substantial research effort placed on understanding the effects of telling one's story. So much information can be gained through listening to stories of illness and struggles (Sunwolf et al., 2005). The powerful personal narratives that are shared through story have the potential to provoke insight for the listener and help them find connection beyond illness or struggle and truly see the person behind the story.

Story sharing is a type of storytelling utilized by Sunwolf et al. (2005) to explore the use of storytelling within the medical model. Story Sharing is described as a dynamic process in which the stories are transformed in the telling, and further transformed in the receiving (Sunwolf et al., 2005). Sunwolf and collaborators suggest that story sharing is an important tool for caregivers and clients alike in five significant ways; first they connect people, they help to better understand the world of the client, allows for the ability to create and recreate reality, to help with remembering events of the past, and lastly to create a vison for the future (Sunwolf et al.,2005). Using storytelling as a tool within the medical model of mental health treatment and with those struggling with medical illness can be beneficial to the caregiver and allow new perceptions and avenues of treatment to become available.

There can be some limitations with using storytelling within the medical model and Sunwolf et al. (2005) describes these limitations as fear of falling into the helper's pit. The helpers pit refers to the role that the therapist or helping professional could fall into while engaging with the client's story, the pit is created by the distressed client and the therapist is placed into a position of rescuing the client (Sunwolf et al., 2005). While storytelling is a bridge between individuals it can also expose connections to personal material that the therapist needs to be aware of during the treatment process. If the therapist becomes too entangled in the

helper's pit there is the danger of the empathy felt for the client's situation or experience becomes internalized distress for the therapist (Sunwolf et al., 2005).

Use of Storytelling in Hospital Settings with Children

Narrative interventions have been explored within the medical of a hospital setting for some time and advancements in the storytelling have been made over the years to streamline the intervention and allow it to be used within the evolving culture of the hospital. The narrative interventions are used to increase patient involvement in treatment and coping with whatever struggles they have faced on their journey to healing. At Boston Children's Hospital, children with cardiac illness partook in an intervention that used a three- dimensional, multiuser computer environment that was designed to help the children build coping skills (Bers et al., 1998).

The participants were seven to sixteen years of age and they used SAGE or Storytelling Agent Generation to create a virtual space that could be designed with objects and characters that had been programmed with storytelling behaviors (Bers et al., 1998). SAGE could be used in different ways and the clients could interact with the characters that were created, it also helped to expand the child's perspective of their personal experience and allowed them to take on the perspective of others going through a similar experience (Bers et al., 1998). SAGE allowed the children to unpack and explore their emotional and physical recovery while exploring their inner world and finding connection with other members of the SAGE storytelling community.

For the most part, storytelling is being used in hospital settings as well as outpatient settings as a way to assess individuals and their needs. Cook (2004) and his associates wrote, "The Application of Therapeutic Storytelling Techniques with Preadolescent Children: A Clinical Description with Illustrative Case Study," which was conducted utilizing clients enrolled

in outpatient therapy to discover new ways of fostering motivation and willingness of children to participate in their treatment. Clinicians identified the presenting problem of the child during an intake to learn as much as they could from the child and their parents as to what the goals of treatment would be. This was done to help guide the child in creating a story that would be parallel to the issues that were present in their life (Cook et al., 2004).

The clinician would then take the child through a five-step story telling method: identify the main character that paralleled the child's struggles, identify the problem, talk to a wise person or someone who could help the main character overcome the obstacle, try a new approach, and finally summarize the lesson learned (Cook et al., 2004). The overarching purpose of the storytelling in this research study was to open new possibilities and choices for the child, when they connect with the character of the story the child becomes aware of different ways to get their needs met (Cook et al., 2004).

The hopes of the authors were to foster an interest in furthering the research into using therapeutic storytelling as an intervention to help children access and explore their feelings about their treatment and explore in what they are going through in a new way (Cook et al., 2004). The limitations of this research were the limited access to research of which to compare and expand upon also this stud could have benefited from the inclusion of another case study to explore the success of the intervention with another client. These limitations were noted by the researcher and authors of the Cook et al., study (2004), their hopes of publishing this work was to create awareness of this method of treatment and the need for more well controlled, larger scale, and procedural research studies to be done around the validity of using therapeutic story telling in treatment for children (Cooks et al., 2004).

Not only is storytelling being used to foster and assess a child's ability to participate in treatment, it is also being used to asses the child's mental health status. A study done by Hudson et al. (1987), used storytelling to measure anxiety in hospitalized children. Storytelling was chosen as the preferred method because it was a nonthreatening approach into the exploration of feelings. Though this study is more antiquated having been completed in 1987, it still holds relevance to the success that storytelling can have with children that are hospitalized for various reasons and therefore has been included in this literature review. The participants consisted of sixty-seven hospitalized children between the ages of 4 and 17 years of age at Children's Hospital in Birmingham, Alabama (Hudson et al., 1987). Participants were given pictures taken from different standardized assessments that measured anxiety, from those pictures the children created stories. The themes that were identified consisted of fear, death, sadness, desertion, loneliness, but also contained themes such as love, safety, and happiness (Hudson et al., 1987). The study showed a positive relationship with the ability to assess anxiety, those children whose stories contained heavy or negative themes were also found to be more anxious as determined by the Anxiety Rating Scale (Hudson et al., 1987).

For Hudson et al. (1987) storytelling was the preferred method because it was able to be administered across a large age range as well as varying diagnoses and conditions. For most of the children in the study, their longest stay at the hospital could be up to four days and the storytelling assessment was a more manageable assessment than a full psychological test packet (Hudson et al., 1987).  An added benefit to the study was that it determined that the caregivers were able to achieve greater insight into the child's specific anxiety from their individualized story which allowed for more specific treatment of the child (Hudson et al., 1987).

Because this research was conducted within a short term medical treatment environment there was not enough time to assess the participants with a battery of psychological tests, so there is no comparative data included in the study. Due to cutbacks at the hospital the length of stay for treatment for some participants was a short as four days and therefore the storytelling interventions success or benefit had to be assessed quickly (Hudson et al., 1987). Due to the large number of diagnosis being worked with there was no way to track how the storytelling intervention affected children with differing diagnosis and Hudson et al. (1987) recognized that this is an area where they study could be expanded upon.

Though this next study was completed with adolescent participants, I believe it is still beneficial to include and could be modified to be used within a child population. Visual storytelling was used by the research team of Drew, Duncan, and Sawyer (2010), as an intervention with 34 adolescents 10 to 18 years of age who were experiencing symptoms of asthma, diabetes, or cystic fibrosis. The study aimed to start a dialogue between the researchers and the participants to get detailed information from the young people rather than using biased observations from outside experiences. The researcher believed that storytelling would create the mutual relationship that would inform the decisions being made around the treatment of children and adolescents (Drew et al., 2010).

The adolescents were given 36-exposure film-based disposable cameras to document what it was like living with a chronic illness (Drew et al., 2010). This study's focus was on the development of self-management among adolescents with long term illnesses (Drew et al., 2010). Through the combined efforts of the visual storytelling and interviews collected that were based off the visual stories revealed prominent themes such as enjoyment of the exercise, difficulty creating the images, forethought and planning, representing normal life and being a

normal kid (Drew et al., 2010). This study found that the storytelling expanded the scope of the participants reflection and communication around topics that were often hard to conceptualize and express (Drew et al., 2010).

Though Drew et al. (2010) were able to find a strong correlation between visual storytelling and exploring the lived experience of the participants, there were some limitations noted by the research team. One of the key issues noted by the team was that there was not enough data collection time and the visual storytelling process took longer than they anticipated (Drew et al., 2010). Drew et al. (2010) noted that they would incorporate a weekly check in to help guide participants who were finding the directive difficult, the research team also decided that more time should have been allotted to the interview piece of the research to get a full understanding of how the participants engaged with the visual storytelling. More research needs to be done around visual storytelling and the researcher acknowledges this fact, their study did not have a comparison or control group to compare the results of the visual storytelling group to, and Drew et al. (2010) acknowledges that their study is lacking this comparison.

Use of Storytelling in Expressive Therapies

Along with medical professionals, expressive therapists have been using storytelling as a therapeutic intervention with their clients to better meet their needs in the treatment process. Use of expressive therapies as an assessment falls under a subjective approach of administering assessments, meaning that it supports the interviewer's ability to make observations of the client's behavior and how they relate to the intervention (Mills, 2006). This type of assessment yields complex and valuable information that can be used by the therapist to test the emerging hypothesis about the client's diagnosis as well as their strengths (Mills, 2006).

Using storytelling as an assessment tool benefits both the client and the therapist because it allows the client to explore their inner world and inner struggles safely. Mills (2006), purposes that this subjective approach to assessment allows the expressive therapist access to the curiosity of an artist but also the rigor of a scientist. This impressionistic approach seems to create an opportunity for the expressive therapist to create a treatment plan that holds space for all the complexity of the client.

Psychodrama is a form of expressive therapy that can be used to fundamentally change the way therapists relate to their clients. Psychodrama puts the client in the leadership role, the therapist follows the cues of the client, this is a very different dynamic from many traditional therapeutic relationships. This reversal of the power dynamic within the therapeutic relationship allows the client space to explore their personal experience in the way they need to with guidance from the therapist. Psychodrama allows its participants to draw on their natural creativity and use it to help heal the self (Kende, 2017). Hanna Kende (2017), uses psychodrama with a wide range of children with varied symptoms by creating a safe environment that allows children to express themselves freely. Children have a natural language of play and Psychodrama taps into that natural language to help foster new perspectives and reshape negative self-images that the children may have.

One of the ways in which Kende (2017) creates the Psychodramatic space and can connect to the child's creativity is through storytelling. In Psychodrama the child should feel that they are somewhere else, they need to create a world where they make the rules, and everything is possible. Kende (2017) does this by using storytelling as a warm up because children are comfortable with the idea that fantasy exists within the world of a story. It is important that the child be the storyteller, not the therapist, the child is prompted to create a magical world through

storytelling where they can begin to explore their own omnipotence (Kende, 2017). Through the familiarity and comfort of fairytales and myths, the child can explore their own power and autonomy over their life. Storytelling becomes a vehicle for exploration and perspective taking within Psychodrama that fosters the idea of choice and ownership of the therapeutic journey.

In this section we saw many different applications of storytelling within different medical environments. Storytelling is a versatile intervention that can be easily adapted to any of these medical environments as well as any population. In these studies, storytelling was used with medically diverse children and over many decades. Universally these studies found that storytelling was an agent of change within the treatment process. It engaged the children in their treatment and allowed the clinicians a clearer understanding of the individuals experience. This unique perspective allowed the children to take a more active role in their treatment and more agency with which to explore their experienced.

Drama Therapy as an Assessment

Within the field of expressive therapy there is a branch called drama therapy that emerged in the 1980's as a form of therapeutic practice. Drama therapy has been used as a bridge between the creative and artistic world to the world of psychology. To build that bridge drama therapists began creating assessments that used the creative arts such as projective techniques, role play, and storytelling (Pendzik, 2003). Like the assessments found within the clinical psychology world, the drama therapy assessments are used to evaluate the development and overall function of an individuals mind. The key difference in a drama therapy assessment is that it is grounded in what drama therapists call the "dramatic reality," or a space that is deemed safe and where an individual can experiment with their perception of the world (Pendzik, 2003). The dramatic reality is a container that is built by the client as well as the therapist and within this

therapeutic space, fantasy can be made real and enacted upon in a therapeutic relationship. This is where assessment in drama therapy stands alone from other psychological assessment domains, this place between fantasy and reality is created within the bounds of drama therapy.

Six Key Model in a Drama Therapy Assessment

There is no one way to create the dramatic reality and no specific script to follow once the dramatic reality has been entered. Therefore, many drama therapists have created assessments that best correspond to how they engage with and understand the therapeutic relationship with the dramatic reality. The various drama therapy assessments use six key elements that help to organize the drama therapy methodologies within the assessment. Susana Pendzik (2003) describes these six domains of a drama therapy assessment.

As a practice, drama therapy explores the internal realities of those engaging in drama therapy activities as part of their treatment. Some elements that make up internal realities and individuals subjective realities are the roles the client fills on a day to day basis, their ability to perform those roles, their ability to switch between different social environments and interactions, as well as how they respond to the different themes and conflicts that may arise on any given day within any given relationship. Pendzik (2003) was able to streamline this broad exploration of drama therapy into an assessment form that focuses on six areas of interest that could be used to meet the therapeutic needs of a client.

These six areas of assessment are an ability to transport oneself to and from ordinary reality, a quality, roles and characters, patterns: plot, themes, and conflicts, a response to it, and finally a subtext (Pendzik, 2003). The Six Key Model can help drama therapists track the therapeutic process through all aspects of the dramatic reality (Pendzik, 2012). Drama therapy is

still creating its language within the clinical world, which is why Pendzik's work is important to the field because it is an intersection point between all the drama therapy methodologies and streamlines the language with which to refer to the dramatic reality (Pendzik, 2012). It helps to synthesize a wide breath of interpretations into six key assessment factors. The Six Key Model as Pendzik (2003) calls it, provides a ground work that can be built upon and foster further drama therapeutic interventions that are best suited for the individual or the group partaking in treatment.

Types of Drama therapy Assessments

David Read Johnson (2012) created an assessment using his theory of Role. His Role-Playing Test is based on a pre-established series of roles and scene improvisations. The client is asked to act within the assessment. There are ten roles that are commonly experienced across many individuals experience and the client is asked to act out five separate roles, one at a time (Johnson, 2012). After the roles were enacted, Johnson (2012) would inquire as to why the client chose to portray the roles in that way and if they connected to any real-life experiences that the client may have lived.

The instructions for the improvised scene work part of the assessment was to act out a scene between three beings in any way the client wishes, and the beings may be anyone or anything the client wants them to be (Johnson, 2012). The roles, or beings, that the client can choose to act out are grandparent, bum, politician, teacher, and lover (Johnson, 2012). During the scene the client was being evaluated to see if with each character they could portray four qualities of that being, those qualities are nurturance, control, sexuality, and competence (Johnson, 2012). After each scene the client is asked to describe their interpretation of the scene in detail and describe the characters. Giving the drama therapist context for how to formulate an

impression of the client's ability to connect to interpersonal themes in their lives (Johnson, 2012). From the inquiry after the assessment scenes, the drama therapist can pull specific therapeutic needs and from there appropriate interventions can be brainstormed.

Robert Landy is another drama therapist who connects the importance of role to an individual's mental health. Landy uses Role Method, which is based on archetypal roles that one may play or encounter through their life (Landy & Butler, 2012). It was Landy's belief that using archetypal roles as an assessment could create a framework that could foster diagnosis, effective treatment plans, as well as prevent further decompensation of mental health (Landy, 1996).

Storytelling Assessments

Tell-A-Story is an assessment that evolved out of Landy's Role Profiles assessment and is another example of how storytelling can be used within an assessment format (Landy & Butler, 2012). Tell-A-Story was unlike Landy's Role Profiles and Role Checklists assessments because it encouraged the client to take a more creative approach to the assessment process (Landy & Butler, 2012). In this assessment the clients are asked to tell a story and then reflect upon it, the client has complete freedom when creating the story and can use any structure they wish (Landy &Butler, 2012). The therapist asks questions after the storytelling is complete to encourage the client to explore the story and roles created in the framework of the story more deeply. Some of the questions that may be asked are "Could you describe the character?" "What is the theme of the story?" "What is the title?" "What is the connection between the characters I your story and your everyday life?" (Landy & Butler, 2012, pp. 168-169). The facilitator is assessing the client's ability to tell a cohesive story and notes the client's verbal and nonverbal reactions to the process, there is no judgement placed on the topic or themes of the story being told. The Tell-A-Story assessment can be used to seek information about how the client

perceives themselves as well as their openness to engage with drama therapy (Landy & Butler, 2012).

Six-Piece Story Making Assessment

Storytelling has been used as a drama therapy assessment by Mooli Lahad (2012), an Israeli drama therapist, who created and implemented the Six-Piece Story Making. The model that Lahad created was initially conceived as a way to assess the way in which people cope with stress, however it has been discovered to be useful in assessing many mental health concerns (Pendzik, 2003). The assessment that Mooli Lahad created allowed for individuals to explore new ways of engaging with their lived experience, it its essence the storytelling assessment gives insight in to how an individual communicates with the outside world.

The story making contains a main character, a task, helpful and unhelpful factors, a main action or climax, and an aftermath or ending (Lahad & Dent-Brown, 2012). The client is instructed to draw a sketch or write down brief descriptors that can be as simple as stick figures or full landscapes. The purpose of sketching or briefly describing the story is to begin to engage the imagination and give the creator a foundation that they can then build their story on. These six parts of the story making helps the client to define the foundations of their story. By using the six-part template the client is able to explore deeper in the main character, their wants and needs, the obstacles in the way, and the possible solutions or outcomes.

Once the outline is made the client is told to tell the story to the therapist (Lahad & Dent-Brown, 2012). Lahad developed this method to assess clients coping resources and help drama therapists map out a drama therapeutic plan for their clients (Lahad & Dent-Brown, 2012). Through the Six-Piece Story Making therapists can assess how individuals absorb information

and relay that message to the world. By asking clients to tell a story based on elements of fairytale or myth, the therapist is able to observe the way that the client projects themselves into reality and how they interact with the world around them (Lahad & Dent-Brown, 2012). The story becomes a personalized Rosetta stone that unlocks the individual's subjective language that they use to relate and interact with the world.

Just like Susana Pendzick, Lahad provided a scaffolding through which the Six-Piece Story Making can be evaluated. These categories can be beneficial to developing a well-rounded understanding of a client. Those levels include coping style, themes, here and now, conflicts, the developmental stage, the quest, and symbols. These categories align with the six parts of a drama therapy assessment as outlined by Susana Pendzick (2003), providing a translation of the client's subjective expressive language and the dramatic reality in which the therapeutic work exists. The assessment categories used within the Six-Piece Story Making are used to help the drama therapist create interventions that are best suited for the client in that moment.

Six-Piece Story Making has been used as an intervention for all ages as well as to clinically diagnose clients. In this section we saw how drama therapy assessments can be used to gain a deeper understanding of how a client interacts with the world. We also saw how drama therapy incorporates storytelling as an instrument to gather clinical information about the client in an imaginative and playful way. By using storytelling as part of an assessment the therapist can evaluate what the client wants to work on in the moment and create a more detailed treatment plan to support the client. Further research is needed to assess the validity and utility of the levels of the various storytelling assessment as well as the effectiveness and impact of Six-Piece Story Making (Landy & Butler, 2012). This is where my research will begin using the

outline of Moolie Lahad's Six Piece Story Making as an assessment tool in a partial hospitalization environment with children.

## Method

For this research the Six-Piece Story Making was implemented as a Check In activity to begin the day at a partial hospitalization program. The goal of using the assessment in this way was to engage the clients in the morning check in, so that it might foster creative exploration of a client's safety during the daily risk assessment. Due to the lack of research done around interventions and assessments within partial hospitalization programs, there is a need for this kind of research to evaluate the type of work being done in that specialized environment of short term care.

Setting

The focus of a partial hospitalization program is short-term day program that consist of group therapy. The clients that attend this program are struggling with depression, anxiety, anger, bodily safety concerns, and trauma. The length of stay varies with everyone; however, it is recommended that the client be in the program for eight to ten days. During their time at the program clients follow a structured schedule of therapeutic groups designed to foster insight into mental health struggles and coping skills to support the challenges that the individual may be facing.

Each day begins with a Check In group that consists of a warm up activity as well as a daily risk assessment, during which the child's mood and safety risks are evaluated. During this time the client is asked to set a treatment goal for the day or an area they would like to focus on. Check In is followed by an hour of tutoring in which the clients have time to work on school

assignments. Then they engage in two therapeutic groups Expressive Therapies and Psychotherapy to begin learning language with which to communicate their mental health needs. Then there is a forty-five-minute lunch followed by a Psychoeducation group and a Check Out where once again the client's mood and safety concerns are evaluated before heading home.

Research Method

Journaling and art making were also used to track the mood and internal process of the facilitator. In my experience, the mood and level of engagement that the facilitator embodied was a factor in the client's willingness to engage not only with the risk assessment but also with the Check In activity. It was also used to record what transpired in the group such as the stories and things the participants said during the intervention. The journaling and art making was an effort to track the possible influence that I felt I had over the group's mood as well as how the engagement with the Six-Piece Story Making influenced my energy level and mood during the Check In.

This journaling was completed within a few hours of the Check In and was done in a stream of consciousness form. Putting pen to paper and exploring the different emotions and noticing what had occurred during the Check In process utilizing the Six-Piece Story Making intervention. When it came to the art making, it was used to create abstract visual art that was inspired by the client's stories as well as how I was feeling after completing the journal. The art making happened several hours after the Check In and journaling. This allowed for the emotions and thoughts around the intervention to settle and be explored in a more abstract and open way.

After journaling and hearing the client's stories I felt like I was holding a lot so the art making enabled me to work through what my feelings about the Six-Piece Story Making were

and what might be coming from the client's experience. Once the data collection was complete, I went back and re-read the stories and journal entries and was able to pull out recurring themes and observations form the various intervention sessions. Though the art making was intended to be a part of the data collection it became more of a self-expression that was not analyzed as part of the data and remained as a personal form of releasing the emotions and thoughts I was filled up with after the intervention was completed.

Participants

The Six-Piece Story Making was implemented four times during the Check In portion of the program as a warm up to answering the daily risk assessment questions. Each time that the intervention was implemented there were different participants. The participants included five female clients and five male clients ranging in age from 7 to 13 years of age, all from various economic and racial backgrounds. Their diagnosis ranged from Depression, Mood Dysregulation Disorder, Generalized Anxiety Disorder, Oppositional Defiant Disorder, and Post Traumatic Stress Disorder. The participants had completed the intake process and had been admitted into the program, due to the format of short term treatment each client was on a different duration of time in treatment. The Check In group consisted of no more than six clients at a time, and each client had ten minutes to create their story using the Six-Piece Story Making template.

Intervention Method

As the clients entered the group room they were informed that they would be telling a short story to the group as part of their check in activity. To help the clients find their way into a playful and creative mind space, their attention was directed to a bin of objects that consisted of different miniature toys such as dinosaurs, army men, dragons, and some identifiable figures

such as superman and pooh bear to name a few. The clients were directed to pick out an object that they felt connected to and wanted to use as their main character. Plain white paper was given to each client and they were instructed to draw the Six-Piece Story Making template on their paper.

In the first box of the template, the clients were to draw or write down who the main character of their story was. In the next box to the right the client was instructed to draw or write the setting of the story. In the third box to the right the client was to draw or write about the task that the main character wishes to accomplish. In the fourth box the client was instructed to draw or write about the helpful or unhelpful factors that may aid or get in the way of the main character completing the task. In the fifth box the client was asked to draw or write about the main action of the story. And finally, in the sixth box was used to draw or write about the aftermath or ending of the story.

Once this was completed the clients were called up to answer the Check In risk assessment questions, however the facilitator did not ask the client to set their therapeutic goal in this moment, that will be done after the client has told their story to the group. Once the Check In questions had been answered by the clients individually, the group came together to hear each client's short story.  Ten minutes was given to each client to tell their story to the group, the facilitator asked some questions during the storytelling to expand upon areas of the story that seem significant or interesting. After the clients told their stories they were asked back up to finish the check in questions and create a therapeutic goal for that day. If the client struggled to set a goal, the facilitator referred to the story the client told to see if they could pull a theme or goal out of the story that might guide them towards a therapeutic goal for the day.

Materials

The clients were each given blank pieces of white paper to create the story making template. For clients who needed to warm up their imaginations, they had access to projective objects, small figurines that could be easily manipulated and held to help the clients generate their stories. Colored pencils, markers, crayons, and graphite pencils were provided to the clients, so they could choose the medium they wanted to use to draw or write down their story. As the directions were explained to the group the facilitator drew the template on the white board to ensure that every learning style was able to follow the story making directions.

Record Keeping

The morning Check In sheets are filed at the end of everyday in the clients confidential file to track their progress and safety during the program. This is where the daily therapeutic goals are recorded to track throughout the course of treatment. As the facilitator, I wrote down the stories that the clients generated verbatim for data collection and documentation in my journal. The clients were encouraged to keep the visual representation of their story for their own use during treatment with the other art they made throughout their time in the program. This was encouraged so the clients would have access to their stories throughout the day and potentially continue to use the story they created to remind them of the goals they had set.

## Results

During Check In the clients are asked a standard set of questions every morning that were used to assess their mood and the level of safety they were feeling in their body. During the Check In prior to the storytelling intervention, clients were asked to fill out a worksheet or answer a short journal prompt. Many of the participants had expressed frustration that the Check In questions and activity because they were always the same and that they always gave the same

answer. The purpose of the storytelling assessment was to help foster engagement within the

Check In activity and add some playfulness into the Check In routine. Upon reflection of the data

collected it was successful in adding an element of play as well as new perspective into the

client's individual treatment goal of the day.

Observations

These observations are pulled from the data recording in my journal and from the stories

that the participants told that were also recorded and kept with the journal. Upon being told that

the Check In would contain an element of storytelling the participants affect changed. The

directive of creating a short story was met with comments such as "Oh cool!" "That's different!"

Really? That sounds fun," the participants on the older end of the age range also responded to the

storytelling directive with enthusiasm with comments such as "That sounds better than a

worksheet." The overall affect in the room was filled with a brighter mood and the participants

shared laughter and connection over the miniature objects chosen to help generate the story. This

was a marked difference from the usually silent and low mood that the clients exhibited during a

routine Check In.

There was also a noted difference in the client's willingness to answer the risk assessment

questions without needing to be pressed to go deeper into detail. The most unexpected difference

observed was when it came to the goal setting and identifying gratitude, the participants were

able to create goals that pertained to specific themes of struggle that arose through the story

making. For example, bullying was a theme that emerged through a participant's story, this client

had a history of being bullied and then befriending his bullies, and conforming to the activities,

games, and clothing that the bullies found "cool" to better fit in. This client told a story about a

killer whale that loved to dance but was made fun of because he did not have any legs, to

overcome the obstacle of the bullying the whale learned how to grow legs, but the killer whale

realized that he enjoyed dancing better without legs. The story ended with the killer whale

winning a dance competition without his legs and being happy with who he was because he

enjoyed what he was doing. In the end of the story, the killer whale realized he didn't need to be

like everyone else to enjoy dancing. After telling this story the client was asked to set a goal for

his day and the client chose to focus on setting boundaries and exploring those boundaries within

his friendships.

For another participant who was struggling with social interaction, the theme of helping

others and connection came up in their story making.  This client had a reputation for being the

"bad kid" at his school and the client had expressed frustration around being judged this way.

The client had reported that he tried to make the right choices but always got in trouble anyway.

He told a story about a villain that was trying to protect a magic stone and keep the good guys

from getting the stone. Halfway through the story the villain learned that his villain partner was

keeping the stone all to himself and using it to do bad things. The main character was not happy

about learning this and befriended some characters on the good team and ended up joining them

to help defeat the evil villain that was keeping the stone all to himself. After telling this story the

client set a goal to find a way to connect with each member of the group that day. This client

previously kept to himself during the group and had a history of being isolated from his peers.

After creating a story about team work the client was able to identify that he needs to focus on

building connections within his peer group.

It was not just the goal setting that seemed to be influenced by the story making but the

ability to identify something the participant was grateful for, which is another component of the

morning risk assessment. A participant who told a story about a young girl who had lost her

family was able to identify that they were grateful for their family because that meant they were not alone, this was a client that was struggling to find support in her life and to identify her family as one was a large step for this client. Another participant who was struggling to accept the help being offered in his mental health treatment told a story in which the obstacle in the main characters way ended up became an ally in a war to come. After the story making the client was asked to identify what he was most grateful for, he identified the partial hospitalization program. The story making engaged the participants in a playful and creative way that opened new perspectives not only into the Check In routine but also allowed for new perspectives of how they viewed their individual needs.

Through the journaling process I was able to track observations within myself that I found to be important when approaching the Check In with the clients. One of those observations was that my own excitement about the intervention seemed to be correlated to the client's willingness to participate. From experience running the Check In group there was more enthusiasm among the clients to participate in the Check In activity because it was different and because I was interested in the stories that they created as well giving them time to share. Prior to implementing the Six-Piece Story Making, clients would be asked to complete a worksheet or journal prompt but would rarely have time to share it. With the Story Making, I ensured that they had time to tell their stories and was excited to hear them. Through journaling I found this to be a very important piece of the intervention, giving the clients a space where their creativity could be heard and expanded upon.

Another observation was that I had more material to work with when communicating with the clients during the risk assessment. If the client was having difficulty defining a goal or something they were grateful for I was able to refer to the story and see if they were able to draw

connections from their stories or their main character to create goals that fit how they were feeling after exploring the Six- Piece Story Making. Many times, framing the goal setting through the lens of the story helped the client connect their own needs in that moment.

Apart from two participants, all others made use of the projective objects that were provided to help generate the main character of the story. Those who chose not to use the projective objects has shown themselves to be very warmed up to their creative mind space. The clients were given the option to write or draw out the six parts of the story, 6 of the participants chose to write bullets or short phrases in each box and 4 of the participants drew in the boxes. The stories that the participants created progressed linearly meaning they had a beginning, middle, and end.  Two of the stories began with "Once upon a Time," four of the stories began with "There once was," two stories began with "I," and two of the stories began with the name of the main character. An observation made was that the older participants, 11-13, were the ones who chose to use the name of the main character or "I" to begin their story using less fantastical language to distance themselves from the content of the story.  When it came to the storytelling part of the activity most participants held the object they had chosen to tell a story about in their hands as they recounted their story. Two of the male participants chose to act out their stories with the projective objects moving them around as the story progressed.

Facilitator's Personal Observations

One of the findings that surprised me as I pulled out themes from the journal entries was the lack of resistance to the activity, the Check In is one of the more difficult groups of the day because the clients are tired and often resistance to being at the program. The excitement caught the me off guard but aided in my own comfort giving the story making directive. The feeling that I was filled up with a feeling of hunger, a hunger for something different, that feeling upon

reflection was coming from the participants readiness to jump into the work. Naming the feeling as hunger came from an art piece that I created while exploring the emotions that I had been experiencing while facilitating the intervention. My own increase in mood and affect was correlated to an increase in the participants. The increased mood of the space was infectious and other clinicians from the site were drawn to the space to check out what was the cause of the chatter and laughter.

The Check In process can get stale for the facilitator as well, having to ask the same questions every morning. Safety is the top priority to ensure that the client is in a space where they are feeling supported and heard within the space and I wanted to explore if there were ways to ensure this information is gathered without following the same script daily. As a facilitator it is understood that the questions are needed for a very specific purpose but if the facilitator is bored with the questions, how do they expect the child to feel any more enthusiastic to answer the same battery of questions every day? The Six-Piece Story Making assessment added a level of play and openness that the Check In had been lacking.

This intervention allowed for me to gain deeper insight into the child's mood and safety because it created within the child an openness to sharing that had not been present previously. The clients put thought into their answers and appeared to really think about how they were feeling instead of giving the answers they felt they had to give or responding with what they knew to be the "right" answer.

## Discussion

Implementing the Six-Piece Story Making during the Check In seems to have helped the clients advocate for their treatment goals based on the themes that arose in their stories. In this

study I found that the clients showed greater insight into their needs and a willingness to communicate those needs during the risk assessment. Six-Piece Story Making provided an active framework in which the clients were able to explore their internal content in a way that was accessible to their level of emotional intelligence and insight. This finding links to the Cook et al. (2004) study, where the researcher found that by using a story that paralleled the client's internal struggles, the client was more involved and committed to the treatment process. Just as Kende (2017) uses storytelling as a warm up for children in psychodrama to create their own worlds, the Six-Piece Story Making intervention allowed the children to access the healing power of their creativity.

This specific storytelling intervention helped the clients interpret their feelings and streamline those emotions into a manageable goal that they could work towards during their treatment. The insight gained through the Six-Piece Story Making intervention also allowed the client autonomy over their treatment goal, they were not told what they need to work on but rather the participants were able to identify the underlying problem that needed their attention, so it could be resolved.  In other drama therapy interventions used by Landy (2012), Johnson (2012) and Pendzik (2006), the Six-Piece Story Making uses the client's subjective understanding and experience of the world to help create a meaningful treatment plan that best serves the client.

The focus of a partial hospitalization program is to teach important skills and support to children who are struggling with a variety of mental health issues. Part of that education is around how to best advocate for their needs and providing the clients with the confidence to voice those needs. Storytelling within the Six-Piece Story Making became a bridge in that educational model. Just like in the Drew et al. (2010) study, and the study done at Boston

Children's Hospital by Bers et al. (1998) storytelling was versatile enough to be relevant to all diagnosis and medical struggles.

Through journaling I realized that through the storytelling I was able to meet the child where they were and hear their concerns for their treatment in the here and now. With the knowledge of the client's history and long-term treatment goals, the storytelling offered a way of incorporating that knowledge in a way that integrated the clinical needs of the client with the personal experience of the client in a meaningful way. Just as in the Drew et al. (2010) study I did not assume what the children were going through I allowed them to tell me through the Six-Piece Story Making.

Through the Six-Piece Story Making intervention I, as the facilitator, was connected directly to the internal world and experience of the child. This connection allowed for personalization of the risk assessment questions as they pertained to the client, through hearing the story I was able to connect to the child in a way that can sometimes be missed by using a standardized assessment such as the risk assessment. Therefore, it seems that the Six-Piece Story Making was a successful intervention used in tandem with the standardized risk assessment question, providing the child the opportunity to find empowerment and autonomy over their needs in the moment.

This research relates to other literature that explores storytelling as a beneficial intervention to use with children experiencing a wide variety of mental health diagnosis. Unlike the Hudson et al. (1987) study, this research focused on the benefits of using storytelling with many different mental health diagnoses not just with anxiety. There is a large gap in research when it comes down to the various levels of care that individuals struggling with mental health can encounter. Much of the research using storytelling as an intervention that was explored

previously in this paper, was conducted within hospital such as the Bers et al. study (1998) and the Hudson et al. (1987), inpatient such as the Drew et al. (2010) study, or private outpatient environments as in the Cook et al. (2004) study , there has been little written about the use of storytelling within a partial hospitalization program.

This research has shown that there is room for this type of storytelling assessment within the short-term treatment model. As shown in the literature storytelling can ground the participants in their experience in a safe, playful, and creative way that elicits a deeper understanding of the person and the struggles they face. The Six-Piece Story Making can bring the clients focus into the here and now bringing the expansiveness of possible treatment to a manageable place.

## Conclusion

Some limitations of this research were that the intervention was not able to be tracked over the entirety of client's attendance to the program. This is due to the rotating schedule of clinicians during the Check In group during the week and the varied length of stay from client to client. There was also no control group from which to pull comparative data and that element could strengthen further data collected around using Six-Piece Story Making within a partial hospitalization program. Moving forward with this research these are some of the things that should be kept in mind to improve upon the foundations of this study.

Further study will be needed to explore the benefits of using Six-Piece Story Making with the risk assessment process. Further studies could include a control group of children who did not use the storytelling so that more comparative data could be collected and analyzed. Another expansion of the research could be to include client interviews to get data around how they felt

the incorporation of the Six-Piece Story Making changed the Check In and risk assessment process.  It appears from this data that this form of storytelling can be implemented with a variety of different diagnosis and a wide age range. With further research, refinement, and integration Six-Piece Story Making could become an important tool in the treatment of children engaging in a partial hospitalization treatment, helping to facilitate and individualized daily treatment goals within a group-based practice.

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