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Solution Focused Brief Expressive Arts Therapy

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Abstract

This graduate capstone thesis paper and project proposes a new therapeutic intervention called Solution-Focused Brief Expressive Arts Therapy (SFBExAT). This intervention and approach is based on the synthesized theories, techniques, and principles of Expressive Arts Therapy (ExAT) and Solution-Focused Brief Therapy (SFBT). A review of relevant literature on the combined use of SFBT, ExAT and expressive therapies, as well as on the foundational literature of the individual theories establishes conceptual grounds for a SFBExAT model. A SFBExAT intervention is developed and explained. The intervention was ultimately applied in a hospital outpatient setting with a teenage client. The process, results and implications of the intervention are explored. The paper and project ultimately offers SFBExAT's potential for further research and use by mental health professionals.

Introduction

Expressive Art Therapy (ExAT) and Solution Focused Brief Therapy (SFBT) are two modern therapeutic modals. This capstone thesis explored the ways ExAT and SFBT may be integrated. The aspiration is that SFBT's treatment model and concepts will be expanded beyond talk therapy in the hope that clients may dance, draw, act, play and embody their solutions, while framing ExAT concepts and practices within SFBT's formalized treatment. SFBExAT will expand on the language and experience of SFBT while focusing and grounding ExAT's creative expression.

The solution-focused brief therapy treatment model is an evidence-based, client-centered therapy model (Gingerich & Peterson, 2012). Solution-focused brief therapy clinicians aspire not to narrate or solve their client's history and problems but to listen and select from the client's own expressed thoughts to assist the client in building their own solution to their own perceived problem (Froerer & Connie, 2016).

Expressive arts therapy uses creative expression as a means and an end for therapeutic treatment. Expression, creativity and art-making are universal languages and ExAT and expressive therapies have been clinically utilized with diverse populations (Knill, 2005; Matto, Cocoran, & Fassler, 2003; Moosa, Koorankot, & K, 2017; Tyson & Baffour, 2004; Ylonen & Cantell, 2009).

Expressive arts therapy is a psychotherapeutic approach unto itself and can also be utilized harmoniously with other clinical approaches and theories (Tyson & Baffour, 2004). By integrating ExAT with other evidence-based modalities, the techniques of expressive therapies can be more sharply focused in a modern clinical context.

This thesis expands the development of Solution Focused Brief Expressive Therapy (SFBExAT) by comparing relevant literature on each approach and examining instances where the two modalities were integrated to develop a new effective treatment method.

Personal Introduction

I have had two internships during my graduate studies in mental health counseling and ExAT. In my first internship, I worked in a residential facility for young men aging out of the foster care system. Many of the residents were teenage male refugees who were quite resistant to formal therapy. Furthermore, the language and cultural barriers meant traditional talk therapy was a difficult task. Interning at this site was the initial inspiration for exploring SFBT. Moosa, Koorankot, and K (2017) as well as Ylonen and Cantell (2009), showed effective use of SFBT, specifically integrated with expressive therapy practices, when working with refugee clients. Expressive arts therapy, in its gentle approach and use of universal artistic language, had already shown promise when working with these young men. SFBT's effectiveness with mandated clients (De Jong & Berg, 2001), as well as its ability to work with multiple cultural perspectives in a

less than ideal therapeutic environment (Moosa, Koorankot, & K, 2017), drew me to SFBT.

The inspiration to develop SFBExAT was further inspired by the environment and the patients at my current internship position as an outpatient expressive arts therapist in the behavioral health services department at a children's hospital. As an outpatient therapist in a metropolitan city, I work with patients from multiple cultural and socio-economic backgrounds. The realities of life (transportation difficulties, monetary issues, unstable family structures, weather, etc.) mean patients often struggle to attend their appointments. Insurance companies also limit the number of therapy sessions allocated for patients. These factors all speak to the benefits of brief therapeutic approaches.

By integrating my expressive therapies training with the evidence-based theory of SFBT, I hope to continue aligning my ExAT orientation within the more accepted or understood therapeutic practices. Many of the proposed benefits of ExAT are difficult to measure (Donohue, 2011). A goal of this project was that by jointly applying ExAT and SFBT the more ephemeral yet still effective aspects of ExAT would be grounded by the very tangible work of SFBT.

Literature Review

In this literature review, the core principles, practices, techniques, and approaches of SBFT and ExAT were presented and compared. Modern research in the combined use of expressive therapies with SFBT were discussed and

synthesized. The studies cited are dynamic in their use of different art modalities and the approach to combining these art modalities with SFBT techniques and practices. The literature review ultimately showed the potential for the continued research and use of SFBT with ExAT as well as the development of the SFBExAT intervention and model.

Introduction to Solution-Focused Brief Therapy

Solution-focused brief therapy (SFBT) is a modern therapeutic model currently employed by mental health professionals around the world. Solution-focused brief therapy was introduced during the 1970s in Wisconsin by de Shazer, Berg and colleagues while working in family therapy (Berg & De Jong, 1996). The team created a client-centered therapeutic approach that focused on solutions in a brief timeframe (Trepper, McCollum, De Jong, Korman, Gingerich & Franklin, 2012). Unlike traditional psychoanalytic models, SFBT does not rely on the therapist to derive answers or solutions by exploring the psychological roots of problems. In the practice of SBFT, clients develop solutions by changing their perception of and interaction with their goal (Berg & De Jong, 1996). SFBT focuses on solutions through the identification of clients' strengths in order to set goals. This strength-based model motivates small changes in a brief time frame, with the hope that these small changes inspire and/or beget larger change that continue in the longer run. Basic tenets of the model include a belief in all clients' desire to change, their intrinsic individual strengths and unique personal solutions (Schmit, Schmit, & Lenz, 2016).

While SFBT's name seems to say it all, how SFBT is implemented is dependent on individual clinicians. In their meta-analysis on SFBT, Schmit, Schmit and Lenz (2016) assessed the fidelity of the use of SFBT in qualitative studies by identified specific SFBT techniques. The techniques included: (1) setting goals, (2) the miracle question, (3) scaling questions, (4) finding exceptions, (5) the relationship question, (6) consulting break, (7) compliments, (8) homework, and (9) focus on what is better (Schmit, Schmit, & Lenz, 2016). None of the studies analyzed by Schmit, Schmit and Lenz (2016) employed all nine techniques.

In their Delphi Study, Froerer and Connie (2016) identify the concept of solution building, not the aforementioned SFBT techniques, as the key tenent of SFBT. Solution building, according to De Jong and Berg (2001), is a collaboration between clinician and client to resolve problems by empowering the client's strengths and resources. After interviewing who they deemed as relevant SFBT clinicians, Froerer and Connie (2016) defined solution building as "a collaborative language process between the client(s) and the therapist that develops a detailed description of the client(s) preferred future/goals and identifies exceptions and past exceptions" (p. 25). The study suggests that the cornerstone of SFBT is a collaborative language between client and clinician, where the clinician adeptly participates in a three-part practice of listening, selecting, and building (Froerer & Connie, 2016). SFBT clinicians *listen* to the clients' specific language when discussing past successes and preferred futures.

They *select* the clients' stated words and goals to ask thoughtful questions, identify exceptions and offer compliments. The clinician helps clients *build* solutions by making apparent the details of the client's expressed future goals, current strengths and past exceptions (Froerer & Connie, 2016). Berg and De Jong (1996) deem this selecting and amplifying of a client's expressed thoughts as "deconstructed exposure." While a portion of available research defines SFBT mainly by specific techniques (Gingerich & Peterson, 2012; Kim, 2008; Matto, Cocoran, & Fassler, 2003; Moosa, Koorankot, & K, 2017; Schmit, Schmit, & Lenz, 2016), others put more emphasis on the skill and intent of the practitioner (Berg & De Jong, 1996; De Jong & Berg, 2001; Froerer & Connie, 2016; Tyson & Baffour, 2004; Ylonen & Cantell, 2009). Ultimately, SFBT is a solution-oriented language and perspective that uses specific techniques within that perspective to elicit change (Trepper, et al., 2012).

Solution-Focused Brief Therapy Techniques

This emphasis on the clinician/client collaborative conversation is not to belittle the unique techniques intrinsic to SFBT. These techniques can be applied differently but always with the intention of assisting the client to build solutions (De Jong & Berg, 2001). A SFBT approach to goal setting is strength-based, client-centered, concrete and accessible. Clinicians assist the client to identify a goal that they deem worthy and phrase their goal in solution-focused language, e.g., "I will" not "I will not" (Nims, 2007). The clinician assists client to identify a goal that is realistic in size and scope.

While solution building is the foundational goal of SFBT, the use of the miracle question is the keystone of the practice (De Jong & Berg, 2001; Gingerich & Peterson, 2012). The miracle question helps clients experience their goal by directing them to imagine that while they were asleep a miracle occurred where their solution has suddenly become reality. By exploring this possible future, the client better defines their goal and experiences a "virtual rehearsal" of their solution (Trepper, et al., 2012). Clients may use this time to explore how their daily lives, interpersonal connections and sense of self would improve if their goal is achieved.

The exception question assist clients to find a time when they did not experience their obstacle, an exception to their usual experience. By identifying a time when the client has experienced their solution, the client realizes that their solution is possible (Trepper, et al., 2012). Additionally, identifying an exception is an opportunity to explore what elements (people, environments, etc.) the client would need to reach their goal (Trepper, et al., 2012). Lastly, by acknowledging that they have, if only for a moment, experienced their solution, clients can identify the personal traits and strengths they can use to reach their goal more sustainably (Nims, 2007).

This technique of compliments seems simple enough; clinicians continue to praise and compliment their clients whenever possible and for any small step they have taken towards their goal (Trepper, et al., 2012). This technique is an example of the overall positivistic perspective an SFBT practitioner expresses.

SFBT homework is an opportunity for clients to experiment with finding and experiencing exceptions and solutions in their daily lives (Trepper, et al., 2012). Homework experiments may include making the client's goal more concrete or pretending your miracle has happened and seeing who notices (De Jong & Berg, 2001).

Introduction to Expressive Arts Therapy

ExAT began forming in the 1960s. Early theorists such as Sean McNiff and Paolo Knill found connections between cultural healing methods and creative expression, which they applied to psychotherapy (Donohue, 2011). Knill (2005) found healing value in the movement between art forms. Another ExAT pioneer, Nathalie Rogers (1993) integrated her father's client-centered therapeutic theory into her ExAT theory of transferring between art forms/modalities, which she named the Creative Connection. Mitchell Kossak (2015) proposed that the improvisational elements of art-making creates therapeutic healing. More recently, Carmen Richardson (2016) has developed an ExAT treatment model for work with adolescent survivors of trauma. Richardson's work inspired this thesis in its evolving of ExAT into more defined clinical formulations. As Nathalie Rogers (1993) stated, "Part of the psychotherapeutic process is to awaken the creative life-force energy. Thus, creativity and therapy overlap" (p. 1).

While there are many theories, principles and practices of ExAT that differ from practitioner to practitioner, at its core ExAT is the practice of integrating

imagery, storytelling, dance, music, drama, poetry, movement, and visual arts, to nurture growth, development and healing (Rogers, 1993; Richardson, 2016). What differentiates ExAT from individual expressive therapy modalities (i.e. art therapy, music therapy, drama therapy, dance-movement therapy, etc.) is not only ExAT's use of multiple traditional art modalities (painting, dancing, acting, etc.) but a belief that all play, creation, and expression can be therapeutic practice (Rogers, 1993). McNiff (2009) spoke to the intrinsic similarities and overlapping concepts between various art forms, such as movement, narrative, metaphor, embodiment, play, spontaneity and self-realization. Additionally, expressive arts therapists find therapeutic healing in the transfer between artistic modalities: moving from painting into dancing, drumming to poetry (Donohue, 2011; Knill, 2005, Kossak, 2015; Rogers, 1993; Richardson, 2016). This movement between modalities is known as intermodal transfer (Donohue, 2011). By moving through art modalities, a client can access a flow of art making that continually stimulates the senses and awakes creativity (Knill, 2005). The intermodal approach pushes clients to move around the Expressive Therapies Continuum, a hierarchical theory of expressive therapies where different areas of the brain and levels of creativity are stimulated by different artistic experiences (Hinz, 2009). ExAT intermodal approach utilizes multiple forms of verbal, non-verbal and bodily expression, which involves both of the brain's hemispheres as well as cortical and subcortical processing (Cozolino, 2002). ExAT recognizes the power of each artistic modality and the movement between modalities to inspire

healing, creativity and change (Donohue, 2011).

Solution-Focused Brief Therapies and The Expressive Therapies

There are notable examples of the use of SFBT with other specific modalities of expressive therapies. By examining the use of SFBT with these more singularly dimensional modalities, one can explore the potential for integrating SFBT with intermodal ExAT techniques, interventions and theory. This section reviews the use of ExAT practices within a SFBT context.

In their 2009 case study, Ylonen and Cantell created a model integrating SFBT with Dance Movement Therapy (DMT). Working with refugee minors, Ylonen and Cantell (2009) used the narrative aspects of DMT to encourage self-esteem, goal-setting and solution-building. These researchers found that their clients were able to build solutions through narrative dance. In their practice, Ylonen and Cantell (2009) did not introduce the SFBT techniques explicitly, but did integrate SFBT interviewing techniques into DMT directives, maintaining their work as SFBT-informed practiced and calling for more development of the combination of SFBT and DMT theory and practice.

In their work with adolescents in an inpatient facility, Tyson & Baffour, (2004) found success integrating Music Therapy principles and practices with a SFBT approach, while also employing visual arts and creative writing. Tyson and Baffour (2004) directed their patients to find inspiration and to recognize their strengths within different art modalities, then to apply these strengths in building solutions to their presenting concerns. Their clients responded to this

method through an observable increase in engagement and hopefulness.

Matto, Corcoran, and Fassler (2003) built an effective cohesion between Art Therapy and SFBT. They stated, “art therapy works toward collaboration between practitioner and client. In directed art experiences, the practitioner sides with the client by soliciting visual representation of the client’s reality” (p.266). The same study found significant similarities between the manner in which an art therapist collaboratively processes artwork with a client and the solution-building interview techniques of SFBT. According to the study, in art Therapy/SFBT, the clinician collaborates with the client by offering solution focused art prompts. After the artwork is completed, the clinician uses a client-centered language in assisting the client to elicit personal metaphors and narratives from their artworks. Matto, Corcoran and Fassler (2003) applied the SFBT conversational model with Art Therapy, and additionally applied therapeutic art-making to SFBT techniques such as scaling and the miracle question.

Moosa, Koorankot, and K (2017) combined SFBT and Art Therapy in their work with refugee children. Their study used visual arts to overcome differences in culture and language to help their clients experience their miracle question through drawing and painting. While their process did not seem as comprehensive as Matto, Corcoran and Fassler’s (2003), they derived an effective method when using art making in the context of the miracle question.

Current research offers concepts and methods for using expressive

therapies within the SFBT model. The use of narrative dancing/drama can lead clients to discover new possibilities (Ylonen & Cantell, 2009). Visually representing the miracle question offers clients a way to explore, express and process their miracle (Moosa, Koorankot, & K, 2017) In order to identify problems, clients can act or visualize the problem: “if your problem was an animal” for example (Matto, Cocoran, & Fassler, 2003). Using visual arts, clients draw their problem, identify the strengths they exhibit in their drawing, and reframe them in a new way (Matto, Cocoran, & Fassler, 2003). Implementing music therapy interventions, clients can write a motivational song or choose a personal theme song and write a story to go with the song. (Tyson & Baffour, 2004). These studies show great potential for combining techniques and theories of SFBT and other expressive therapies.

Exploring Solution-Focused Brief Expressive Arts Therapy

By reviewing relevant literature, the combination of SFBT and expressive therapies seem to expand and elucidate on the theories of the respective approaches. These reviewed studies show not only a harmony between the theories but also potential for SFBExAT as a new and relevant model.

Solution-building is a foundation for SFBT (Froerer & Connie, 2016). To build a solution is, in essence, a form of creative aspiration: an expression of a new narrative. This concept has been effectively and naturally adapted with expressive therapy interventions (Matto, Cocoran, & Fassler, 2003; Moosa, Koorankot, & K, 2017; Tyson & Baffour, 2004; Ylonen & Cantell, 2009).

SFBT and expressive therapies, including art therapy and dance/movement therapy, have been utilized when working with refugee youth (Moosa, Koorankot, & K, 2017; Ylonen & Cantell, 2009). Both studies found potential in integrating ExAT and SFBT in that artistic expression was a useful tool for transcending language and culture, and that focusing on solutions was pragmatic and concise in unstable therapeutic settings. Both studies reported that through expressive therapies, clients were able to create, innovate, express, and embody their solutions beyond the scope of solely talking. In describing the compatibility of art therapy and SFBT, Matto, Corcoran and Fassler (2003) explained, "Art therapy is a way to operationalize specific SFT techniques, allowing for multi-sensory engagement that includes visual and motor modalities" (p.265). This multi-sensory engagement is only intensified when comparing SBFT to the multi-art modality method of ExAT. Froerer and Connie (2016) spoke to the importance of language in SFBT, referring to the process of solution building as "a collaborative language process between client(s) and the therapist that develops a detailed description of the client(s)' preferred future/goals and identifies exceptions and past successes…" (p. 32). Goal development and solution-building can move beyond collaborative spoken language to a collaborative artistic expression.

When one views creative expression as a language, the potential of SFBExAT becomes clearer. The artistic expression is a form of communication that can communicate feelings often hidden by verbal language (McNiff, 2009).

The research shows that the use of expressive arts therapies works harmoniously with, while also expanding upon, the language and techniques of SFBT.

Relevance of SFBExAT Explored

In the development of an SFBExAT intervention, it is important that the intervention is effective and realistic for clients and patients in a modern therapeutic environment. A review of the concepts that make SFBExAT relevant for clients and clinicians will follow.

Benefits and Necessities of Brevity

The Helsinki Psychotherapy Study found that those practicing SFBT averaged 10 sessions, as opposed to long-term psychodynamic therapy, which averaged 232 sessions or short-term psychodynamic therapy with an average of 18.5 sessions (Gingerich & Peterson, 2012). Clients who received a SFBT approach reported an increased sense of success within fewer sessions in a shorter timeframe than with other psychodynamic approaches (Gingerich & Peterson, 2012). Focusing on ExAT through an SFBT lens may increase the potential for utilizing expressive therapies within the structure of institutional treatment plans, as well as in differing therapeutic environments.

SFBExAT and Adolescence

ExAT and other expressive therapy modalities have great potential when working with adolescent populations (Richardson, 2016). ExAT is effective with teenagers as it offers a non-verbal means for expression and a gentler way to approach difficult subjects, while also accessing their innate creativity (Moosa,

Koorankot, & K, 2017; Richardson, 2016; Riley, 1999; Tyson & Baffour, 2004). Two prominent meta-analyses of SFBT, both citing about a dozen studies of SFBT with teens, found data supporting its effectiveness with teenagers (Kim, 2008; Schmit, Schmit, & Lenz, 2016). De Jong and Berg (1998) reported that 89% of teenagers made progress towards their goals with SFBT intervention. Promising studies on the integration of solution-focused therapies and expressive therapies with adolescent populations is available (Matto, Cocoran, & Fassler, 2003; Moosa, Koorankot, & K, 2017; Richardson, 2016; Tyson & Baffour, 2004). Art therapist, Riley (1999), proposed that expressive, solution-focused, and brief therapies are all beneficial for teenage populations when administered singularly or in conjunction.

In my experience that teenagers may be resistant to expressive therapy. Adolescents may be mandated, or feel as though they are mandated, to attend therapy. SFBT is an effective model for engaging involuntary clients as it focuses on the client's own understanding and strengths (De Jong & Berg, 2001). As a client-centered approach that focuses on clients' innate wisdom and creativity, SFBExAT has the potential to work with teenagers by giving them the controls and art supplies to create their own solutions. Many adolescent clients are resistant to therapy due to their preconception that therapy will last indefinitely (Riley, 1999). Solution-focused brief therapeutic approaches not only encourages teens to participate in therapy but also suggests that, no matter the seeming immensity of their problem, a solution is possible (Riley, 1999). A

more skeptical opinion on SFBT's effectiveness with teenagers may be that teens are drawn to the instant gratification SFBT offers over the more incremental changes possible in longer-term therapies (Schmit, Schmit, & Lenz, 2016).

SFBT Interviewing and Client-Centered Approach

In practicing SFBT and ExAT, there is not only emphasis on specific directives but also on the approach, perspective, and intention of the clinician (Rogers, 1993; Trepper, et al., 2012). ExAT is unique in allowing for clients to express themselves while using their creations as a means for self-exploration. Just as the SFBT therapist assumes that clients are the expert on their own reality and solutions, ExAT therapists believe that the client is the sole proprietor of their artworks' meaning and purpose (McNiff, 2009). ExAT and other expressive therapies utilize inquisitive practices to solicit a client's own exploration and understanding of their art (Matto, Cocoran, & Fassler, 2003). Just as traditional SFBT practitioners use language-based interviewing to affirm and amplify clients' goals, successes, strengths, and resources, those utilizing SFBExAT can utilize art-making to accomplish these same objectives. SFBT interviewing aspires to assist clients in revealing their problems over deconstructed exposure (Berg & De Jong, 1996). This deconstructed exposure is made apparent through the details, metaphors, experiences, and creation of artistic expression. Moora, Koorankot, and K (2017) achieved the same affirmation and amplification through visual art. Beyond simply using arts to evade language and cultural barriers, their uses of drawing and painting allowed clients to surpass language

to find new resources for building solutions. Art-making furthers personal investment in their process of change (Matto, Cocoran, & Fassler, 2003). Making art helps the client externalize their problem, seeing it outside of and apart from themselves. These studies show the effective use of SFBT language in a non-verbal context.

Method

I developed and implemented an intervention with the hopes of discovering how SFBExAT may be implemented in clinical practice. The method is based in SFBT and ExAT theories as well as research that integrated both approaches. I hoped to examine its use with a particular client while also exploring the method's universal applicability. The project was implemented with one client over three sessions in an out-patient behavioral health department of a children's hospital.

Goals

My goal was the application of differing art forms as a means to express and process the different steps or aspects of SFBT treatment and interviewing. My hope is to use art to visualize problems. Dance/movement would help client embody their miracle. Acting would serve to practice and remember their past successes. Music would express the client's feelings. Through multi-modal and intermodal work, the client will be able to express themselves in multiple dimensions of expression and experience their solution through multiple senses. With this SFBExAT method, the client can have creative tools for solution-

building and artistic evidence of their ability to change. One objective of the project was its effective implementation with the client, meaning the client will participate in the intervention. Another objective was to lay a foundation for the further development of SFBExAT. Ultimately, the hope was for the client to begin to express their solutions.

Subject

This SFBExAT intervention was implemented with one teenage client diagnosed with anxious and depressive symptoms. I consulted with my supervisor and professors to ensure this intervention was in line with the client's treatment plan and goals. The client had been seeing me in an outpatient setting for some time and we had established a notable level of therapeutic rapport. In the name of transparency, the client was informed about the intervention and its relationship to my graduate studies. Including this client as the subject of my project was theoretically sound as SFBT and ExAT are relevant to treating the client's diagnosis and current developmental stage (Berg & De Jong, 1996; Kim, 2008; Gingerich & Peterson, 2012).

The client was a 17 year-old female with a diagnosis of major depressive disorder and generalized anxiety disorder. As a 17 year old, the client was concerned about her symptom's effects on her academic goals, which include applying for colleges. I believe the project was beneficial for the client as it focused her therapy by establishing clear goals while empowering and engaging the client in the therapeutic process.

Process

For this process section I have written my proposed intervention in a directive style. This choice is in the hope that other clinicians may understand and replicate the intervention in their own practice. This section may be viewed as step-by-step directions for implementing this SFBExAT intervention. An explanation and processing of the actual execution of the intervention is explored in the results section.

The proposed method was broken into three sections is carried out over three sessions. I ultimately decided on using three session for a number of reasons: (1) I did not want to rush the sessions, giving patients time to work on their artistic expressions, (2) I wanted to leave time in the sessions for patients to be able to check in with the therapist and be able process or report any pressing information outside of the SFBExAT intervention, (3) I hoped to leave time in session to complete two sections if for any unforeseen reason it was necessary. As I developed the project, three distinct sections became apparent.

Section One: Goal Setting and Strength Building

The first section of the intervention works in two distinct parts. The first part intends for the client to warm up artistically while also clarifying their goals. In this visual art intervention, the client clearly express a sense of self, a goal and an obstacle. This part of the process takes on the goal setting techniques of SFBT through an ExAT experience (Berg & De Jong, 1996). In expressing a sense of self, a goal and an obstacle, the client can reach new meanings, metaphors, ideas,

and clarity (Matto, Cocoran, & Fassler, 2003).

Goal Setting

A large piece of paper or canvas and art materials for painting or drawing are supplied. The client is directed to delineate three vertical sections on the paper. On the section to the left, the client depicts themselves in any way they are inspired. Questions the clinician may ask while the client creates should be strength-based and could include: “Who is the *you* that deserves love?” or “Who are you at your best?”. If the client is unable to connect with these questions due to resistance or a negative sense of self, the clinician might ask, “Who is the person you want to be? Who is the person that got out of bed and made it to therapy today?” Once this depiction of self is completed, client is directed to the section on the right of the paper. Here they are instructed to depict their goal. While the client should be the one to create their own goal, the clinician can help them build their goal through thoughtful questions such as: “What do you hope to accomplish in therapy?” or “Where do you hope to be in three months?” Once the goal is visualized, the client is asked to take a moment to reflect before moving to the third step of the intervention. This last step occurs in the middle portion of the canvas. The client is directed to express the obstacle keeping them from their goal. The clinician can collaboratively build with the client by asking questions such as “What is the obstacle *you* can change?” or “What is the obstacle inside of you?” The clinician then allows the client time to reflect on their completed piece. By working non-chronologically on the paper, the client is

hopefully struck by the final art product, clear metaphor of the obstacle blocking their self from their goal. The opportunity to add or change any part of the finished art piece they feel inspired to change. If a negative reaction occurs, the client should be directed to add a source of strength to accompany their depiction of self. This source of strength may be a person, a personal talent or symbol. Lastly, the clinician asks the client to write a word, sound or name for each section of their art.

Strength Building

For the second section of this first session, the self/obstacle/goal artwork is placed somewhere away from the workspace. The client is given a piece of paper for writing and a writing instrument. The clinician instructs the client to think of personal strengths and/or a time they were proud of themselves. The client is then told that they will, for a short time, become a new character; a newspaper journalist with the assignment to write an article on the client. This article will focus on a specific time the client felt accomplished or on the client's general strengths. If the client expresses resistance, it may be explained that this only needs to be a short paragraph. When the client finishes, they are directed to circle the three most positive or strength-based words in the article. The client is then asked to memorize these words.

Next, the client is informed that they are no longer the journalist with a writing assignment; they are now a famous actor at an important audition. The clinician designates an area that invokes the feeling of a stage. The client takes

the stage. The clinician, taking on the role of the director, explains that the lines of this audition are the three positive words they have memorized. The client performs their three words three times and each time they will be performing in a drastically different movie genre. The clinician may prompt this experiential with the directions to “Say your lines as an action hero hanging off the side of a helicopter over a building where they just saved the day,” and/or “Repeat the lines as a dramatic actor in a scene where the truth is revealed to the world on every TV screen on the planet,” and/or “Now, say your lines as a soap opera star revealing a secret to their romantic interest.” The client could add any genre scenarios they desire. The clinician is encouraged to applaud the performance. Finally, the client is given a large sheet of paper or poster board and asked to write their three words as big possible on the paper. The paper is saved for future sessions. This concludes the first session.

Second Session: Miracle Question

The second session focuses on the miracle question. The session involves mindfulness, visual arts and embodied movement. Before the session, the self/obstacle/goal artwork and the poster with strength words in the room. The client is given paper or a canvas and art-making tools and will be invited to sit comfortably and directed to either close or lower their eyes. When the client is comfortable, the lights in the room will be dimmed to invoke a relaxed state, while relaxing music or sounds can be played softly. The clinician will begin a story of the overnight miracle.

*Imagine you are sleeping on an average night. You sleep peacefully. (*Here the clinician may allow time for the client to fall into mindful relaxation). *While you are off dreaming, unknown to you, a miracle occurs.* (Here the clinician will use a wind chime, singing bowl or other whimsical instrument to invoke a sense of the miracle happening. *Your obstacle has miraculously and suddenly disappeared!* (the clinician will turn on the lights.) *It is time to wake up to live, what you think, is an average day. But you will soon find out your miracle has happened!*

The client should have their eyes open and awareness of being back into the room. The client is instructed to visually depict their miracle day, expressing themselves on the canvas continuously and allowing their creativity to flow uninterrupted. While the client creates, the clinician offers solution-building questions, such as: “How do you discover your miracle has occurred? When do you figure it out? While you were brushing your teeth? On the way to the bus?” The client is advised to answer these questions on the paper, not verbally to the clinician. Time will be left between questions for the client to create their answers. The clinician begins offering more directive questions, “Who else sees that your miracle has taken place? Is it your mother, your friend? How do they know?” After some time, the clinician inquires on how the day differs from an average day now that the obstacle is gone. The clinician asks what feelings might arise in the client as they go through their day without their obstacle. The client is guided to think about where they would be, who would be there and

how what would they be doing a week, a month or even a year after living without their obstacle; would they accomplish their goal?

When the client feels a sense of completion of their artwork, they are directed to stand and enter an open area of the therapy space. The clinician requests that the client walk around the space and act out daily tasks in the manner of an average day with the focus on posture and bodily-engagement. For example, the client may walk to the bus stop with their shoulders slumped and their feet shuffling. The client will then be directed to move and go about their day in a manner they imagine they might if their miracle had occurred. The client is inquired on how their body feels after they have experienced their miracle. The clinician may invoke scenarios for the client to enact, such as how the client greets a friend or walks home from school. The clinician can encourage the client by reflecting the changes they see in the client's movements from baseline to miracle. To conclude the session, the client takes time to name their completed artwork and write it somewhere on the canvas.

Third Session: Exception

The third session is oriented around the exception question, where the client identifies a time, even if only a brief moment, when their obstacle was gone (Berg & De Jong, 1996). Moosa, Koorankot, and K (2017) deemed the exception the *small miracle;* I enjoy calling it the cuter name of mini-miracle.

Again, like the previous session, the art of the past is arranged or presented for the client when they arrive. The client reviews, either alone or with the

clinician, their self/obstacle/goal, strength words, and miracle question artworks. Paper/canvas/art materials are made available for the client. The clinician should admit to client that overnight miracles may not be real, however, mini-miracles do occur. The client takes a moment to think of a time, no matter how short, when they experienced a mini-miracle, a time where their obstacle was gone and their miracle was occurring, or when they met their goal. The client visually represent this mini-miracle moment. The clinician may offer prompts such as "How did you feel while this mini-miracle was occurring? What was different about that day?" When the client feels a sense of completion, they are asked to search their art for people, things or any other element that helped them experience their mini miracle. They are directed to look for anything in the art that may have prevented their experience of the mini-miracle from persisting. The client is then be encouraged to erase, paint over or change these hindrances, as well as add any elements that would help their mini-miracle last even a little bit longer. Finally, they will name their mini-miracle artwork.

Musical instruments are then offered to the client. This instrument may be rhythmic or melodic. They are asked to improvise music that is inspired by their self/obstacle/goal art piece. Once they are ready, the clinician guides them to find a song, pattern, melody, theme or motif that encapsulates their improvisation. Afterwards, the client is next guided to improvise music based on their miracle, big and mini. Again, the client creates a song, pattern, melody, theme or motif based on their miracle improvisation. Finally, the client is asked

to play their self/obstacle/goal song, then to switch to their miracle song. Client switches between these songs a few times, ultimately finishing with the miracle song. Clinician offers an explanation of this musical metaphor:

> We sometimes experience our obstacle and we sometimes experience our miracle. Just because our obstacle appears does not mean we are stuck. Because we have experienced a mini-miracle and we can experience it again. No miracles happen overnight, but we can use our strengths and resources to make mini-miracles happen more often and for longer durations

Now the clinician may reflect back to client the strengths they identified and the hard work they put into these last sessions. At the conclusion of session, client may take their artworks home. Client is given an experiment to try outside of session. Client is asked to pick a meaningful person in their lives and, in this special person's presence, act as though their miracle has actually occurred. The client is directed to continue to act this way until their person notices the change.

This three-session SFBT treatment intervention integrates the SFBT techniques of goal-setting, complementing, miracle question, and exception question with the ExAT techniques of intermodal creative expression, intermodal transfer, and embodiment. The intervention directs the client to build-solutions through creative expression.

Results

In this section, the actual implementation of the SFBExAT intervention

with the client will be explained. The client participated in the entirety of the intervention. The following describes these sessions.

First Session

On arrival at the first session, client one immediately expressed that she was ready for *the project.* The client is inclined towards visual arts and quickly engaged in the self/obstacle/goal experiential. I offered guided questions and thoughts as client drew. As I had expected, she wanted extra time to complete the self-portion of the artwork. I explained that this process was meant to be spontaneous and that the client would be able to elaborate artistically on their piece at another time. The client interpreted the directive at a perceptual/affective level, expressing the self/goal/object figuratively and graphically (Hinz, 2009). For example, the self was a human figure with the characteristic features of the client. The final product looked similar to a comic strip. When the client looked at the final product she expressed surprise at the clear picture she had produced of herself being obstructed from her goal by a clear obstacle. The client was given some additional time to add or change the image in any ways she felt necessary.

The client used most of the time allotted to write her article. When identifying and circling her strength-based words client asked if she could circle as many words as she wanted but ultimately chose only three.

For the reciting of the strength-based words, the client was reluctant to stand and enter the area deemed the stage. I encouraged client to engage by

explaining that she could participate however she felt comfortable as long as she participated. She warmed to the activity and ultimately offered her own additional movie scenarios to play out. The client and I both finished this section of the session with large smiles.

When writing her three words, the client picked personally meaningful colors to write each word and filled the entire large page. I offered compliments on the client's participation, openness, as well as reaffirming the strengths the client self-identified. Client was offered the homework to say these words to herself if her obstacle became present during the week.

Session Two

This session occurred one week after the initial session. Client spoke on a specific issue that was on her mind before engaging in the activity. The client displayed engagement during the introduction to the miracle question. Once the lights were on and the art intervention was introduced she initially began drawing in a small section of the paper, but as time went on the art became very elaborate. Client again appeared to work at the perceptual/affective level, drawing scenes with stick figures (Hinz, 2009). After the client reported she felt finished with her art, she was given questions to ask herself about her artwork. She expressed some concern when she realized clinician would not process the finished product with her. It was explained that the art could be processed at another time and the client was encouraged to trust her own understanding. The client reported that she felt highly inspired by this aspect of the process.

During the movement portion of this session, the client acted out morning ritual routines with a dramatic slumping of the shoulders. When she was asked to transfer to moving/acting out the day after her miracle, she noticeably straightened her posture. The client was allowed to act out her miracle without much clinical direction; however, after only a few minutes she expressed a feeling of disengagement. I began to narrate the client's day, "How would you walk to school with your solution achieved? What would you do differently on the way?" I also played characters informed by client's instruction, such as the teacher who is happy that client completed her homework or her brother who is surprised she is not sleeping in the afternoon. Near the activity's end, the client reported difficulty in acting out the miracle. The client was asked to simply move in a way that expressed her feelings about the miracle. She responded with increased engagement to this more expressive take on the intervention.

The client left session with the homework to try to act as though her miracle had occurred and see if any of her family members would notice.

Session 3

The third session took place two weeks after the second session due to client illness. After a quick check-in, the client was reintroduced to the art she created and the strength words she wrote in the previous sessions.

To express her exception visually, the client again chose color penciled and created a figurative drawing. The client was then offered a range of musical instruments and decided on a xylophone. When client was invited to make a

song about a *typical* day, she expressed confusion. The instructions were elaborated that this song would be improvisational and open to her interpretation. Client engaged in freestyle playing and, after some minutes, was able to condense her song into a simple motif. The motif was a single reoccurring note with an offbeat rhythm. Client was given time to reflect on how she felt during her big and mini-miracles before performing the miracle song. Her playing utilized more notes and had a spritely rhythm. When client was asked to focus this song into a motif she created a melody with a very silly feel, which made her laugh. Despite her humorous take on the miracle song, the effect was evident when client alternated between the everyday song and the miracle song. Once client stopped playing, the possible metaphors of this experience were discussed. Client clearly explained how she felt that even if she is having a tough day it can change for the better.

To finish the session, I offered the client praise for her engagement and reiterated how she had embodied her strength words throughout the last three sessions. Possibilities for homework/experiments were discussed and it was decided that the client would remember to compliment herself anytime she felt her miracle occurring even if she could not sustain it indefinitely. She decided to leave her art with the clinician to be processed in a fourth session.

Discussion

This three-part SFBT was successful on a few levels. On one level, the client was engaged in art making and its inherent therapeutic healing (McNiff,

2009). On another level, the client identified goals, personal strengths and began building solutions (Berg & De Jong, 1996). The client engaged in intermodal expression, where she could integrate her solutions through different senses and experiences (Knill, 2005). Through the integration of SFBT and ExAT into a SFBExAT model, the client ultimately was able to visualize, embody, and express her goals, strengths and solutions.

Materials

In keeping with the client-centered nature of SFBT, the client was allowed to choose her art-making materials. Colored pencils were the only material client chose to work with over the three weeks. This choice of material is linked to how client interpreted the artistic directives, which she did in a figurative, graphic and narrative manner. While this choice was left to the client and appears to have been beneficial for her, I question how this intervention may have been different if client was only given pastels or told to finger paint. Would the miracle artwork have been more metaphorical or kinesthetic (Hinz, 2009)? The benefit of this could have been to open the client to different thinking and experiences (Knill, 2005). However, by allowing the client to choose her own materials and means for expression, the client has been given the control over her own solutions.

Processing

In my past experiences with this client, she has been very reluctant to process her art in a meaningful way with me. I decided not to process the art

during these three sessions to allow the client to decide what her art means to her without the pressure of an outside witness. Not emphasizing processing the artwork frees the client from the concern about the finished product and allows them the freedom to experience reflection and expression in the moment (Kossak, 2015). I believe this choice was effective. The client was able to create art free from any reality but her own, while being empowered to listen to her own process.

By not making the processing of art mandatory, the client felt the desire to talk about her art emanate from herself. In a follow-up session, we did return to the artworks for processing from the client.

Strength-Building

When working with teens, Tyson and Baffour (2004) put particular attention on building self-esteem in their patients as a key aspect of their expressive SFBT treatment. By putting focus directly on the client's personal strengths through expressive therapies techniques, the client was given a creative way to identify and celebrate her own sources of strength. The selection of three words offered an indirect way for the client to compliment herself and create a personal-strength mantra of sorts. For the client, positive self-talk is difficult. Using art as a means for strength-building circumvented her resistances.

Visual Arts

The use of visual art gave the client the opportunity to express her feelings

and see her thoughts. The art pieces allow the client to externalize, visualize and express the possibilities and effects of their miracle (Moosa, Koorankot, & K, 2017). By expressing this mini-miracle experience visually, the client can process the event while adding resources and changing limitations (Matto, Cocoran, & Fassler, 2003). The visual art expression can be narrative, metaphorical, literal or expressive while still serving the client in their solution-building (Matto, Cocoran, & Fassler, 2003). The level of artistic skill is not important, as the art only has to have meaning for the client.

Movement

The use of movement was difficult for the client to access. The client was initially resistant to the movement portion of the miracle question intervention but with time and proper clinical directives client ultimately engaged. The movement mixed expressive and narrative elements, which took the miracle off the page and created a bodily experience. The use of movement can offer the client a somatic understanding of the miracle apart from the visual one she experienced with drawing (Ylonen & Cantell, 2009). Through movement, the client saw how her body changed quite drastically between her baseline experience and when she experienced her miracle.

Drama

While Ylonen and Cantell (2009) take a DMT approach to SFBT, the narrative elements of their work and my own experiences as an expressive therapist gave ample inspiration to integrate drama therapy into the intervention.

By acting out the miracle day or auditioning with the strength words, the client was allowed to explore her solution from a different perspective from talking or drawing. A clear example of this was when the client acted out a scene with her brother during her miracle. The client had not otherwise thought about how happy her brother would be to see her achieve her goal. While the narrative aspect of the miracle movement was not initially used, this clinician integrated it to meet the client's needs. It became apparent in this exchange that, clinicians who want to practice SFBExAT need to be skilled in the practice of ExAT, as well in the SFBT approach.

Intermodal Transfer

While the client fell into a comfortable pattern when engaging in visual art with colored pencil, by using intermodal transfer and multiple art modalities, the client is made to move between different states of being and levels of expression (Knill, 2005). This intermodal experience allows the client to experience her solution through different hemispheres of the brain and multiple senses of the body (Hinz, 2009). If the interventions had been solely visual arts based, the client's multi-sensory engagement in the process would have been limited. The project utilized and transferred between visual arts, free writing, poetry, drama, movement, and music. The client employed imagination, narrative, performance, improvisation and embodiment (Donohue, 2011; Knill, 2005; Kossak, 2015; McNiff, 2009). The use of multiple art forms, some familiar to the client and some not, offered new avenues for expression and solution-building. Overall, the

client has experienced the therapeutic benefits of multi-modal expression and intermodal transfer invoking different levels of experience on the Creative Continuum and Expressive Therapies Continuum (Hinz, 2009; Knill, 2005; Roger, 1993).

Time Frame

The three-session plan for this project worked out very well in regard to fitting in necessary time for client to engage in the multiple activities. The client asked for a fourth session, and I agree that a fourth session would have great benefit. In the follow-up session, client expressed the felt benefits of presenting and processing her art, her goals, and her solutions. During this follow up, clinician continued to take a SFBExAT approach, by listening, selecting and building from client's perspective (Trepper, et al., 2012).

Implications

It seems apparent that SFBExAT could take on many forms depending on the strengths of the clinician or the needs of the client. To use more or less drama, dance, visual art, free-writing, or integrate new ideas seems beneficial. As Trepper, et al. (2012) state, a principle of SFBT is "If something is working, do more of it" (p.33). In the same spirit, clinicians skilled in SFBExAT should understand that the process is one that can be adapted and changed as long as the intention is to benefit the client.

Limitations

While the creators and experts in SFBT have researched and theorized the

practice in the attempt to create a *true* practice of SFBT, they acknowledged that an aspect of personal therapeutic style or interpretation is an implicit part of therapy (Berg & De Jong, 1996; De Jong & Berg, 2001; Gingerich & Peterson, 2012; Trepper, et al., 2012). The SFBExAT project I proposed and implemented is clearly distinct from a *pure* SFBT approach. For example, my project did not include scaling to monitor client's sense of solution completion. I hope others' and my future research will find new and exciting ways to implement SFBExAT techniques.

The ExAT interventions used in this project may not be the perfect or sole fit for each corresponding SFBT technique. For example, the improvisational miracle song intervention could be replaced with a poetic writing intervention. I would propose that future clinicians change the ExAT interventions and modalities as they see fit for their clients or their own professional strengths.

Conclusion

SFBExAT proposes a new therapeutic model through the conjoining of the multisensory expression of ExAT with the goal-oriented approach of SFBT. The SFBExAT project showed potential benefits for each therapeutic modal by focusing ExAT principles and practices while expanding the creative language of SFBT theories and techniques. Relevant literature has studied the benefits of a SFBT approach with expressive therapies.

The three session long intervention was sectioned according to SFBT techniques. These techniques included strength building, goal setting, the

miracle question, exceptions and homework. Each SFBT technique was actualized through the creative expression of ExAT practices. The use of ExAT intermodal interventions was meant to engage the client viscerally in the SFBT solution-building process through play, artistic expression, embodiment, improvisation, and movement. ExAT modalities utilized in the project were visual art, writing, drama, dance/movement, and music, as well as, intermodal transfer. SFBT interviewing approach and techniques were integrated into the ExAT interventions to create solution-focused and goal oriented directives. While there are many interpretations of SFBT and ExAT, this SFBExAT project stayed true to essential principles and practices of each therapeutic modal while expanding on these techniques and theories. This paper and project will hopefully push further understanding and advancement of SFBExAT. SFBExAT is a modern, relevant, pragmatic and accessible modal with implications for various settings and populations. This paper and project offer grounds for further study and use of SFBExAT.

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