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Storytelling as an Expressive Arts Therapy Intervention

with Children via Telehealth

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Capstone Thesis

May 5, 2021

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Abstract

As an expressive arts therapist in training working in the midst of a global pandemic, I sought to develop a creative, safe, accessible, and effective intervention for children via telehealth during a time of great uncertainty. Coronavirus 2019 has had a massive impact on mental and physical health and disrupted the lives of billions across the globe; the pandemic also forced mental health professionals to online formats. I found a significant lack of literature around expressive arts therapy via telehealth. Through considering theoretical approaches from cinematherapy, narrative therapy, metaphor therapy, play therapy, and expressive arts therapy, I developed an eight-week storytelling intervention for four clients between six and eleven years old at an outpatient child and family counseling center. I worked collaboratively to create six unique stories with each client to begin to conceptualize parts creatively and safely. The intervention was a successful and incredible experience for myself and my clients. Common themes across clients included family, isolation or loneliness, needing help, helping others, confusion, and problem-solving. In the end, I was astounded at their insight, reflection, and growth. I hope this intervention can help other professionals who may struggle with implementing expressive arts therapy via telehealth just as I did.

Keywords: Expressive arts therapy, storytelling, children, telehealth, telepsychotherapy, narrative therapy, cinematherapy, metaphor therapy, play therapy, COVID-19, pandemic, mental health

Storytelling as an Expressive Arts Therapy Intervention with Children via Telehealth

> *I tell a story, and therefore I exist.* I exist because there are stories, and if there are no stories, we don't exist. We create stories to define our existence. If we do not create the stories, we probably go mad. (Kapur, 2020, 7:55)

We have all heard the spiel at this point: we are living in *unprecedented* times filled with uncertainty in the midst of the outbreak of Coronavirus 2019 (COVID-19) that descended upon our society here in the United States in early 2020. Our daily normal, fluid social activities are no longer the safe passive interactions they once were; from crowded restaurants to health appointments, there are now significant risks associated with any human contact. In their research on the impact of the pandemic on mental health, Marroquín, Vine, and Morgan (2020) introduce the highly contagious COVID-19 as an "inherently social phenomenon" (p. 1) that requires limiting social contact through social distancing and stay-at-home orders to contain its airborne spread. As a result of these orders and general pandemic fear, there has been a significant increase in depression, generalized anxiety, acute stress, and intrusive thoughts across the population (Marroquín et al., 2020). Many mental health providers have moved to online formats exclusively to continue providing services during this time of exceptional need, for this pandemic is one of both physical and mental health danger and disruption.

During these times, art has the power to connect, hold, and heal. Gupta (2020) believes this because art "reminds us of the powerful will of the human spirit to remake and transform both internal and external realities… [and] empowers us to *participate*, having faith in our ability to make a difference" (p. 594). For myself as an emerging expressive arts therapist at my first clinical internship suddenly thrusted into telehealth, sitting at home staring at a computer screen,

I had no idea where to start. Expressive arts therapy (EXAT) in general relies heavily on in-person resources. Working with the arts remotely through telehealth was never introduced in my courses nor covered in a single text I read. Experientials frequently depend on art materials that counselors or group leaders themselves provide for clients. Physical supplies and physical boundaries, as leaving one setting and entering another can both physically and mentally transition one to a new activity or feeling. A pervasive feeling of stuck began to settle in, and I realized my first ever clinical work would be sitting at home, staring at a computer screen. I began to research EXAT and telehealth and found an overwhelming dearth of information. The lack of existing literature meant that I would be on my own for the most part, finding a way to navigate my little corner of the immense mental health crisis at hand. At first, I was daunted by the task of adapting EXAT interventions to this new online world. I found that translating the arts to telehealth settings demands creative solutions to once physically collaborative work. Given my placement with an outpatient child and family counseling center, I knew my methods would need to be designed for students who were already spending hours a day staring at a screen, doing school from home remotely.

I began to build a repertoire of ideas inspired by these schools of thought that would lend themselves to both creative and therapeutic experiences with young clients remotely. I sought to develop an accessible EXAT intervention that would be useful specifically for children via telehealth and adapted to at-home settings with limited supplies. I discovered storytelling and narrative therapy, which opened more doors to deep dives into cinematherapy, metaphor therapy, and play therapy. Storytelling as an intervention would be a creative and playful way of exploring, understanding, and coping. Burns (2005) shares that stories are "words that invite the listener on a journey into a world of imagination where reality may be suspended and learning

can be potent" (p. 3). Metaphor and externalization present ways to take a step back and inspect the self's rich and complex feelings and experiences rather than condensing the whole self to a thin narrative lacking dimension. The goal is to name these parts, where they come from, and when and why they emerge. Once the part is identified, the counselor explores the relationship one has to the part through narrative about their history and relationships. Russel and Carey (2002) write,

> It is the rich description of the alternative stories of people's lives that provides people with more options for action and therefore enables significant changes to occur. Life is not only about problems and difficulties… It is also about hopes, dreams, passions, principles, achievements, skills, abilities and more. (p. 82)

I realized that the principles of playful storytelling through narrative, metaphor, and externalization lend themselves to expressive arts theories. Using these concepts would offer creative expression through play, imagination, experimentation, and exploration for my young clients. Plus, these interventions necessitate minimal material and are perfectly suited for telehealth. I just had to design it.

In this paper, I will review relevant research and literature about the past year, COVID-19's global impact both physically and mentally, the utilization of telehealth, and compendiums of theories followed by a description of my intervention methodology. I tracked my experience through journaling after each session and, in conclusion, did my own shortened storytelling exercise to explore my experience around myself as an expressive arts therapist and the intervention as a whole. Finally, I will discuss my method's results, general themes, limitations, implications, applications, and further use in the EXAT community.

Literature Review

In order to understand how this thesis came to be, we must first examine the context in which I am applying my work. COVID-19 has produced both a physical and mental health crisis that is taking the world by force. At the time of submitting this paper in May of 2021, the world has lost 3,250,439 lives, and the United States has lost 592,948 on its own citizens, making it the country with the most officially reported deaths in the world (Worldometer.info, 2021). These heartbreaking numbers continue to rise. In addition to the amount of collective grief our society is facing, there is pervasive fear, uncertainty, and fatigue as the pandemic ravages. Many researchers are undoubtably finding that the effects of COVID-19 have an intense impact on mental health and counseling services (Imran, Zeshan, & Pervaiz, 2020; Marroquín, Vine, & Morgan, 2020; Rettie & Daniels, 2020; Rosen, Glassman, & Morland, 2020; Villano, 2021; Wade, Gies, Fisher, Moscato, Adlam, Bardoni, Corti, Limond, Modi, & Williams, 2020). Rosen and their colleagues (2020) predicted that the global pandemic will increase levels of psychological distress for countless people as they experience "persistent fear; illness; social isolation; economic stress; resource loss; or the death of a family member, friend, or patient" (p. 174). This distress may be exacerbated by the prevailing 24-hour news cycle and social media influence that creates unparalleled exposure in real time, unverified information, and aggravation of mental distress (Rosen et al., 2020; Imran et al., 2020). As a result of economic, social, and emotional disruption, some individuals will develop chronic long-term issues (Rosen et al., 2020). Studies have shown that "genetic predispositions are modified by environmental influences, such as those experienced during a pandemic, and affect learning capacities, adaptive behaviors, lifelong physical and mental health, and adult productivity" (Araújo, Veloso, Souza,

Azevedo, & Tarro, 2020, p. 2). Distancing required to reduce transmission simultaneously disrupts social support networks on a variety of levels that leads to emotional distress, depression, anxiety, insomnia, acute stress, intrusive thoughts, and post-traumatic stress (Marroquín et al., 2020).

These overwhelming consequences are hard enough for an adult to manage, let alone the children that are significantly impacted by this global calamity. While adults have more severe physical symptoms of COVID-19, children arguably are having exceptionally acute mental health symptoms with even greater consequences. According to pandemic studies similar to COVID-19, "excessive concern with cleanliness, excessive fear of falling ill or losing a loved one, concern for the elderly, increased domestic accidents, mood disorders, anxiety disorder, panic, or obsessive-compulsive disorder, and post-traumatic stress are consequences that children and adolescents may experience" (Araújo et al., 2020, p. 6). Children are therefore especially at risk because of their stage of development, cognitive abilities, propensity for anxiety due to isolation, and familial stress with potential presence of at-home threats.

There is not a lot of research or data available that looks specifically at the impact of epidemics on children's growth and development (Araújo et al., 2020). Araújo and their colleagues (2020) found that the existing literature declares:

> Balanced nutrition, immunity to diseases, restful sleep, a family environment rich in positive stimuli, and a high-quality educational system as the fundamentals for optimal child growth and development. All these fundamentals are relevant to the prevention of toxic stress and for the development of strong and lasting neural connections in the child's brain. (p. 5)

Toxic stress impacts neurological development, cardiovascular systems, social development, sleep routines, and activity levels (Araújo et al., 2020). These invisible symptoms precipitate mental consequences. Children do not yet have the language or cognition to label, process, and communicate their fears and feelings like adults and are therefore currently struggling to regulate themselves in this time of crisis (Imran et al., 2020; Villano, 2021). Children find it hard to comprehend the pandemic's magnitude and impact because of its incorporeality (Villano, 2021). Imran and their colleagues (2020) assert that "children are particularly vulnerable because of their limited understanding of the event. They are unable to escape the harms of the situation physically and mentally as they have limited coping strategies" (p. 68). Children are therefor in "cognitive overload" (Villano, 2021, para. 10). The virus is seemingly everywhere, yet they cannot see it and may feel powerless to its contagion.

Fear of viral spread lead to social distancing measures and school closures, leaving millions of students out of school for over a year now (Villano, 2021). School closures and separation from friends leads to increased amounts of isolation, stress, and anxiety in children (Imran et al., 2020). Imran and their colleagues (2020) go on to write that:

> The rapid rise in the number of infected cases and deaths, disruption of daily routines, home confinement, fear of infection, social distancing from peers and friends, and lack of access to educational resources have created a feeling of uncertainty and anxiety among the children and the adolescents. (p. 68)

Children no longer have access to "external support networks such as school, tutoring services, friendly environments, and play activities" (Araújo et al., 2020, p. 7). Students are grieving the way things used to be, getting lost in the furious current of disappointment and uncertainty, and struggling to organize their thoughts, feelings, and temporal orientation. Clinical social worker

and family therapist, Jennifer Kelman, shares that children's sense of time differs from adults because "they live their lives in a series of events: practice, dance recital or someone's party. None of those things have happened normally in a year" (as cited in Villano, 2021, para. 20) Kelman goes on to emphasize that many children may be stuck in grief phases anger and depression (Villano, 2021). Villano (2021) writes, "It doesn't even matter how dramatically kids' lives have changed, experts say. The fact that disruption has become normalized is traumatizing enough" (para. 6). Araújo and their colleagues (2020) warn us that "depending on levels and kinds of support, high and continuous stress may either be tolerable or become toxic to children and adolescents" (p. 2). This paints a critical picture of the mental state of the children in the world right now, particularly in countries such as our own that do not have control over the pandemic and its spread.

In addition to their own personal stress, children are also severely at risk of injury from their family's economic and psychological well-being. Caregivers have lost financial stability, safe and reliable childcare, and social contact and support (Imran, 2020). Extensive research shows that "fear can be contagious, and children are extremely sensitive to the emotional state of the adults around them, who are their essential source of security and emotional well-being" (Imran, 2020, p. 68). In response to the pandemic, "many caregivers have experienced symptoms of post-traumatic stress, confusion, anxiety, and anger" (Araújo et al., 2020, p. 7). Araújo and their colleagues (2020) stress that "the pandemic experience of COVID-19 aggravates the rates of substance abuse, domestic violence, and untreated and pre-existing mental health problems" (p. 7). This leads us to believe that children are at greater risk of abuse and exploitation at the hands of caregivers, which is compounded upon by the fact that valuable, lifesaving organizations and resources are harder to access (Imran et al., 2020). When conflict

exists in the home, children frequently internalize and self-blame when they have no idea who to blame. This is why developing a nurturing, caring therapeutic alliance and implementing an accessible, safe telehealth intervention a space for my young clients was critical.

Though it existed in fringe systems far before the pandemic, telehealth has never been so widely used and extensively necessitated. The pandemic demands flexibility and access with highlighted sensitivity to disaster mental health knowledge and considerations (Rosen et al., 2020). *Telepsychotherapy* is defined as conducting psychotherapy remotely via telehealth mediums such as telephone or video conferencing (Rosen et al., 2020). Individuals have a growing acceptance, comfort, and frequency with technology that works in favor of online services (Wade et al., 2020). While both therapist and client remain safely at home, telepsychotherapy can be used to "provide support to help distressed people cope during a period of high stress and social isolation [and to] remotely treat people who have developed significant posttraumatic stress symptoms" (Rosen et al., 2020, p. 175). Wade et al., (2020) writes, "Numerous studies have supported the acceptability and efficacy of telepsychotherapy services, suggesting that it may be just as effective for many diagnoses and therapeutic issues as traditional psychotherapy practices" (p. 334). Other studies have shown that despite technical difficulties, telehealth has the ability to significantly reduce symptoms associated with anxiety, depression, post-traumatic stress disorder, and anger management, and clients rate telehealth with high overall satisfaction that is no statistically significant differences with face-to-face therapy (Springer, Farero, Bischoff, and Taylor, 2016; Wade et al., 2020).

The success of telepsychotherapy relies heavily upon clinician comfort, adaptability, willingness to step outside their comfort zone, and establishment of safety protocols (Rosen et al., 2020; Springer et al., 2016). Rosen and their colleagues (2020) go so far as to declare

telepsychotherapy as "not only feasible, but in many cases preferable" (p. 184). This research was particularly encouraging to hear, as "the usefulness of telepsychotherapy for children and adolescents with emotional and behavioral difficulties is particularly pivotal now, because the current climate may exacerbate their problems" (Wade et al., 2020, p. 333). Rosen and their colleagues (2020) suggest telehealth interventions should focus on strength-based approaches, positive coping strategies, and validation of pandemic-related uncertainty and disruption to establish safety, calm, self-efficacy, hope, and connection.

In regard to EXAT through telehealth, there is a significant lack of existing literature. Springer and their colleagues (2016) discuss the use of *experiential interventions* through telehealth as a way for clients to "experience themselves and others differently… [and] be more expressive" (p. 149). Experiential interventions give clients "alternative ways within the restrictive environment of tele-mental health to be heard and to feel that their experience is valued, providing emotional depth and connection" (Springer et al., 2016, p. 149). Therapists must appropriately manage emotional vulnerability in experiential work to assure safety because they are not physically present if there were to be an emergency (Springer et al., 2016). Establishing safety in an online format includes knowing the clients' location, confidently managing clients' emotions, moving at an appropriate pace for the clients' process, and respecting the uniqueness of clients' emotional experience (Springer et al., 2016). My internship site includes client and clinician location in progress note documentation for this very reason. I believe experiential interventions through telepsychotherapy have the power to provide an enriching experience for clients, strengthening clients' emotional disclosure and the therapeutic alliance.

The only actual information about EXAT via telehealth in concrete practice is Levy, Spooner, Lee, Sonke, Myers, and Snow's (2018) work with rural veterans. They assert that remote EXAT has the ability to benefit those experiencing depression and anxiety by improving one's quality of life and motivation (Levy, et al., 2018). When creating art together in a virtual space, Levy and the other authors (2018) stress the importance of a client's verbal description of their artwork because of limited visual abilities due to cameras and screens. Levy and their colleagues (2018) also highlight the phenomenon of camera angle and visibility wherein if a client holds up their artwork, the therapist can no longer see their face or expression. These were considerations to keep in mind as I developed my own intervention. There were no articles to be found about working with children via telehealth using the expressive arts.

My inspiration for storytelling came from an eight-week course taught by Lani Peterson called *Storytelling and Healing* and subsequently from a beautiful, collaborative story writing exercise with one of my first clients at my internship site. I felt the powerful therapeutic potential there in that session and, with guidance from Lani, I dove into the literature to learn more. As I read, there was not a simple one-stop-shop approach, so instead I began to gradually create a mosaic of theories and ideas.

I first and foremost drew from EXAT theory. EXAT is based in using any form of creation as artistic expression, from painting, dancing, writing, to making music. A key element of EXAT is intermodal transfer. Intermodal transfer is the process through which one flows and shifts through different mediums of creativity in order to focus, deepen expression, and "offer less threatening modes for finding words than those habitually used in conversation," (Knill, Levine, & Levine, 2005, p. 130). EXAT theorizes that what comes from artistic expression is its own language to translate and understand in the therapeutic space in order to listen to the psyche

and its needs; essentially, the psyche's experience exists in images and feelings through which the arts express (Knill, Levine, & Levine, 2005). Neuroscience confirms that art therapy accesses the same sensory areas of the brain that encode trauma (Walker, 2015). Walker (2015) declares:

> Philosophers have told us for thousands of years that the power to create is very closely linked to the power to destroy. Now science is showing us that the part of the brain that registers a traumatic wound can be the part of the brain where healing happens too. And art therapy is showing us how to make that connection. (5:21-7:31)

Creativity begins to unpack trauma in a nonthreatening way through a pillar of EXAT: imagination. In one's imagination, everything is in their control and anything is possible.

Cinematherapy contains similar concepts and claims stories foster control, empowerment, and boundaries by containing narratives with "a reliable temporal structural—a beginning in which a conflict emerges, a middle during which the crisis is grappled with, and an ending during which the conflict is resolved" (Gupta, 2020, p. 600). Gupta (2020) writes, "it can be empowering to 'control the narrative' by making a film of one's own. Making movies helps us restore agency, gain mastery, and reduce the anxiety that corresponds with feeling out of control in crisis situations" (p. 600). I was inspired by this theory and its structure, but realized that having the technology to make a movie presents challenges, and the idea of a script felt too rigid to me; its structure is rigid and lacks explanatory thoughts and feelings, as that is left to actors to nonverbally convey. This structured storytelling empowers clients and gives them control in their own creative world.

Storytelling and play are universal, empowering, and restorative (Burns, 2005; Hofler, 2020; Goodyear-Brown, 2010; Gupta, 2005; White, 2005). Data affirms the healing power of

stories, as one study found that health care students who participated in storytelling opportunity "show between 36 and 51 percent decrease in distress" (Braitman, 2019, 7:41). But when tasked with writing a story, some may feel their inner critic rearing its head and telling them they are not a writer, they are not good enough. Hofler (2020) affirms, "sometimes storytelling can be daunting for some people, but we are human. We are natural storytellers… we have a beginning, a middle and an end. That is a narrative. Our memory exists and subsists through the act of storytelling" (10:03). Narrative therapy contains elements of storytelling, but storytelling is not always narrative therapy. Narrative therapy typically relies on a person's life narrative, events, and experiences, while storytelling has much broader and more creative applications.

Narrative therapy seeks to put together a therapeutic, self-directed lens to stories. Carey and Russell (2020) tell us, "narrative therapy doesn't believe in a 'whole self' which needs to be integrated but rather that our identities are made up of many stories, and that these stories are constantly changing" (p. 82). A key component of narrative therapy is *externalization*. Externalization was developed in the 1980s for family therapy work with children and emphasizes separating the person from the problem (Carey & Russell, 2002). Its antithesis, internalization, leads people to believe that they themselves are the problem. Externalizing seeks to identify problems and parts not as living permanently within people but as products that have been socially created over time. Through externalizing, we begin to "'unpack' this trait, to learn about its history and how it is linked to certain problem-solving skills and knowledges that might be helpful at this time." (Carey & Russell, 2002, p. 78). Externalizing makes the client the expert, removes blame which promote relief, increases collaboration, examine power, not just talking about faults and flaws but instead relationships and skills and problem-solving, find alternative ways of being, behaving, responding, reacting, reclaiming lives from the effects of

problems. Specifically, I identify adjectives as a way to identify self-concept through how people describe themselves. By using EXAT to shift the adjective from the self to a character in a story, a child is able to both understand the adjective and explore it as something other than the self.

Stories can mirror our own lives and are a powerful way through which children understand information and make sense of the world. In storytelling, "there are opportunities for children to experience the stories of their lives linked anew with the stories of the lives of others" (White, 2005, p. 13). Their lives can creatively bend and mold to exist through the worlds and characters they create in their own stories with more control than real life. Through externalization, they can address these stories indirectly through what the psyche is ready and willing to explore and share.

Narrative therapy story work can "provide an alternative territory of identity for children to take recourse to in speaking of their experiences of trauma" (White, 2005, pp. 11-12). Given the trauma children are currently living through, they desperately need a creative, non-threatening space to explore their changing stories, to take control over the beginning, middle, and end. A narrative therapist would move into the client's personal story line, but I chose to remain in the realm of expressive arts imagination for a few reasons.

In my experience, telehealth has slowed relationship building and prolonged children's sense of comfort with a unknown person. For this reason, I felt it may be too emotionally unsafe to explore traumatic personal stories mere weeks or months into our therapeutic alliances. Alongside the distance in telehealth is also the fact that trauma has a tendency to be pre-linguistic (Carey & Russell, 2002; Goodyear-Brown, 2010). Walker (2015) shares that "due to advances in technology and neuroimaging, we now know there's an actual shutdown in the Broca's, or the

speech-language area of the brain, after an individual experiences trauma" (4:01). This is where the creativity and play of EXAT is necessary in processing events to which children do not have the words or safety to describe their painful experiences. As an expressive arts therapist, I focused on safe, creative, and collaborative approaches. Thankfully, "children generally have an unbridled creative imagination that makes collaborative storytelling both easy and effective" (Burns, 2005, pp. 24-25). Collaborative storytelling presents an opportunity for problem-solving, either through children finding their own solutions or through "being a metaphor in which the therapist can join the child to help shape an outcome if a solution is not immediately found by the child" (Burns, 2005, p. 249). This collaboration has the ability to both nurture creativity, comfort, and playfulness.

Play is engaging. It is highly important for the telehealth space to be exciting and engaging because so many children can become bored quickly with a two-dimensional screen. Goodyear-Brown (2010) writes "children are naturally drawn to play. Play is inherently fun and is as natural to children as breathing" (p. 25). Play creates a positive mood, facilitates relationship building, establishes a desirable context for leaning, and can heighten a child's awareness of resources and competencies as well as help develop new skills (Burns, 2005). Play is "essential to the process of maturation and the process of healing, serving several functions" (Burns, 2005, p. 37). Play also provides a space to share stories in a nonthreatening, externalized way. Just as Carry and Russell (2002) describe the balance of life, Burns (2005) too believes "life has its beauty *and* its thorns" (p. 10). This inspired me to consider how I would structure the storytelling in a way that would promote this balance in my clients' experiences.

A final consideration for my exploration of telepsychotherapy was the computer screen itself. You inevitably miss nonverbal cues and the very energy of being in the same room with

another person when you communicate exclusively via video. The screen is both a barrier and an inspiration (Kent, 2020). Kent (2020) expands upon the idea of screens, writing that "Screens act as gateways between what is revealed and what is concealed… [and] the laptop, desktop or mobile device screen used from people's homes is an entryway between the personal and the impersonal" (pp. 158-159). Walking the same line between personal and impersonal, I sought to use storytelling as an impersonal way to get personal, a nonthreatening way to both build therapeutic alliance and safety.

Method

As previously established, the purpose of this study was to create an effective expressive arts intervention for children during the COVID-19 pandemic and its telehealth tenure and to learn about myself as an emerging expressive arts therapist. Participants were chosen through their enrollment in services provided an outpatient child and family counseling center in Boston, Massachusetts. As an intern who worked remotely, I met with students from a variety of school districts in and around the Boston metro. I chose four children between the ages of six and eleven with a mix of varying adjustment disorders to take part in this eight-week intervention. Each child had been given an adjustment disorder because of precipitating symptoms in reaction to the pandemic's impact on daily life and other stressors in their lives related to big changes. I met with them weekly for 45 minutes to an hour via Zoom, an online conferencing platform.

The online work had to be thoughtful. In telepsychotherapy, there is a lack of control over the environmental, materials, presence, and visual cues (Springer et al., 2016). When implementing experiential strategies based in art making and mindfulness interventions, Springer and their colleagues (2016) emphasize utilizing creativity, verbal reinforcement, and *planfulness*. The lack of physical proximity and conversing with technology create a unique experience that

requires extensive consideration. Non-verbal cues may be delayed, disrupted, or missed in the online format, meaning that emotional expression and interpretation must be heightened (Springer et al., 2016). An office affords some spontaneity, but an online format necessitates thinking ahead, considering what can be done and what materials are needed, and making sure instructions are clear so that the client has materials in place. As a result, my storytelling intervention would require very little supplies outside of each child's imagination and perhaps a pencil and paper. In addition to managing material considerations, therapists must appropriately manage the emotional vulnerability inherent in experiential work to assure safety, because they are not physically present if there were to be an emergency (Springer et al., 2016).

There are so many feelings associated with this pandemic, blending and blurring with the everyday qualities and qualms of life that still exist in distorted ways. I wanted to explore challenging feelings around clients' present lives in a safe way that focused on containment through creating a predictable schedule, labeling specific feelings, relying on narrative structure, developing characters, and collaboratively playing and problem-solving. It was then important to keep in mind that "life is not only about problems and difficulties… it is also about hopes, dreams, passions, principles, achievements, skills, abilities and more (Carry & Russell, 2002, p. 77). So, I decided upon a structure that would allow children to equally choose "easy" and "hard" parts. I hesitate to call these parts "easy" and "hard," because all emotional parts are welcome and valuable sources of information and easy and hard vary person to person. This is not an assumption that there are strictly easy or hard parts, as happy or proud can be just as hard to acknowledge as sadness depending on the context, but people tend to be able to label them quicker than parts such as anger or worry that may carry more shame. I recognize that anger or worry may be harder emotions to label and feel in the body because of the stronger felt sense of

danger. I have labeled these parts for the purpose of exploring duality and balance, for without one there cannot be the other.

Intervention Procedure

I created an eight-week structure to provide boundaries, consistency, and predictability for clients. In week one, I introduced the exercise and clients selected their characters; in weeks two through seven, we spent time exploring the stories of easy and hard parts; the final eighth week was a retelling of the client's stories and making them into a whole book for them to read and reflect upon.

During week one, I presented each child with their own unique list of character traits I identified for them after hearing from their parents during the intake process and getting to know the children for a few sessions. I call these emotional adjective labels; there was a column of seven easy traits and one of seven hard traits, and an example of that list can be found in the appendix (see Appendix A). Each child was instructed to select three traits from each column that they felt resonated with them or felt right to write a story about. In this way, there was control on my part as the therapist providing boundaries while simultaneously providing control for each client through agency and self-directed input. This created a balance in power that promoted collaboration and coordination. In addition to selecting adjectives, each client chose whether their characters were people, animals, or other beings such as monsters or creatures. This gave some clients control over how much distance they had from their parts because they could attach them to things that were not human.

Weeks two through seven alternated between the positive and negative parts, as each week was wholly dedicated to the collaborative story creation. The child would pick which character they wanted to write about that week and either work on an illustration, sit, or wander

as they told me what to write down. I wrote on paper because it felt like a break from the screen and because I was able to hold it up to the laptop camera to offer clients a visual representation of how many words they had created so far. I would guide clients with questions such as:

> *What does this character look like? Where do they live? Do they have any friends or family? Do they live alone or with others? What do like they like to do? What do they like to eat? Where do they like to go? What do they not like?*

These questions helped the children keep thinking about and exploring their characters whenever they got stuck. When conflict arose, I would ask the client how we could help that character in that moment, what they could do next, or what would make the character feel better. The invitation for illustration was based in EXAT theory and intermodal transfer as a way to flow between creative mediums. I invited clients to create a visual representation of our stories because "visual arts help make the unconscious conscious… creating an image brings tangible form to psychological realities… thereby allowing us to become aware of and confront these realities." (Gupta, 2020, p. 597), but not every child drew every session. At the end of each week's session, I took Burns' (2005) suggestion that "healing stories are likely to have their greatest impact when you assist listeners to seek, and find, their own meaning" (p. 44). I would ask the child what they learned from that character or what the moral of the story was. Each child was typically eager to share with me what they thought the lesson was and work collaboratively again to discover new meanings and possibilities as well, even if that conclusion was that sometimes there is no meaning!

In the final week, each client and I looked over the work they had done. We looked at what stories stood out the most and what lessons felt the most powerful. I praised them, sharing how proud I was that they created such beautiful stories. Clients reported feeling excited to

share their books, proud of their own work, and some even wanted to keep making stories together in the weeks to come.

At the end of my intervention after eight weeks of journaling, I did my own storytelling and artmaking process around the parts that came up for me at the conclusion of the work with these four clients (see Appendix B and Appendix C). I chose one easy and one hard part, Pride and Worry, wrote their stories, and did an illustration with supplies representative of my own clients' resources.

Results

To keep track of the stories, themes, and personal reflections, I journaled throughout the intervention process after each session. I included a summary of anything that the client spontaneously brought up about their life at that time, a brief overview of the story content, anything I did or felt during the story process that stood out, emerging or recurring themes, my assessment of the content, and any planning or changes going forward. I found that in the first week of stories, each client taught me something new. One client created gender neutral characters without prompting, which reminded me to also keep characters gender neutral until the client specified otherwise on their own, or to offer, *Is this character a boy, girl, other, neither?* at the beginning of the story. Another client started with a hard part, which inspired me to note that by tackling a hard part first, then going back and forth, we would end on an easy part and potentially a high note or happy ending.

The beginning of each story sometimes required more questions on my part to establish the world in which we were creating. Clients frequently crafted character conflict all on their own without prompting. I followed Burns (2005) guidance when he shares, "Once you have commenced the story with a problem that may parallel that faced by the child, it is possible to

ask, 'What do you think happens next?' Keep the child exploring possible solutions with questions that presuppose a satisfactory outcome" (p. 42). Sometimes, what happens next was too big of an open-ended question, and if the child responded with, "I don't know," I would give options for them to choose from to decide which direction the story goes next, sometimes deliberating including some more helpful coping strategies or harmful ones to see what the client was drawn towards. Some clients' stories were inspired by their drawings, while others experienced the opposite, as their words inspired the images. As with all creativity, there is not a right or wrong way to find inspiration.

I chose to write each story on notebook paper, dedicating sections to each client's stories. Some clients found a visual representation I could hold up to present to them very engaging and inspiring. Clients would remark in wonder and excitement at how much progress they had made or look at half of a page and say they wanted to write more to fill it up all the way! As the weeks went on, I was able to show them page after page filled with their words. It was a helpful, powerful visual cue for them to feel both accomplished and encouraged about their work as the sessions progressed.

At the end of each story, I would ask the client what the main character learned or what the client themselves thought the moral of the story was. Clients were typically quick to find one, even if it was a silly one! Depending on the story and what I felt was therapeutically appropriate, I would sometimes offer an additional lesson or moral in addition to what the child shared. I never felt as though any lesson client's shared was "bad" or inappropriate, because it gave me insight into how they see both their story world and their own real world.

As an expressive arts therapist in training, I found myself walking a fine line between counselor and teacher. I have a very person-centered approach that relies on validation,

reiteration to convey active listening, reassurance, and acceptance. Sometimes it is good to wholly validate a client's experience; most of the time I found myself validating the feelings but emphasizing that it's what we do with our feelings that is important. I walked another fine line between story and life. Our characters can do things that are extraordinary, for they can do things we cannot because they are in a story; what we do in life to our self and others may be different because we have different consequences. I found these teaching parts to be very reflective and curious, guiding clients and offering new ideas. One of the additional lessons I offered a client after one story emerged in a subsequent story spontaneously two weeks later; I had told them I noticed an additional moral could be that you can ask for help, to which the client responded maybe, and two weeks later, the moral of a completely different character was just this. This client liked to be in control, but when he bottled his feelings to the point of overflow, he lost control and felt guilty. We talked about our characters' feelings and how they could talk about their feelings with trusted others and ask for help. The relationship between others trying to control him versus trying to help him came out through his characters.

Common themes across clients were that of family, isolation or loneliness, needing help, helping others, confusion, and problem-solving. Some clients showed more insight than others, wherein they had more active control over the story, while others sometimes sat back and asked me what I thought. Each child was different but possessed their own unique creativity. I believe these themes were emerging in these clients' stories as a result of the COVID-19 pandemic and its massive impact on their lives. They were subsequently spending much more time at home with their families and suffering immense social deprivation and isolation. And yet, each child's characters possessed at some point throughout their story process the desire to be helped or help others, to notice and extend a hand to someone in need. On the topic of problem-solving,

sometimes this was a default place. Depending on the client and context, I would sometimes ask why a character was feeling a certain easy or hard trait or how they became that way. Some clients would have an answer, and some would not. I was sure to validate this unknown, saying "it's ok to not know sometimes," or "we can figure it out together if you'd like help, but it's your choice." Some stories had conclusions, while others were a bit open-ended. I made sure to allow space for all parts and conclusions, as life doesn't always tie up in neat little bows, and the uncertainty looming about the pandemic did not have an end either. I noticed my own parts that came up around some clients' use of weapons in their stories, as I have a fear of them. But I recognized that in their story universes, their characters were just seeking power to feel safe and in control because at the moment they were lacking.

This entire process was so rich and powerful, and in the end, I created my own art (see Appendix B and Appendix C). I chose Pride and Worry, as I felt so proud of each client's creative exploration and also worried about my own skills and ability. These parts took on a life of their own in Appendix B and are visually illustrated in Appendix C. I felt emotionally connected to the stories I constructed. I utilized a similar style as I did with my clients: being curious and free flowing, accepting what came naturally, and questioning what the character would do next. My prideful part mirrored my experience with my clients, while my worried part mirrored my experience within myself. I allowed that story to not have a clear ending, as it is not over. I believe the worried part will slowly be calmed and reassured as I continue to grow and learn in the EXAT field.

Discussion

In her TEDMED 2020 talk, Shekinah Elmore says, "Learning to live with uncertainty means walking forward into a life that is as full of beauty as it is of challenges" (7:13). In the

face of vast uncertainty surrounding the largest global pandemic of our time, it may be challenging to see beauty in the midst of colossal challenges, worries, and disruptions. Many children feel as though there is no end in sight as the days of COVID-19 dragged into weeks, months, and now an entire year. Children spend hours on their screens with remote learning as schools moved online to decrease spread. Contagion was on everyone's minds. I had faith in the power of expressive arts to sooth, escape, expand, and begin to combat this chaos, but given the restrictions and compulsory move to telepsychotherapy, my hands felt swiftly tied. I found a creative solution in storytelling and the belief that what needs to be expressed *will find a way*. I found this to be true.

Language gives voice to the voiceless, organizes experience into communication, presents an opportunity for exchange, and restores power to a teller. Burns (2005) writes, "words invite the listener on a journey into a world of imagination where reality may be suspended, and learning can be potent" (p. 3). Storytelling was an incredible accessible expressive arts therapy tool because many children at home lack access to other art supplies they would normally be supplied in person. I scaled back my own materials, limiting myself to pencil and lined paper to align with children's conditions and make them feel less alone in their constraints. The world flowed and evolved throughout the weeks as I got to know each child a little deeper and watched their creativity bloom in both illustration and story.

By telling your story, you can take power back that has been taken away (Hofler, 2020). When so much control has been lost for countless children because of our politics, our shortcomings as a country, and simply the highly contagious nature of the virus, powerlessness crept into our lives. Stepping into a new world completely by their design gives children power and peace back. Martin (2020) articulates that creativity and drawing taught her "to open [her]

eyes to see not only what is, but what can be" (6:25). Stories capture, compel, and have massive potential to initiate change because "writing it down acknowledges its existence… to kind of un-silence things we've been keeping silent" (Hofler, 2020, 0:40-1:50). The playful, creative potential of the story space provides a vital outlet for children during this pandemic. There is power in creativity in the face of great adversity.

The limitations of this study are those imposed by telehealth as a whole: network connection problems, occasional lags, mic malfunctions and muddled audio, and the lack of a whole-body nonverbal conversation. Despite these limitations, there are potent applications of this intervention for the expressive arts therapy field as a whole. Expressive art is a way to capture the things that do not have words, and when we are far apart and our supplies are absent, we have our bodies and our minds. It is vital to design a creative container that is safe, accessible, and takes into account the physical limitations of social interactions at this time. Future use of this intervention may consider including reflection inspired by mindfulness to tap into the body further in a safe, nonthreatening way. I have learned the power of externalization and healing through working with the brilliant minds of my clients.

I hope this intervention can help other practicing professions as we rise from the ashes to provide essential services to those in need of coping and healing. As Braitman (2019) tells us, "Communicating with each other with vulnerability, listening with compassion, is, I believe, the absolute best medicine that we have" (9:20).

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Appendix A

Sample Character Traits List

Determined	Anxious
Strong	Sad
Creative	Confused
Caring	Angry
Proud	Fearful
Resilient	Disappointed
Brave	Overwhelmed

Appendix B

Pride

Pride was a caring being. They were short and small, but their heart was big. Pride lived in a little home in the base of a tree. Its roots twisted and bent around the outside of their door. They had many neighbors in the forest, both big and small, fast and slow, happy and sad. Pride wanted to help others more than anything in the world. One day, Pride's neighbors came to them concerned. They told Pride about their children and talked and talked about not knowing what to do. Pride felt their concern and told them they would help. Pride met with the children of the neighborhood individually and heard their stories. The children created the most beautiful art. Pride's heart swelled with happiness as the children created intricate tales of strength, resilience, and love. Pride knew that there would be bad days, hard days, days where no one knew what to do. But in the moments of togetherness, pencil in hand, they could create worlds to hold all of the uncertainty and plant hope.

Worry

Worry was a nervous little one. She felt very small compared to the very big world. She lived in a big, bustling city filled with people. There were many sounds, sights, smells, and scenery. The pace of the city was swift and jarring for Worry. She felt like if she wasn't running, she was behind. A sense of dread and constant fear of lateness and fault crept into Worry's every waking moment. Questions swirled the second she woke up. Would she be fast enough to keep up with the city today? Would she be smart enough to keep up with the city today? Would she be good enough? Worry looked at her ceiling, wanting to crawl back under her covers and go back to sleep, but knowing this would only make her feel worse. She took a deep breath. She could get through today. Maybe tomorrow would be better.

Appendix C

Figure C1: Pride Illustration, pencil on notebook paper.

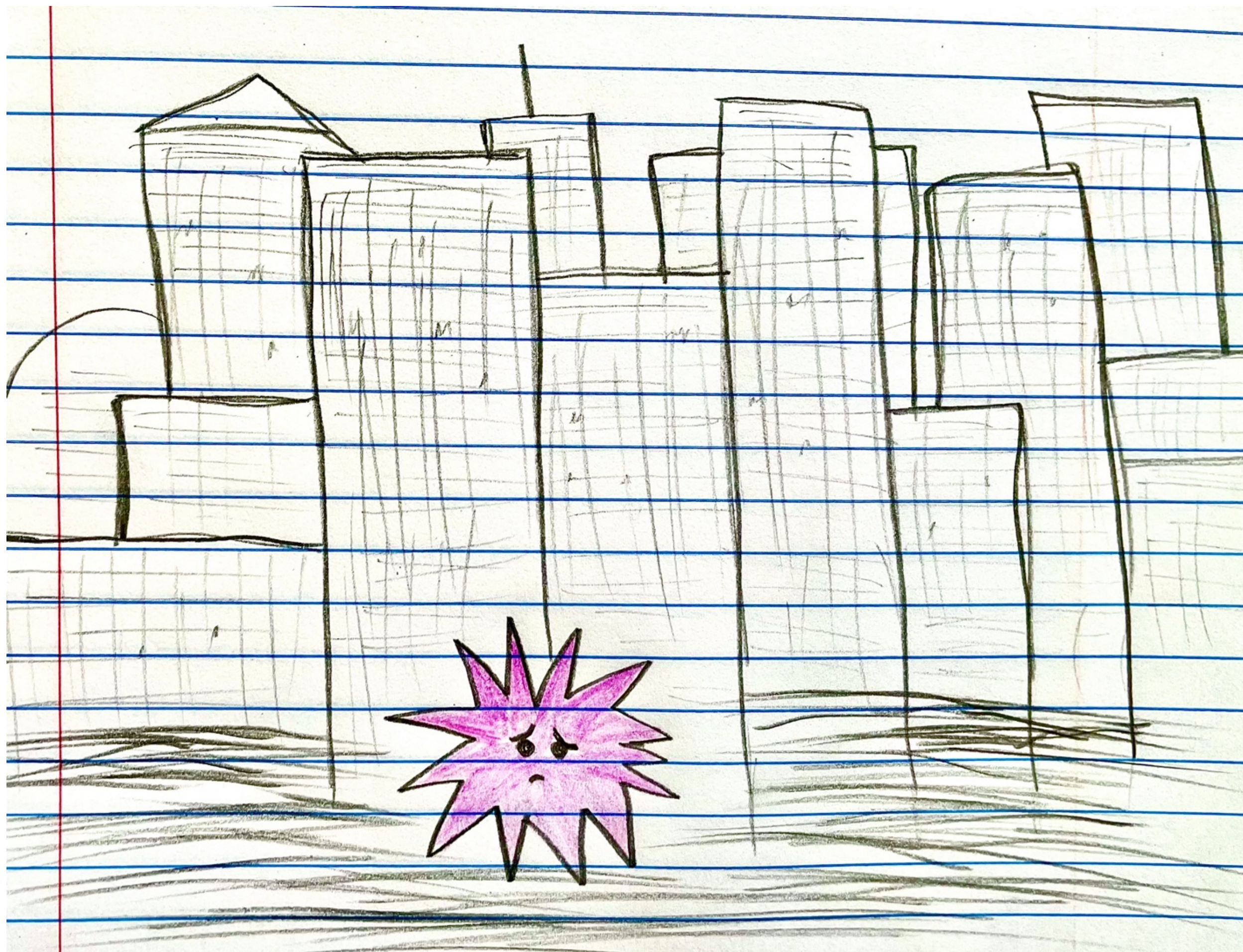

Figure C2: Worry Illustration, pencil on notebook paper.

THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Expressive Arts Therapy, MA

Student's Name: Sidney Marie Joines

Type of Project: Thesis

Title: Storytelling as an Expressive Arts Therapy Intervention for Children via Telehealth

Date of Graduation: May 22, 2021

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Meg Chang