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Finding a Middle Path: Using Expressive Arts Therapy to Engage Adolescents in Dialectical
Behavior Therapy: A Literature Review

Capstone Thesis

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Expressive arts therapy

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Abstract

This critical literature review explores the limited research on integrating expressive arts therapy (ExTH) with dialectical behavior therapy (DBT). DBT, an evidence-based, third-wave cognitive-behavioral intervention, has been adapted for use with adolescents struggling with emotional and behavioral dysregulation. Yet, the didactic and almost rigid nature of DBT can feel more like a school lesson and less like therapy, making it difficult for adolescents to engage with the treatment. This is problematic as DBT's effectiveness requires the client to be fully committed and willing to engage in the therapy. This paper explores the literature on combining ExTH with DBT and conceptual connections between DBT and ExTH, and compares the literature to the lived experience of increasing participation in DBT groups through adjunct skills-based arts groups.

Keywords: Dialectical behavior therapy, expressive arts therapy, engagement, adolescent treatment, borderline personality disorder.

Author Identity Statement: The author identifies as a gay, Jewish, first-generation American by way of Romania.

Exploring the Integration of Expressive Arts Therapy into a Comprehensive Dialectical Behavior Therapy Program: A Literature Review

Introduction

Dialectical behavior therapy (DBT) is an evidence-based, cognitive-behavioral intervention originally developed for individuals diagnosed with borderline personality disorder (Linehan, 1993). Since then, DBT has been applied to many other diagnoses and has grown in popularity as a therapy to help clients struggling with emotional and behavioral dysregulation. DBT helps clients change patterns of behavior that are ineffective by building skills in four key areas: emotion regulation, distress tolerance, acceptance and mindfulness, and interpersonal effectiveness (Linehan, 2015).

DBT skills groups are, by nature, extremely structured, always following the same format. Each group begins with a mindfulness exercise; then the group reviews and goes over homework from the previous session, a new skill or skill set is taught, and the group practices the new skill. At the end of the session, homework is assigned. In many ways, DBT skills groups are more like a class than a therapy group. Yet, “As a comprehensive and intensive treatment, DBT requires a large amount of buy-in from the client” (Coyle et al., 2019, p. 23). In my experience, the very nature of these groups may push children and adolescents away and decrease willingness. This is problematic as DBT only works if the client is willing to do the work.

I believe that individual buy-in, and thus results, will increase if art is used to introduce and practice DBT skills. According to Clark (2017), exposing someone to new information in a novel manner, such as art making, enhances mental interest and “can promote an attachment of personal meaning to that information, increasing the likelihood of long-term retention” (p. 114). Furthermore, creating and engaging with the material helps group members gain a deeper

understanding of the skills, and the art product produced in the group can serve as a concrete reminder of the skills learned long after the group has finished (Clark, 2017).

In this critical literature review, I compile the current literature relevant to integrating DBT with expressive arts therapy (ExTH). I also explore conceptual connections between ExTH and DBT while sharing my experience of increasing participation in DBT groups through adjunct skills-based arts groups.

Literature Review

DBT Overview

Based on the concepts of dialectics and grounded in the biosocial theory, DBT provides the foundation for understanding the development of emotional sensitivity and offers skills to help cope with the effects of emotion dysregulation (Linehan, 1993). According to the biosocial theory, individuals are born with a biological vulnerability towards emotional sensitivity, often exhibiting high emotional sensitivity, a slow return to baseline, and difficulty regulating emotions. These biological factors, coupled with an invalidating environment in early childhood, affect how the individual learns to process, internalize, tolerate, and regulate their feelings leading to difficulty with distress tolerance and emotion regulation (Linehan, 1993).

The dialectical philosophy is one aspect of DBT that sets it apart from other cognitive-behavioral treatments. In this framework, clients learn that reality consists of naturally opposing forces (Chapman, 2006). In other words, it is possible for two things that are opposites of each other to be true simultaneously. The main dialectic in DBT is a balance between acceptance and change (Dobson, K. S., & Dozois, 2009). Clients learn to radically accept feelings and situations that they cannot change and to be effective and change what they can when they can. Ultimately,

the use of mindfulness in DBT is to "synthesize acceptance and change and promote the creation of, and full engagement in, a higher quality of life" (Dobson et al., 2009, p. 359).

Overview of DBT modules

Dialectical behavior therapy was originally developed to treat chronically suicidal individuals who also met the diagnostic criteria for borderline personality disorder (Linehan, 2015). Thus, many individuals who come into DBT treatment are frequently engaging in life-threatening behaviors and may feel that their life is currently not worth living. Therefore, the ultimate goal of DBT is to help individuals build a life worth living (Linehan, 2015). This is achieved by building therapeutic skills in four key areas or modules (Linehan, 2015). The modules can be divided into two sets, one focusing on change and the other focusing on acceptance (Heard & Linehan, 1994). The basic focus of each of these modules follows here to set the stage for integrating DBT skills with expressive arts therapy.

Mindfulness

The mindfulness module is at the core of DBT as mindfulness skills "underpin and support all of the other DBT skills" (Linehan, 2015, p. 151). The core mindfulness skills are the first skills taught and involve the "intentional process of observing, describing, and participating in reality nonjudgmentally, in the moment, and with effectiveness (i.e., using skillful means)" (Linehan, 2015, p. 151). In DBT, core mindfulness skills are divided into the "what" and the "how" skills. The "what" skills focus on what to do to practice mindfulness, such as "observe," "describe," and "participate." Learning to observe allows one to experience the moment without clinging or pushing away. Describing involves the ability to label events and responses, helping a person learn that emotions are feelings and not facts. Finally, the last "what" skill, participate,

has to do with fully entering an activity in the current moment; it includes the ability to be fully present and attentive (Linehan, 2015).

The "how" skills, on the other hand, focus on the way of doing the "what skills," or how one observes, describes, and participates. These skills include taking a nonjudgmental stance, being one mindful or focusing entirely on the single task at hand, and being effective, or doing what works in the moment. The skill of effectiveness is directed at reducing a participant's tendency to be more concerned about what is right versus what is needed in a certain situation (Linehan, 2015).

Also included in the mindfulness module is a discussion on the three primary states of mind. Often presented in the form of a Venn diagram, the states of mind include reasonable mind, emotion mind, and wise mind. Reasonable mind, the rational, logical part of one's mind, attends only to facts without regard to emotions. On the other extreme is the emotion mind, where decisions and behaviors are ruled by the current emotional state. In emotion mind, it is hard to think logically, and behaviors may come without a second thought. The synthesis of emotion and reasonable mind is wise mind. "Wise mind adds intuitive knowing to emotional experiencing and logical analysis" (Linehan, 2015, p. 153). It is the inner wisdom found within each person. The mindfulness skills are vehicles for learning to balance the emotional and reasonable mind. By practicing mindfulness skills, individuals can reduce suffering and increase happiness, increase control over their minds, and be present in their own life (Linehan, 2015).

Distress Tolerance

The distress tolerance module focuses on increasing the ability to tolerate and accept pain and distress. According to Linehan (2015),

Distress tolerance is the ability to perceive one's environment without putting demands on it to be different, to experience one's current emotional state without attempting to change it, and to observe one's own thoughts and action patterns without attempting to stop or control them (p. 416).

The main goal of the distress tolerance module is to tolerate a painful experience without making the experience worse. Therefore, these skills include crisis survival skills such as creating pros and cons lists so as to not act impulsively, distraction methods to temporarily reduce contact with an emotional stimulus, and self-soothing strategies (Linehan, 2015). Also included in the distress tolerance module are skills for accepting reality when painful facts cannot be changed by problem-solving. Individuals are taught to use distress tolerance skills when a situation cannot be immediately changed; thus, the only way to proceed is to accept reality as it is in the moment (Linehan, 2015).

Interpersonal Effectiveness

While the mindfulness and distress tolerance modules focus on acceptance, the remaining modules, interpersonal effectiveness, and emotion regulation, focus on change and problem-solving behaviors. The interpersonal effectiveness module emphasizes teaching and learning skills related to assertiveness and obtaining objectives. In this module, individuals are taught how to assert themselves in getting their needs met while still maintaining self-respect and not damaging the relationship. Furthermore, clients are introduced to skills that help them build new relationships and end destructive ones (Linehan, 2015).

Emotion Regulation

The final module in the change and problem-solving set is called emotion regulation. This module provides psychoeducation in understanding the function of emotions. By applying

mindfulness techniques such as observe and describe, clients learn to identify and label emotions as well as understand their purpose. This understanding of the model of emotions is the first step in changing unwanted emotions (Linehan, 2015). The second half of the module focuses on how to change emotional responses by checking the facts of the situation and learning to act opposite to emotions when those emotions do not fit the facts (Linehan, 2015). Finally, the latter part of the module concentrates on reducing vulnerability to negative emotions and involves more psychoeducation on accumulating positive emotions, coping ahead of difficult situations, and taking care of the body to reduce vulnerability factors (Linehan, 2015).

DBT for Adolescents

Since its development, DBT has been adapted for adolescents struggling with non-suicidal self-injurious behavior and emotion dysregulation (Miller et al., 2007). Miller et al. (2007) designed an adaptation of dialectical behavior therapy for adolescents (DBT-A). The adolescent version of the manual includes modifications such as simplified worksheets and examples and applications relevant to teens. In addition, the adolescent manual includes a brand-new module called walking the middle path.

Walking the middle path focuses on three central problems specific to teens and their families (Miller et al., 2007). First, the module provides a general understanding of dialectics and its applications to specific dialectical dilemmas that frequently come up between families and their teens including "excessive leniency versus authoritarian control, pathologizing normative behaviors versus normalizing pathological behaviors and fostering dependence versus forcing autonomy" (Rathus et al., 2015, p. 164). Validation, a central part of DBT, is examined closely in this module. Teens are most often still living in the invalidating family environment that likely played a role in their current behavior. Therefore, by teaching the adolescent and their family

validation skills, the cycle of invalidation is lessened, and all family members leave with greater interpersonal effectiveness. Walking the middle path also focuses on changing behaviors in oneself and others, specifically behavioral change strategies like positive and negative reinforcement, shaping, extinction, and punishment. The idea is that by teaching the entire family techniques for behavior modification, the parent and adolescent will be more likely to generalize the skills they learn in the home (Rathus et al., 2015). Although DBT-A is becoming more common, little research has explored the effectiveness of the adaptations to Linehan's (1993) original protocol.

McCredie, Quinn, and Covington (2017) evaluated a yearlong DBT-A program in a residential setting. They measured changes in symptom severity over time and tracked the use and effectiveness of specific DBT skills by module as reported by the adolescents. The participants included 48 adolescents between the ages of 12 to 18, with a mean age of 15.2 years ($SD=1.24$). The sample consisted of 46% male adolescents and 54% female. The sample was relatively diverse, with 54% identifying as Caucasian, 38% African American or biracial, and 8% other. No information was given on socioeconomic class. Prior to admission to residential treatment, the participants had experienced an average of close to five hospitalizations and countless failed treatment attempts. The diagnoses of the sample were diverse, with high comorbidity throughout. There were no exclusionary criteria. All individuals were assessed with a battery of tests, including the Youth Self Report (YSR), Kiddie Schedule of Affective Disorders and Schizophrenia—Present and Lifetime (K-SADS), and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II). A questionnaire was also developed in-house to assess DBT skill usage.

The study found that DBT-A is effective for male and female identifying adolescents across a variety of symptoms, with the greatest effect size found for depressive symptoms (McCredie et al., 2017). The K-SADs and SCID-II were analyzed with paired sample t-tests and indicated a large significant decrease in the number of diagnoses between admission and discharge. Participants had, on average, 3.13 diagnoses upon admission ($SD=1.06$), while at discharge, they had an average of 1.33 diagnoses ($SD=1.27$). Therefore, after spending at least twelve months in this DBT program, individuals met criteria for fewer diagnoses as compared to a year prior. Furthermore, symptom severity decreased for both genders. After major depressive disorder, the largest effect size was for externalizing disorders which is notable, since others (Aspche et al., 2006; Wasser et al., 2008) have suggested that DBT-A may not be effective for externalizing behaviors.

The study also examined which DBT skills residential adolescents found effective, with 71.7% of teens choosing the distress tolerance skills and 50% identifying emotion regulation skills. The study, although more diverse and with a wider sample size than past studies (Apche et al., 2006; Wasser et al., 2008), was limited by a lack of randomization and absence of a comparison group. Furthermore, there was no mention of individuals identifying outside of the gender binary. Despite these limitations, McCredie et al.'s research (2017) provides preliminary evidence to support the effectiveness of DBT-A in a residential treatment setting.

Little research has been completed on the long-term outcomes of adolescents who struggle with self-harm and suicidal ideation. A study by McCauley et al. (2018) evaluated the treatment effects of (DBT-A) and compared it to another client-centered treatment referred to in the study as individual and group supportive therapy (IGST). Over the course of two years, 173 participants were recruited from hospital emergency rooms as well as through inpatient and

outpatient services. Inclusion criteria for participants included at least one suicide attempt in their life, increased suicidal ideation over the past month, and at least three self-harm episodes throughout their lifetime, with at least one occurring in the past 12 weeks. All participants were between the ages of 12 and 18, with 56% identifying as White, 28% Hispanic, 7% African American, and 6% Asian American. Forty-seven percent of the participants reported that their parents were married, and the majority of the parents graduated from college (54%). More than half of the adolescents reported a family income over \$50,000 per year (55%), while 14% made less than \$30,000 per year. Exclusion criteria included an IQ less than 70 and a primary diagnosis of psychosis, mania, or anorexia. Furthermore, the adolescents included were required to be fluent in English and have at least one parent fluent in either Spanish or English.

Participants were randomized into either six months of comprehensive DBT or the individual and group supportive therapy (IGST) group. Adherence to treatment modalities was monitored and evaluated randomly once per month initially and once every eight sessions going forward. DBT therapists were monitored using the DBT Adherence Scale, and the IGST group was monitored using the Client-Centered Therapy Adherence Scale (McCauley et al., 2018).

McCauley et al. (2018) found that the adolescents in the DBT group had a higher treatment completion as compared to the IGST participants. High treatment completion was defined as attending at least 24 individual sessions. In the DBT group, 39 [45.4%] of 85 completed treatment compared to the IGST group's completion total of 14 [16.2%] out of 87. Suicide rates were significantly lower in the DBT group as compared to the IGST group. In the first six months, 9.7% in the DBT group versus 21.5% in the IGST group reported suicide attempts. The DBT group was also found to have a "significantly higher rate of clinically significant change as defined by the absence of self-harm" (McCauley, Berk, et al., 2018, p.

782). After six months in the study, 46.5% of DBT participants had no self-harm, compared with 27.6% in the IGST group. This trend continued at 12 months, with 51.2% in the DBT group having no self-harm episodes versus 32.2% in the IGST group.

McCauley et al.'s (2018) study is one of the first DBT related studies to randomize and have a comparison group. However, the research is limited due to the predominantly female (94%) sample. This is especially relevant because males are more likely to complete suicide compared to females (McCauley et al., 2018). This study was unable to generalize if DBT-A is effective for the treatment of all adolescents at high risk for suicide. Rather, it found that DBT-A is effective for white female-identifying adolescents in the United States.

Challenges of Therapeutic Engagement with Adolescents

Adolescents can be one of the toughest crowds to engage in therapy (Gregory, 2015). Most teens are not in therapy voluntarily; they are attending because a parent/guardian felt they should, a state agency required them to, or due to the structure of their treatment program. "Boredom is the nemesis of teenagers" (Gregory, 2015). Therefore, when running an effective group intervention for adolescents, worksheets, workbooks, long discussions, and videos should be avoided as much as possible as they lead to daydreaming, napping, and potentially challenging behaviors (Gregory, 2015). Activities that involve movement, creativity, and speak to the adolescents' interests can help support engagement. Furthermore, peer influence can go a long way in promoting engagement.

Clinical psychologist Katie McIntyre (2020) evaluated a DBT skills group for seven adolescent females in a Scottish residential program. Semi-structured interviews with staff and clients were performed and analyzed using thematic analysis. Most relevant to this literature review was the adolescents' perception of DBT and what they found useful in their group

experience. One adolescent stated that the worst part of group was "when you're sitting and they ask you to sit still, silently, not fidgeting, not doing anything while you're listening ... it just makes me more agitated...it makes me more angry..... it just makes me wanna smash the radio player" (McIntyre, 2020, p. 10). A different adolescent said they like group better when they get to do something; they were more engaged in group when they got to "draw or paint or something rather than just sitting talking about it" (McIntyre, 2020, p. 10). When asked what they thought went well in the skills group and what they would change, one individual said that they would want to change the amount of talking. They mentioned, "the dragging on...like the talking...it feels like you're walking through woods ...they keep like talking... and like...cold dark woods. And getting pure bored..... I think we should be like ...do like active things (McIntyre, 2020, p. 12-13). Overall, the analysis from the interviews suggests that the adolescents felt most engaged when the groups was hands-on with activities and experientials rather than merely sitting, talking, and listening to each other.

McIntyre's findings are consistent with Miller et al. (2007), who stated that teaching DBT in as "lively and experiential a way possible engages adolescents most effectively" (p. 229). Additionally, the use of experiential activities can aid in facilitating engagement and sustaining the attention of adolescent group members (Woodberry & Popenoe, 2008). When I think of experiential activities that may aid in increasing engagement and willing participation in a group, I cannot help but think of incorporating ExTH into DBT as a way to increase treatment engagement.

Overview of Expressive Arts Therapy

Expressive arts therapy is the newest discipline under the umbrella of the expressive therapies. Developed in the 1970s in Cambridge, Massachusetts, ExTH is different from the

single modality creative therapies such as art therapy, dance/movement therapy, drama therapy, and music therapy. Each of these modalities uses its respective discipline to assist in accessing inner resources and cultivating personal growth (International Expressive Arts Therapy Association, n.d.). ExTH is an integrated approach of its own, “based upon the interrelatedness of the arts— that common ground of imagination, play, and self-expression” (Richardson, 2015, p. 2). According to Cathy Malchiodi (2020), ExTH, “capitalizes on both the imagination and the integrative possibilities inherent to the arts. The goal is to enhance the interplay of the arts to support self-exploration and to connect to oneself through arts-based experiences” (p. 19). The use of expressive arts can help individuals access parts of themselves that traditional talk therapy cannot. According to Degges-White (2017), the

arts provide a medium through which we [the client] may draw on inner feelings and the unconscious to produce a tangible product...Engagement in the expressive arts allows clients to explore their deepest and often hidden feelings, to use symbols to represent their inner feelings and conflicts, and to physically express their internal issues. (p. 1).

Essentially, the use of the expressive arts adds an additional dimension to the therapeutic process that allows clients to engage deeper and more fully with their challenges. Several theories related to ExTH that are of particular importance when integrating DBT and expressive arts therapy will now be examined, including Knill’s intermodal theory, Levine’s understanding of poesies, and Roger’s person-centered expressive arts theory.

Central to Paulo Knill’s theory of intermodal expressive therapy is the theory of polyaesthetics, or the idea that all modalities exist within one another. For instance, when working with clay, the body, while pounding on the clay and the rhythm that experience evokes is dance, the sounds created by the clay on the table and hum of the wheel, music, and the

structure and form of the clay, visual art. "Each art form contains within it the seeds of the other arts through aesthetics and sensory perception" (Estrella, 2005, p.31). Levine and Levine (1999) described expressive arts therapists as "specialists in intramodality; that is, ...capable of grasping the junctures at which one mode of artistic expression needs to give way to or be supplemented by another" (p.11). In expressive arts therapy, the approach is multimodal "at times working with the arts in sequence, at times using the arts simultaneously, and at other times carefully transitioning from one art form to another within the therapeutic encounter" (Estrella, 2005, p. 183).

Moving from one modality to another "encourages a deepening relationship between the client and [their] art. In this way, as [the] client stays in the creative process, the meaning of the work or play becomes clearer" (Richardson, 2015, p. 18). Meaning may emerge through this creative process of moving through the different art modalities. This process is referred to as the crystallization process (Knill, Levine, & Levine, 2005). When a client is in an environment that is so saturated with creativity and imagination, a simple creative act can serve as the seed of a crystal. The longer the client can stay in the process of creating using various modalities, the clearer the meaning of the art can become (Richardson, 2015). "Therapists can encourage clients to move to other art modalities to expand their range of experiences and knowing with their art" (Richardson, 2015, p. 18).

Levine and Levine extend the concept of poiesis to their framework for understanding expressive arts therapy. The arts are often thought of as a way to express and/or contain emotions and experiences (Atkins & Erberhart, 2104). Beyond that, however, art is also a mode of inquiry and a way of knowing. When the client or artist is able to completely let go, they may feel that the images, sounds, and movements came to them to show or teach them something (Moon,

2009). Art making is a process of transforming and understanding, and the process and experience of poiesis brings meaning (Moon, 2009). The process and the product of poiesis help the client and therapist discover new possibilities (Levine, 2015).

Person centered expressive arts therapy (PCEAT), is based on the belief that “each individual has worth, dignity, and the capacity for self-direction” (Rogers, 1993, p. 3). The main principles central to PCEAT include that the creative process is in itself healing and that all people carry the innate ability for creativity and healing (Rogers, 1993). Furthermore, when one ventures into the depths of their emotions, their journey leads to an increase in self-awareness and understanding, allowing for growth. The feelings that emerge on this journey can then be focused on the expressive arts, which aid in the transformation and help one reach a new level of awareness and authenticity (Rogers, 1993). The same conditions that can help a client feel safe and understood can also help support creativity. For this safety to be palpable, however, the therapist must create a space where one can be seen and heard without judgment.

The Creative Connection is a central piece to PCEAT. Similar to Knill’s theory of crystallization, the Creative Connection is the idea that there is constant interplay among the arts (movement, art, writing, sound) and that when one moves from one art form to another, a kind of flow emerges in the process. From this flow one experiences a sort of unfolding similar to the opening of the petals of a lotus; as the creativity flows and the petals open, the individual's inner essence is revealed. The feelings that emerge can then become a resource for more self-understanding and creativity (Rogers, 1993).

Parallels between DBT and the Arts

There are many parallels that naturally exist between DBT and the expressive arts. These parallels, in my opinion, illuminate how ExTH could almost seamlessly be integrated into DBT

to create a middle path between the cognitive behavioral approaches and the more kinesthetic, creative focused work found in expressive arts therapy. I will now touch on several of these parallels, including common elements found in both DBT and expressive arts therapy such as acceptance of emotions, nonjudgement, and mindfulness, as well as the use of metaphors. I will also examine similarities between skills and techniques used in both DBT and expressive arts therapy.

The use of metaphors

Expressive therapy and DBT both employ the creative use of metaphors to help facilitate change (Clark, 2017). Linehan (2015) states that “metaphors and stories have been used throughout history to convey complex events that can have multiple meanings” (p. 292). In DBT, therapists are encouraged to use metaphors and stories to increase engagement and help clients grasp concepts of more abstract skills. For instance, when learning about wise mind, clients are introduced to several different metaphors and imagery, including the concept of an inner spiral staircase descending into one's core (Linehan, 2015). Furthermore, “one of DBT's dialectical strategies is to use a metaphor that captures the dilemma and opens new avenues for conversation” (Swenson, 2016, p. 12). In DBT, metaphors are also used to help explain one's point of view in the interpersonal effectiveness module, as using metaphors and storytelling can help “unstick and free the mind” (Linehan, 2015, p. 151). DBT relies on metaphors both as a strategy for communicating abstract ideas as well as a way “to help clients both recognize where they are (acceptance) but also how they might change” (Swale, 2009, p. 169).

Metaphors also play a key role in expressive arts therapy. For instance, the physical properties of the art materials used can themselves function as a metaphor for the client's needs including “a need for autonomy, protection of borders of personality, control of emotions, or,

vice versa, a need for liberation from control" (Lusebrink, Martisone & Dzilna-Silova, 2013, p. 82). Davis (2015) asserted that metaphors possess an ability to "act in concert with images because they help capture the essence of emotion-based associations, and forge links between subjective and objective experience" (p.135). Therefore, metaphors are a powerful tool in expressive therapy because they can communicate thoughts and feelings in dynamic and direct yet still non-threatening ways (Malchiodi, 2003). Daria Halprin (2002), a leader in the dance/movement realm of expressive arts therapy, describes how the body and movement are in themselves a metaphor for how individuals live and tell their stories. Halprin (2002) stated that:

Through movement and multimodal art mediums (drawing, poetic writing, music making, singing), we are able to bring forward the material of our lives, reveal what has been hidden, and express old stories in new ways. The passion and creativity of the arts allow us to live with our suffering and find release through creative play. In such a process, we can symbolically face the demons of the past and the present (p. 21).

The use of metaphors to expedite change, understand different points of view, and communicate and explain complex concepts and feelings plays an integral role in both ExTH and DBT. When creatively used, metaphors and "guided imagery can facilitate the process of bringing together a cognitive, emotional, and/or spiritual understanding that otherwise might have been elusive" (Rosen & Atkins, 2014, p. 294). The creation of art of any kind is, at its core, symbolic. Therefore, I see the use of the arts in DBT as a way to capitalize on this commonality and strengthen the impact of metaphors and imagery in DBT.

Acceptance and mindfulness

According to Marsha Linehan (1993), "therapeutic change is only possible in the context of acceptance of what is; however, 'acceptance of what is' is itself change (p. 99)". DBT's focus

on acceptance of emotions naturally correlates to expressive therapy, where clients identify and process their feelings through different forms of creative expression (Clark, 2021). Just as DBT states that "suffering is pain plus nonacceptance of the pain" (Linehan, 2015, p. 459), expressive therapy and "the therapeutic power of art rests not in its elimination of suffering but rather in its capacity to hold us in the midst of that suffering so that we can bear the chaos without denial or flight" (Levine & Levine, 1999, p. 31). In other words, the power of the arts is in its ability to accept what is. In expressive arts therapy, "acceptance of what exists is a prerequisite of creative transformation" (McNiff, 2004, p. 219). Similarly, poiesis in ExTH is understood as the making or shaping of art only possible when the maker takes on an attitude of mindfulness and acceptance, simply allowing the meaning to emerge through the art (Knill et al., 2004). Poiesis in expressive arts practices can only be achieved by letting go of the art-making process and allowing oneself to be guided in what emerges (Levine, 2016). In this way, poiesis, acceptance, and mindfulness go hand in hand.

Another aspect of mindfulness is the concept of intuition, and spiritual knowing found both in DBT and in expressive arts theories. For instance, in PCEAT, the Creative Connection and the process of moving from one art form to another helps individuals find their center and reach their core (Rogers, 1993). This core seems very similar to the DBT concept of wise mind, which emphasizes an awareness of the body to help one center themselves into wise mind. Wise mind in DBT is known as the place of intuition between the emotional mind and the rational mind. It is the space in which a person can think clearly, take into account their emotions, and make an informed decision (Linehan, 2015). Breathing and movement can help clients find this space called wise mind. In PCEAT, sessions often begin with meditations as a way to help clients center themselves and inspire creativity (Chang, 2009). Wise mind has also been

described as the "phenomenon of being aware of the current moment and noticing what is present in a nonjudgmental and accepting way" (Follette & Hazlett Stevens, 2016, p. 275).

Likewise, according to Rogers (1993), "As we begin to be aware of our way of moving in life, we also become conscious of how our emotional and physical well-being are connected" (p. 51). Wise mind as a way of being can be a challenging state for clients to reach. Yet, the introduction of experiential and creative activities that help clients into the imaginal realms can make the wise mind more accessible (von Dal & Schwanbeck, 2012). Not only does the use of the arts make the concept of wise mind easier to embody, but the openness and playfulness that comes with exploring the arts can also help lower willfulness and resistance in a client (von Dal & Schwanbeck, 2012).

In expressive therapy, the medial space of imagination connects with DBT's concepts of wise mind, dialectical thinking, and mindfulness. "Within the realm of imagination, there is "a state of consciousness, where the different perspectives and participants in a situation can meet, influence one another, and create new patterns of interaction....that avoid the traps of polarization" (McNiff, 2017, p. 25). Similar to the concept of dialectics, where two seemingly opposite things can both be true at the same time, the imaginative realm is a place where one can be "thoroughly immersed in the experience of the world but open to new perspectives, unfettered by fixed ideas, and always longing to create anew" (McNiff, 2017, p. 25). The use of imagination can open spaces "beyond linear thinking and categorizations toward new possibilities, multiple perspectives, and unconscious processes" (Atkins & Erberhart, 2104, p. 13). The creative process requires complete mindfulness. Individuals deep within their imagination will feel a relaxed yet also completely focused flow (McNiff, 2017). Furthermore, "Imaginative engagement requires a letting-go of "end-gaming" and a willingness to explore

whatever may come. It requires a giving-up of control and a willingness to let something be” (Levine & Moon, 2019 p. 93).

Opposite to emotion, irreverence, and decentering

The skill opposite to emotion is a DBT skill taught in the emotion regulation module that involves "acting in a way that is opposite to an emotional urge, to decrease the presence or intensity of an emotion” (von Dal & Schwanbeck, 2012, p. 118). This skill is used to help change the client’s emotional experience when either their emotion does not fit the facts (is not justified) or when the emotion does fit the facts, but acting on the urge would not be effective in getting the client closer to their long-term goals (Linehan, 1993). Opposite action frequently relies on changing body position to impact how one is feeling. For instance, when a client is feeling sad and depressed in a session and their body language reflects this (for instance, they are curled up in a ball), the DBT therapist may suggest that they try some body-based opposite action. In this case, the client would change their curled body position to a straight backed, more confident position with their feet on the ground. This concept parallels Rogers' (1993) view that movement can be used to transform feelings (Rogers, 1993), as well as embodiment approaches to expressive arts therapy, which use movement to directly affect affect and cognition. Research demonstrates that "the mere taking on of a dominant versus a submissive body posture has been shown to cause changes not only in experiencing the self but also in testosterone levels in saliva and risk-taking behavior" (Koch & Fuchs, 2011, p. 277).

Related to the concept of opposite action is the DBT skill of distraction or the intentional shifting of one's attention away from a distressing experience or feeling. Distraction can be used as a distress tolerance and crisis survival skill and involves the client distracting away from their current thoughts and feelings. Distraction can be necessary as a first step in developing more

adaptive responses to potentially triggering experiences (Clark, 2017). Distraction is similar to the expressive art therapy concept of decentering. In expressive art therapy, decentering involves turning the focus away from the presenting problem so that it can be viewed in different, more imaginative ways (Levine, 2015). The art-making experience can be used to take the focus off of the crisis and instead allow the imagination to process and explore the issues in an indirect manner (Donohue, 2011). Furthermore, when therapists approach the creative process with a spirit of play, it can help take the serious edge off, allowing the client to loosen up a little (Rogers, 1993).

Decentering from a DBT standpoint might look like the use of distractions to place the focus on a different emotional experience. For instance, perhaps the client tells their therapist about an accomplishment from the past week, or the DBT therapist might ask the client to stand up and do a silly dance. This short distraction away from the current feelings can be used in a very similar way to decentering in an ExTH session. DBT therapists also rely on the occasional use of irreverent communication and humor, which serves a similar function to decentering. Irreverent communication can help shift emotions as well as thoughts and behaviors, as it often takes a client by surprise and helps facilitate change (Pederson, 2015). Irreverence in DBT can jolt the client "into seeing things from a new, more enlightened perspective" (Linehan, 1993, p. 52), just as decentering can move someone into the imaginal reality, taking the problem "out of the "center" of focus in order to investigate imaginative possibilities that may have been concealed therein" (Levine, 2015, p. 16).

Nonjudgement

A large part of person-centered expressive art therapy, like person-centered therapy, is the therapist's faith that every person has the ability to reach their full potential (Rogers, 1993). It

is unusual to feel accepted and understood when experiencing emotions that many would consider negative, such as anger or jealousy. Yet this is exactly what the PCEAT therapist does for the client. The act of truly hearing and understanding a client's experience can help the client feel empowered and safe. With that safety comes the courage to explore the expressive arts, ultimately leading one to discover their own potential (Rogers, 1993). Similarly, DBT values validation, and therapists work to approach each client in a nonjudgmental manner. The principle of viewing life through a nonjudgmental lens is a common thread throughout person centered expressive arts therapy and DBT (Chang, 2009). DBT therapists have a core belief that each client is doing the best they can, and they can also do better (Linehan, 1993). So, although the therapist accepts that a client is doing their best with what they have, they also recognize that changes and improvements can be made. This allows the therapist to validate the client's suffering, while also leaving room to make effective changes.

Recent Work Integrating DBT and the Arts

Huckvale and Learmonth (2009) noted that “Working with [clients experiencing] chaos, deep distress, acute disturbance and imminent life-threatening danger to the person demands containing structures” (p.62). Through their work, Huckvale and Learmonth (2009) became very aware of the limitations of traditional creative modalities, which often follow a less structured, more organic, and non-directive approach, and did not serve their highly dysregulated clients, as there was not enough containment. They noted that although creative expression did often lead to emotional catharsis, there was no opportunity to learn new behaviors or skills which could be used for future crises. On the other side of the spectrum, the more heavily evidence-based therapies, such as DBT, often favor the cognitive side, excluding the sensory, creative, and imaginal realms. It would make sense to integrate the two, finding a middle path between the

highly structured, cognitive-based approach of DBT and the creative, embodied, and multisensory way of the expressive arts (von Daler & Schwanbeck, 2012). “Creative interventions serve as a catalyst for individuals to explore thoughts, feelings, memories, and perceptions through visual, tactile, olfactory, and auditory experiences” (Malchiodi, 2008, p. 15). Therefore, the use of the arts can actually expand the emotional experiencing and learning of DBT skills (Reber and Lebowitz, 2011).

Reber and Lebowitz (2011) “recognized the potential benefit to the patients in providing an arts-based approach to learning and personalizing the skills learned in DBT treatment” (p. 337). They hoped that their integrative approach of combining DBT with ExTH would provide clients with a visual guide of the skills learned, as well as strengthen knowledge of the skills, resulting in more frequent independent skills use (Reber & Lebowitz, 2011). Furthermore, they believed that adding an arts-based component to DBT would help the kinesthetic and tactile learners engage more effectively in the more didactic, classroom-like learning of a typical DBT skills group. As Huckvale and Learmonth stated (2009), “It is the synergistic and catalytic processes between art, learning and therapeutic understandings that are the differences that make a difference” (p. 62).

Reber and Lebowitz (2011) focused their integration of the arts and DBT in a specialized program at McLean Hospital, in which the main treatment model is adapted from DBT. This program is for female adolescents only and, because it is self-funded, caters to individuals from financially privileged backgrounds. Most of the adolescents in the program had emerging borderline personality disorder traits and a history of self-harm and suicidal ideation.

Reber and Lebowitz (2011) developed and ran their expressive arts-based groups for two years and, as a result, made many observations related to the effectiveness of the groups. They

noticed that the individuals participating in the groups tended to fall into several categories in regards to their reactions to the group session.

Some of the girls came into the group with a high level of anxiety related to perfectionism; these individuals initially were fearful and hesitant to participate in group. Their anxiety frequently led to agitation and frustration and sometimes was so overwhelming that they struggled to begin with the art prompt. Reber and Lebowitz (2011) supported these girls by working in a “directive fashion” (342). They also frequently modeled DBT skills such as cheerleading statements and self-validation. Other residents came into the group with enthusiasm and an eagerness to engage in a creative activity. These residents engaged willingly and fully from the start; they often chose to display their artwork in their rooms and seemed to create art and images that held personal meaning to them.

Reber and Lebowitz (2011) deduced from their observations that their group had value across the board for all residents. They discussed one resident who always rolled her eyes when it was group time, stated she had no artistic ability, and chose to write about the prompts instead of using the art materials. Despite her initial resistance, over time, the group leaders noticed an increase in her self-esteem and a decrease in her isolating behaviors. They also had many residents ask them for second and even third art journals, choosing to use them to help build mastery and as a mode of distress tolerance outside of group time. One resident who initially struggled with group avoidance, preferring to stay in her bed, slowly began attending group. At first, she would frequently arrive over thirty minutes late to group due to the amount of time it took her to get out of bed; however, over time, she became more engaged and would even ask for art supplies so that she could finish the directives on her own time. Since her discharge, she has

been back to visit and has shown her post-program sketchbook to the therapists (Reber and Lebowitz, 2011).

Through their trial and error process of developing a fusion between the expressive arts and DBT, Reber and Lebowitz (2011) observed many positive changes in their clients. They hope in the future to address the issue of minimal research in this area by taking the step to pursue qualitative research on the benefits of an expressive arts-based DBT group.

Megan Shiell began combining art therapy and DBT during her internship in a private psychiatric hospital in Australia. Clients commented that it was sometimes hard for them to concentrate in the didactic DBT skills group, furthermore, Shiell noticed that clients seemed to engage in group more when they were able to be creative. Shiell also reported a change in how they shared at the end of each group, noting that when clients did art, they were better able to communicate the skills they had learned (Sheill, 2021). She felt that "by creating original artwork in response to the formal psychoeducation based lessons, they could more fully articulate DBT concepts in ways that made personal sense" (Shiell, 2021, p. 60).

In Shiell's sessions, if a client engaged in a target behavior, a behavior chain analysis was conducted. After, she reviewed with the client DBT skills that could help them avoid the problem behavior in the future. Additionally, Shielle had the client create an image that relates specifically to that skill. Shiell noticed that discussing art metaphorically was less threatening for many clients and increased their willingness to share their distress (Shiell, 2021). Furthermore, the possibility of change was explored through the created art (Shiell, 2021). Shiell wrote about an experience with one individual client who shared that her art helped her retain the information learned in the session. The client would, at times, refer back to earlier pieces because the art

allowed her to connect with the "DBT skills she had explored through those previous artworks" (Shiell, 2021, p. 62).

Karin von Daler and Lori Schwanbeck developed Creative mindfulness (CM) in 2004 out of a need to work "creatively and effectively with highly reactive clients presenting with emotional vulnerability and self-harm impulses" (von Daler & Schwanbeck, 2014, p. 182). They noticed that extremely dysregulated clients often needed an immediate focus on behavioral and cognitive change in order to help the client stay safe. Therefore, CM was formed as a way to "integrate the effectiveness of DBT with the creative and sensory modes of self-expression and learning of expressive arts therapy" (von Daler & Schwanbeck, 2014, p. 182). Creative mindfulness fully integrates the possibilities that come from engaging with the imagination and creativity of expression, deepening the potential for transformation, growth, and engagement in DBT (von Daler & Schwanbeck, 2014).

von Daler and Schwanbeck (2014) hypothesized that using creativity to explore concepts from DBT would create more interest and engagement. They observed that the playful atmosphere allowed clients that frequently responded with willfulness and hopelessness to be more interested and open to the experience (von Daler & Schwanbeck, 2014). Furthermore, the use of the expressive arts provided opportunities to learn and practice skills *in vivo* rather than purely through theoretical discussions. After participating in Creative Mindfulness, clients began to report more skill use (von Daler & Schwanbeck, 2014).

Creative Mindfulness is inspired by neuroscience research (van der Kolk, 2014). CM seeks to engage the brain in both top-down and bottom-up approaches (von Daler, 2021). Mindfulness as a tool for emotional regulation can be thought of as a top-down approach since mindfulness focuses on the brain's higher functions, such as awareness and cognition. By

focusing on changing one's awareness and cognition, increased emotion regulation may follow. However, persistent emotion dysregulation often originates from earlier preverbal trauma, which may require a bottom-up approach that directly engages the body and senses (von Daler, 2021). CM combines the bottom-up and top-down approaches to create a method that aims to "access the deeper sensory imprints while tapping into the regulatory benefits of mindful attention" (von Daler, 2021, p. 202).

van der Kolk's (2014) research suggests that multisensory memories are more accessible than cognitive ones. Therefore, CM hypothesizes that an experience will make a more significant impression on the brain if multiple sensory centers are engaged during the new learning experience (von Daler, 2021). This suggests that combining expressive therapy with DBT as is done in CM allows individuals to engage more fully with the content and gain a deeper, more personal understanding of the skills.

Expressive therapy, when used in combination with DBT, incorporates the best of both worlds. It utilizes the containing properties of the arts to practice the DBT skills of emotion regulation and distress tolerance while still balancing the dialectic between acceptance and change. Furthermore, the arts provide sensory input as well as practical applications of mindfulness in action all while increasing engagement in treatment (Shiell, 2021).

Discussion

The expressive therapies can be used as a tool to increase engagement and help clients take on a more active role in the therapeutic process. "The experience of doing, making, and creating can actually energize individuals, redirect attention and focus, and alleviate emotional stress, allowing clients to fully concentrate on issues, goals, and behaviors" (Malchiodi, 2005, p. 10). Having discussed parallels between DBT and expressive arts therapy and reviewed the

existing research on integrating ExTH with DBT to increase DBT's effectiveness, I will now reflect on some of the limitations of the current research, examine my own lived experience on implementing an arts based DBT skills group and consider future research directions on this topic.

Limitations to the Current Research

Currently, research on DBT, specifically adolescent DBT in residential settings, is fairly limited. These limits are even more noticeable relative to research on the integration of DBT with expressive arts therapy. Common limitations include samples often consisting of primarily female identifying clients (McCauley et al., 2018, and Reber & Lebowitz, 2011). Furthermore, none of the studies I read mentioned gender identity or sexuality. All studies stayed within the gender binary, so they either did not include individuals who identified as non-binary or they required those individuals to select the gender they were assigned at birth when collecting participant data. This is notable considering that suicide risk is significantly higher for individuals identifying as transgender or non-binary. Over 60% of transgender and non-binary youth report engaging in self-harm, and more than 50% of transgender and non-binary youth have seriously considered suicide, while 29% have actually made suicide attempts (The Trevor Project, 2021). By staying within the gender binary, a large group of individuals who could potentially benefit from the treatment were excluded from the research.

Additionally, I noticed that most of the research included in this literature review included participants coming from relatively affluent socioeconomic backgrounds, presumably because few DBT practices take insurance. Thus, DBT frequently self-selects individuals from more privileged economic backgrounds. For instance, Reber and Lebowitz (2011) conducted research at McLean hospital in a self-funded treatment program; therefore, most of the

participants in their program came from affluent backgrounds. In contrast, the population I worked with at my internship site was quite different. Many of the individuals are in foster care or are living with guardians other than their biological parents. Furthermore, many have experienced poverty and food insecurity, and the motivation to engage in treatment is quite variable. There is limited research on DBT within such populations.

Practical Applications

Although the ongoing COVID-19 pandemic delayed my ability to create a method, I was still able to begin to put my ideas of integrating ExTH into a DBT skills group into practice. Here I will describe some of my experiences as well as takeaways that I hope to apply to future research on this subject matter.

I began by creating an arts-based group for individuals in comprehensive DBT at my internship site, an alternative public educational and clinical center that serves children and adolescents between the ages of ten and twenty-one. This group catered to the needs of five residential girls in comprehensive DBT. The students in this particular DBT program typically struggle with emotion regulation, low self-esteem, low tolerance of frustration and distress, as well as interpersonal challenges such as difficulty getting along with peers and conflict with authority figures. I chose to add a group to their treatment plan rather than integrate art directly into the didactic skills group. This way, I did not take away any of the preexisting aspects of comprehensive DBT. The fidelity of the model remained, and the program the teens are in is still considered comprehensive DBT. This hour-long group met weekly and followed along with the content taught in the didactic skills group (also weekly). Each week, in this arts-based group the group used the arts to explore one or two aspects discussed in the didactic group. At the time of

this writing, I had conducted four weeks of the arts-based skills group. The response to the art-based skills group has been overwhelmingly positive.

In each group, my goal was for individuals to engage with the creative activity, thus interacting with the material taught in the didactic group in a more personal manner. I hoped that the girls would begin to apply the skills to their own lives and would come away from each group with a concrete reminder of the skill that they could refer to in the future to either help them remember the skill or aid in applying the skill to their own life.

One unexpected positive result of this group has been that some of the activities (particularly the mindfulness-based projects) also worked on interpersonal effectiveness skills. For instance, in one of the first groups, we reviewed the core mindfulness skills known as the “what” and “how” skills (Linehan, 2015). This group started with a relatively simple yet involved origami project. Each group member chose eight pieces of origami paper and was instructed on how to fold each piece in turn. They were then shown how to fit and fold the pieces together to create a dynamic origami piece that moved from a pinwheel to an octagon. Although the girls did experience some frustration during this endeavor, with assistance from me and my co-leader, they were able to tolerate their distress. Although this was designed to be an individual experience, the girls ended up working together and helping each other as they figured out how to complete the octagon. This was especially nice to see as the girls frequently struggle to get along with each other and engage appropriately. Although this activity was meant originally as purely focused on mindfulness, it became evident that it also developed interpersonal effectiveness skills.

In this same session, the group made slime. The girls knew we were going to make slime from the beginning of the group. I believe this acted as an incentive and reinforcement to stick

with the origami project. For the remaining part of group, the girls each made their own slime, adding colors, glitter, and even essential oils. We briefly discussed using the observe and describe skill while making the slime and remaining mindful while creating the slime. In the following days and weeks, I have observed the girls using their slime as a distress tolerance skill both in the classroom and in the residential unit.

DBT offers many metaphors and guided imagery to help individuals find ways to visualize and feel connected to their wise minds. In one of my groups, I wanted to introduce the girls to several ways of picturing wise mind to help them figure out what might work for them. Using a complex multi-step process that included multiple imagery exercises, by the end of group individuals created a small portable booklet of skills they found effective or would be willing to try to help them find wise mind in times of distress.

The girls were less engaged in this activity. They had an immediate reaction when they saw the drawing materials they were to use, stating that they did not like drawing. Furthermore, this group came the week after slime making, and it seemed like anything we did would have fallen short of making slime. One group member left after we did the guided imagery exercises, stating she had a headache; another group member did not create her own set of cards and opted to do her own art. Next time, I would try other art-based activities to familiarize participants with wise mind, perhaps using masks or clay to create 3D representations of their wise mind since the girls were not inspired by the drawing aspects of the activity.

Throughout the past month of conducting these arts-based DBT skills groups, I noticed that the girls were most engaged when the activities resulted in a takeaway object. This particular group has so far expressed disinterest in drawing and painting. They showed higher levels of engagement when there was more structure to the materials, such as collage-making from precut

magazine images and words. They gravitated towards activities that included a step-by-step process with a finished product that they could use or play with. Interestingly, they also seemed to really appreciate writing and poetry-related activities. Direct feedback from one group member was that they found the blackout poetry group on self-validation most meaningful and relevant to their life and treatment goals.

Anecdotally, it does appear that this group helped the girls become more engaged in their DBT treatment experience. For instance, one resident has incorporated the sensory bottles we made into her daily routine. Each morning and night, she shakes her sensory bottle and says the phrases on it out loud, similar to an affirmation. These sensory bottles were made as a way to reflect on all-or-nothing thinking traps that the girls frequently experience. The girls challenged these thoughts using dialectics and wrote on the outside of the bottle phrases to help them remember both sides of the dialectic. They wrote phrases such as "I can be sick of using DBT skills and yet decide to keep using them," "I can be brave and still have struggles," and "I can be independent and still need support."

I have also noticed an increase in engagement in the didactic skills group. For instance, one week, at the start of the didactic group, the girls were sharing their DBT homework. One individual was very excited to share a haiku she had made about self-validation the previous day in our arts-based group. I was amazed that she knew her poem by memory and wanted to share it, especially considering that she had already shared it with her fellow group members the day before.

Future Research

I look forward to continuing this research post-graduation. As an individual coming from a science background, I am motivated to increase the breadth of quantitative research in the

expressive therapies. I want to fold my science experience into my future research as an expressive arts therapist. This is not to say that there is no value in qualitative and arts-based research; however, I believe that in order to increase belief and acknowledgment of the field as a valid treatment option, there is a need to use research methods that the medical world, insurance companies, and government agencies value (Kottler & Shepard, 2015). Comprehensive DBT as a whole is already well researched and accepted as an evidence-based practice. Therefore, it is time to take a “value-added” approach (Malchiodi, 2021, p. 23) to demonstrate how an expressive arts-based approach to DBT can further increase the value of DBT by increasing engagement and willingness of adolescents in comprehensive DBT.

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

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