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**THE POWER OF FILM:  
A MODEL FOR THE USE OF GROUP CINEMATHERAPY IN THE  
THERAPEUTIC TREATMENT OF CLINICALLY DEPRESSED ADOLESCENTS**

**BY**

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B.A., University of New Hampshire, 2001  
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**THESIS**

**Submitted to the University of New Hampshire  
in Partial Fulfillment of  
the Requirements for the Degree of**

**Master of Arts  
in  
Counseling**

**September, 2006**

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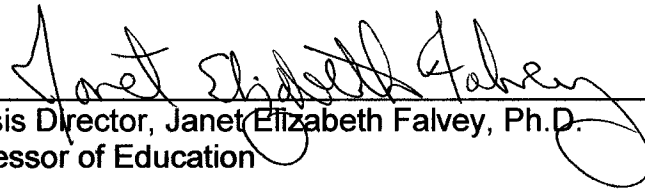
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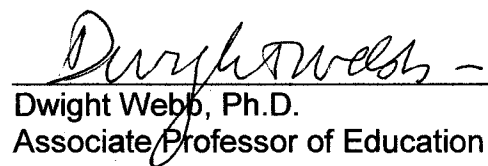
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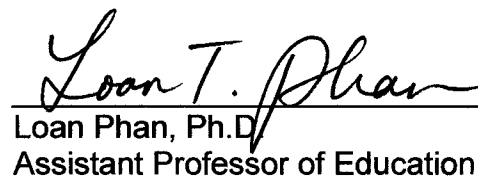
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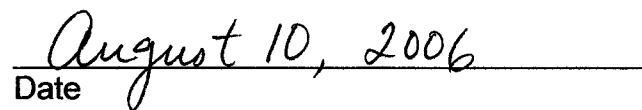
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\_\_\_\_\_  
Date

## DEDICATION

To my husband Jim –

My best friend, my confidant, my partner in life. I could never have done this without you. I can't wait to see where the next adventure will take us.

To my very loving family –

Thank you for always encouraging, always believing, always loving. I am blessed to have a wonderful family, and am thankful every day for your love and support.

To my mother –

You are my hero, Mom. I could only succeed by having you to look up to.

To my Gram –

My other role model. I miss you. Thank you for giving me such an extraordinary example of a life well-lived, and for continuing to keep an eye on me.

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I would like to thank my peers within the graduate program. Tara Jordan, Jennifer Conant, and Christopher Hanes have been instrumental in completing this work. Chris, thank you for checking my formatting, proofreading copies, and reminding me that eventually it will all get done. Tara and Jenn, thank you for giving me the opportunity to brainstorm new ideas, to develop the model that eventually included the group therapy approach, and giving much-needed emotional support throughout the process. You are wonderful friends and I look forward to working with you as colleagues, not just peers.

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## ABSTRACT

# THE POWER OF FILM: A MODEL FOR THE USE OF GROUP CINEMATHERAPY IN THE THERAPEUTIC TREATMENT OF CLINICALLY DEPRESSED ADOLESCENTS

by

Erin E. Farrell Bowen

University of New Hampshire, September, 2006

The following thesis proposes a model for the use of cinematherapy as part of treatment for clinically depressed adolescents. The thesis outlines the rationale for such a model, including the relative convenience and potential benefits of using movies as a therapeutic technique. This thesis also examines the professional literature regarding the topics of cinematherapy, bibliotherapy, group therapy, therapeutic metaphor, metaphoric techniques in therapy, and adolescent depression. A model is proposed to offer a specific framework in which cinematherapy may be used in the group treatment of adolescent depression, as well as tools that may assist clinicians in monitoring treatment outcomes. Finally, a discussion is offered regarding the potential benefits and drawbacks of the proposed model, as well as implications for future research and applications of the model.

## CHAPTER I

### INTRODUCTION

Adolescent depression is certainly not a new or unique concept within the field of counseling. For decades counselors have struggled with the presenting problems of depression, as well as the difficulty of effectively working with an adolescent population. Multiple approaches have been utilized with depressed adolescents with varying degrees of success. The following model proposes one method of working with a variety of adolescents who may be experiencing depression in unique and different ways by offering cinematherapy in a group format for depressed adolescents.

#### **Statement of the Problem**

Adolescent depression represents a major problem in the U.S., both in the field of mental health and for society as a whole. Current estimates place the rate of adolescent depression anywhere between four and ten percent (Dopheide, 2006), with a lifetime prevalence for depression estimated at 18% to 23% for women and 8 % to 11% for men (Chen, Lu, Chang, Chu, & Chou, 2006). Adolescents often present with unique depressive symptomatology, and are frequently resistant to traditional talk therapy. Increasing health care costs, coupled with lessening insurance and HMO coverage for mental health care, has led to fewer people accessing mental health care and having less time with a clinician in which to address their difficulties. Additionally, new research indicates

that antidepressants, while safe for adults, may not be safe for adolescent clients (United States Food & Drug Administration [FDA], 2004). These issues present a quandary for the mental health counselor, who is left with limited options to treat a pervasive problem.

Depressed adolescents can present with a variety of symptoms including irritability, social withdrawal and isolation, depressed mood, loss of emotional affect, guilt, acting out socially or at home, drug and/or alcohol use, increased or decreased sleep, increased or decreased appetite, anhedonia, fatigue, tearfulness, anxiety, excessive worry and/or obsessing, inattentiveness, difficulty concentrating, suicidality and/or suicidal ideation, and complaints of physical pain (American Psychological Association Diagnostic and Statistical Manual of Mental Disorders, 2000 [*DSM-IV-TR*]; NIMH, 2005). The issue is complicated further when one considers the range of developmentally appropriate inconsistent moods and behaviors of adolescents who do not have depression. Given the exorbitant number of potential symptoms, as well as the potential for suicidality, it is easy to identify why the treatment of such difficulties is of great import.

The need for effective treatment becomes even more apparent when examining recent statistics regarding adolescent depression. The National Institute of Mental Health (NIMH) and the National Alliance for the Mentally Ill (NAMI) estimate that four percent of adolescents will experience Major Depression in their lifetime (NAMI, 2003; NIMH, 2004). When this percentage is compared with the population statistics of the latest U.S. Census (2000), it can be estimated that 1.6 million teenagers may experience Major Depression in their

lifetime. This percentage does not include other depressive disorders, such as Bipolar Disorders I and II, Dysthymic Disorder, Cyclothymic Disorder, and Depressive Disorder Not Otherwise Specified.

Many types of treatment have been attempted by clinicians, with varying degrees of success, to treat symptoms of adolescent depression. One of the most common treatments for adolescent depression and a variety of other mental illnesses is traditional talk therapy. Other methods include sandplay therapy, narrative therapy, family therapy, dance therapy, and adventure-based therapy. Recently, in an attempt to match counseling techniques with the technology of the new millennium, computer software programs have been utilized as an attempt to treat a variety of mental illnesses (Cavanagh & Shapiro, 2004). It also would be impossible to ignore the popularity of bibliotherapy, the use of the written word to create therapeutic metaphors for clients, in the treatment of mental illness from a variety of theoretical viewpoints including the treatment of adolescent depression.

The implementation of group therapy techniques in the clinical treatment of adolescents is popular with counselors. Group therapy has been used to treat a myriad of presenting adolescent problems including aggression, social phobia, sexual abuse, and suicidality (Hayward et al., 2000; Hazzard, King, & Webb, 1986; Kastner, 1998; Miller, 1999). Considering the importance of peers during the time of adolescence, it seems likely that adolescent clients may perform well in a group setting due to their need to complete developmental tasks around socialization with peers and detaching from adults (Aronson, 2004). However,

social withdrawal is often a symptom of depression (*DSM-IV-TR*, 2000), and may hinder treatment in a group setting with some adolescents.

Bibliotherapy has also proven to be a fruitful technique for many clients; the plethora of self-help literature is evidence of this. It has been widely used with varying degrees of success to treat depression (Ackerson, Scogin, McKendree-Smith, & Lyman, 1998; Gregory, Schwer Canning, Lee, & Wise, 2004). However, in this age of rapidly changing technology, books are simply not as popular as they once were, both with clients and clinicians. While books can be a powerful and meaningful clinical resource, clients are increasingly disinclined to take a great deal of time and effort to read a book. When considering that depressed adolescent clients may be lethargic, apathetic, or anhedonic, reading may not be an activity in which they are willing to participate. Additionally, adolescents tend to rank reading very low on scales of their preferred leisure activities, far below video games, watching movies and television, and listening to music (Nippold, Duthie, & Larson, 2005). Therefore it would seem that bibliotherapy is not an adequate tool for this population.

On the other hand, it may be easy to convince a client, especially an adolescent client, to watch a popular film as a part of their counseling process. As many researchers point out, watching movies is a pastime in which many people already engage (Dermer & Hutchings, 2000; Lampropoulos, Kazantizis, & Deane, 2004; Sharp, Smith, & Cole, 2002). In addition, films are inexpensive, enjoyed by almost everyone, can fit into a variety of theoretical approaches, and generally take only about two hours to view (Dermer & Hutchings, 2000; Sharp et

al., 2002). Films can be used in the therapy session in clips or segments, or can be used outside of therapy as an adjunct therapeutic tool (Lampropoulos et al., 2004; Wedding & Niemiec, 2003). Generally speaking, the use of popular or commercial films in counseling or therapy is known as “cinematherapy.”

### **Purpose of the Model**

Considering the popularity of movies with adolescents, it seems only natural that cinematherapy could be an appropriate therapeutic technique to use with this population. In addition, since this model concentrates specifically on clinically depressed adolescents, it may be easier to motivate a depressed adolescent client to watch a film than to engage in other, more strenuous therapeutic techniques. Furthermore, by pairing film-viewing with another popular adolescent pastime, peer interactions, it seems as if a cinematherapeutic group technique would hold great value for this population. The proposed model offers a specific structure for the use of cinematherapy as a group treatment for depressed adolescents.

### **Implications**

The implications of the proposed model are varied. Cinematherapy may have a positive influence on the depressive symptoms, self-concept, and hopelessness of clients. It may be more widely used by clinicians in clinical practice if given access to the proposed guidelines. Furthermore, the structure of the model may be modified for use with other clinical populations.

The inclusion of cinematherapy in clinical practice will allow for an additional tool for use in short-term counseling. This approach offers cost-



effectiveness to clinicians and agencies with growing financial concerns, as films are readily available and relatively inexpensive to rent or purchase. The use of cinematherapy in a group format also lends to increased cost-effective treatment.

Potential drawbacks also exist for the use of cinematherapy as a treatment option. As indicated in the cinematherapy literature, films must be screened by treating therapists before recommending or viewing the film with clients (Dermer & Hutchings, 2000; Lampropoulos et al., 2004; Sharp et al., 2002). This can take a great deal of time, and may require therapists to view many films outside of their workplace due to busy schedules and agency unwillingness to pay employees while they view movies. In addition, agencies would have to have the appropriate equipment to view films available in order to utilize this particular technique, which could be costly for some mental health centers and/or schools that may already have budgetary concerns.

### **Definition of Terms**

For the purpose of this model, *cinematherapy* is defined as a specific therapeutic intervention that involves selecting commercial films for clients to view individually or with others outside of the therapy session as a means for therapeutic gain (derived from Berg-Cross, Jennings, & Baruch, 1990). This intervention should be provided by the group leader and would be adjunct to traditional therapy approaches.

*Adjunct treatment* is defined as a therapeutic intervention that is auxiliary to traditional therapy (e.g., talk therapy in a clinical setting for fifty minutes) as a means of increasing positive therapeutic outcomes.

An *adolescent client*, for purposes of this treatment, is defined as any individual between the ages of 14 and 17 years who is currently involved in counseling or therapy services and has a clinical diagnosis within the depressive mood disorders category of the DSM-IV-R.

*Clinical depression* is categorized as a set of behaviors that meet the criteria for Major Depressive Disorder, Major Depressive Episode, or Depressive Disorder NOS as defined by the *DSM-IV-R*. Adolescents should not be considered for cinematherapeutic techniques if they have suicidal ideation, auditory or visual hallucinations, delusions or paranoia, or have a Global Assessment of Functioning (GAF) score of below 50, indicating severe disturbance in functioning (DSM-IV-TR).

*Therapeutic metaphor* will be defined as a symbolic or figurative intervention used as part of therapeutic treatment of a client. Examples of such metaphors can be seen in the use of bibliotherapy, adventure-based therapy, dance therapy, and cinematherapy.

### **Summary**

The proposed model offers an alternative treatment option for the pervasive and challenging diagnosis of adolescent depression. The following chapter will present professional literature related to the topics relevant to the model, including adolescent depression, group therapy, therapeutic metaphor, bibliotherapy, and cinematherapy. Following the literature review, the specific framework for utilizing cinematherapy with a group of depressed adolescents is presented, with specific films being used in the model to offer an example of

appropriate processing of specific films. Finally, the fourth chapter discusses the implications for use of the proposed model, as well as recommendations for future research within the area of cinematherapy and adolescents. Appendices are included following the list of references for the specific forms and tools used within the proposed model.

## CHAPTER II

### LITERATURE REVIEW

#### **Introduction**

The proposed model aims to provide a framework for utilizing cinematherapy with clinically depressed adolescents, which requires the understanding of several concepts within the professional literature. This chapter will focus on findings within the professional literature into several topic areas, including 1) the symptoms, risk factors, comorbidity and treatment of adolescent depression; 2) the use of group therapy in the treatment of depression, the treatment of adolescents, and indications of the efficacy and drawbacks of group therapy; 3) the definition and uses of therapeutic metaphor in the treatment of depression, including bibliotherapy and cinematherapy; 4) the use of bibliotherapy with depressed adolescent and adult participants; and finally 5) the current definition and use of cinematherapy and film within the counseling field, as well as the influence of movies on adolescent behavior.

#### **Adolescent Depression**

The literature regarding adolescent depression is provided to understand how a cinematherapeutic approach is useful with this population, as well as specific information regarding the identification of depression, risk factors for developing depression, and the challenges in working with clinically depressed adolescents. The literature in the following section is examined in terms of the

symptomatology of adolescent depression, risk factors for depression, comorbidity of depression with other disorders, and treatments for adolescent depression.

### Depression Symptomatology

Research regarding the symptomatology of adolescent depression has been fairly consistent in identifying a list of potential symptoms of clinical depression, as well as risk factors that may contribute to adolescent depression. A study conducted by Petersen, Compas, Brooks-Gunn, Stemmler, Ey, and Grant (1993) examined various facets of depression in adolescence, including symptomatology, risk factors, and prevention and treatment programs. According to the authors, depression tends to be categorized into three areas: depressed mood, depressive syndromes, and clinical depression (Petersen et al., 1993). Each categorization has led to different types of research, though the characteristics of depression remain consistent. Typically, “sad or depressed mood is usually experienced with other negative emotions, such as fear, guilt, anger, contempt, or disgust” (Petersen et al., 1993, p. 156). Depressed mood is also “likely to be linked with other problems, such as anxiety and social withdrawal” (Petersen et al., 1993, p. 156). These symptoms are consistent with the criteria found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychiatric Association, 2000) for Major Depressive Episode, Major Depressive Disorder, and Depressive Disorder NOS. It should be noted that agitated behaviors, such as fidgeting or an inability to sit still, are also associated with depression in childhood and adolescence (DSM-IV-TR, 2000).

## Depression Risk Factors

Lewinsohn, Roberts, Seeley, Rohde, Gotlib, and Hops (1994) examined the psychosocial risk factors for adolescent depression. The authors' findings indicate a variety of risk factors, including history of current and past psychopathology; previous suicide attempt; depressotypic cognitive style; negative body image; low self-esteem; excessive emotional dependence on others; more self-conscious; using less effective coping mechanisms; and reporting less social support (Lewinsohn et al., 1994). These results imply that the potential for depression is great for many adolescents who report such traits.

In 2001, a study was conducted regarding gender differences in the vulnerability of developing internalized symptoms as a result of parental discord (Crawford, Cohen, Midlarsky & Brook, 2001). Results indicated no gender differences in early adolescents; however, significant differences were found in mid-adolescence, at which time parental distress was increasingly internalized by participants. The authors found that parental distress was significantly associated with internalizing symptoms in female adolescents but not in male adolescents during mid-adolescence (Crawford et al., 2001). These results indicate that female adolescents may be at higher risk for developing depressive symptoms than their male peers, and thus clinicians must use caution when working with adolescent girls.

A study by Monroe, Rohde, Seeley, and Lewinsohn (1999) regarding the first onset of major depressive disorder in adolescence examined relationship loss as a risk factor. The authors' findings indicate that relationship loss is

associated with a “heightened likelihood of first onset (of) major depressive disorder during adolescence” (p. 606), particularly if a recent break-up is reported. However, a recent break-up did not necessarily indicate a recurrence of depression. The results were consistent and significant for both genders (Monroe et al., 1999). These findings indicate that the risk factors for the onset of adolescent depression are varied, and should be taken into account when working with adolescent clients who may not be reporting depressive symptoms, but do report such risk factors for depression.

A study conducted by Schneiders et al. (2006) examined the effects of daily negative effects on the mood reactivity of adolescents as it relates to the development of psychopathology. The authors compared the mood reactivity to negative events between high-risk and low-risk adolescent groups (Schneiders et al., 2006). The authors found that adolescents in the high-risk group were more reactive to negative events, experienced greater decreases in positive affect, and experienced greater increases in depressed mood (Schneiders et al., 2006). Negative events consisted of poor interactions with family members, bad events at school, negative interactions with peers, and “other” events that the participants rated subjectively (Schneiders et al., 2006). The results of this study point out the high risk for development of depressive symptoms among particular groups of adolescents, particularly those who have low socioeconomic status (SES), poor familial and/or peer relations, and poor self-esteem. What is also interesting to note about this study is the adolescents in the high-risk category did not report significantly more negative events or less positive daily events than

their low-risk counterparts; they appeared to have an increased negative reaction to negative daily events (Schneiders et al., 2006). The adolescents in the high risk group also rated negative daily events as more stressful than those in the low risk group. It should be noted that there were only 25 participants in the high-risk group, while there were 106 participants in the low-risk group, a significant limitation of this particular study. However, the study does indicate the importance of awareness regarding the increased likelihood of depression among high risk adolescents.

In a similar study, Allen et al. (2006) examined the development of depressive symptoms in adolescents through a social-interactional model. The participants of the study were 143 seventh and eighth graders, along with their parents and close friends (Allen et al., 2006). The results indicated that for adolescents with higher baseline levels of depressive symptoms, behavior undermining autonomy and relatedness with their mothers was a stronger predictor of future depressive symptoms than for those with lower baseline levels of depressive symptoms (Allen et al., 2006). In addition, behavior undermining relatedness with close friends, calls for emotional support from close friends, and social withdrawal were all found to be predictive of future depressive symptoms (Allen et al., 2006). It seems clear through examining these results that the relationships with both family and peers must be examined when working with adolescent clients, as each contributes significantly to the potential development of depressive symptoms.



Another interesting article regarding the risk factors in the development of depression among adolescents was by Erermis et al. (2004), in which the authors examined the effects of obesity as a risk factor for psychopathology among adolescents. The participants, adolescents living in a major Turkish city, were placed into three groups: an obese clinical group, an obese non-clinical group, and an average-weight control group (Erermis et al., 2004). The mean scores resulting in the study indicated the clinically obese group had higher rates of aggressiveness, anxiety-depression, social problems, social withdrawal, internalizing behavior and externalizing behavior (Erermis et al., 2004). Interestingly, the results also indicate that the male participants in the obese group had significantly lower self-esteem than the female participants in the obese group, while the female participants in the obese group had significantly higher rates of aggressiveness and externalizing behavior than the male participants of the same group (Erermis et al., 2004). The presence of depressive disorders was also higher in the obese groups than in the normal weight control group, particularly among the clinically obese participants (Erermis et al., 2004). The results of this study are indicative that obesity may be linked to depression among adolescents, and again is important for clinicians to note when working with an adolescent population.

#### Comorbidity with Depressive Disorders

Adolescent depression has been linked to a variety of other mental health problems, as well as a myriad of other psychosocial and physiological issues. A study conducted by Rohde, Lewinsohn, and Seeley (1991) examined the

comorbidity of unipolar depression with other mental disorders. Their results indicated that adolescents who were depressed at the time of the study were “more likely than expected by chance to have an additional current mental disorder, except bipolar disorder” (Rohde et al., 1991, p. 216). The authors’ findings suggest a potential hurdle within the therapeutic process, as treatment for depression may be compromised by comorbid disorders.

Similarly, a study by Latimer, Stone, Voight, Winters, and August (2002) examined gender differences in psychiatric comorbidity among adolescents with substance use disorders. Their results indicate that female adolescents who abuse drugs exhibited higher rates of major depressive disorder (Latimer et al., 2002). However, the rates of comorbidity between substance use and dysthymia, ‘double depression’ (dysthymia and major depression) and bipolar disorder were even among both genders (Latimer et al., 2002). Unfortunately, the study could not determine if substance use led to higher rates of depression, or if depression led to higher rates of substance abuse among participants (Latimer et al., 2002). Therefore, substance use and abuse should also be closely considered when treating adolescents reporting depressive symptoms, as should depression and other mental disorders when treating substance abusing adolescents.

Repetto, Caldwell, and Zimmerman (2005) found that depressive symptoms in a population of 623 African-American youths were linked to smoking in later life during a longitudinal study investigating depression, African-American youth, and cigarette use. Similarly, Weiss et al. (2005) found a distinct association between levels of adolescent hostility, depressive symptoms, and

smoking. In their study conducted with 1699 culturally diverse sixth grade participants, with a follow-up in seventh grade, the authors found that higher levels of hostility and depressive symptoms led to increased smoking among the participants (Weiss et al., 2005). The results of these studies indicate the potential negative behaviors that can arise from adolescent depression.

### Treatment of Depression

Various treatments for depression in adolescence are found throughout the professional literature. Specific treatments incorporating bibliotherapy, cinematherapy, and other metaphorical techniques are discussed later in the chapter. Lewinsohn, Rohde, and Seeley (1998) examined the types and frequency of mental health treatment for depressed adolescents. They found that the treatments included inpatient and outpatient psychotherapeutic treatment, as well as psychopharmacological treatments. The authors also found “treatment utilization for depressed adolescents to be higher than has been reported in some previous studies” (Lewinsohn et al., 1998, p. 51). This may be an indication that adolescents are utilizing available services more frequently for depressive symptoms; however, the results could have been skewed based on the sample population, whose racial, ethnic, and socioeconomic demographics were not discussed within the study; or the geographic location of the study, western Oregon.

Glass (2004) explores the treatment of adolescents with fluoxetine (brand name Prozac), a selective serotonin reuptake inhibitor. Results of a major trial indicate that the combined use of fluoxetine with cognitive-behavioral therapy

(CBT) yielded the most significant decrease in depressive symptoms. The use of fluoxetine alone was also found to be significant in decreasing depressive symptoms, but did not reduce the symptoms as much as the combination of fluoxetine and CBT. However, considering the recent warning by the FDA regarding potential suicidality in adolescents using anti-depressant medications (United States Food and Drug Administration [FDA], 2004), the use of medications for depressive symptoms in adolescence may not be a safe treatment modality.

### **Group Therapy**

To understand the importance of group therapy as a therapeutic intervention, literature regarding this topic is reviewed. Group therapy is a popular treatment for a variety of clients and clinical disorders, particularly for adolescence. It is important to understand both the clinical gains and positive outcomes of group therapy as well as potential drawbacks and negative outcomes.

#### **Efficacy of Group Therapy**

There is an abundance of literature regarding group therapy, the efficacy of group therapy, and specific aspects of group therapy that often lead to successful group treatment. Since the literature in this particular area is abundant, only a subsection of the literature will be reviewed in this section.

In a study by Roark and Sarah (1989), the authors investigate the factors related to group cohesiveness. Yalom (1985) and others have identified group cohesiveness as an essential part of group efficacy. Roark and Sarah (1989)

investigated the correlation of the factors associated with group cohesiveness: Empathy, self-disclosure, acceptance and trust. The authors found that all four factors are inter-correlated as indicated by group member responses to a questionnaire. In addition, the authors also determined that all four factors are significantly correlated with group cohesiveness (Roark & Sharah, 1989). Finally, Roark and Sharah (1989) determined that personal growth groups were more cohesive than either Driving Under the Influence (DUI) groups or psychotherapy groups. These results indicate that personal growth groups are more likely to have group cohesiveness. However, it should be noted that this study was merely correlational in nature, and a causal effect cannot be determined from the authors' results.

A study conducted by Flowers, Booraem, and Hartman (1981) also investigated the effects of group cohesiveness on client improvement on higher and lower intensity problems. The researchers found that when speakers were attended to by other group members as a function of group cohesion, more problems were disclosed (Flowers et al., 1981). Furthermore, the researchers also discovered that external raters noted subjects' improvement on higher intensity problems disclosed in highly cohesive sessions was significantly greater than on the problems disclosed in lower cohesive groups (Flowers et al., 1981). Finally, the authors note that "the cohesion measure of attending-to-the speaker was also correlated to the number of members trusted and ratings of satisfaction each session to validate this criterion measure" (Flowers et al., 1981, p. 246). In other words, cohesion was related to increased trust of other members and

satisfaction with group sessions. These findings are also significant when considering how to most efficaciously facilitate a therapy group.

In another study related to group cohesiveness, Marmarosh, Holtz, and Schottenbauer (2005) examined several factors related to group efficacy. The results of their study demonstrated significant correlations between collective self-esteem, group cohesion, and depression. Furthermore, Marmarosh et al. (2005) determined that collective self-esteem significantly predicted personal self-esteem and also significantly inversely predicted depression. In other words, collective self-esteem was negatively correlated with depression in group members. The results also indicate that a model that has group cohesion that leads to collective self-esteem fits current data better than a model with group collective self-esteem leading to group cohesion. In other words, groups that establish cohesion may lead to collective self-esteem, which in turn predicts decreased levels of depression among group members (Marmarosh et al., 2005). This particular finding is significant in terms of the model presented in chapter three, in which group activities are outlined to increase group cohesiveness.

A study by Burlingame and Krogel (2005) examined the efficacy of group therapy compared with individual therapy. Previous meta-analyses comparing the two treatment types indicated no significant difference in efficacy (McRoberts, Burlingame, & Hoag, 1998; Robinson, Berman, & Neimeyer, 1990). The authors of the current article found that no significant differences in outcome were found in their comparison. However, the participants receiving group treatment made rapid gains in treatment with some minor setbacks, while those receiving

individual treatment “made slower but steadier progress” (Burlingame & Krogel, 2005, p. 610). Overall, the previous findings that indicate there are no significant differences in efficacy between group and individual treatments were upheld.

In another study regarding the efficacy of group versus individual therapy specifically for depression, Wierzbicki and Bartlett (1987) compared the scores on several depressive symptom inventories over time of participants receiving individual therapy, group therapy, and in a delayed treatment condition.

Interestingly, the authors’ findings indicate those in the individual treatment group improved more than those in the other two conditions, contrary to evidence found in previous studies (Wierzbicki & Bartlett, 1987). However, group therapy was still found to be somewhat effective by the researchers. It is also important to note that the study was conducted on a very small group (thirty-eight participants) and the results may not be generalizable to a larger population.

#### Group Therapy for Depression

A study by Chen, Lu, Chang, Chu, and Chou (2006) examined the impact of cognitive-behavioral group therapy on depression and self-esteem. The researchers found that patients who were receiving cognitive-behavioral group therapy were significantly less depressed after group therapy, with the mean Beck Depressive Inventory (BDI) scores changing from 40.15 to 9.42 (Chen et al., 2006). In addition, levels of self-esteem increased significantly for participants receiving cognitive-behavioral group therapy (Chen et al., 2006). It is clear that cognitive-behavioral group therapy is an effective treatment for depression as well as for increasing self-esteem. However, it should be noted that this study

incorporated participants over the age of 18, and that the results may have been different had the researchers examined an adolescent population.

In a related study, Enns, Cox, and Pidlubny (2002) examined cognitive-behavioral group therapy for residual depression. The researchers also examined the influence of self-criticism, self-oriented perfectionism, and socially prescribed perfectionism on the outcome of group cognitive-behavioral treatment. These researchers determined that group cognitive-behavioral therapy led to statistically significant improvements in depressive symptoms as well as self-reported functional status over the course of treatment (Enns et al., 2002). The authors also found that high levels of self-criticism was related to poor outcome of treatment, and that self-criticism was related to both symptom outcome and functional outcome (Enns et al., 2002). These results indicate again that cognitive-behavioral therapy in the treatment of depression can lead to significant improvements in depressive symptoms, and that clients presenting with high levels of self-criticism may have poorer outcomes. Much like the study by Chen et al. (2006), though, this study focused only on adult patients, and included only women, a potential limitation of this research.

Another study focusing on the efficacy of cognitive-behavioral group therapy in the treatment of depression focused on patients with psychotic disorders (Hagen, Nordahl, and Gråwe, 2005). The authors found that the cognitive-behavioral group treatment of patients with psychotic disorders resulted in a significant effect on depressive symptoms both at the post-treatment measure and at the six-month follow-up measure (Hagen et al., 2005).



Additionally, following the group treatment patients indicated a significant decrease in the clinical personality patterns of Compulsive and Negativistic, as well as an increase in psychosocial functioning (Hagen et al., 2005). The researchers determined that group cognitive-behavioral treatment was not effective in changing hopelessness, self-esteem, maladaptive schemas, or psychotic symptoms within the group members (Hagen et al., 2005). The results of this study indicate the potential usefulness of group cognitive-behavioral therapy with patients exhibiting psychotic features. However, it also demonstrates this particular treatment's limitations with this particular population, particularly in its failure to significantly change self-esteem or hopelessness, two key factors in depression.

Areán et al. (2005) examined the treatment of depression in low-income older adults through the use of cognitive-behavioral therapy. Older adults, much like adolescents, can present with unique symptomatology as well as a host of risk factors not seen in other demographic groups (Areán et al., 2005). Unlike previous studies regarding the use of cognitive-behavioral group therapy, this study examined clinical case management in addition to cognitive behavioral group therapy, as well as the effects of combining both treatment types (Areán et al., 2005). The results indicate that group cognitive-behavioral therapy combined with clinical case management led to significantly lower depressive symptoms in 12 months than cognitive behavioral group therapy alone (Areán et al., 2005). This study indicates the potential usefulness of group therapy as an adjunct treatment to other individual treatments, such as clinical case management.

However, as with the previous studies, the results could have differed if examining an adolescent population instead of an older adult population.

In an earlier study by Shaffer, Shapiro, Sank, and Coghlan (1981), the changes associated with both group and individual cognitive behavioral therapy on depression, anxiety, and assertion were measured. Participants were randomly assigned to a cognitive behavioral group treatment, cognitive behavioral individual treatment, or an interpersonal group therapy treatment. Interestingly, the authors found main effects for all three of the treatment modules (Shaffer et al., 1981). This finding is significant, as it indicates that group therapy other than a cognitive-behavioral model may be effective in the treatment of depressive symptoms.

#### Group Therapy for Adolescents

Aronson (2004) examined the appropriateness of group therapy treatment for adolescents based on the novel *Where the Wild Things Are* (Sendak, 1963). In his article, Aronson (2004) describes the struggle of the adolescent much like the protagonist of Sendak's (1963) novel. Aronson indicates the importance of peer interactions in the experience of adolescents, and thus the potential for growth that exists by using a group treatment modality with this age group (Aronson, 2004). Finally, Aronson (2004) indicates how group leaders must nurture and support members while also challenging and confronting them, particularly with adolescent clients. This article provides an appropriate introduction to the literature regarding group therapy with adolescents, which is broad and encompasses many of Aronson's (2004) points. However, it is

important to note the relatively small number of studies regarding the specific treatment of depression in a group modality versus other psychiatric disorders of adolescence, such as anxiety disorders.

Baer and Garland (2005) examined the effects of community-based cognitive behavioral group therapy on the symptoms of social phobia of adolescents. The researchers indicated that participants within the treatment group (cognitive-behavioral group therapy) showed significant improvements in both observer and self-reported symptoms of anxiety than those in the control (wait-list) group (Baer & Garland, 2005). However, no significant changes were observed in the depressive symptoms of adolescents in either group. In addition, it is important to note the small size of the sample; the study contained only twelve participants, six assigned to each treatment group. However, these results indicate the potential for success of a group model with an adolescent population.

In another study regarding social phobia, Hayward et al. (2000) examined the effects of cognitive-behavioral group therapy on the symptoms of social phobia. Participants of the study were female adolescents randomly assigned to treatment and no treatment groups. The results of this study also indicate the success of group treatment on the symptoms of social phobia. At the conclusion of the study, there was a significant reduction of the number of participants who met the DSM-IV criteria for social phobia within the cognitive-behavioral group therapy treatment group (Hayward et al., 2000). In addition, the researchers found that 41% of those in the no treatment group met the criteria for major

depression at the conclusion of the group, while only 18% of those within the treatment group met the same criteria (Hayward et al., 2000). At the one year follow-up, 78% of those in the untreated group met the criteria for major depression and/or social phobia, while only 40% of those in the treatment condition met the criteria for these disorders (Hayward et al., 2000). However, like the study by Baer and Garland (2005), the sample used was small, and may not be representative of a larger adolescent population. Both of these studies (Baer & Garland, 2005; Hayward et al., 2000) are significant due to the overlap of social phobia symptoms and depressive symptoms (Hayward et al., 2000).

Muris, Meesters, and van Melick (2003) investigated the effects of cognitive-behavioral group therapy versus a psychological placebo intervention on the treatment of childhood anxiety disorders. High-anxiety children between the ages of 9 and 12 years were assigned to three groups: cognitive-behavioral group therapy; psychological placebo intervention; or no treatment. The results of the study indicate that cognitive behavioral therapy achieved greater results than the psychological placebo as well as the no-treatment condition (Muris et al., 2002). Approximately 80% of the children within the cognitive behavioral treatment condition achieved significant improvements in clinical symptoms of anxiety (Muris et al., 2002). In addition, children within this group also demonstrated a decline in depressive symptoms (Muris et al., 2002). As with many of the other studies discussed in this section, it should be noted that a small sample size was used (n=30), which could indicate results that are not generalizable.

In another study regarding childhood anxiety disorders, Manassis et al. (2002) examined the efficacy of group versus individual cognitive-behavioral therapy. In this study, the researchers compared the effects of cognitive-behavioral group and individual treatments, both with parental involvement (Manassis et al., 2002). The results indicated that both the individual and group treatments led to decreased symptoms of anxiety and increased global functioning scores as rated by treating clinicians (Manassis et al., 2002). These results are again indicative of the success of group treatment. However, the results must be viewed cautiously with respect to the proposed model of this thesis, given that parental involvement is not a key piece in this thesis.

A study by Wood, Trainor, Rothwell, Moore and Harrington (2001) examined the effects of group therapy for repeated self-harm in adolescents, a potential symptom of major depression. The researchers found that adolescents who were in the group therapy group tended to have fewer episodes of deliberate self-harm than those who were in the routine care group (Wood et al., 2001). In addition, it was more likely for an adolescent within the routine care group to repeat acts of self-harm than those in the group therapy group (Wood et al., 2001). The researchers determined no significant effect of the intervention on depressive symptoms or suicidal thinking, however, which could be indicative that developmental group psychotherapy and routine care may be ineffective in treating the symptoms of depressed adolescents.

## Therapeutic Metaphor

To understand the concept of cinematherapy it is important to understand therapeutic metaphor, as both bibliotherapy and cinematherapy are considered forms of this rather broad counseling concept. What is the use of communicating metaphorically within the counseling session? As indicated by Groth-Marnat (1992):

Metaphor has the advantage of bypassing conscious resistance, holding the client's attention, speaking directly to the part of the personality which controls change, dealing effectively with complex relationships, increasing rapport, and being flexible enough to encompass a variety of interpretations (p. 40).

In other words, as Barker (1996) points out, "(s)toried and other metaphorical devices may suggest ideas subliminally...many authors...believe that they are ways of communicating with the 'right brain'"(p. 7). Likewise, Zuniga (1992) states that "(i)n a therapeutic setting, the use of metaphor to make points and to reach the unconscious provides a clearer clinical advantage" (p. 56). The literature surrounding the use of therapeutic metaphor is vast, encompassing many different approaches and focusing on many different client issues. However, as in the case of cinematherapy literature, the focus within the therapeutic metaphor literature is predominantly theoretical or conceptual, rather than empirically-based findings.

Berlin, Olson, Cano, and Engel (1991) explored the role of metaphor within psychotherapy as well as within other professional disciplines. The authors categorize the various therapeutic metaphors into several sub-topics including generative metaphors, metaphors used to create a new way of understanding a

problem and possible solutions; somatic metaphors, metaphors derived from experiences individuals have with their bodies; and the conduit metaphor, in which “the speaker puts ideas (objects) into words (containers) and sends them (along a conduit) to a hearer who takes the ideas/objects out of words/containers” (p. 363). They suggest that metaphors are critical in human thinking and action, particularly in psychotherapeutic situations, for a variety of reasons. These reasons include the use of metaphors to simplify an idea or behavior in order to reframe the problem; the use of metaphors as an intimate or personal means of communication due to the frequent referrals within metaphors to bodily experiences; the use of metaphors as both playful and serious in order for therapists to communicate about personal aspects of clients without appearing intrusive; and the use of metaphors to transfer readily from one situation to another to emphasize relationships between situations (Berlin et al., 1991).

The Berlin et al. (1991) article suggests that the use of metaphors within the therapeutic process can have a myriad of both purposes and effects. However, the authors reference only metaphors that use language such as poetic therapy, therapeutic storytelling, and hypnotherapy. While it is suggested that these techniques involve the use of metaphor, the authors fail to explain *how* metaphor is used in each technique. The authors’ suggestion that metaphor can be a useful part of the psychotherapy process is somewhat limited due to the lack of information about other types of metaphorical therapeutic approaches, such as bibliotherapy, the use of objects as metaphors, or even the use of

pictures or film in a metaphorical manner. Their conclusion is also limited by the lack of empirical evidence supporting the efficacy of such metaphorical approaches.

Alternately, a study conducted by Utay (1998) focused on the metaphorical use of common objects within counseling. Again, the author highlights the potential benefits of using common objects as therapeutic tools, or “therapeutic prop(s)” (p. 37), including the physical reliability when other therapeutic tools are unavailable; the multisensory nature of the metaphorical use of common objects; their use as physical stimulants to the counseling process; and their use as projection objects for clients. Utay (1998) describes the use of therapeutic props as a creative approach by counselors, but admits there is no directly related research within the topic of common objects as therapeutic metaphors. A limitation with Utay’s article (like much of the related therapeutic metaphor literature) is the lack of empirical evidence for the efficacy of the use of therapeutic props.

In 2003, Pistole explored the use of dance as a therapeutic metaphor within counseling. Pistole (2003) maintains that in work with couples, “dance” is a metaphor that links the image of dancing with a partner to “repetitive relationship interaction, including the couple’s pattern of provoking and maintaining each other’s behavior” (p. 232). Dance is encouraged as a potential metaphor due to its historical and cross-cultural pertinence, as well as its ability to convey emotional meaning through physical expression. Again, the use of metaphor as a potentially powerful experience for clients is explained, but the potential risk for



inhibiting therapeutic change is also addressed, as clients may have varied experiences and beliefs regarding the metaphors used. Like the previous literature reviewed, this article offers the reader a concrete example of the use of therapeutic metaphors within counseling. However, it too is lacking an empirical base, and offers no information regarding the efficacy of such a metaphor in its therapeutic use.

More recently, Aten (2004) explained the use of a Rubik's Cube as a metaphorical therapeutic intervention with clients. In one of the few empirically-based studies found within the therapeutic metaphor literature, Aten (2004) offers a brief case-study with a 24-year-old woman suffering from obsessive compulsive disorder as well as overwhelming anxiety. Aten (2004) used the Rubik's Cube metaphor with her client to "a) empower (Aten's) client; b) educate her about the process of therapy; c) bring God into (their) conversation; d) understand how she conceptualized her problems; and e) help (her) integrate her sense of self" (Aten, 2004, p. 258). Aten's case study is educational in learning how to use a specific therapeutic metaphor. However, the study was certainly not generalizable to a larger population, as it was specifically designed for the 24-year-old (presumably Caucasian, as it was not explicitly addressed) female client in the sessions. Additionally, the religious aspects within the counseling session further limit the generalizability of the study.

Clearly, the use of metaphors within the therapeutic process is not uncommon among practitioners. Many different types of metaphors are available and used as part of the therapeutic process. There are several major rationales

offered concerning the use of therapeutic metaphor, the most important being a) by-passing client resistance (Bierman, Krieger, & Leifer, 2003); b) using creative, right-brain processes with clients (Barker, 1996); and c) using less directive means to address very personal and intimate client issues (Dermer & Hutchings, 2000; Sharp, Smith, & Cole, 2002). There is a great deal of literature regarding the potential uses of different types of therapeutic metaphor, some of which are outlined in the following section. Greater emphasis will be placed on the therapeutic interventions of bibliotherapy and cinematherapy, each of which is outlined in an individual section of Chapter II.

### Metaphorical Interventions with Adolescents

The literature regarding the specific use of metaphorical interventions with adolescents is broad and encompasses many different types of therapeutic treatment. Early (1993) examined the use of allegorical tales in the treatment of children of divorced parents as a means of incorporating myth into therapeutic treatment. These allegorical stories are used by the author within the study to provide enough interest for the child in treatment to maintain their attention, but also allow enough distance to work around the natural defense systems of the children (Early, 1993). In her paper, Early (1993) provides a framework with which a clinician may utilize these allegorical tales in order to enhance therapeutic outcomes with children of divorced parents. Early (1993) points out that the approach she has provided within the paper offers a means for clinicians to work with children who may be experiencing a range of emotions. A similar paper on the use of narrative metaphor (Zimmerman & Dickerson, 1994)

examined the implications of such a technique on clinical practice. Much like Early (1993), the authors offer specific ideas for the use of narrative metaphors in clinical practice, and give specific examples of the types of narrative metaphor to use both with couples and with families with adolescents (Zimmerman & Dickerson, 1994).

The use of an image as a metaphor for treatment is described in an article by Gusella, Casey, and Schurter (2002). The authors demonstrate how the language of clients is used to create a symbol for treatment and recovery in the treatment of adolescent girls with eating disorders (Gusella et al., 2002). The writers point out how use of the metaphor can assist the clients in treatment in a greater understanding of where they fall within their treatment, as well as what work is left to accomplish before they have met their outcomes (Gusella et al., 2002). This paper illustrates how a metaphor may be used not only as a *part* of therapeutic treatment, but as an illustration of the *course* of therapeutic treatment.

Literature also exists on the use of adventure-based counseling as a metaphorical intervention with youth, though the articles on this topic are relatively few and generally not of an empirical nature. Carns, Carns, and Holland (2001) provide an overview of challenge courses (ropes courses), their purpose and intent, a brief history of challenge-based counseling, and the metaphorical lens of this approach. They also offer a synopsis of literature regarding the steps to creating a therapeutic metaphor within challenge courses, and the specific criteria to screen potential clients in or out of such an intervention (Carns et al.,

2001). Similarly, Huber (1997) offers an explanation of challenge-based counseling as well as how the tenets of this approach may be incorporated into office-based family therapy. Huber (1997) also offers a case illustration to outline the steps taken within adventure family counseling.

### **Bibliotherapy**

Bibliotherapy, the predecessor of cinematherapy, is seen frequently within the professional literature as a therapeutic tool for clients with a myriad of presenting problems and diagnoses. Specifically, bibliotherapy is the use of written materials in the treatment of a client. This section focuses on both the uses and efficacy of bibliotherapy, as well as potential limitations for the use of metaphorical counseling approaches.

#### **Bibliotherapy as Therapeutic Metaphor**

The use of bibliotherapy as a therapeutic metaphor was quite limited in the professional literature, yielding only one article in various database searches. Myers (1998) discusses the use of bibliotherapy as a strategy for co-creating therapeutic metaphors with clients, and cautions to use bibliotherapy only in conjunction with other counseling approaches, as does Pardeck (1994). The author further suggests using a developmental counseling and therapy approach to assist clients in processing the assigned written materials in order to construct meaning. Much like the literature discussed in the *Therapeutic Metaphor* section, the author's suggestions have merit. However, the article is lacking any empirical support for the techniques suggested.

## Bibliotherapy Techniques for Depression

The use of bibliotherapeutic techniques in the treatment of depression across a variety of populations is rife throughout the literature, particularly the use of bibliotherapy in the treatment of older adults. Gregory, Canning, Lee, and Wise (2004) performed a meta-analysis of twenty-seven studies to determine the efficacy of bibliotherapy techniques for depressive symptoms. The authors found a .99 effect size, with an effect size of over .80 considered to be “large” (versus an effect size smaller than .50, which is considered “small”). The authors point out that bibliotherapy may be most effectively used with clients who have mild to moderate depression, as the risks associated with severe depression would make such a minimally-involved treatment unsafe (Gregory et al., 2004). These results indicate the potential efficacy of bibliotherapy with a variety of client populations, and could be considered a positive endorsement of therapeutic metaphor.

Are the effects of such intervention long lasting, considering their initial effectiveness in the reduction of depressive symptoms? Smith, Floyd, Scogin, and Jamison (1997) studied the durability of therapeutic gains of bibliotherapy with a depressed population over time. Results indicated that treatment gains were maintained over the three year period before the follow-up; the authors note the results indicate the usefulness of cognitive bibliotherapy in the treatment of mild to moderate depression (Smith et al., 1997). Again, the authors point out that bibliotherapeutic techniques are effective as an adjunct to traditional therapeutic treatments, not as an independent intervention.

The above studies focus on adult populations; however, they do not indicate whether the effects of bibliotherapeutic interventions would be appropriate in the treatment of adolescent depression. Ackerson, Scogin, McKendree-Smith, and Lyman (1998) investigated the efficacy of such bibliotherapeutic techniques for adolescents. The researchers found the use of cognitive bibliotherapy to be an effective approach with adolescents, both immediately following treatment and at a one month follow-up (Ackerson et al., 1998). From the results of these studies, it seems clear that bibliotherapy is overall an effective metaphorical technique in the treatment of depression, though there are few studies regarding the treatment's efficacy specifically with depressed adolescents.

#### Bibliotherapy Techniques for Adolescents

The literature regarding the specific uses and techniques of bibliotherapy is considerably broader than that of bibliotherapy as a therapeutic metaphor. Calhoun (1987) examined the use of bibliotherapy to enhance adolescent self-perception, and found mixed results within the literature. Overall, he recommends using bibliotherapy as the advantages far outweigh the potential disadvantages for using such a technique to enhance self-concept. However, the lack of empirical findings or data within the article suggests a limitation in the author's argument.

A study conducted by Lenkowsky, Barowsky, Dayboch, Puccio, and Lenkowsky (1987) found that the use of bibliotherapy with learning disabled and emotionally handicapped adolescents increased the adolescents' self-concepts.

In this instance, the efficacy of the technique was established through an empirical measure, thus lending greater reliability and validity to the authors' position that bibliotherapy can be an effective intervention in improving self-concept.

Pardeck (1994) examined the use of literature within counseling to help adolescents cope with problems including family breakdown, foster care, and adoption placement. Pardeck (1994) presents alternative goals of bibliotherapy including: providing information about problems; providing insight into problems; stimulating discussion about problems; communicating new values and attitudes; creating awareness that others have dealt with similar problems; and providing solutions to problems (Pardeck, 1994). The article introduces strategies for determining client readiness, book selection and introduction, and follow-up strategies. Despite helpful suggestions for the specific uses of bibliotherapeutic techniques with adolescents to assist in coping, this article lacks an empirical research base as to the efficacy of such an approach.

Holman (1996) investigated the use of bibliotherapy in validating ethnic identity with a Puerto Rican adolescent client. The case study outlined the use of a Puerto Rican poem in the counseling of an adolescent with marked low self-esteem. The poem chosen for the bibliotherapeutic intervention was written by a Puerto Rican poet, and was intended to assist the client in further ego and ethnic identity development. The author found that ethnically appropriate bibliotherapy could be empowering for a client (Holman, 1996). Due to the idiographic nature of this study the results cannot be generalized to a larger population.

The use of bibliotherapeutic interventions with adolescents with depressive symptoms, poor self-image, and difficulty coping with problems implies that bibliotherapy can be a vital intervention with this population. Considering the available lists of potentially useful bibliotherapeutic resources (Christenbury & Beale, 1996; Hipple, Comer, & Boren, 1997; Pardeck, 1994), as well as the suggestions made for specific interventions, the use of this form of therapeutic metaphor certainly seems appropriate for adolescent depressive symptomatology.

### **Cinematherapy**

Cinematherapy is defined by Tyson, Foster, and Jones (2000) as “a therapeutic intervention allowing clients to visually assess a film’s characters interaction with others, the environment, and personal issues, thereby developing a bridge from which positive therapeutic movement may be accomplished” (p. 35). According to the authors of this article, cinematherapy is a technique that is rapidly gaining in popularity in the mental health field. Others define cinematherapy as “a specific therapeutic technique that involves selecting commercial films for clients to view individually or with others as a means for therapeutic gain (Berg-Cross, Jennings, & Baruch, 1990)” (Dermer & Hutchings, 2000). Still others discuss cinematherapy as “video work,” and define video work as

(A) therapeutic process in which clients and therapists discuss themes and characters in popular films that relate to core issues of ongoing therapy...we use films to facilitate self-understanding, to introduce options for action plans, and to seed future therapeutic interventions (Hesley & Hesley, 2001, p. 4 – 5).



Like bibliotherapy, cinematherapy is a form of therapeutic metaphor, a term used to describe the myriad of counselor techniques meant to by-pass client resistance in order to assist the client in achieving goals. However, the relatively new therapeutic technique of cinematherapy has been minimally addressed in the professional literature. Moreover, when cinematherapy has been discussed within the literature it has been a conceptual discussion, lacking in empirical research and data. The following section focuses on the limited cinematherapy literature, including the definition and description of cinematherapy, the suggested uses of cinematherapy, and the use of film and cinema within the field of counseling.

### Defining Cinematherapy

The use of film as part of the psychotherapeutic experience is fairly new, and certainly received a boost with the availability of VHS tapes and later, DVDs. In a study by Lampropoulos, Kazantizis, and Deane (2004), the use of motion pictures in the clinical practice of psychologists is examined. The authors refer to the use of motion pictures in clinical practice as the psychologists' use of self-help materials within clinical practice. Specifically, the authors point out

(i)n treatment, movies can be seen as therapeutic metaphors that can introduce clients to material that is sensitive or perceived as threatening (Lampropoulos et al., 2004, p. 535).

By conducting a survey with psychologists, the authors determined that "the majority of responding psychologists have at some point discussed a movie in session, have positive attitudes toward motion pictures, and use motion pictures in clinical practice" (Lampropoulos et al., 2004, p. 539).

In a conceptual study, Wedding and Niemiec (2003) discuss the ways in which films influence client attitudes regarding mental illness, therapy, and clinicians. The authors offer explanations regarding the myths perpetuated in films and how they influence the beliefs about mental illness. They further suggest that the use of films in psychotherapy can be beneficial as a way to “introduce clients and family members to mental disorders” (Wedding & Niemiec, 2003, p. 210). Here, film is used as a therapeutic tool to influence client ideas regarding mental illness.

Berg-Cross, Jennings, and Baruch (1990) point out that the use of movies as a part of therapy can help create a therapeutic alliance “by creating a common bridge of understanding between the client’s angst and the therapist’s empathy” (Berg-Cross et al., 1990, p. 138). In one of the first articles regarding the subject of cinematherapy, these authors define cinematherapy and its potential applications while offering a list of films that may be appropriate for such an intervention. However, the article lacks any empirical data, thus the validity and reliability of the authors’ argument to use cinematherapy are limited.

### Movies as Metaphors

Common throughout the cinematherapy literature is the notion of motion pictures as therapeutic metaphors. Christie and McGrath (1987) examine the use of film as a therapeutic metaphor when working with grieving clients. The authors explain the use of film as part of the therapeutic intervention with an 11-year-old boy who had recently lost his mother. The movie *The Never Ending Story* was prescribed as part of the therapeutic intervention in order to bypass the client’s

“conscious mental set(s)” (Christie & McGrath, 1987, p. 195). The conclusion of the case study emphasized the efficacy of the intervention with the client, particularly in the therapy interventions following the film that were related to the cinematherapy intervention (Christie & McGrath, 1987). The client was able to reduce his anger associated with his grief and his family was able to maintain reasonable expectations for his behavior. However, due to the nature of the study, the results may not be generalizable to a larger population.

In 1997, Heston and Kottman explored the concept of movies as metaphors in counseling interventions. Again, the authors explain the use of film as metaphor within therapy, and note “(m)ovie viewing, whether prescribed or serendipitous, can frequently give clients a new perspective for looking at the ‘characters’ in their own lives and give them added clarity into the fundamental complexity of close interpersonal relationships” (Heston & Kottman, 1997, p. 92). The authors offer examples of two case studies in which film was used effectively as a metaphorical intervention. Much like the previous study, however, the generalizability of the results is limited due to the case study structure.

Finally, Sharp, Smith, and Cole (2002) studied metaphorically promoting change in therapy through the use of cinematherapy. The authors offer specific guidelines for the use of cinematherapy as an adjunct to other therapeutic interventions, and point out that the use of movies rather than books has advantages such as increased client compliance; the importance of movies in the lives of many people; the allowance for a positive reframe of an activity people are already doing (movie watching); and the powerful impact of film versus books

or other written materials (Sharp et al., 2002). The authors also offer a case example of the use of cinematherapy with a 15-year-old girl. But much like the previous examples, the empirical evidence for the efficacy of cinematherapy is lacking, and the case study structure reduces the generalizability of the authors' findings.

### Cinematherapy Applications

Christie and McGrath (1989) examined the use of cinematherapy in the treatment of a client in a case study, this time focusing on the use of film as a family therapy intervention. In this case, *The Karate Kid* (film) was used as the cinematherapeutic intervention, and the authors offered detailed explanations about the potential uses and meanings of the film (Christie & McGrath, 1989). Likewise, Dermer and Hutchings (2000) offer detailed guidelines for using movies in family therapy, and the potential implications of such an intervention with families, couples, and individuals. The authors include a detailed list of potentially therapeutic films organized under headings addressing specific client issues. In both examples, empirical support was not offered for the efficacy of a cinematherapeutic intervention.

Dole and McMahan (2005) offer specific guidelines for the use of the movie *Rudy* to help adolescents cope with social and emotional difficulties. Dole and McMahan (2005) suggest that "videotherapy" (or cinematherapy) can be used effectively with adolescents with learning disabilities. While the discussion in the article is useful for clinicians to learn to use a specific technique, there is no research base suggesting the efficacy of the technique. Hebert and

Neumeister (2001) suggest using the guided viewing of a film as a way to counsel gifted teenagers. The authors offer scenarios to illustrate the potential use of cinematherapy with a specific population, and give detailed guidelines about how to implement guided viewing of films with gifted students (Hebert & Neumeister, 2001). Again, the authors present a conceptual view of the use of cinematherapy, and do not offer research data to bolster the argument that cinematherapy can be a useful technique with this population.

Bierman, Krieger, and Leifer (2003) explore the use of group cinematherapy as a treatment for adolescent girls. The authors offer a case study on the use of films in a residential setting with adolescent girls, and give detailed explanations regarding the choice of specific films for the purpose of the intervention. The authors found that the use of movies with the adolescent girls “enabled the girls to access therapeutic material with less difficulty” (Bierman et al., 2003, p.11). This indicates that one of the main tenets of the use of therapeutic metaphor, to bypass client resistance, was found in this study. However, again due to the case study structure, the authors’ findings are not necessarily generalizable to a larger population.

Beyond these reported case studies, the use of cinematherapy as a therapeutic intervention has had relatively little attention in the professional literature. The availability and convenience of film and the potential for film to be used metaphorically make this intervention potentially useful for many clinicians. Repeatedly, the literature suggests that cinematherapy be used as a supplement or adjunct to other therapeutic interventions, and should not be used

independently. However, a large gap exists between the potential benefits of cinematherapy and empirical evidence backing this claim. The lack of research on the efficacy of cinematherapeutic approaches is striking and problematic.

### **Influence of Film**

#### **Effects of Media on Adolescent Behavior**

The professional literature regarding the influence of film on adolescent behavior examines many different behaviors, including smoking, drinking alcohol, drug use, and violence. As Stern (2005) indicates in an article concerning the influence of drinking, smoking, and drug use in film on the behavior of adolescents, film is one of few media outlets that has substantial images of teens and teen behavior. Additionally, Stern writes

Because movies, like other mass media, are commonly believed to both reflect and shape social attitudes and behaviors...we should concern ourselves with the representation of teen characters in films as they may play a role in defining or authenticating normative teen activities and roles for teen viewers (2005, p. 331).

As Stern (2005) indicates, film is widely known to have an influence on the behaviors and beliefs of viewer. For this reason, the following section is concerned with the influence of film and movies on the behavior of adolescents.

There have been a myriad of studies conducted regarding the influence of violent media on the behavior of adolescents. In one such study, a meta-analysis of research regarding the effects of violence in media was conducted by Anderson et al. (2003) Specifically related to viewing violent films, the authors note that in each of the experimental studies reviewed, the level of violent

behavior after viewing a violent film or film clip is significantly increased within children and adolescents (Anderson et al., 2003). Furthermore, the authors point out that “(c)ross sectional surveys over the past 40 years have consistently provided evidence that the current physical aggression, verbal aggression, and aggressive thoughts of young people are correlated with the amount of television and film violence they regularly watch” (Anderson et al., 2003, p. 86). Perhaps most importantly, upon examining the longitudinal effects of viewing violence through film, Anderson et al. (2003) note that exposure to violence in media at young ages is correlated with increased violent behavior in later adolescence. The results of this study give a clear indication that violence within films has a dramatic effect on the behavior of adolescents, and should be carefully monitored to avoid potential negative outcomes within adolescent populations.

A great deal of literature has focused on the influence of alcohol, drug, and tobacco use in film on the behavior of adolescents. In a study by Kulick and Rosenberg (2001), the influence of drinking behavior in films on the outcome expectancies of adolescents was examined. In the study, young college students (between the ages of 18 and 19 years old) were placed into three groups and shown corresponding film clips: positive effects of drinking, negative effects of drinking, and neutral (no drinking behavior in the films) (Kulick & Rosenberg, 2001). Results indicate that those in the group observing positive effects of drinking increased their level of liquor consumption in the month following the film viewing. In addition, participants within the positive outcomes of drinking group had significantly higher positive expectancy scores regarding the consumption of

alcohol than those in the control group (Kulick & Rosenberg, 2001). Interestingly, participants in both the negative and positive effects of alcohol consumption groups had significantly higher *negative* expectancies for alcohol consumption than the control group (Kulick & Rosenberg, 2001). The results of this study indicate the extent to which older adolescents may be influenced in their beliefs about drinking simply by viewing films. Again, the influence of movies on behavior cannot be ignored, despite its potential negative consequences.

Stern (2005) examined the messages presented to teens in popular films regarding the use of alcohol, drugs, and tobacco. As the author points out, studies regarding the use of tobacco in films are more frequent than those concerning drugs or alcohol. It was noted that smokers in films are typically male adults with higher socioeconomic status and increased romantic and/or sexual activity. Despite the fact that most films depict smoking at least once, there were seldom, if ever, consequences shown in the film for this behavior (Stern, 2005).

#### Negative Film Images and Stereotypes

As the previous section illustrates, film and other audio-visual media can have a strong influence on the behavior of adolescents. This is noted by Bischoff and Reiter (1999), who point out “movies both reflect and influence cultural stereotypes” (p. 180). Considering this, it is important to examine the potentially negative images and stereotypes that adolescents may encounter when viewing media, particularly as these images relate to adolescents experiences within a cinematherapeutic intervention.



One of the most prevalent topics within the literature regarding negative film images and stereotyping is the negative film image of persons of color. St. John (2001) examined the ramifications of the “mammy” figure within American cinema, a role popularized in the film *Gone with the Wind* (Fleming, 1939). St. John (2001) argues that such a figure, a full-figured Black woman who works as a cook, maid, or in other serving capacity, contributes to individuals’ understanding of race (St. John, 2001). Furthermore, the character, often imitated in more recent films, perpetuates a negative stereotype of African-American women (St. John, 2001). This paper gives a clear description of only one character that continues to negatively influence the public’s understanding of race and maintains negative social images of Black women.

In a similar study, Eschholz, Bufkin and Long (2002) researched women and racial and ethnic minorities in film. These researchers examined the roles of women and minorities within fifty popular films from 1996 using content analysis. Their results indicate that although some advancements have been made by women and racial/ethnic minorities within media, these individuals continue to be underrepresented in the media (Eschholz et al., 2002). In addition, the authors found that racial/ethnic minorities and women also tend to be placed in roles that perpetuate stereotypes regarding those minorities (Eschholz et al., 2002). Again, this study indicates the continuation of negative stereotypes of women as well as racial/ethnic minorities within the mass media, which certainly could have a negative influence on the attitudes and behaviors of adolescents.

A study by Kawai (2005) also examines the effects of stereotyping Asian Americans within film. Kawai discusses the intricacies of the Asian American stereotype, with Asian Americans often being portrayed as inferior to Caucasian Americans but superior to African Americans (Kawai, 2005). Kawai also examines how these conflicting images are often combined as Asian Americans are portrayed within the media (Kawai, 2005). In this article, Kawai also examines the stereotype of the Asian American as “yellow peril” as seen in the 1993 film *Rising Sun* (Kawai, 2005). The portrayal of Asian Americans within the media can perpetuate one or both of the harmful stereotypes that surround this minority group, again contributing to negative attitudes toward ethnic and racial minorities.

Stereotypes and negative film images are not reduced to the damaging portrayals of racial and ethnic minorities and women within the media. Bischoff and Reiter (1999) looked at the stereotypes perpetuated through the presentation of mental health professionals within the media. By examining ninety-nine movie characters within sixty-one films all portraying mental health clinicians and analyzing these characters, the researchers determined that two stereotypes stood out (Bischoff & Reiter, 1999). Generally, women clinicians within movies tended to be sexualized, while male clinicians were portrayed as incompetent (Bischoff & Reiter, 1999). Again, these images can have a negative influence on the audience viewing them, and may be particularly damaging if clients believe their treating therapist to be either incompetent or sexualized.

In a similar article, Butler and Hyler (2005) examined the portrayals of child and adolescent mental illness within motion pictures. Their paper discussed the myths commonly perpetuated in Hollywood films regarding the psychiatrist treating children and adolescents, as well as mental illness within these populations (Butler & Hyler, 2005). The myths discussed include ideas that with enough love, any child may be cured; if the child or adolescent does not do what the psychiatrist wants, she/he will be locked up forever; and that mental illness is actually a gift that mental health clinicians somehow take away (Butler & Hyler, 2005). As in the previous example, these myths can create negative attitudes and feelings toward mental health professionals, and may create potentially interfering behaviors within the clients with whom mental health professionals are trying to work.

### **Summary**

As the research indicates, adolescent depression is a serious problem facing youth in the U.S., and is complicated by a variety of factors. Symptomatology of adolescent depression typically resembles that of adults with the exception of agitated symptoms, such as inability to sit still or fidgeting (DSM-IV-TR). Clinical depression includes a variety of symptoms including sadness, depressed mood, social withdrawal and isolation, anxiety, irritability, fear, and worry. There is almost unlimited professional literature on the topic of adolescent depression and its treatment, though the use of therapeutic metaphors in the treatment of adolescent depression is not well represented. Findings indicate that adolescents utilize a variety of different services for treatment of depressive

symptoms, though the use of pharmacological treatments may not be as viable following the FDA warning about their potential for increasing suicidality.

Traditional therapeutic approaches in the treatment of depression may be a safer approach for adolescents, though client resistance and lack of awareness regarding depression may be a potential obstacle.

The literature regarding group therapy is plentiful, and is overall indicative of the efficacy of group therapeutic approaches, particularly those that foster the development of group cohesion. The literature clearly identifies the success of group therapy in the treatment of depression, which is supportive of the proposed model in chapter three. Additionally, group therapy approaches have been determined to be effective with adolescent populations, though the studies discussed addressed depressive symptoms secondary to other symptoms, such as anxiety. Adolescence is a time of peer influence and involvement, and clearly group approaches can help to facilitate this natural developmental tendency.

The uses of therapeutic metaphor within counseling are varied and broad. Additionally, "therapeutic metaphor" is not necessarily the only term used to describe the myriad of counseling techniques involving metaphor. It is clear the use of therapeutic metaphor can bypass client resistance while offering different perspectives to clients in a creative format. However, as indicated in the literature, there is a lack of empirical research and data indicating the efficacy of such techniques.

The use of bibliotherapy in the treatment of depression and, more specifically, with adolescents is well represented. Bibliotherapy has been used to

treat such difficulties as poor coping skills, poor self-concept, and grief, as well as depressive symptoms of adolescents. While it is well-represented in the literature, there is a significant lack of empirical data regarding the efficacy of bibliotherapeutic treatments.

Cinematherapy is not as well represented in the literature as bibliotherapy, perhaps due to its relatively new inception. Considering the convenience and allure of watching movies for therapeutic gain, this approach is likely to be popular with many clinicians and clients alike. However, as in the bibliotherapy literature, there is a significant lack of empirical evidence regarding the efficacy of using film for therapeutic gain with clients. The influence of film on the attitudes and behaviors of adolescents is represented well within the media, though, and should be considered when contemplating a cinematherapeutic intervention.

The proposed model would contribute to the cinematherapeutic literature by providing a specific outline for the use of group cinematherapy with depressed adolescents. This model involves a common diagnosis within the field of counseling and will introduce the approach of cinematherapy as part of the treatment of depressive symptoms. By utilizing a format that has been proven through the therapeutic metaphor literature to be successful with many clients, including adolescents, as well as including an activity that is pleasurable for adolescents, this model offers an alternative treatment option for the challenging work of intervening with depressed adolescents.

## CHAPTER 3

### A MODEL FOR THE USE OF GROUP CINEMATHERAPY IN THE TREATMENT OF ADOLESCENT DEPRESSION

The previous chapter illustrated the prevalence, challenges, and successful treatments of adolescent depression. It also demonstrated the overall success of group therapy, particularly with adolescents, as well as the use of therapeutic metaphor in the treatment of many disorders of adolescence. Considering the many hurdles of effectively treating adolescent depression, it is clear that having many treatment options would maximize the prognosis for success. Therefore, the proposed model offers a treatment option that combines the cost-effectiveness and developmentally appropriate option of group therapy with the popular and effective technique of cinematherapy. Due to limited literature regarding the use of group cinematherapy, the model has been derived from literature regarding the specific use of cinematherapy interventions as well as general guidelines for group therapy (Berg-Cross et al., 1990; Capuzzi & Gross, 2002; Dermer & Hutchings, 2000; Lampropoulos et al., 2004; Rose, 1998; Wedding & Niemiec, 2003; Yalom, 1985).

#### **Specifications of the Model**

The proposed model would be applicable to a group consisting of eight to twelve adolescents between the ages of 14 to 17 years of age who have been

diagnosed with a mild to moderate depressive disorder based on the criteria in the DSM-IV-TR. Participants will be identified by their primary clinician (counselor, case manager, psychiatrist, or guidance counselor) and will be receiving concurrent individual treatment for symptoms of the depressive disorder. Due to the nature of some of the material being viewed in the films of the cinematherapy group, it is important the potential members have a level of maturity to appropriately manage difficult emotions. Therefore, clients who have developmental delays may not be appropriate for the group outlined below. However, the model could be modified to include films that are appropriate for younger, less mature, or developmentally delayed clients by incorporating different films into the group.

The model is designed for a closed, time-limited counseling group. Given that the information in the beginning sessions will build up as the group continues, it would be inappropriate to admit new members once the second session has concluded. The group will meet for eight sessions, with each session lasting approximately 120 minutes (two hours). This is necessary to allow at least partial viewing of a film as well as time to process the material within one session.

#### Group Leaders

The proposed group will be lead by two Master-level clinicians within a community mental health or other agency setting. Preferably these clinicians will have experience in facilitating counseling groups as well as with cinematherapy. These leaders will have continued contact with the clinicians providing individual

treatment to the group members. Communication between group leaders and the individual therapists/case managers/psychiatrists/guidance counselors is essential to track the progress toward treatment outcomes of decreasing depressive symptoms, as well as to insure that appropriate measures are taken to properly process information received within the group. To this effect, it is important that individual clinicians be at least somewhat familiar with the films being viewed during the group, and to be prepared for some of the feelings that may arise from certain characters, scenes, or plots. It would also be helpful for the individual clinicians to have the timeline of the group to know precisely which movies are being viewed and what topics will be covered within each session of the eight week group.

#### Screening and Informed Consent

Prior to admission to the group, potential participants will be screened through the use of a simple preliminary questionnaire that assesses the individual's readiness and motivation for change (Appendix A). This questionnaire will be administered to potential group members by their primary clinician. Scores that total 5 or below indicate that the potential participant is not motivated to change, is unwilling to complete assignments or talk with peers, or is unwilling to view movies in a therapeutic way. This individual would not be appropriate for participation in the group. It is important to note that any client who experiences psychotic symptoms, such as hallucinations or delusions, would not be an appropriate candidate for cinematherapy in any capacity (Lampropoulous et al., 2004).



When the pre-group questionnaire has been completed with the participant receiving a score of 6 or higher, an informed consent form will be given to both the potential participant and her/his parent(s) or guardian(s) to outline the potential risks and benefits of the group, as well as give a brief overview of the group goals and format (Appendix B). The parent(s) or guardian(s) of the participant will also receive an agreement form which they must sign to give permission for their child to view movies of a certain rating (Appendix C). This form contains the specific ratings of each film as well as a brief synopsis regarding the plot of each film.

Once the informed consent form and parental permission forms have been appropriately explained, reviewed, and signed, the participant will be given a brief questionnaire related to his/her depressive symptoms (Appendix D). This questionnaire will be used to assess change in symptoms through the course of the group by also being administered at sessions five and eight. The questionnaire was designed through the DSM-IV-TR criteria of a Major Depressive Episode, as well as on the depressive symptomatology indicated in the literature regarding adolescent depression (DSM-IV-TR, 2000; Petersen et al., 1993). The purpose of this tool as an evaluative device is discussed in the Evaluation section of this chapter.

### Film Selection

In regard to the specific outline of the model, provided below, it is important to note that the films suggested were for the purpose of explaining how to appropriately process films in a group setting with depressed adolescents

within the given age range. Film selection may be modified by the group facilitator to better suit the needs of the population participating in the group; for example, less mature movies may be chosen for a group of younger children, or movies with positive African-American characters for a group with predominantly African-American members. It is important to remember, however, the following key elements in choosing appropriate films to use in the cinematherapeutic intervention.

Films used for cinematherapy need to possess several qualities. The films chosen should be enjoyed by or familiar to adolescent clients and recommended by other therapists (Hesley & Hesley, 2001; Lampropoulous et al., 2004). Lists of films to use for specific presenting problems and/or populations may be found in Dermer and Hutchings, 2000; Hebert, Neumeister, and Speirs, 2001; Hesley and Hesley, 2001; Peske and West, 1999; and Wedding, Boyd, and Niemiec, 2005.

Movie characteristics that are most desirable include “the ability to inspire and evoke emotions, the depiction of characters solving problems, and, generally, of appropriate role models” (Lampropoulous et al., 2004, p. 539). Therapists should also be sure to review all films before using them for cinematherapy (Dermer & Hutchings, 2000; Lampropoulous et al., 2004; Sharp et al., 2002), and should be aware of scenes, plots, or characters that may evoke strong feelings from clients.

The most salient aspects of the group process, as explained in the previous chapter, are a) conveying and understanding the metaphor presented in the film(s), b) the ability of the participant to transition the experience of the film

to their own experience; and c) the overall experience of the peer interactions within the group experience. When choosing films for use with a cinematherapy group, it is important to consider these goals before selections are made.

#### Films Used in the Model

The following represents a detailed framework of the group cinematherapeutic intervention, including questions relevant to the appropriate processing of the films after viewing. The first film to be viewed, *Napoleon Dynamite* (Hess, 2004) is a relatively newly released film that is quite popular with adolescent and teenage viewers as evidenced by winning the MTV Best Movie Award for 2005 on the MTV Movie Awards, as voted by MTV viewers, as well as the Teen Choice Award for Best Comedy of 2005 (Internet Movie Database [IMDb], 2006). While this film was not specifically included in the film lists reviewed for this thesis (likely due to its relatively new release), it depicts an average existence of a teenage boy in a rural area who is isolated and alienated from his peers. In this film the main character, Napoleon, struggles through living in a dysfunctional family, having very few friends and peer supports, and having financial difficulties. Additionally, the film's comic approach differs from the other two selections for this group, and may reach certain group members in a more poignant way than the dramatic films. This humorous film may also allow group members to laugh and joke with one another in the first few sessions, thus serving as an additional icebreaker within the group.

The second film to be viewed in the group, *Dead Poets Society* (Weir, 1989), is a drama portraying adolescent boys at a private school struggling with

issues of individuality and conformity. This film was recommended on several movie lists within the literature reviewed (Dermer & Hutchings, 2000; Hesley & Hesley, 2001; Lampropoulos et al., 2004) as being particularly useful in the area of depression, suicide, and adolescence. The film focuses on several young men who, after being strongly influenced by a passionate teacher, decide to form a secret society to study poetry and to make more out of their lives.

The final film to be shown in the group, *Ordinary People* (Redford, 1980) is a well-known film within the field of psychology, and was listed on many movie lists reviewed for this thesis (Dermer & Hutchings, 2000; Hesley & Hesley, 2001; Lampropoulos et al., 2004; Wedding, Boyd & Niemiec, 2005). This dramatic film shows the lives of a family grieving the loss of a brother and son in a tragic accident. This emotional film demonstrates the way such a loss can affect family members differently, and how these differences may forever change the ways in which family members interact together. This film is appropriate for issues surrounding grief and loss, depression, and difficulty with family relations.

### Evaluation

The proposed cinematherapy group will be evaluated for efficacy both at the fourth and eighth sessions of the group. The evaluation form may be viewed in Appendix E. The evaluation form contains both quantitative and qualitative measures that aim to measure the effectiveness of the group intervention based on group members' ratings. In addition, the depressive symptoms of group members will also be evaluated throughout the group using the inventory found in Appendix D. This questionnaire will be administered prior to the first group

session by the primary clinician, as well as during the fifth and eighth sessions of the group. This questionnaire will be used by the primary clinician as well as group leaders to determine the level of change in depressive symptoms according to the self-ratings of group members.

## **Session I**

### **Introduction to Group Leaders**

The first session will begin with an informal introduction of the group leaders. This introduction will also include the introduction to the purpose of the group, as well as an explanation about the group format. Leaders will explain their role as facilitators, as well as the roles of the group members. This explanation will include a brief overview of the expectations of group members in terms of participation, attendance, and appropriate behavior. Leaders will also want to emphasize the importance of the contribution of each member to the overall experience of the group. It is important for leaders to be aware of the potential negative reactions of group members, and to use redirection when possible to avoid sabotage of the group by a member who is presenting with problematic behavior (Capuzzi & Gross, 2002).

The group leaders will want to briefly discuss the three movies that will be viewed: *Napoleon Dynamite* (Hess, 2004), *Dead Poets Society* (Weir, 1989), and *Ordinary People* (Redford, 1980). The leaders should give a brief overview of the plots of these films, and may ask group members to provide information about these films if members have seen these movies previously. Leaders will want to inform members that at times during the viewing of the films, if it seems as if

members are having strong reactions, the group leaders may pause the movie to briefly discuss members are reacting to the film. This introduction will last approximately fifteen to twenty-five minutes.

### Introduction of Group Members

Following the introduction of leaders and the brief description of the group, members will be introduced to each other. This can be done in a variety of ways, but it is important for members to know the names of the other group members. During this time, it would be appropriate to conduct icebreaker activities with the members in order to increase their comfort level in the group. There are multiple resources to determine appropriate icebreaker and team-building activities (Christian & Tubesing, 1997; Jones, 1999; Rohnke & Butler, 2003; West, 1997). In addition, it is important to note that activities found in books for adults may easily be modified for use with an adolescent population (Jones, 2002; Jones, 1999; Jones, 1998). These activities are greatly important for use in the group, as Yalom (1985) suggests that group cohesiveness is essential for group efficacy. As indicated by Roark and Sarah (1989), increasing group cohesiveness by developing trust, comfort with self-disclosure, and acceptance by other members is essential, and icebreaker activities help to facilitate such cohesiveness. It also would be appropriate for group leaders to provide snacks or candy to group members as another way for group members to share an experience together, thus increasing group cohesion.

An icebreaker that may be completed around the topic of films could be a variation of the *ABCs* icebreaker suggested by West (1997). This icebreaker

would involve the members breaking into pairs or triads preferably with a peer or peers they do not know. Each small group would receive a list of each letter of the alphabet. Within a time limit (around five minutes), the small groups would write the titles to films starting with each letter of the alphabet on the sheet that had been given to them. At the end of the five minutes, the small groups would gather in a large group and share their answers. This activity would promote team-building as well as allow the members to become better acquainted.

A second option for an icebreaker activity also related to films would involve group members "interviewing" one another. Each group member would be given a list of information to get from other group member through the interview process. The leaders would then allow members to try to interview one another for a period of five to ten minutes, attempting to learn such information as favorite food, favorite movie, favorite TV show, etc. The goal of the activity would be to interview as many other group members as possible while being sure to get all of the information on the form. This activity not only promotes group members becoming better acquainted, but also fosters creative thinking, problem-solving, and communication on the part of group members.

A third icebreaker activity that may be used at the onset of the group would be the Group Top 10 List (Jones, 2002), in which the group members would break into smaller groups and create top ten lists on a variety of subjects. Topics for the lists could include favorite movies, favorite songs, qualities of friends, favorite foods, favorite sports, or leisure activities. The group could then come together and share the top ten lists together. This activity would promote

communication and collaboration, and would give members the opportunity to further their knowledge of one another.

All of these icebreaker activities may be used at this time, or only one or two depending on the amount of time taken by each icebreaker. The introduction by leaders and introduction of group members will likely take well over an hour to complete (including icebreaker activities). Thus, following the icebreaker activities, the leaders will then offer the group a ten to fifteen minute break.

### Group Rules

Following the break, leaders will engage the group members in a discussion regarding appropriate group rules. Leaders may begin the discussion by reviewing the informed consent form given to members before the group began (Appendix B), and may then have an informal discussion with the group members about what these rules mean for behavior both in and outside of the group. Additionally, leaders may ask group members for any other suggestions for rules they may want to contribute. This dialogue may give the members a greater sense of control over their own participation in the group, and will also encourage increased trust and cohesiveness.

Leaders will also want to give members a description of the upcoming sessions. They may tell members exactly what to expect each week, including the depression questionnaires to be completed at the fourth and eighth sessions, as well as the evaluation forms to be completed at the fifth and eighth sessions. Leaders may also encourage any questions members may have about the group's timeline and scheduled activities.



Following the discussion around rules and other group guidelines, leaders may engage members in an informal discussion around movies. Since this group is a cinematherapy group primarily, determining the members' experiences with movies as well as types of movies they enjoy or care about, is essential for this group's efficacy. Such a discussion, much like the icebreaker activities, also will allow members to begin connecting with one another, and may foster further comfort in group participation and acceptance by other members.

### Conclusion

Before concluding, a final group activity is recommended to further solidify group cohesion and trust. If all of the icebreaker activities were not completed during the introduction of group members, it may be appropriate to use one of those activities at this time. An activity that is appropriate for concluding the group may be movie charades, during which members and leaders may act out the titles to popular films while remaining group members guess what the film is.

Another activity appropriate for the conclusion of the first session is for each member to list things learned about another member that they had learned during the "interview" activity. The group would sit in a circle, and those sitting across from one another would be paired up to list new things learned about the other member. This activity would conclude when everyone had listed at least one thing they learned about another group member during the session.

Leaders will then want to discuss the upcoming session in which *Napoleon Dynamite* (Hess, 2004) will begin to be viewed. Leaders may want to advise members about the coarse language in the film and the interactions

between Napoleon and his older brother, Kip. To engage members in the discussion, leaders may want to ask about any previous experience with this film, and encourage members to assist leaders in the synopsis of the movie. Members will be dismissed following this brief description of the upcoming session

## **Session II**

### **Introduction**

Group leaders will introduce the film *Napoleon Dynamite* (Hess, 2004) at the start of Session II following a brief check-in with group members. Leaders will want to address important characters and scenes that may be upsetting for some of the viewers. As this film is a comedy, there are fewer scenes likely to cause discomfort. However, some of the group members may find the interactions between Napoleon and his older brother, Kip, distressing, as well as Napoleon's general identity as a social outcast at his school. Leaders may also want to direct members' attention to several of the main characters, including Napoleon Dynamite (played by Jon Heder), Napoleon's best friend Pedro Sanchez (Efren Ramirez), and Napoleon's older brother, Kip (Aaron Ruell).

Following the introduction to the film, leaders will then show approximately half of the film to group members. As this film is only 86 minutes long, it should be fairly easy to allow for the viewing of half of the film following the introduction. It is important for leaders to offer the members a break at roughly the halfway point of the group session, so leaders may want to schedule the viewing of the film to fall within the first 60 to 75 minutes of the group session. As in the first session, it would be appropriate for group leaders to provide snacks to members while watching the film, such as popcorn or cookies. After viewing approximately

half of the film, leaders may stop the movie and offer group members a ten to fifteen minute break.

### Preliminary Processing of *Napoleon Dynamite*

Following the break, members may then begin to process the film in a preliminary manner. Leaders may want to start with very basic questions, such as:

1. What are your impressions of the movie so far?
2. Of what you have seen, who is your favorite character?

Leaders may then want to move on to slightly more detailed questions, allowing the members to begin processing the first section of the movie in an introductory and somewhat superficial manner. Questions to ask at this time include:

1. Are you enjoying the movie?
2. Why or why not?
3. Were there certain scenes that you enjoyed the most?
4. Were there certain characters you felt you could relate to?
5. Right now, what do you think the message of the film is?

By offering members a chance to begin processing the film in an innocuous manner, leaders may allow for comfort and trust to build within the group, and thus the group to become more cohesive. Additionally, since the group is starting the process of viewing films with a comedic film, this may promote laughing and joking among group members, again leading to increased cohesion and communication among group members.

## Conclusion

After roughly 30 to 45 minutes of preliminary processing, leaders may ask members to think about their emotional reaction to certain characters or parts of the film in order to be prepared to discuss the film further at the next session. Leaders may remind clients that they may discuss this film, as well as their reactions to it, with their individual clinicians as well as in the group. Leaders may also encourage informal discussion about the movie so far, and allow the members to chat among themselves for a few minutes before dismissing them.

## Session III

### Introduction

Leaders will introduce the session informally and engage group members in an activity. An option for a group activity appropriate for this session would be *Team Thumb O' War* (Jones, 2002), during which the group would separate in half, with each member partnering with another (if there is an odd number of group members, a leader may pair with a member). The pairs will form two lines facing one another, and must disclose something unexpected about themselves before engaging in a "thumb war" with their partner. This activity is meant to increase comfort around group participation, as well as getting to know and develop trust with other group members.

Following the group activity, the group will view the remaining half of *Napoleon Dynamite*. As in Session II, leaders may want to watch for exceptionally strong reactions to scenes or characters, at which point pausing the film would be necessary. Again, providing snacks for group members while

viewing the film would be appropriate. After viewing of the remainder of the film, leaders may offer members a ten to fifteen minute break.

### Processing *Napoleon Dynamite*

Leaders should preface the processing of the film with a reminder that members may “pass” if they do not want to discuss certain topics, or may leave the room if they feel very uncomfortable. Leaders will want to begin the processing of the film informally, perhaps with a general overview of the film’s plot and characters and a synopsis of the previous session. Members may also contribute to this discussion, offering their own reflections about the preliminary processing of this film during Session II.

Following the informal discussion around the film, leaders may then get a sense of the scenes and characters that have evoked the strongest emotions from the participants. There are specific questions leaders may use to process *Napoleon Dynamite* with the members. These questions include:

1. In what ways did you relate to Napoleon?
2. What brought Napoleon and Pedro together as friends?
3. What was your reaction to Napoleon’s interactions with his older brother, Kip?
4. Have you experienced difficult interactions with family members?
5. Have you ever felt like you didn’t belong at school (with friends, with family members)?
6. What was your reaction to the final scene in the movie, when Napoleon dances in front of the school to support Pedro?

7. Why do you believe Napoleon decided to take up dancing?
8. Do the characters in the film remind you of people in your own high school (family)? What kinds of feelings were evoked for you when you saw a) Napoleon; b) Pedro; c) Kip; d) Summer; e) Don; f) Deb?

### Conclusion

The processing of the film should take approximately 45 to 60 minutes. Leaders should remind clients that they may further process their reactions to this film with their individual clinicians if they desire. Following this discussion, leaders will want to introduce the film *Dead Poets Society* (Weir, 1989), which will begin to be viewed at the next session. Leaders may ask the members if they have seen this movie previously, and perhaps ask for some feedback about the members' impression of the film if they had viewed it prior to this group. Leaders will also want to remind members that if a scene or a film is making them feel uncomfortable, they may leave the room for a short time. Leaders may then encourage members to chat informally for a few minutes before dismissing them in order to promote relationship-building among group members.

## **Session IV**

### Introduction

At the beginning of session two, the group leaders will introduce the film *Dead Poets Society* (Weir, 1989) including specific characters to watch for and scenes that may be difficult to view. One scene that may be particularly difficult for group members to view is the suicide of one of the main characters, which is done by a firearm, though this scene will not be viewed until Session V. Leaders

will need to provide guidance around the violent death and be prepared to talk about suicide with the group. Group leaders also need to remind members that they may take a break or request that the movie be paused if they are having difficulty with certain scenes.

Characters to direct group members' attention to include Neil Perry (played by Robert Sean Leonard), a student who struggles between his own desires and the pressure he feels to please his father. A second character, Todd Anderson (Ethan Hawke), demonstrates the quiet suffering that some adolescents go through when they are shy and afraid to speak up. Finally, John Keating (Robin Williams), the main character of the film, demonstrates passion for life, as well as sometimes irresponsible behavior on the part of a teacher. Leaders will also want to remind group members that they will be asked to complete the midpoint evaluation at the conclusion of this session. This introduction should take no longer than fifteen minutes.

Leaders will then show approximately the first half of *Dead Poets Society*, stopping at the conclusion of a scene in order to have greater ease with completing the film at the next session. Due to the length of this film (128 minutes), showing half of the film will take over an hour. Leaders should again provide snacks for group members while they view the film. Leaders will be able to offer members a ten to fifteen minute break approximately 75 to 85 minutes into the session.

#### Preliminary Processing of *Dead Poets Society*

Following the break, leaders will open an informal preliminary discussion

about the film similar to that of Session II. Leaders may again want to start with basic questions about the film, such as:

1. What are your impressions of the movie so far?
2. Of what you have seen, who is your favorite character?

As in Session II, leaders will then want to move on to slightly more detailed questions, allowing the members to begin processing the first section of the movie in an introductory manner. Questions to ask at this time include:

1. Are you enjoying the movie?
2. Why or why not?
3. Were there certain scenes that you enjoyed the most? The least?
4. Were there certain characters you felt you could relate to?
5. Right now, what do you think the message of the film is?

Because leaders will also have to administer the midpoint evaluation at this session, time may be limited for this preliminary discussion. It may be possible to only process this film for a brief period of fifteen to twenty minutes.

### Conclusion

After the discussion, leaders will ask members to think about their reactions to *Dead Poets Society* so far, and to be prepared to conclude the film at the next session. Leaders will also remind the group members that they may discuss their emotions about this film with their individual clinicians before the next group session. Leaders will do a final check-in with members before introducing the midpoint evaluations to the members.



### Administration of Midpoint Evaluations

Following the conclusion, group leaders may exit the group room to allow members to complete the midpoint evaluations (Appendix E) privately. Leaders should ask for a volunteer, or appoint one member (if no members volunteer) to distribute and collect all evaluations and place them in a large envelope. These evaluations will not be viewed by leaders until the group has ended, and leaders should advise members of this before the evaluations are distributed.

### Session V

#### Introduction

Leaders will introduce the final half of *Dead Poets Society* (Weir, 1989) at the beginning of Session V. Leaders should again remind members about what to do in case of uncomfortable feelings, as well as remind members about the difficult scene involving suicide that will be viewed during this session. Leaders should also remind members that they will be asked to complete the second depression questionnaire at the conclusion of the group. As time is needed to complete the viewing of the film, appropriate processing of the film, and to complete the depression questionnaires, no team building activity will be scheduled during this session. The remainder of *Dead Poets Society* may then be viewed by the group, with the leaders again providing snacks for the group members. Following the conclusion of the film, members will be allowed to take a ten minute break.

#### Processing *Dead Poets Society*

Prior to leading the processing discussion about the film, leaders should

remind members that if they feel uncomfortable or do not want to answer any questions, they have the right to “pass,” or to leave the room if they are feeling very uncomfortable. The leaders may begin processing the film by giving a brief reminder about the plot and characters of the film, again encouraging participation from group members in reviewing the discussion from the previous session.

Following this informal introduction to the processing of the film, leaders may begin to understand which scenes and characters evoked the greatest emotions for the group members. Leaders may then begin to ask more in-depth questions about these scenes and characters to process the film. Examples of such questions include:

1. In what way do you believe the boys were most influenced by John Keats?
2. Do you believe that it was Mr. Keats' fault that Neil decided to commit suicide?
3. Can other people influence the choices you make about your own behavior (follow-up to question two)?
4. Have you ever experienced the pressure of a parent in the same way that Neil did?
5. How have your parents (teachers, friends) pressured you?
6. What were the obstacles faced by Neil, Todd, and the other boys in trying to accomplish their personal goals?
7. Have you faced obstacles like these?

8. What can you do (or have you done) when faced with obstacles that can prevent you from accomplishing your goals?
9. What kinds of feelings did you have when a) Neil was pressured by his father; b) Mr. Keats encouraged the boys to make the most out of their lives; c) when Neil committed suicide; d) when Mr. Keats was asked to resign?

The discussion around the film should last approximately 45 to 60 minutes. It is likely that the group will move the discussion on its own and may not need many cues or questions from the leaders. It is important for leaders to check in with the group members before dismissing them, as this film is likely to evoke strong emotions due to its content and dramatic nature. Leaders should also encourage the members to discuss their emotions about the film with their individual clinicians before the next group session if they desire.

#### Administration of Depression Questionnaire

Following the group discussion, leaders will administer the second depression questionnaire (Appendix D). The members will be given fifteen minutes (longer if necessary) to complete this questionnaire, and will be encouraged to refrain from discussing their answers or sharing answers with other participants. It is important for group leaders to monitor this carefully, and leaders are encouraged to give members plenty of space in which to spread out within the group room while completing this questionnaire. When everyone has finished completing the questionnaires, leaders will collect them and place them into a large envelope.

## Conclusion

Following the completion of the depression questionnaires, leaders will give a brief introduction to the final film to be viewed in the group, *Ordinary People* (Redford, 1980). Leaders may want to caution the members about the emotional intensity of this film. It would also be appropriate to warn members in advance of the difficult scenes involving the death of Jordan "Buck" Jarrett, as well as the suicide attempt of Conrad Jarrett. Leaders should also mention the foul language and sexual suggestion found in *Ordinary People* (Redford, 1980) in order to prepare members appropriately. As in previous sessions, members should be encouraged to talk with each other informally before being dismissed. The depression questionnaires may be viewed by leaders after the session has concluded, and should be passed on to each member's individual clinician.

## **Session VI**

### Introduction

Leaders will begin the sixth session by introducing the film *Ordinary People* (Redford, 1980) to be viewed by the group. Leaders will again remind members that they may take a break or request that the movie be paused if they feel particularly uncomfortable or upset about the film. Leaders will point out the particularly difficult scenes, especially the death of "Buck" Jarrett and the suicide attempt of Conrad Jarrett.

Group leaders will also point out the important characters in *Ordinary People*. These characters include Conrad Jarrett (played by Timothy Hutton), the grieving brother of Buck (Scott Doebler), who is isolated and displaced within his

own family following the death of his brother; Beth Jarrett (Mary Tyler Moore), Conrad's mother, who in her own grief is alienating herself from her family; and Calvin Jarrett (Donald Sutherland), Conrad's father, who is trying desperately to keep the family together after the tragic death of one of his children. Another important character in the film is Dr. Tyrone Berger (Judd Hirsch), Conrad's therapist, who works with Conrad in trying to manage his myriad of emotions and struggles. It may also be important to discuss the era of the film, as some of the group members may find the movie to be somewhat dated.

Following this brief introduction, approximately half of the film will be viewed by the group members. As with *Dead Poets Society*, this film is fairly lengthy (124 minutes), and viewing half of the film will take over one hour. Leaders again should provide snacks to the group members while they are viewing the film. Leaders should then allow for a ten minute break once half of the film has been viewed and viewing is complete for this session.

#### Preliminary Processing of *Ordinary People*

Following the break, leaders will open an informal preliminary discussion about the film similar to that of Sessions II and IV. Leaders may again want to start with basic questions about the film, such as:

1. What are your impressions of the movie so far?
2. Of what you have seen, who is your favorite character?

As in Session II and Session IV, leaders will then want to move on to slightly more detailed questions, allowing the members to begin processing the

first section of the movie in an introductory manner. Questions to ask at this time include:

1. Are you enjoying the movie?
2. Why or why not?
3. Were there certain scenes that you enjoyed the most? The least?
4. Were there certain characters you felt you could relate to?
5. Right now, what do you think the message of the film is?

Due to the dramatic nature of this film, as well as the difficult scenes viewed within the first half of this movie, it is likely that this discussion may become more in-depth than the preliminary discussions of sessions II and IV. Members may experience a great deal of emotions, and may wish to discuss and explore these feelings during this preliminary processing. Leaders should allow ample time for this to occur; it is likely that this discussion may last 45 minutes or longer.

### Conclusion

At the end of the preliminary processing discussion, group leaders may want to validate the strong emotions evoked by this film, as well as the need to discuss any other concerns or feelings with individual counselors before the next session. Leaders will also remind members to be thoughtful of their emotional reactions to the film, and to be prepared to view the second half of this film at the next session. Following this conclusion, members will again be encouraged to talk informally among themselves before being dismissed.

## Session VII

### Introduction

Leaders will introduce this session much the same as sessions III and V. Leaders may ask members if there are specific points about the film from the previous session that they would like to discuss, and may offer another reminder regarding what to do if members begin to feel exceptionally uncomfortable while viewing the film. As in Session V, due to the length of the film and the need for appropriate time to process the film at the conclusion, there will not be time for a team-building activity during this session. Leaders may then show the final half of *Ordinary People*, and again will provide snacks for group members while they view the film. At the conclusion of the film, group members may have a ten to fifteen minute break.

### Processing *Ordinary People*

As in the previous sessions, leaders may want to begin this process through an informal discussion with members about their initial reactions to the film. Following the informal discussion, leaders will want to engage members in a deeper discussion about the film. As this film is perhaps the most emotionally challenging of all three films, it is likely that the discussion around the film may be pointedly difficult, and may last longer than discussions around the previous two films. Leaders will need to be cautious when processing this film, as it is likely to evoke very deep feelings for the members. Questions to use when processing this film include

1. To which character(s) could you most relate?

2. What was your reaction to the death of Buck?
3. In what way(s) did the death of Buck affect the members of the family (Calvin, Conrad, Beth)?
4. Have you experienced a loss within your family?
5. In what ways did this loss affect your family members?
6. How did you feel when Conrad attempted suicide?
7. Have you ever considered suicide?
8. If so, how did you decide not to attempt it? Who (if anyone) did you talk to about it?
9. What supports did Conrad have when he was going through his grief?
10. What supports do you have when you are depressed?
11. How would you react if Beth was your mother?
12. Could Conrad have coped with the loss of his brother more effectively?
13. Could he have coped with his mother more effectively?

### Conclusion

The discussion around this film will likely take 45 to 60 minutes, if not longer. It may be necessary for group leaders to pause the discussion if it becomes apparent that group members are having emotional difficulty. Leaders may also have to stop the discussion due to time limits of the session, but should also remind members that they may talk further about their reactions to the film with their individual clinicians. Following this discussion, leaders will offer a short debriefing about the session, acknowledging the difficulty of the discussion around *Ordinary People* (Redford, 1980). Leaders will then give a brief overview



of the eighth and final session, in which the members will discuss all three films and engage in several group activities. Members will be dismissed after this discussion.

## **Session VIII**

### **Introduction**

During this final session, leaders will introduce the schedule of the session and begin with a brief group activity before the group discussion. An activity that may foster support within the group is the *Stand-Up*. Group members will pair off (if there is an odd number of members a leader may pair up with a member) and try to find someone roughly the same height as themselves. The pairs will then sit on the floor with their backs pressed against each other and link arms at the elbow. The two pairs will then attempt to stand up, as a pair, using only their legs to push themselves up (they are not allowed to use their hands). This exercise facilitates supportiveness, as well as communication and trust.

Another option for this activity is *Around the World*, a game in which all members stand in a circle with their hands linked. A hula hoop is placed between two members (who will hold hands together to keep the hoop on their arms), and the goal of the game is to move the hula hoop completely around the circle within a set period of time, with members having to move around and assist each other in getting through the hoop without letting go of each others' hands. This activity will also facilitate supportiveness, as well as collaboration and communication.

### **Discussion**

Following the group activity of the introduction, leaders will facilitate a

discussion regarding all three of the films viewed. The discussion does not have to be formal, as the members will likely have a great deal of input regarding the films. Leaders may also want to provide snacks, or perhaps even pizza and soda, at this point in the session. Questions that may help to facilitate this discussion include:

1. Did you notice any common themes between all of the movies we viewed?
2. Which of the movies was your overall favorite?
3. Which movie did you have the strongest emotional reaction to?
4. Of all three films, which character(s) did you feel you could relate to the most? Why?
5. What were some of the strengths of the main characters of the films?
6. What were the weaknesses of the characters of the films?
7. How are you able to take what you learned or felt from these films and incorporate them into your own life?

Following this discussion, leaders will want to offer the members a ten to fifteen minute break.

#### Administration of Depression Questionnaires

After the break, leaders will distribute the third and final set of depression questionnaires (Appendix D) to the group members. Members will be given at least fifteen minutes to complete the questionnaires, and again will be given plenty of space within the group room to spread out in order to avoid sharing answers with other group members. The questionnaires will be collected by leaders, and the group will then proceed to another group activity. As with the

questionnaires completed during Session IV, these questionnaires will be reviewed by leaders and by individual clinicians of the group members. Upon review of all three sets of questionnaires, both a qualitative and quantitative measure of the change in depressive symptoms will be available.

#### Group Activity and Certificates of Achievement

Group leaders will then engage the group members in a final group activity. An activity that may be successful for the final group session would be the Human Knot. This is a physically challenging exercise in which the group members stand in a circle, each reaching across to join their right hand with someone standing across the circle from them. Members would then join their left hands with a different person in the circle, creating a “knot” of arms and hands. Once all of the hands have been joined together and the group is in a “knot”, the members must then work together to undo the knot and create a circle. However, they cannot let go of each other’s hands. This task requires teamwork and communication skills, and is meant to encourage communication and support among group members.

Once the Human Knot activity has been completed, members will sit together for the presentation of Certificates of Completion by the group leaders (Appendix F). These certificates will indicate that each member has successfully completed the cinematherapy group. At this time, members will be encouraged to chat informally among themselves and with group leaders, as well as enjoy snacks that the group leaders have provided.

### Administration of Final Evaluations

After the presentation of certificates and a brief time to socialize, members will be given the second and final evaluation of the group (Appendix E). As with the midpoint evaluation, the leaders will leave the room while members complete the evaluations. Again, a volunteer (or a trusted group member, if no volunteers come forward) will collect the final evaluations, which will then be placed in a large envelope within the room. When all evaluations have been completed and placed into the envelope, this group member may find the leaders and invite them back for the conclusion of the group.

### Conclusion

At the very end of the group, leaders will offer a final debriefing about the films viewed during the sessions, as well as the progress group members have made in establishing trust, processing the difficult material within each of the films, and creating their own list of supports to better manage their symptoms. Group leaders will congratulate the members upon the successful completion of the group, and dismiss all of the group members at this time.

## CHAPTER IV

### DISCUSSION AND RECOMMENDATIONS

The model for the use of group cinematherapy described in the preceding chapter has many potential implications. As discussed in the introduction, it offers one of the first concrete, step-by-step explanations of how specifically to facilitate a cinematherapeutic group. This model may have great success with depressed adolescents, particularly considering the general inclination of many teens to watch movies (Dermer & Hutchings, 2000; Stern, 2005).

In addition, though the model contained examples of specific films for use with this population, it offers flexibility for use with other populations, including younger adolescents and children, adults, and developmentally disabled persons. All of the activities described within the model can also be modified for use with other populations. This flexibility gives the model far more range in terms of its application than simply use with depressed teenagers.

#### **Limitations**

The proposed model also has several drawbacks. First, the model itself has not been empirically tested. While it was based on the documented use of three films considered therapeutically advantageous and/or popular with adolescents, as well as on documented successful group therapy practices, there was no quantitative evidence indicating its success with a depressed adolescent

population. Thus, the first recommendation would be for further research to be conducted in order to empirically test the proposed model.

Another potential flaw of this model also lies within the evaluation system. The tool provided to measure adolescent depression was developed by the writer. While this tool was established based upon established symptoms of depression as well as on frequently-used Likert-like scales, this tool has also not been empirically tested for reliability and validity. As with the model itself, it is highly recommended that this evaluative tool be tested empirically in order to substantiate its validity and/or reliability.

Clinicians and researchers wishing to evaluate the changes in depressive symptoms with more traditional tools may want to utilize the Beck Depressive Inventory–Second Edition (BDI-II). This twenty-one item inventory is used to measure the existence and severity of depression based on several sets of depressive symptoms (Harcourt Assessment Inc., 2005a). Each of the items is measured on a four-point Likert scale between zero and three, with zero indicating no symptoms and three indicating severe symptoms. Items include questions regarding sadness, hopelessness, guilt, self-blame, crying, agitation, loss of energy, and fatigue (Moses, 2005). On items 16 and 18, a seven-point scale is used to measure differences in appetite and sleep patterns. This instrument has been used in many studies involving depression and has been shown to have a high reliability of internal consistency rate of .90, as well as inter-item correlations ranging between .69 and .91 (Grothe et al., 2005; Storch, Roberti, and Roth, 2004).

Clinicians interested in measuring changes in self-concept over the duration of the cinematherapy group may wish to use the Beck Self-Concept Inventory for Youth (BSCI-Y). This twenty item inventory is part of the Beck Youth Inventories of Emotional and Social Impairment. The BSCI-Y assesses the self-concept of adolescents using a Likert-scale rating system and contains statements regarding thoughts, feelings, and behaviors. Items on the inventory include questions regarding competence, potency, and positive self-worth (Harcourt Assessment Inc., 2000). The inventory is written at a second-grade level and is easily understandable.

Finally, clinicians concerned with changes in members' levels of hopelessness during the group may consider using the Beck Hopelessness Scale (BHS). This instrument assesses levels of pessimism and negative attitude, particularly with depressed persons (Beck, Weissman, Lester, & Trexler, 1974). The scale consists of twenty true or false items that measure hopelessness in three areas: feelings about the future, loss of motivation, and expectations (Psychological Corporation, 2003). Research on the BHS indicates it is sensitive to change in client's level of pessimism over time of treatment and that it has an internal consistency coefficient of .93 (Beck et al., 1974). Other research indicates the BHS has an internal consistency of scores of .88 (Steed, 2001).

A final limitation of the model involves the films chosen within the model. As discussed in Chapter 2, stereotypes and negative film images may have a strong influence on the attitudes and behaviors of those viewing films. In regard

to the films chosen for the model, it is important to note that all three of the films selected have main characters that are predominantly White males. These films may lead to members of other racial or ethnic background, gender, or sexual orientation to feel as if they cannot relate well to the characters. In choosing films for cinematherapy, it is important that counselors think carefully about who will be viewing each film and make their selections accordingly. The demographics of the group members must be carefully considered before film selections are chosen.

### **Implications**

Chapter one indicated that a potential implication of the use of cinematherapy in general would be the cost of video equipment, renting or purchasing movies, and time needed to view films to determine their appropriateness for use with clients. It is certain that the cost of a television and DVD player would be daunting for some agencies and schools. However, if cared for properly, this equipment could last for many years, and could be used by many clinicians for therapeutic gains. Additionally, it should be noted that videos in general are fairly inexpensive to purchase, and are even less expensive to rent for a short period of time. Compared with more costly therapeutic treatment options, such as adventure-based counseling or long-term psychotherapy, it seems as if cinematherapy may provide a less expensive intervention for many clinicians.

### **Recommendations**

As noted in chapter two, there have been relatively few empirical studies



regarding the efficacy of cinematherapy despite its popularity with psychologists (Lampropoulous et al., 2004). It is apparent that more research in general needs to be conducted within this growing area of therapeutic intervention. Suggestions for specific research in this area includes content analyses to determine the appropriateness of films with certain populations; empirical research regarding the specific effects of cinematherapy on the symptoms of certain presenting problems; and studies regarding the effectiveness of cinematherapy with various types of mental illness.

Cinematherapy is an exciting, relatively new technique within the field of counseling. Even though research is limited on this particular topic, its growing popularity and potential for use with a wide variety of clients cannot be denied. By conducting new research, particularly empirical studies, within the realm of cinematherapy and videowork, clinicians and researchers alike may find a wealth of therapeutic knowledge. Despite the potential drawbacks, the model described in this thesis is a starting point for conducting future empirical research. It also offers a first step to clinicians wishing to utilize cinematherapy but are unsure how to start. In the end, only further research into the efficacy of cinematherapy can determine its potential as a future best practice in counseling and psychotherapy.

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## Appendix A

Group Therapy Questionnaire

1. How motivated are you to work toward decreasing your depression?

Not at All	Somewhat	Very Much	Unsure
0	1	2	0

2. Have you ever participated in a group in which you are expected to participate through conversation and completing activities?

Not at All	Somewhat	Very Much	Unsure
0	1	2	0

3. Do you enjoy watching movies as a leisure activity?

Not at All	Somewhat	Very Much	Unsure
0	1	2	0

4. Would you be likely to join in group discussions with your peers?

Not at All	Somewhat	Very Much	Unsure
0	1	2	0

5. Would you be interested in attending a group with your peers during which you watch movies, talk with others, and complete activities to work toward goals of decreasing depression?

Not at All	Somewhat	Very Much	Unsure
0	1	2	0

## Appendix B

## Informed Consent for Cinematherapy Group

This group is designed for teens to talk with each other, as well as with group leaders, about issues related to depression. In the group, members will have the opportunity to participate in team-building activities with their peers that will promote positive social interaction. In addition, teens will watch and discuss movies with their peers. Group members will have a chance to share snacks and ideas with one another while working to better manage symptoms of depression.

The group will meet once per week for roughly two hours over a period of eight weeks. There will be a total of eight sessions, with group members watching movies during six of those sessions.

The goals of this group are outlined below. By participating in this cinematherapy group, we hope that you will be able

- a. To decrease symptoms of depression, such as tearfulness, irritation, isolation, and lack of interest (as well as others) through the guided viewing of popular movies.
- b. To increase involvement with peers through discussions and activities related to the viewing of the films.
- c. To increase self-esteem and sense of control for all participants in order to avoid future depressive episodes.

If you are interested in participating in this group, we ask that you review some of the following group guidelines.

1. Everything that is said in group is **confidential**. This means it cannot be repeated outside of this group, even if you are talking with another group member. Trust is a big part of the group, and we want everyone to feel safe to talk in the group.
2. Your attendance is voluntary, and you or your parent can choose for you to stop attending the group. We would like for you to attend all group sessions, though, so you may fully benefit from the group, and other group members may fully benefit from your participation.
3. You have the right to be treated respectfully in the group. Likewise, we ask that you treat other group members and group leaders with respect. This means keeping foul language, put downs, inappropriate gestures and faces, sarcasm, and all other disrespectful behavior out of the group.



4. We would ask that when you come to group, please be prepared to *participate* in the group. Examples of participation means coming to group on time, contributing to group discussions, and joining in on group activities.
5. Group leaders will let you know about scenes that may be difficult to watch before viewing any film. If at any point you become uncomfortable, you may leave the room for a moment, or you may request to stop the film and talk about your reaction at that time.
6. A topic may be discussed in group that makes you feel uncomfortable or increasingly upset. If this happens, you may discuss your feelings privately with group leaders, or with your counselor/case manager/psychiatrist/guidance counselor. You also may choose to take a quick break from the session if you feel very uncomfortable.
7. Group leaders will be in contact with your individual therapist, case manager, psychiatrist, or guidance counselor about the group activities from week to week. This way, if there are any questions or concerns that you are unable to address during group time, you may discuss this with your individual clinician as well.
8. If you are not able to follow the guidelines of the group, or if you miss two or more group sessions, you may be asked to leave the group. However, you will have the opportunity to attend the group the next time it is offered.

By signing below, you are indicating that you understand each of these points and are willing to consent to participation in this group.

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Participant Signature

---

Date

---

Parent Signature

---

Date

---

Witness Signature

---

Date

## Appendix C

Parental Permission to View Movies

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_,

give permission for my daughter/son to view the following films during the cinematherapy youth group. The specific films for which I give my permission for my child to view are:

*Napoleon Dynamite* (2004) – Rated PG  
(Rating for thematic elements and language)

A humorous film about a teenage outcast struggling with a variety of teen issues.

*Dead Poet's Society* (1989) – Rated PG  
(Reasons for rating unavailable at time of film release; the film contains coarse language, sexually suggestive language, and violence)

A dramatic film about the challenges of teen life at a private school when an unconventional teacher influences the lives of his students.

*Ordinary People* – Rated R  
(Reasons for rating unavailable at time of film release; the film contains coarse language, violence, and references to sexuality)

A dramatic film about the tragic loss of a son and brother and how family members attempt to cope with their grief.

I understand the group leaders may not explicitly address each occurrence of foul language violence, or reference to sexuality, but know that they will offer appropriate adult guidance when viewing the films with the group.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## Appendix D





## Appendix E





For the following questions, please answer each question briefly.

7. What has been the most helpful group activity so far?
8. What has been the least helpful activity?
9. How have the group leaders been most helpful to you in the group?
10. What have the leaders done that has not been helpful?
11. If you could change one thing about the group, what would it be?
12. What has been your favorite part of the group?
13. What has been your least favorite part of the group?

## Appendix F

# Certificate of Achievement

This Certificate of Achievement is Awarded to

\_\_\_\_\_

For the Successful Completion of the  
Teen Cinematherapy Group

\_\_\_\_\_

Date

\_\_\_\_\_  
Signature of Group Leader

\_\_\_\_\_  
Signature of Group Leader