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# Enhancing Cognitive Behavioral Therapy and Expressive Arts Therapy by Applying a Hybrid Approach

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Enhancing Cognitive Behavioral Therapy and Expressive Arts Therapy by Applying a Hybrid

Approach

Capstone Thesis

Lesley University

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Expressive Arts Therapy

Donna Owens

### **Abstract**

Therapists often draw from multiple therapeutic modalities in order to find appropriate treatment options for a client; however, little is written on the subject of how these modalities may be able to enhance each other in a strategic way. When considering the field of expressive arts therapy and the struggle it has faced in the effort to legitimize itself, it is worth considering how other therapeutic modalities could work in tandem with it in order to improve the overall experience. Alternatively, cognitive behavioral therapy is a strong, evidence-based practiced that sometimes lacks in the qualitative experience realm, providing a gap that may be filled by applying unique, expressive arts therapy techniques to achieve therapeutic goals. This literature review explores the possibility of therapeutic enhancement through a hybrid approach to cognitive behavioral therapy and expressive arts therapy. The proposal for a hybrid approach is based on an investigation into the published literature and historical texts of each modality, their underlying theories, an analysis of the strengths and weaknesses, potential overlap of the two modalities, and gaps that may be filled by a tandem application. The final component of this literature review provides samples for application by focusing on adolescents with anxiety as a target population. The research presented here encourages practitioners to perform further research on the utilization of this particular hybrid approach and opens the door for further communication about other potential hybrid approaches.

## Enhancing Cognitive Behavioral Therapy and Expressive Arts Therapy by Applying a Hybrid Approach

There are therapeutic benefits to applying techniques from varied modalities in order to enhance or supplement the work. Each therapeutic modality has its own strengths and weaknesses, and rather than applying a singular therapeutic modality to a session, therapists should be encouraged to try to improve the therapeutic experience by combining approaches. This concept will be explored here by considering the strengths and weaknesses of cognitive behavioral therapy (CBT) and expressive arts therapy (EAT), and how the two can be utilized in tandem for an enhanced therapeutic experience.

EAT is a treatment modality “founded on the interrelatedness of the arts and takes an integrated approach to the use of the arts as a tool for psychotherapy” (Estrella, 2005, p. 183). It draws its application techniques from several well-established creative arts therapy (CAT) practices, leaving room for interpretation on how to apply it in practice and making it a somewhat undisciplined therapeutic modality with minimal published research. The future of EAT has two potential paths: 1) expressive arts therapists can work to legitimize the field by building in more structure, discipline, and published research; or 2) it can become a supportive practice to other treatment options instead of a stand-alone treatment modality. Expressive arts therapists bring a breadth of artistic and clinical experiences to the table, leading to wide variability in potential approaches. Because of the fluidity and inherent creativity of EAT in practice, it is a prime candidate for supplemental or supportive practice to the qualitative experience of other more standardized practices.

CBT is a well-established, evidence-based therapeutic modality. It was developed based on the theory that dysfunctional thinking is the basis of all psychological disturbances (Beck, 2011). This discipline tends to use a prescribed approach with an emphasis on psychoeducation,

homework, measurable goals, and perceivable change, it lends itself well to the development of research (Corey, 2013). However, while these aspects of CBT are benefits to the field of research, it has been reported that the experience can be boring and repetitive (Donellan, Murray, & Harrison, 2012). Thanks to the wealth of pre-existing knowledge on the subject and its emphasis on structure and the client-therapist relationship, CBT has become a very accessible and reliable form of therapy, making it a desirable place to start when looking to enhance the practice of EAT. Meanwhile, EAT is able to provide qualitative enhancements to the CBT experience through the use of creativity and play.

This literature review defines and describes the basic elements of EAT and CBT in order to draw connections between the two, as well as to consider the gaps that each could fill for the other. Then, in order to demonstrate the potential enhancements, sample directives for applying this hybrid approach are provided by using adolescents with anxiety as a case example.

## Literature Review

In pursuance of developing an enhanced therapeutic model utilizing a hybrid approach to CBT and EAT, it is important to examine the existing literature so as to lay the foundation for something new. The following sections summarize the history, theoretical bases, basics of application, strengths, and potential areas of growth, for each modality. A brief exploration into pre-existing research on similar hybrid approaches is also included. This literature review was performed by taking a deep dive into published texts on both EAT and CBT, as well as by applying the following search terms to the Lesley University online library: *cognitive behavioral therapy, expressive arts therapy, integrative arts therapy, expressive therapy, creative arts therapy, effectiveness, session structure, experience of CBT, experience of EAT, adolescents, and anxiety.*

### Expressive Arts Therapy

**History.** The field of EAT was developed in the 1970s at Lesley College Graduate School's Institute for the Arts and Human Development (Levine & Levine, 1999). The unique quality of the field and the program was rooted in an interdisciplinary approach to the CATs (p. 9). The early trailblazers of the field brought a deep respect for the arts by highlighting the ancient human traditions of art-making and innate creativity. The program at Lesley supported this work by encouraging the development of a "creative therapeutic community" (p. 9) made up of students and faculty working side by side on the tradition of community art-making. Since then, programs in EAT have been developed all over the world and in 1994, the International Expressive Arts Therapy Association (IEATA) was founded in order to put forth professional status and training opportunities (p. 10).

**Theories and Basics of Application.** Levine and Levine (1999) point out that defining EAT with any specific terms is a difficult task, as "it cannot be limited to a particular framework" (pp. 10-11). Accepting this, it is important to note what theories and ideals the modality is rooted in

so as not to be perceived as “an incoherent collection of approaches” (p. 11). EAT is based on the idea that artistic expression is a fundamental human capacity, and because of the unique quality to each individual’s form of expression, EAT cannot be contained by one unifying theory, but rather by multiple connected theories of expression. The forefathers and foremothers of EAT acknowledged that each individual will have a unique form of expression; thus, it does not restrict clients to one specific art form and allows clients to find meaning through making art. Levine’s (2005b) theory of *poiesis* describes this basic human desire to make new things, but more specifically refers to the need for art-making. *Poiesis* is described as “the capacity to respond to and shape the world” and places “the play of imagination...at the center of the human capacity for shaping” (Levine, 2005a, pp. 10-11).

EAT approaches the arts from an interdisciplinary perspective. There is a distinct focus on the interrelatedness of each art form in EAT and “practitioners are trained to be sensitive to the unique properties within each art form, to be attentive to the creative process as a method of inquiry, and to be skilled at the integration of the arts, at times through a process known as the intermodal transfer” (Estrella, 2005, p. 183). Intermodal transfer is “the practice of shifting from one art form to another” (Knill, 2005, p. 125). The concept of intermodal transfer is somewhat rooted in the performance arts, as performance is an inherently interdisciplinary act (Knill, 2005). Intermodal transfer is seen as a constant exploration for “the most effective material” to achieve the desired performance and “is not restricted to one artistic discipline” (Knill, 2005, p. 125).

Knill (1999) describes a variety of other theories that are foundational to the application of EAT:

- Interpersonal theory describes the “group dynamics of play in the various art disciplines and characteristics of intervention” (p. 45). This theory supports a communal aspect of play and art-making, such as the socialization of group music-making.

- Intrapersonal theory describes the “cultural and biographical conditions that influence the response towards the various art disciplines” (p. 45). This theory supports the “low-skill high-sensitivity” (p. 45) model, where a client is encouraged to focus more on awareness and expression than on skill.
- Transpersonal theory describes the experience of “an inquiry into the traditional embeddedness of the different art disciplines in rituals and daily use” (p. 46) and supports the many ways we have been using the arts to support our human traditions for centuries.
- Polyaesthetic theory describes “the understanding of the sensory connections between perception and expression with respect to the arts disciplines” (p. 46) and acknowledges that artistic expression is inherently intermodal.
- Crystallization theory describes “the elucidation in the artistic process from its inception to the ongoing interventions and final interpretative activities” (p. 47) and is based on the development of crystals from a scientific standpoint, in which they continue to grow and develop in new directions based on a focal point. This process is supported by the use of intermodal transfers, amplifications, and substitutions.
- Aesthetic theory “embraces the theoretical challenge introduced by any therapy that expands the realm of imagination” (p. 48) and acknowledges the possibility of interpretation of our artwork in therapeutic settings.

Expressive arts therapists often ask their clients to revive dormant creativity in order to explore hidden or suppressed emotions. Because of this potential for depth and vulnerability, significance is placed on the client-therapist relationship and the creation of a safe space. Natalie Rogers (1993) describes her unique approach to EAT as the “process of discovering ourselves through any art form that comes from an emotional depth” (p. 2) and in order to support this self-

discovery, she recommends the application of a person-centered approach to the work called the Creative Connection. Chiu, Hancock, and Waddell (2015) explain that person-centered EAT is based on the concept that “individuals hold the inherent capacity for self-direction and [the] ability to empower themselves” (p. 38). Corey (2013) describes Rogers’ approach by explaining that “personal growth takes place in a safe, supportive environment created by counselors or facilitators who are genuine, warm, empathic, open, honest, congruent, and caring, [which are] qualities that are best learned by first being experienced” (p. 176). Corey (2013) goes on to explain that “taking time to reflect on and evaluate these experiences allows for personal integration at many levels—intellectual, emotional, physical, and spiritual” (p. 176). The basic principles of person-centered EAT are as follows:

- All people have an innate ability to be creative.
- The creative process is transformative and healing. The healing aspects involve activities such as meditation, movement, art, music, and journal writing.
- Personal growth and higher states of consciousness are achieved through self-awareness, self-understanding, and insight.
- Self-awareness, understanding, and insight are achieved by delving into our feelings of grief, anger, pain, fear, joy, and ecstasy.
- Our feelings and emotions are an energy source that can be channeled into the expressive arts to be released and transformed.
- The expressive arts lead us into the unconscious, thereby enabling us to express previously unknown facets of ourselves and bring to light new information and awareness.
- “One art form stimulates and nurtures the other, bringing us to an inner core or essence that is our life energy” (p. 175).

- A connection exists between our life force—our inner core, or soul—and the essence of all beings.
- As we journey inward to discover our essence or wholeness, we discover our relatedness to the outer world, and the inner and outer become one. (Corey, 2013, pp. 175-176)

The inherent flexibility and creativity of EAT leaves room to explore the concept of play.

When experimenting with multiple art forms, we may be inclined to refer to the experience as “playing” with materials or mediums. Fink (as cited in Knill, 1999) explains,

play has an extraordinary position within the fundamental existential phenomena. . . and has priority because. . . humans make a distinction between reality and unreality, while in play. . . the connection between reality and unreality has purpose and makes a sense that breaks into the total reality of things. (p. 39)

The arts provide a structure for play and can allow for a therapeutic experience that is freeing and/or fun.

**Strengths and Potential Areas of Growth.** While there are many known strengths of EAT as a therapeutic modality, for the purposes of this project, this review focuses on three unique qualities of the work: fluidity and improvisation, the endless opportunities for creativity, and play.

Chiu, Hancock, and Waddell (2015) have neatly described the benefit of the fluidity that is inherent in EAT by explaining that the recognition and integration of “these various expressive capacities... [allows practitioners to] more fully encourage each person’s abilities to communicate authentically and effectively” (p. 34). Their experience with running an EAT open-studio group in an acute care psychiatric hospital setting highlights the incredible flexibility that is afforded to clients by utilizing EAT. The EAT open-studio format is a unique setting in which a wide variety of art making may be happening in the same room. For example, some participants may be painting in one area while others are moving to the background music or playing their own nearby. Facilitators

often work alongside clients and are equally engaged in art making. For facilitators and therapists, the focus becomes flexibility and “being in the present moment” (p. 37). A client may begin by playing with a certain medium but become inspired by something another client is using, so a community of intermodal transfer may be formed. Alternatively, observation is equally important in an EAT open-studio, so a client will always have the flexibility to make the decision to excuse themselves from the art making and become an observer.

Flexibility for the sake of meeting the client’s needs is an important aspect of EAT. Kossak (2009) describes the importance of improvisation and play in EAT as an opportunity for learning via curiosity, adaptation, and experimentation. Flow and attunement become an important part of the practice as encouraging this level of improvisation requires the therapist to learn to follow the needs of the client. Zarate (2016) describes methods of clinical improvisation in the field of music therapy that are equally as important and applicable to EAT; these include matching, reflecting, grounding, dialoguing, role-playing, and several other techniques, that are designed to enhance the therapeutic experience. While Zarate’s work is focused on an individual CAT, these themes of clinical improvisation are similar to how an expressive arts therapist would find flow with a client. Additionally, Zarate’s research in applying music therapy and clinical improvisation techniques in clients with generalized anxiety disorder shows the benefits of this practice, resulting in an improvement in everyday functioning and management of anxiety symptoms.

The improvisational aspect of EAT naturally brings a playful element to the work. The integration of play into EAT provides an important qualitative enhancement to the practice. Perryman, Moss, and Cochran’s (2015) research on child-centered EAT and play therapy with at-risk adolescent girls showed an improvement in a variety of therapeutic outcomes, but also described stress release, increased self-expression, and group cohesion. Play and improvisation in EAT give more freedom to the therapist when searching for appropriate interventions for the client, which

would improve the experience of being in therapy, as the client's unique needs are able to be met. Speaking candidly from personal experience, there is also an element of enjoyment that CAT directives bring to the therapeutic experience. The CATs are uniquely suited to conceal the work of therapy, as they are able to bring a playful element to sessions.

Acknowledging the strengths to EAT in practice, there are some important areas for growth worth noting. Levine and Levine (1999) explain that the "interdisciplinary nature [of the work] requires an ability to bring together disparate perspectives and practices without privileging any one of them" (p. 11). However, as it currently stands and is often applied by expressive arts therapists, EAT has become a toolkit of CAT techniques that are very rarely used intermodally. This can be seen when considering the published literature. When applying the search term "*expressive arts therapy*" in the Lesley University online library, there were 64 unique results over the last two years (date parameters were set between 2016 and the search date of April 8<sup>th</sup>, 2018). Of these, only six (9.4%) represented articles on traditional intermodal EAT, utilizing two or more interconnected modalities, while eight (12.5%) represented articles on what could be multimodal EAT, utilizing a series of at least two modalities that were not interconnected. Twenty-six (40.6%) articles represented research on singular CATs, including art (13), music, (5), drama (4), DMT (1), and other CATS, such as writing (3). Twenty-four (37.5%) articles were excluded from this review, including unrelated articles, such as editorials and book reviews (16), review articles (3) as they may have led to representing duplicative results, four articles that could not be opened, and one article that was not in English.

An expressive arts therapist may choose to specialize in one particular therapeutic art form for the sake of comfort or for the sake of ease depending on their employment. This may be one of a variety of reasons why there is almost no published literature on the field of EAT, but rather on the concept of applying an expressive art intervention, in which one particular therapeutic art form

becomes the focus of the work. It may feel easier to distill down to a singular CAT as it may provide a more structured format for research. For example, although their work focuses on a singular creative arts modality, Forrest-Bank, Nicotera, Bassett, and Ferrarone's (2016) work on the use of poetry therapy with urban youth in low-income neighborhoods, they are applying the term "expressive arts therapy" to their keywords and, therefore, it is a misleading search result.

Alternatively, researchers may apply a series of CATs to their work, though they will not apply them intermodally. For example, Van Westrhenen et al. (2016) have applied a creative arts psychotherapy protocol for children who have experienced recent trauma, which features a multimodal approach (a series of individual CAT directives). While this work is a promising step towards applying intermodal EAT, a gap in the published literature remains.

Part of the benefit of EAT is the fluidity and flexibility it allows for; however, this does not necessarily support the development and execution of research and has led to the reinforcement of a relatively unstructured practice. Johnson (2009) points out that the vast majority of CAT research is based on qualitative data that is near impossible to quantify, leaving practitioners to draw conclusions based on personal feelings and opinions of situations. Qualitative research is important for describing the experience of a client, but the inability to quantify research makes it difficult to appreciate outcomes.

### **Cognitive Behavioral Therapy**

**History.** The field of CBT was developed in the 1950s and 1960s by Dr. Aaron T. Beck (2011), who had been observing his clients' experiences with depression. He noted that their dreams often reflected their emotional states and that their thoughts automatically made negative associations without any specific grounding. As he worked with clients to unpack these automatic thoughts and emotional experiences, he observed rapid improvements in their conditions. In the 1970s, Beck and his colleagues began to apply similar techniques to clients with anxiety and

discovered that the results were equally as positive. Since then, his techniques have been published and applied to a wide variety of populations and CBT is now taught in programs all over the world.

**Theories and Basics of Application.** The core theory of CBT is based on the concept that dysfunctional thinking influences mood and behavior, and therefore, it is the basis of all psychological disturbances (Beck, 2011). The most basic form of CBT requires clients to learn to analyze their thinking in more realistic terms so they are able to make positive improvements in their mood and behavior. In order to make long-term change, therapists assist clients to develop an understanding of their basic belief systems, including beliefs about themselves, systems, and relationships.

An understanding of the cognitive model is essential to practicing CBT. The cognitive model “hypothesizes that people’s emotions, behaviors, and physiology are influenced by their perception of events” (Beck, 2011, p. 30). The cognitive model acknowledges that every individual will perceive situations differently and will thereby have a variety of emotional and behavioral responses (Beck, 2011). These fleeting thoughts are known as automatic thoughts, and are specifically not the result of any evaluation or rationalization; rather, they are spontaneous reactions. Once an automatic thought has been identified, the client can perform a reality check where the validity of the thought is further explored. This exploration into automatic thoughts can allow the client to change their reaction to the situation.

In practice, the vast majority of CBT treatment is based on exploration and challenging these automatic thoughts. According to Beck (2011), there are ten basic principles of CBT treatment:

1. “Principle No. 1. Cognitive behavior therapy is based on an ever-evolving formulation of patients’ problems and an individual conceptualization of each patient in cognitive terms” (p. 7). According to this principle, therapists view their clients from a timeline perspective, where they consider and identify their client’s current thinking and

- associated problematic behaviors, as well as precipitating factors and developmental events that may have led to the client's current presentation.
2. "Principle No. 2. Cognitive behavior therapy requires a sound therapeutic alliance" (p. 7). Therapists who practice CBT point out and break down beliefs that clients have held to be true for great lengths of time, which requires the client to have a good deal of trust in their therapist. This principle encourages the use of "basic ingredients" for counseling in order to be successful: "warmth, empathy, caring, genuine regard, and competence" (p. 7).
  3. "Principle No. 3. Cognitive behavior therapy emphasizes collaboration and active participation" (p. 8). Therapy is viewed as teamwork and requires the client to do their part between sessions in order to be successful. Homework is assigned between sessions and over time, the nature of the work becomes so collaborative that the client is encouraged to develop their own assignments.
  4. "Principle No. 4. Cognitive behavior therapy is goal oriented and problem focused" (p. 8). The therapist works with the client to develop reasonable goals so that both can know what the client is expecting out of treatment. Goals may be based in behavioral terms and the therapist is able to assist the client with seeing how emotional issues may be getting in the way of resolving certain problematic behaviors.
  5. Principle No. 5. Cognitive behavior therapy initially emphasizes the present" (p. 8). It is important to CBT practitioners to address the immediate needs of the client, and therefore, clinicians will focus their time and energy on the present. According to Beck, the therapist should shift focus to the past in two specific circumstances: first, if the client has a strong desire to explore their past experiences and delaying this would jeopardize the therapeutic alliance, and second, if the client's dysfunctional thinking is so

- engrained that a greater understanding of early childhood experiences is deemed necessary.
6. “Principle No. 6. Cognitive behavior therapy is educative, aims to teach the patient to be her own therapist, and emphasizes relapse prevention” (p. 9). As part of this principle, the therapist is expected to discuss the details of the client’s disorder so the course of treatment is made clear. The therapist also teaches the client how to evaluate and address their thoughts and beliefs on their own so that the client is able to successfully move forward when treatment has ended.
  7. “Principle No. 7. Cognitive behavior therapy aims to be time limited” (p. 9). Generally speaking, the ideal course of CBT treatment will be between six and 14 sessions, plus a set of “booster” sessions post-treatment; however, CBT practitioners are flexible to the idea that some clients may require significantly longer courses of treatment.
  8. “Principle No. 8. Cognitive behavior therapy sessions are structured” (p. 9). Session-structure is broken down into an introductory portion, which includes a brief check-in, review of the prior week, and setting an agenda for the session; a middle portion, which includes a review of homework, discussion agenda items, developing new homework assignments, and a summarization of the session; and a final portion, which includes feedback.
  9. “Principle No. 9. Cognitive behavior therapy teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs” (p. 10). The therapist works with the client in a process called collaborative empiricism by performing behavioral experiments that may challenge the client’s thinking and beliefs in order to practice their skills in the real world. This helps the client to be able to regulate their thoughts and reactions independently.

10. “Principle No. 10. Cognitive behavior therapy uses a variety of techniques to change thinking, mood, and behavior” (p. 10). Aside from the other techniques that have already been mentioned, CBT also relies on teaching problem-solving techniques and encourages the application of other therapeutic modalities for the purpose of resolving the goals of the client.

The basic principles of CBT influence how the therapist approaches each client. A final important aspect of CBT treatment is the focus on emphasizing the positive. For many clients, it will be difficult to see positivity in their days, but it is important for the therapist to find ways to insert positive praise that may negate their automatic thoughts (Beck, 2011). All progress is worth noting and this positivity will help to support the therapeutic alliance and will teach clients to celebrate small victories.

**Strengths and Potential Areas of Growth.** The strengths of CBT explored in this review are session structure, the emphasis on the relationship between the therapist and client, proven effectiveness, and accessibility.

Session structure is a key aspect of CBT that is clearly described and laid out, by starting a session with collaborating on the agenda and an introduction to the session, followed by the “work”, an opportunity for feedback, and ending with homework assignments (Dobson & Dobson, 2013). Dobson and Dobson (2013) recommend a “10-30-10” framework for a traditional 50-minute therapy session, where ten minutes are devoted to the introductory portion of the session, thirty minutes are set aside for the primary therapeutic work for the session, and ten minutes are left for the summary and homework discussion (p. 411). As an additional benefit to in-session structure, the process of developing the session provides many opportunities for collaboration, allowing for increased comfort to the client in the treatment plan and process of CBT. Session structure is considered to be a significant benefit to the practice as it has been shown to provide efficiency,

client comfort as it increases clarity of treatment planning and reduces therapy-associated anxiety, and increases client focus (Dobson & Dobson, 2013).

While the session structure is important for practical reasons, it also contributes to the client-therapist relationship by increasing feelings of safety. The client-therapist relationship plays a key part in successful CBT treatment. In order to challenge core beliefs and make recommendations that push a client to the edge of their comfort zone, a strong therapeutic alliance must be established. It is important to acknowledge that there are many characteristics of the client and the therapist that can separately contribute to the relationship that is formed between them. Jacobson (1989) claims that the clinical skills of the therapist help contribute to the therapeutic alliance by providing the client with a level of reassurance in the work and thereby increasing trustworthiness. If the therapist presents as a confident and straightforward teacher, then the client will inherently be more willing to believe in the work and the relationship is strengthened. Jacobson also explains that the interpersonal dynamic between the client and therapist becomes an additional teachable moment, in which previous dysfunctional patterns fail to repeat themselves and the client is able to successfully integrate new skills into their everyday life.

Such emphasis is placed on the therapeutic alliance because it has been shown to predict symptom outcomes, and alternatively, changes in symptoms can also predict variability in the alliance (Accurso et al., 2015). There are a variety of published articles on the positive effects of a strong therapeutic alliance with diverse populations, including Accurso et al.'s (2015) work using CBT for treatment of bulimia nervosa; Kirsch, Keller, Tutus, and Goldbeck's (2018) research on trauma-focused CBT with children and adolescents; and, Clarke, Mun, Kelly, White, and Lynch's (2013) study on CBT and pharmacotherapy for women with substance abuse histories. Accurso et al.'s (2015) research showed that a stronger alliance predicted greater improvements in bulimic behavior. During the course of their study, certain patient characteristics were found to be

associated with a stronger alliance, including lower symptomology, high emotionality and high intimacy problems. Kirsch et al. (2018) have shown that treatment expectancy significantly increased the working alliance in their work with children and adolescents. The working alliance was also positively associated with the children's caregivers' working alliance and, therefore, this information also suggests an indirect prediction of treatment outcome. Finally, Clarke et al. (2013) were able to show that pre-treatment motivation and therapeutic alliance were correlated to better treatment outcomes. These three articles highlight the rationale for the emphasis placed on the client-therapist relationship, as it has been clearly shown to significantly affect treatment outcomes.

Published literature on the effectiveness of CBT has shown a reduction in the severity of symptoms in a variety of settings and the elimination of certain diagnoses post-CBT treatment (Karahan, Yalcin, & Erbas, 2014; Scaini, Belotti, Ogliari, & Battaglia, 2016; Warwick et al., 2017). These three articles provide a snapshot of the immense library of published literature on the effectiveness of CBT in practice. It would be impossible to summarize the full library here; however, it is important to note that the articles cited above demonstrate the effectiveness of CBT interventions in clinical and school settings (Scaini et al., 2016) and show that CBT is capable of providing and sustaining recovery from certain disorders and improvements in severity for others (Warwick et al., 2017; Karahan, Yalcin, & Erbas, 2014).

Accessibility is the final benefit of CBT to be discussed here. The use of CBT in adolescents with anxiety has been shown to be equally as effective in internet-based treatment as it is in clinic-based treatment (Spence et al., 2011). Dryman et al.'s (2017) research on an internet-based, open access CBT program for the treatment of social anxiety demonstrated that, for clients who were adherent to the full content of the program, there was a considerable reduction in symptoms. These results were similar to or exceeded results for those participating in face-to-face CBT in the same study (Dryman et al., 2017). Knowing the effectiveness of internet-based CBT, the accessibility of

using the internet it is a unique benefit, as it means treatment is available to those who may have struggled to afford therapy or who may not have reasonable transportation to sessions. An additional benefit to treating certain diagnoses with internet-based CBT is that it extends services to those whose symptoms are severe enough that they may be unable to attend face-to-face therapy (Dryman, McTeague, Olino, & Heimberg, 2017).

As with any therapeutic practice, there are areas for improvement in CBT as well. For example, adolescents have described their experiences with CBT as predictable and structured, which is a benefit; however, they have also described their experiences as boring and repetitive (Donnellan, Murray, & Harrison, 2012). This raises a question regarding how much flexibility practitioners have when pushing session structure and homework. Perhaps there is an opportunity to practice some flexibility and to implement more creative homework assignments.

An additional area for improvement can be found within the cognitive model. Morris (2014) argues that CBT may go too far into the cognitive model, where it becomes too verbal and abstract. When clients become so verbal and articulate about their issues, it is easy to disconnect from the feeling or emotions attached to these issues. While this does not mean that behaviors cannot be addressed, it misses an opportunity for addressing emotional needs. There may be another opportunity here for improving the practice of CBT by finding a way to integrate the mind with the body.

**Summary of Published Literature on Hybrid Approaches to CBT and CATs.** While the published literature on the topic is minimal and there was nothing found on the rationale for combining CBT with EAT, there was a small number of research articles on the use of expressive arts interventions with CBT. The following sections provide a brief review of the published literature on the use of CATs in combination with CBT. There were no articles found in the Lesley University online library on the topic of CBT in combination with dance-movement therapy.

**Expressive arts interventions and CBT.** In Dorsey et al.'s (2017) review of 37 CBT-based studies on psychosocial treatments for children and adolescents who have been exposed to traumatic events, only two randomized, controlled trials were found covering a CBT and "creative expressive" hybrid approach (p. 323). Both studies were focused on a classroom-based intervention (CBI) that was described as difficult to clinically interpret or generally ineffective due to "methodological or design problems, baseline symptom differences..., insufficiently rigorous fidelity assessment, and/or that CBT elements were not delivered in a sufficient dose" (Dorsey et al., 2017, p. 323). Upon reviewing the two studies further, the intervention itself is worth discussing here, as very few articles have been published on the topic. The first study was focused on a CBI for children in war-affected Burundi (Tol, 2014). The goal of the CBI was to decrease psychological symptoms and to strengthen protective factors. The CBI was implemented in 15 sessions over the course of five weeks by "non-specialized facilitators" (p. 3) who had received training for one year prior to the implementation of the study. While the details of interventions are not specified, the CBI was designed to combine CBT techniques with "creative expressive elements" (p. 4), such as cooperative games, movement, music, and drama. Each session had a specific theme, such as safety, stabilization, awareness, or coping skills, and was structured into four parts, with clear warm-ups and closures, a central activity, and activities for group cohesion.

The second study employed a similar technique with children affected by political violence in Indonesia who were experiencing post-traumatic stress disorder (PTSD) symptoms, but with significantly less facilitator training (two weeks versus one year of training) (Tol, 2008). Participants in this study showed improved PTSD symptoms and increased hope compared to the control group at the 6-month follow-up.

Boals, Murrell, Berntsen, Southard-Dobbs, and Agtarap (2015) discuss the use of an expressive writing intervention in combination with either CBT or acceptance and commitment

therapy (ACT) to reduce event centrality. Participants were randomly assigned to listen to brief segments describing basics of CBT sessions, ACT sessions, or a neutral topic, and were then asked to perform two expressive writing sessions. The ACT analog explained an acceptance-based rationale, followed by a guided mindfulness exercise, while the CBT analog provided a four-part rationale for CBT and was followed by a guided imagery exercise, and the neutral analog provided a brief history of baseball. Participants who were assigned to the ACT or CBT groups were then guided through a twenty-minute expressive writing exercise, in which they were asked to explore their deepest thoughts and emotions on a negative event from their lives. Essays were then analyzed and coded by advanced graduated students with training in both ACT and CBT, applying a score for participants who did not follow the instructions of the analog and a higher score for those who applied a strategy from the audio recording. Participants in the ACT group showed a significant decrease in event centrality at the one-week and four-weeks post-writing time points and participants in the CBT group showed a decrease in event centrality from pre-writing to one-week post writing, but the decrease did not become significant until four-weeks post-writing. While the results support a decrease in event centrality based on an expressive writing intervention, there was no significant effect of expressive writing on PTSD symptoms.

**Art therapy and CBT.** There are several published articles on the use of art therapy with CBT (Breiner, Tuomisto, Bouyeah, Gussak, & Aufderheide, 2012; Pifalo, 2006; Pifalo, 2007; Sarid & Huss, 2010), two of which are summarized here. Sarid, Cwikel, Czamanski-Cohen, and Huss (2017) utilized a hybrid CBT and art therapy treatment plan for women with perinatal mood and anxiety disorders. The authors describe several methods that use CBT as the backbone for arts-based interventions. Sosin and Rockinson-Szapkiw (2016) describe their approach called the Creative Exposure Intervention as part of clinical treatment for adolescents dealing with bullying and PTSD symptoms. The Creative Exposure Intervention integrates CBT with art therapy and mindfulness

by teaching meditation and grounding techniques, applying art-based interventions in each session to explore emotional responses, assigning homework, and addressing negative thoughts and behaviors.

Morris (2014) describes another technique known as cognitive behavioral art therapy (CBAT), “in which art is fully integrated into the goals of an established CBT model” (p. 345). Morris explains the use of art as a desensitization technique for clients with generalized anxiety disorder, where clients are asked to make art about stimuli or fears in order to learn to cope with uncomfortable feelings.

**Music therapy and CBT.** A music-based model called cognitive behavioral-therapy-based music (CBT-Music) was described by Trimmer, Tyo, and Naeem (2016) for the treatment of anxiety and depression. The researchers describe interesting qualitative aspects to the use of CBT-Music, including the delivery of “low-intensity CBT material” (p. 84) in creative adaptations, increased attendance and engagement in CBT, and group cohesion.

Goldbeck and Ellerkamp (2012) describe their approach to CBT and music therapy called multimodal music therapy (MMT) for the treatment of children with anxiety disorders, in which the basis of this nonverbal form of treatment is designed to recognize and address the difficulty that children with anxiety disorders have in communicating their symptoms and feelings. They go on to discuss that CBT is the ideal mode of treatment for anxiety; however, CBT relies on verbal skills, whereas music therapy requires little to no verbal communication to be effective for emotional expression, making MMT a potentially less threatening approach for “verbally inhibited children” (p. 396). Additionally, “music triggers emotions and can help to differentiate its perception and expression” (p. 397).

**Drama therapy and CBT.** The field of drama therapy is relatively under-researched and under-published, especially when attempting to look for literature on combination approaches to drama therapy and CBT. However, there are several benefits that drama therapy techniques may

bring to CBT, including the opportunity for clients to practice skills, roles, problem-solving, and cognitive self-talk (Blacker, Watson, & Beech, 2008). Blacker, Watson, and Beech (2008) implemented a drama-based CBT program designed to treat anger and aggression in male inmates. The results of the program showed significant improvements in anger and aggression scales and demonstrate potential usefulness of a combination approach in violent offenders.

Treadwell, Kumar, and Wright (2002) suggest a combination approach to psychodrama and CBT, in which CBT helps to emphasize goal-setting, problem-solving, and catharsis, in a psychodrama setting. Similar to other CAT-based CBT models, Treadwell, Kumar, and Wright recommend the combination approach because it helps to pull CBT out of its structure and verbally intensive format, into a more spontaneous realm. Unlike other articles reviewed here on the subject of combining a CAT with CBT, a specific set of guidelines is provided to implement this program. The first two sessions are devoted to educating participants on the CBT and psychodrama models, followed by a variety of possible interventions. After the initial psychoeducation sessions, a dysfunctional thought record (DTR) is recommended for implementation, where participants are taught to self-reflect and recognize automatic thoughts both inside and outside of therapy sessions. Psychodrama techniques are not implemented in the first sessions, but once participants begin sharing the contents of their DTRs more openly, the facilitator can begin using traditional psychodrama role-playing techniques, such as role reversal, doubling, self-presentation, interviewing, mirroring, and a variety of other action techniques. Treadwell, Kumar, and Wright reported successful results of their hybrid approach and noted that one of the key improvements CBT brought to psychodrama was the addition of data collection and easy progress tracking.

## **Discussion**

### **Proposal for Hybrid Approach**

In his article on the underlying paradigms of the CATs in trauma, Johnson (2009) asks why practitioners of the CATs have been so slow to catch up with the popularity of integrating CBT in the work. He asks whether creative arts therapists prefer to live in the margin, constantly avoiding or fearing change, or if there is something inherently disparate about the two fields that leaves them doomed to never intertwine (Johnson, 2009). Fortunately, Johnson (2009) was able to find several components of CBT that foundationally integrate the CATs.

As discussed previously, there are many strengths to applying CBT and EAT individually. However, it can also be seen that there are gaps in each practice, as well as a handful of places where the two practices overlap. The basis for the hybrid approach proposed here uses CBT as the framework and EAT as a supportive practice to developing creative interventions. When considering EAT as a supportive practice, it can bring a unique perspective to using an arts-based version of CBT. Similarly, CBT can bring a structured behavioral approach to EAT, which is typically a fluid, emotions-based practice.

In review of the basics of each modality as outlined here, there are several places where CBT and EAT easily fit together. The first and most obvious place where the theories overlap is in the emphasis placed on the client-therapist relationship. The commonly applied practice of person-centered EAT requires a strong therapeutic alliance that follows the needs of the client in order to achieve goals, which in many ways is the same alliance that is required of therapists who practice CBT, as described in Beck's (2011) Principle No. 2. Additionally, the interpersonal theory of EAT encourages communal aspects of art-making and addresses interpersonal dynamics, which can also be reflected in the client-therapist relationship and collaboration that is seen and described by Beck (2011) in Principle No. 3 of CBT.

Another important point of alignment is through the intrapersonal theory of EAT and CBT's emphasis on the present, as described in Principle No. 5. Practitioners of CBT encourage the

client to focus on the issues occurring in the present before delving into issues of the past. The intrapersonal theory of EAT supports the “low-skill high-sensitivity” (Knill, 1999, p. 45) model of art-making, requiring a mindful practice with a present mind. Both practices require the person to learn self-awareness; however, EAT may be able to provide a unique approach to addressing and exploring the issues at hand.

There is a distinct focus on session structure in the practice of CBT, creating a sort of ritual to each session. The transpersonal theory of EAT can work in support of this task, as it asks us to explore how the arts are incorporated into our daily lives through the act of ritual. Session structure and rituals may be redesigned such that the review of the previous week, homework, and the work portion of sessions could shift into an arts-based format. Because EAT does not specify or strongly emphasize session structure, it could be enhanced by the application of CBT techniques in order to quickly build safety in the therapeutic relationship. Additionally, CBT is very goal oriented and focused on problem solving. This is another potential area where CBT could enhance the practice of EAT, which does not necessarily require a therapeutic goal, though the outcome of an experiential can provide a positive therapeutic experience.

Last, and perhaps most importantly, Beck’s (2011) Principle No. 10 encourages the use of a variety of techniques in order to achieve therapeutic goals, making a perfect opening for the application of EAT directives. EAT also acknowledges that each client will have unique needs and creates an opening for an individualized treatment plan that incorporates CBT as a suitable fit.

For clarity, the details of how EAT and CBT intertwine are also provided in Table 1.

Table 1

*Overlap between EAT and CBT*

<b>EAT Theories</b>	<b>CBT Principle (Beck, 2011)</b>
Emphasis on the client-therapist relationship (Rogers, 1993)	“Principle No. 2. Cognitive behavior therapy requires a sound therapeutic alliance” (p. 7).
Interpersonal theory - “group dynamics of play in the various art disciplines and characteristics of intervention” (Knill, 1999, p. 45).	“Principle No. 3. Cognitive behavior therapy emphasizes collaboration and active participation” (p. 8).
Intrapersonal theory - “cultural and biographical conditions that influence the response towards the various art disciplines” (Knill, 1999, p. 45).	“Principle No. 5. Cognitive behavior therapy initially emphasizes the present” (p. 8).
Transpersonal theory – “an inquiry into the traditional embeddedness of the different art disciplines in rituals and daily use” (Knill, 1999, p. 46)	“Principle No. 8. Cognitive behavior therapy sessions are structured” (p. 9).
<i>Poiesis</i> – the basic human desire to create and the acknowledgement of unique forms of expression (Levine, 2005b)	“Principle No. 10. Cognitive behavior therapy uses a variety of techniques to change thinking, mood, and behavior” (p. 10).

### **Sample Application of the Hybrid Approach**

While it is certainly important to discuss the theoretical rationale for this hybrid approach, it is oftentimes most useful to see how something of this nature would play out in practice. Knowing that CBT and CATs are often used to treat adolescents with anxiety, the following sample directives for application were designed with this population in mind. It is important to note that, to my knowledge, none of the following intermodal interventions have been researched for effectiveness and are my own ideas and recommendations, based on Beck’s (2011) principles of CBT and my experiences using EAT in practice. The interventions discussed may draw inspiration from research on the use of singular CATs in combination with CBT that may have been previously discussed in this thesis; however, the intermodal nature of each intervention would formulate a unique experience.

To set the stage for the following sample directives, it is important to briefly discuss the published literature on the use of CBT and EAT separately with this population. There were no published literature found in the Lesley University online library on the use of EAT in adolescents with anxiety. However, there were a very small number of articles on the use of other CATs in treating adolescents with anxiety. There were no articles found on the use of DMT or drama therapy with this population, and only one article was found on the use of music therapy with this population; however, it was not in English and I was unable to review it. Two articles were found on the use of art therapy with this population. The first of these articles examined the use of mandala art therapy as a means of correction for adolescents experiencing school-based anxiety (Kostyunina & Drozdikova-Zaripova, 2016). The researchers were able to conclude that the comprehensive program outlined within the article was an effective means for school-based anxiety correction. The second article explored the effects of art therapy in combination with breath mediation for treating depressed and anxious adolescents (Kim, Kim & Ki, 2014). This article showed a significant improvement in depression and anxiety in the test group, as well as positive effects in subjective wellbeing compared to the group that did not receive therapy. The researchers were also able to show durability of the effects of their treatment model with the same results at follow-up. Despite the lack of published literature on the subject, I have personally seen the positive influence that the CATs have on adolescents with anxiety in my work with this population in school settings.

Published literature on the use of CBT in adolescents with anxiety has shown that CBT can reduce the severity of anxiety symptoms in adolescents in a variety of settings, and can lead to the elimination of all anxiety diagnoses post-CBT treatment (Karahana, Yalcin, & Erbas, 2014; Scaini, Belotti, Ogliari, & Battaglia, 2016; Warwick et al., 2017). More specifically, Scaini, Belotti, Ogliari, and Battaglia (2016) were interested in the “magnitude and duration of CBT effectiveness in children

and adolescents” (p. 105) and performed a comprehensive meta-analysis exploring the role of certain moderators in treatment, including the use of Social Skills Training as part of treatment. Despite the limitations to their study, the results supported the effectiveness of CBT interventions in clinical and school settings (p. 111). Warwick et al.’s (2017) meta-analysis on complete recovery from all anxiety disorders following the use of CBT in children and adolescents demonstrated similarly positive results. The authors struggled to find articles on the specific type of studies they were interested in; however, they were able to perform a meta-analysis that demonstrated that many participants were free from all anxiety diagnoses post-CBT treatment (p. 83). Karahan, Yalcin, and Erbas (2014) explored the beliefs, attitudes and views of young adults about anger and the effects of a CBT-based treatment program for anger and anxiety management, using a mixed methods approach. Participants were asked to respond to open-ended questions in focus groups regarding their experiences with anger and anxiety, and to complete the Beck Anxiety Inventory and the State Trait Anger Scale, once before starting the program and once after termination (p. 2074). The researchers found a statistically significant improvement in participants’ scores and that CBT-oriented anger management was effective (pp. 2077-2079).

**Self-Beliefs Mandala.** The goal of this directive is to explore and analyze the client’s core belief system. This directive addresses Beck’s (2011) Principle No. 9 by beginning to explore the client’s thoughts and beliefs, utilizing a person-centered EAT intermodal technique. It requires basic art supplies (paper, oil pastels, colored pencils, markers, etc.). The client will draw a large circle and break it into pie slice sections, with a circle at the center that represents the self. The client will then jot down several beliefs that they may hold about themselves or their world in separate sections. If the client is struggling to come up with ideas, a few prompts may be provided. For example, “Do you think you are confident?”, “Is life easier for other people than it is for you?”, or “Do you feel worthy of happiness?” Each belief will take up a different section of the mandala. Once a handful

of self-beliefs have been collected, the client will be encouraged to fill in each section abstractly using the materials provided. For example, colors may be selected based on the feeling associated with the belief or symbols that represent the belief may be included. Once the client is done with at least a couple of sections, they will be encouraged to spend time exploring one of these beliefs further through a free write. This directive may take several sessions in order to appropriately address as many self-beliefs as possible. Suggested discussion prompts are included below:

- How was this process for you? Was it difficult to focus on yourself this much?
- Did you notice any themes in your beliefs? For example, some people notice that more of their beliefs lean more positive or negative, or that their beliefs tend to focus more on their relationships or on their inner experience.
- How should we proceed from here? Would you like to explore any of these beliefs further? We can set some goals and talk about how self-talk affects our daily lives.

**The Gratitude Ritual.** The goal of this directive is to address the experience of filtering, in which a client may filter out the positive events in their review of their daily experience, and to help the client to find positivity in the everyday. This directive addresses Beck's (2011) Principle No. 6 by helping the client to become his or her own therapist, as well as Principle No. 5 by encouraging the client to remain present. The directive also encourages the development of a session ritual through EAT techniques. It requires a foam core board, small strips of paper, collage materials, pushpins or glue, basic art supplies (paper, oil pastels, colored pencils, markers, etc.), and writing materials. The client will use the board to create a gratitude board. The client may choose to do this at home, thereby making it easier to attach new items to the board every day, or they may choose to do it as a closing/opening ritual with the therapist. The client and the therapist will work together to come up with a way to greet the board each time the client is adding to it. This may be a movement or a verbal greeting, or some combination of both. The client will then choose one thing to be grateful

for each time they are ready to add to the board. The client will write this down on a strip of paper and add it to the board with pushpins or glue. The client may also choose to add a symbol or image to the board at the same time. An additional optional step would be to date each of the *Gratitudes* so the client and therapist may have the opportunity to review patterns or items of interest over time.

Suggested discussion prompts are included below:

- Some days it will be easier to come up with ideas than on others. How was it for you today?
- I do not want you to feel pressured to come up with a grand idea every time we approach the board. Some days this may be true, but other days you may be grateful for your alarm clock getting you to work on time or other days you may be thankful for your favorite pair of jeans. Have you ever considered all the little things that make your days bearable?
- How did this particular Gratitude affect your day/week?
- Is there anything you are looking forward to between now and the next time we see each other?

**“It’s The End of the World!”**. The goal of this directive is to help the client to identify irrational thinking and consider the consequences of catastrophizing. This directive addresses Beck’s (2011) Principle No. 3 where the client and therapist work collaboratively, Principle No. 4 that helps the client to develop problem-solving skills, and Principle No. 5 where the client is encouraged to remain in the present, using an intermodal arts-based approach. It requires basic art materials (paper, oil pastels, colored pencils, markers, etc.). This directive is designed to address the client’s catastrophic thinking in the moment and is ideally designed with a light-hearted, humorous approach in mind. When the client brings a hyperbolized thought to the surface in a session, the therapist can take the opportunity to push the client to explore this irrational thought further. The

client should be invited to stand and give a dramatized monologue or rant on the idea. When the client gets stuck, the therapist should prompt them with “and then...” For example, the client may be thinking that they will never get into college. The client would stand and take a moment to rant about the feeling of never getting into college. The therapist would then prompt the client to continue with, “and then what?”, forcing the client to think about what could happen next, over and over until it becomes overly ridiculous. Once the client has taken the hyperbole as far as it will reasonably go, they can then take a moment to make some visual art on the subject before processing the irrational thinking with the therapist. Suggested discussion prompts are included below:

- How was this process for you? Was it fun or nerve-wracking? Or both?
- How likely is this event to happen? Has anything this bad ever happened to you before? If yes, how many times?
- Let’s assume for one moment that the worst-case scenario came true. What does that realistically look like? How would you cope? What skills would be useful to you if this did happen? Is it possible that there is a silver lining?
- What about a best-case scenario? Is there a positive or reassuring thing that you would like to say to yourself about this catastrophe now?

**#StopShoulding.** The goal of this directive is to help the client to identify external pressures or self-made rules that are affecting the client’s ability to think realistically. This directive addresses Beck’s (2011) Principle No. 9 where clients must learn to identify, evaluate, and respond to dysfunctional thinking, using an arts-based approach. It requires collage materials and writing materials. The client will be invited to create a series of Facebook status update-style blurbs, based on the many “shoulds” they have heard throughout their lives, utilizing found words in collaging materials. For example, “You should go to college” or “You should lose weight”. The use of

collage is important as it emphasizes the feeling of outside limits and expectations on the person, and it also highlights the use of imagery in social media. As they work, the client should think back to times in their life where they felt external pressure to look, behave, or perform a certain way. After they have completed a few blurbs, the client will review them with the therapist and discuss where the expectations come from and how the client internalizes them. The client will then be invited to respond to each one by placing the Facebook status in a chair and speaking to it. This piece of the process may be as long or as short as the client needs and may vary in intensity and emotion. Finally, the client will explore the directive through a free write. Suggested discussion prompts are included below:

- How was this process for you? Was it fun or frustrating? Or both?
- Was there a theme to your posts? Does the theme relate to your age/life-stage?
- Where do you feel these expectations come from? Are they real or imagined? Did they remind you of posts you've seen on social media in real life?
- In a perfect world without social norms, what would your comments look like on these statuses? What emojis would you use?

**The Case of Your Thoughts v. Reality.** The goal of this directive is to help the client to identify and challenge irrational thinking. This directive addresses Beck's (2011) Principle No. 9 where clients learn to identify, evaluate, and respond to dysfunctional thinking and Principle No. 3, which encourages client-therapist collaboration, using an arts-based approach. It requires basic art materials (paper, oil pastels, colored pencils, markers, etc.). This directive is designed to address the client's irrational thoughts by simulating a courthouse. First, the client will be asked to gather evidence in support of their thought(s). Next, with the support of the therapist, the client will gather evidence against the thought, noting that admissible evidence can only be used if it is a verifiable fact, rather than an opinion or conjecture. The client's thought will then stand trial by having the

client represent the Defense, while the therapist represents the Prosecution. The client will present their case, then the therapist will present theirs. The client and therapist will come together as the jury in order to come up with a verdict. Last, the client will be given the opportunity to create a courtroom sketch of the case. Depending on the verdict, the client may have the option to throw away this sketch as a cathartic experience. Suggested discussion prompts are included below:

- Was it difficult to examine your thought from multiple angles?
- Was it difficult to come up with admissible evidence? Did you notice that some of your evidence was not based in reality?
- How would you like to proceed with your thought? Do we have new solutions available to us?

### **Conclusion**

By performing this work, I hoped to start several conversations. First, I would like to open a line of communication about the future of EAT. In my view, it is important to carve out a more disciplined practice in order to distinguish EAT from the other CATs. Does the future of EAT create a stand-alone practice or is it destined for supportive work to pre-existing disciplines, such as CBT? As expressive arts therapists in training continue to diversify the field by bringing their unique experiences and approaches to the practice, more opportunities will arise to encourage the use of hybrid approaches. As shown in this research, it is relatively easy to form a hybridized approach and I feel that it is worthwhile to consider the development of additional hybrid practices, such as EAT in support of dialectical behavior therapy, EAT in support of family systems therapy, or EAT in support of solution-focused brief therapy.

Additionally, while it may be difficult to measure the enhancements that a hybrid approach can provide, one of my primary goals in developing the approach proposed here was to provide more structure to EAT for research purposes. By firmly applying a traditional intermodal approach to EAT within the structure of CBT, rather than loosely applying EAT terminology to another CAT, researchers may be able to conduct an analysis more easily, as it leaves less to the unknown. Alternatively, my hope was also that using a toolkit of EAT directives would provide an enhanced qualitative experience to CBT. Additional research would be required in order to consider either of these goals.

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