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Exploring the Potential of Expressive Arts Therapy in Crisis Intervention: A Literature Review

Capstone Thesis

Lesley University

May 5, 2021

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Expressive Arts Therapy

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Abstract

In this literature review various crises and crisis intervention techniques are reviewed alongside expressive arts theories and process to determine how the Expressive Arts can be utilized for crisis intervention. As there is not a well-developed relationship between crisis intervention and the Expressive Arts, various acute care setting which utilize the expressive arts and creative arts therapies are explored to determine how effective the Expressive Arts could be in effectively managing, de-escalating, and learning from a crisis. The finding of this research determines that although there are grounds for the Expressive Arts to be utilized for crisis intervention, substantially more research will need to be conducted to effectively and ethically create a method. Further directions of exploration could be research as to how mindfulness-based crisis intervention could assist Expressive Arts therapists working in crisis care settings, and for further research to more specifically target populations to develop a method for crisis intervention for. This research does conclude that there is potential for the Expressive Arts to be extremely effective in crisis intervention, and this relationship should be explored further.

Introduction

As a developing Expressive Arts therapist, knowledge about trauma and trauma informed techniques are vital in developing a therapeutic toolkit. However, working in inpatient hospital settings and residential programs have shown me the importance of being able to identify and appropriately respond to clients in crisis. For the past year I have engaged in Therapeutic Crisis Intervention training, in which a model for crisis intervention is created specifically for residential treatment. This work proposes a critical review of literature exploring how the Expressive Arts are already used for crisis intervention in high acuity settings such as inpatient hospital or residential care settings, and to deduce how the Expressive Arts can be aligned with the needs of various crisis intervention theories.

As a burgeoning Expressive Arts therapist, I have found many points at which Therapeutic Crisis Intervention (TCI) aligns with elements and theories of the expressive arts, where expressive arts interventions could be utilized to guide the process of crisis management, de-escalation, and learning from the crisis. This critical review of literature is intended to offer a method in which expressive arts can be used in conjunction with therapeutic crisis intervention in acute care settings for young adults. This thesis proposes an integration of the expressive arts, mindfulness, and expressive arts theories to find points of connection which can assist clinicians working with clients prone to experiencing crises. This literature review first offers a review of Therapeutic Crisis Intervention, followed by other Crisis Intervention techniques utilized in high acuity settings, how expressive arts are currently utilized in high acuity settings, followed by Expressive arts theories with considerations of the mind/ body connection.

Defining Crisis

Hoff (2014) defines crisis as a “psychological state-an acute emotional upset in which one’s usual problem-solving ability fails” (p. 1). Crisis occurs in response to traumatic experience, which can be anything from violence to illness, natural disasters, conflict, or even bad news (O’Reilly et al., 2019). O’Reilly, Embar-Seddon, and Pass clarify that emotional, physical, behavioral, and mental stress can all be perceived as crisis; however, stressful events do not always lead to a crisis response. They go on to state “a crisis situation develops if the event exceeds the individual’s perceived (not actual) coping skill” (O’Reilly et al., 2019, para. 3). When considering trauma and people in crisis, conversations often move back to children, as children often have less practice vocalizing and introspecting to be able to self-soothe or make sense of their emotional, somatic, and environmental cues (Hintz, 2009). Van der Kolk (2003) explains that individuals, especially children, often have difficulty regulating their emotions when triggered, stressed, or traumatized which can then escalate to them being in crisis. Parad and Parad (2006) state “Crisis is an integral part of ...change; it is the catalyst that disturbs old habits and evokes new responses, charting new growth and development” (p. 15).

Crisis intervention for the purpose of this research is defined as “a short-term management technique designed to reduce potential permanent damage to an individual affected by crisis” (Wang and Gupta, 2020, para. 1). I believe that the more effective crisis intervention is, the lower the risk is of re-traumatizing or further traumatizing an individual. The moment of agitation, escalation, and overwhelm which leads to the apex of being in crisis is often a somatic experience, potentially resulting in violence, fight or flight responses, or dissociation. Holden et al. (2009) describes this as the stress model of crisis, which will be introduced later in this work.

Holden et al. (2009) states “During a crisis a stress response is biological first, then emotional as... ‘fight or flight’ response is engaged” (p. 8). The human nervous systems are specifically designed to ensure safety and survival of our physical body (Rosenberg, 2017). Comprised of the brain, brainstem, cranial nerves, spinal cord, spinal nerves, and enteric nerves, our autonomic and peripheral nervous systems are constantly taking in and processing sensations and information about our environment and physiological needs (Rosenberg, 2017). Conducting this research, I found little information about what happens in the body when experiencing a mental health crisis. Recognizing the relationship between trauma and potential to experience crisis (Holden et al. 2009), I consider trauma responses as an indication of what happens when the body is in crisis. For this I turn to van der Kolk (2014), who while researching the neuroscience of PTSD, was able to record the physiological changes in a patient experiencing a flashback to a traumatic event. Triggered by trauma related narrative, the client’s heart raced, blood pressure jumped, and their breathing rapidly changed. Supported by neural images, van der Kolk was able to identify that “the limbic brain and the visual cortex, showed heightened activation... and the speech center showed remarkably decreased activation” (p. 42). The heightened activity of the limbic system indicated the amygdala sent out stress hormones to prepare the bodies fight or flight responses once triggered. Integrating an embodied practice such as the Expressive Arts could help create an integrated approach to crisis intervention, de-escalation, and processing post-event. Crisis and trauma walk hand in hand, and while working through a trauma informed lens, it is important to be able to de-escalate and help a client actively in crisis.

Crisis Intervention Theories

Therapeutic Crisis Intervention

The Therapeutic Crisis Intervention System (TCI) was formulated at Cornell University in 1979, after a call to assess the nature and extent of child abuse in institutions and group care facilities. Created for residential childcare systems to prevent high risk interventions (such as seclusion or restraints), “TCI system assists organizations in preventing crisis from occurring, de-escalating potential crises, managing acute physical behaviors, reducing potential injury..., teaching young people adaptive coping skills, and developing a learning organization” (Holden et al., 2009, p. vi). Holden and colleagues were instrumental in developing the written material available. Moving forward I will be citing mostly from Holden et. al . (2009) as I describe the methodology of TCI. The TCI training is broken into five modules: crisis prevention, crisis as opportunity, de-escalating the crisis, managing the crisis, and safety interventions (Holden, 2009). As TCI is intended for residential mental health systems, it is assumed that clients in this context have been determined to be unsafe towards themselves or others outside of a staffed treatment facility.

Crisis Prevention

According to Holden et al. (2009) the first step to removing the need for high-risk intervention is to properly train milieu and caretakers to build self-awareness and environmental safety. Staff self-awareness extends to cultural competence, ability to self-regulate and introspect. Holden (2009) discusses how if staff are aware of their own feelings and body signals, they can better attune to and attend to clients. Staff must be able to fully attend to clients, learn their baseline presentation, and be able to uphold a safe and stable environment for clients to live in. It is imperative to encourage continued TCI training as well as reflective supervision to ensure staff feel competent in handling crises as they occur, and to encourage staff personal growth. The physical environment of the milieu can support crisis prevention by offering reliable

routine, structure, and consistency for clients and caretakers. The goal is to encourage perceived safety and security while still offering flexibility to meet individual client needs.

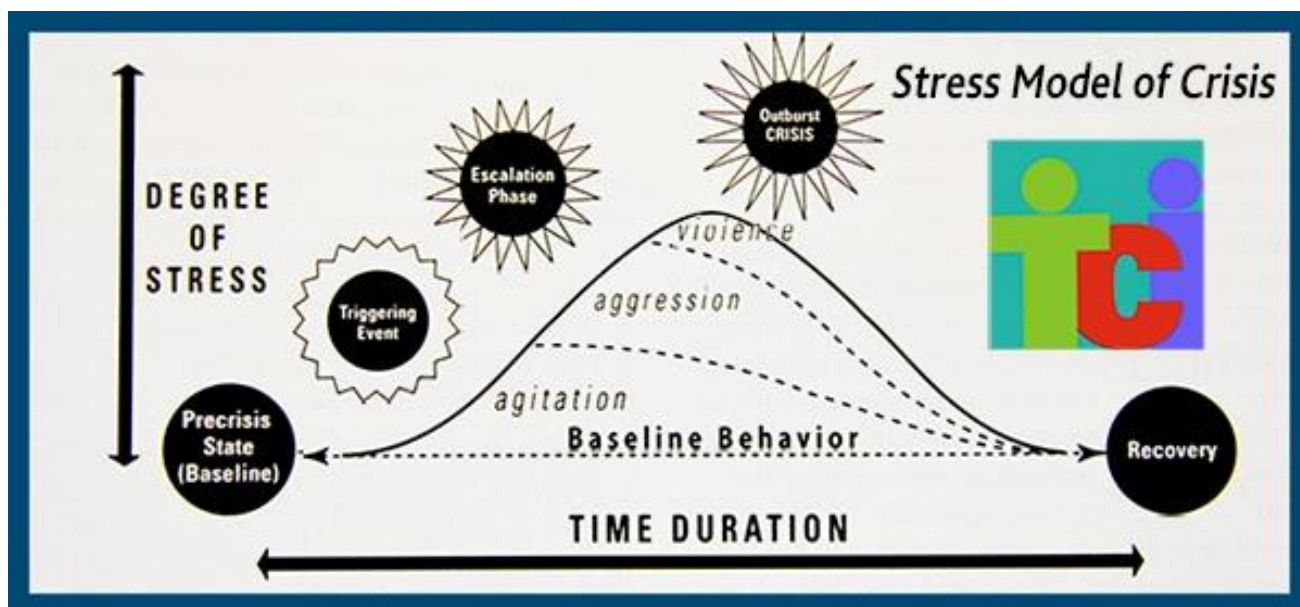
TCI emphasizes the need for strong caretaker and client therapeutic rapport, utilization of Individual Crisis Intervention Management Plans (ICMP), and assessments. Staff reliability and consistency not only allow for staff to have a good understanding of client's baseline behavior (so staff can more easily spot escalation) but allow for co-regulation and strength building during and after crisis (Holden et. al, 2009). Individual Crisis Management Plans (ICMP) are to be developed with the young person and their family (if appropriate). ICMPs are usually completed during intake in conjunction with a risk assessment. An ICMP would include information about triggers for the young person (e.g. language to avoid, loud noises, ultimatums), helpful interventions (e.g. words of affirmation, sensory toys), medications, and any pertinent trauma history which could impact a young person's response to restraints.

A key component to the ICMP is to document after a crisis what worked or did not work and what prompted the crisis in order to continuously learn from each event.

Crisis As Opportunity

TCI calls for normalizing crisis as an agent for potential positive change and solicits care workers as the catalyst to contain a crisis in a way that can promote positive growth. TCI proposes that knowing clients and their baseline presentations assist the staff to be able recognize escalation quickly and intervene appropriately so as to bring the client back to baseline when escalated, and to then process and learn from the crisis. Regardless of the triggering event, during crisis, the environment can feel threatening or overwhelming to the client experiencing escalation, which may leave them feeling powerless or hopeless.

Figure 1

Stress Model of Crisis

Note. (From KNILT. (2020). Therapeutic crisis intervention strategies. Retrieved, from https://knilt.arcc.albany.edu/Therapeutic_Crisis_Intervention_Strategies)

The stress model of crisis (see Figure 1) displays the typical stages of crisis (bell curve), associated behaviors at each stage, and different points at which staff can intervene (the dotted lines) to prevent further escalation. Holden (2009) explains that the goal is to intervene as quickly as possible to start the recovery process and promote the use of coping mechanisms or new skills. The “recovery” stage of this stress model can have three different effects depending on how staff handled the crisis at hand: lower outcome, no change, and higher outcome. The lower outcome takes place when the caretaker loses control of or ignores the crisis, and the client loses trust in their own ability to self-regulate and in the caretaker for not being able to manage. In the lower outcome, the caretaker either neglects or takes part in the traumatization of the client. When there is no change although the crisis is effectively managed, the client does not learn anything from the crisis allowing the same trigger to elicit crisis again .

Finally, the higher outcome occurs when not only the crisis is effectively managed, but the client also learns additional coping skills needed to either prevent the trigger from engaging them again or allowing them to better cope once triggered. New behaviors developed here would be encouraged by the caretaker.

In crisis there is opportunity for staff to utilize their own somatic information and deduction skills to intervene more effectively. TCI suggests doing this by asking four questions: “What am I feeling now?,” “What does the client think, need, or want?,” “How is the environment impacting the client?,” and “How do I best respond?” These four questions are intended to promote self-awareness, calm down the caretaker, observe the scene and situation, and be able to assess a more effective plan of action (Holden et al., 2009).

De-Escalating the Crisis

De-escalating crises requires several components: responding through active listening, behavior support techniques, emotional first aid, and awareness of the conflict cycle. Utilizing active listening allows for the caretaker to validate and support a client through presence and empathy, “listening for meaning” rather than responding directly to what is being said (Holden et al., 2009, p. 28). This also involves the listener being aware of their tone of voice, facial expression, and eye contact and utilizing silence when appropriate. While actively listening, the listener can also utilize questioning in order to gather information when appropriate. This can assist in summarizing and reflecting back to the client to show the client that the caretaker is available and present for them in their moment of need (Holden et al., 2009).

Behavior support techniques are intended to stop feelings and behaviors from escalating through prompting, redirecting, direct support, and changing the environment. These

activities may include asking a client to take space from an activity, giving clear and assertive directions for conduct, prompting change activities or actions, or stopping activities or actions.

Emotional first aid aims to support the client and resolve emotional intensity, resolve the immediate crisis, and keep the client in the program. Active listening and clarifying the events leading to intense emotions can help the client gain perspective as to how and why they are feeling the way they do. Often, children and young people in crisis can have trouble connecting all the feelings associated with an event. For instance, if a client falls down the stairs, they may be hurt, injured, and embarrassed, which could be overwhelming enough to lead to escalation.

The conflict cycle is a loop of client and caretaker behaviors which feed into each other to create a power struggle. Power struggles can easily escalate client behaviors promoting crisis. This can be managed by the caretaker changing their behaviors to stop the cycle, by validating the client's feelings, utilizing inner dialogue to remember the four main questions and gain the awareness needed to have perspective on the situation (Holden et al., 2009). Conflict cycles can also end by managing the environment, giving the client space to decide what is next, redirect to a positive activity, appeal to client self-interest, or by dropping or changing the expectations set for the client (Holden et al., 2009).

Managing the Crisis

Managing the crisis includes managing aggressive behavior, awareness of non-verbal communication, recognizing elements of potential violent situations, crisis co-regulation, and the Life Space Interview. TCI focuses on two types of aggression: reactive and proactive. Reactive aggression happens in the moment in response to stimuli, whereas proactive aggression is planned to achieve a goal. In TCI, reactive aggression can usually be resolved by removing

the agitating stimuli, whereas proactive aggression is best met with containment and negotiation to prevent action from being taken.

Once the type of aggression and the potential risks are observed, the caretaker can then work with the client to co-regulate through deep breaths or giving time and space. The goal of co-regulation is to help the client reduce “fight or flight” response to come back to baseline (Holden et al., 2009, p. 52). Finally, the life space interview developed by Redl and Wineman (1952, cited in Holden et al., 2009) is utilized to finish returning to baseline, clarifying events, repairing the therapeutic relationship, teaching new coping skills, and reintegrating the client back into the milieu. Conducting the Life Space Interview, it is important to take the client to a private space without an audience, to explore and discuss their point of view, summarize feelings and connect feelings to behaviors, and develop a plan to reactive new behavior (Holden et al., 2009, p.54).

Safety Interventions

The final element of TCI is safety interventions, which are the final attempt at containing a crisis in which there is physical violence. Safety interventions are focused on mitigating violence, whether that involves removing a trigger or weapon, or utilizing a physical restraint. Physical restraints are to be the absolute last case scenario and need extensive training to execute. There are many parameters around physical restraints which is not pertinent to the focus of this research. Any safety interventions are to be followed by documentation, supervision, life-space interview, and appropriate recovery processes (Holden et. al, 2009, p. 75).

Therapeutic Crisis Intervention is a comprehensive method to containing and managing clients in crisis in a way that promotes positive growth and prevent additional or re-traumatization. By focusing on staff training and self-awareness it is argues staff can be more

attuned to clients, more effectively de-escalate them, and have a more successful recovery and re-entry into the milieu.

Family Based Crisis Intervention.

Wharff, Ginnis, and Ross (2012) introduced Family Based Crisis Intervention (FBCI) to patients admitted to Boston Children's Hospital emergency room (ER) for suicidal ideation. After the clients returned to baseline, FBCI would be introduced to potentially assist in the prevention of future escalations and crisis which could result in hospitalization. Utilizing the process of narrative and cognitive behavioral approaches to identify the stories of parents and adolescents, FBCI focuses on patient-guardian-provider collaboration to help create a safety plan and assess the potential for the adolescents to safely return home with a combination of psychoeducation, therapeutic readiness, and safety planning. The theory of FBCI is, "if given both an opportunity and effective tools to use,...a family that learns to support an adolescent while...in crisis will be empowered to provide ongoing support once the acute psychiatric crisis subsides (Wharff, Ginnis, and Ross, 2021, p.134)." Each of the candidates chosen as participants were accompanied by a family member in the ER at time of admission, which implies the family member was invested in the client's care and potentially open to assisting in the therapeutic process. When compared to adolescents of similar circumstances who were not accompanied by family or offered FBCI in the emergency room, it was found that those who received FBCI were significantly less likely to be hospitalized again. The power of relationships, support and acknowledgement to destigmatize healing, processing, and coping with traumatic material and stimuli which may result in a crisis such as suicidal ideation which meets hospital level of care.

Psychodynamic Intervention

Research conducted by Viederman (2016) in this psychodynamic intervention model demonstrates how extra support and engagement in treatment can help promote curiosity and willingness to explore and learn from the event, which can aid in increased bandwidth for coping, and ability to engage with difficult emotion. Viederman outlines 9 principles in communicating with clients in crisis. These nine items begin with reflective listening, practicing presence and acknowledging what the client is saying is heard, and suggesting connections in meaning. Suggesting connections in meaning focuses on offering observations of what could have led to the emotion the client is feeling in that moment. Viederman goes on to express that it is also important to comment on or remind clients of their own personality traits or characteristics, and to draw on past associations the client has made, even drawing on previous crises that the client has been able to overcome. Next, Viederman suggests that perspective can be drawn from the narrative that clients share, reflecting that narrative back to clients can assist them in understanding more opportunities for expression which allow for the use of coping mechanisms or feeling as though they can cope. The final three elements Viederman notes as significant are noting potential transference, maintaining appropriate communication as the therapist in order to prevent or to be able to notice countertransference, and to be able to directly assist the client in finding the true issue at hand which is supporting them feeling de-stabilized. Viederman (2016) states that the key component to this form of communication with those in crisis is the therapist's establishment of themselves as a support to the client in need by consistently communicating back the information supplied by the client. The hope with this is to accompany the client in crisis while still attending to their needs and challenging potential unhelpful thought processes (p.409-411).

SAFER-R and Assessment Crisis Intervention Trauma Treatment

Within the context of a hospital setting, Wang and Gupta (2020) explore two methods of crisis intervention techniques, SAFER-R and Assessment Crisis Intervention Trauma Treatment (ACT). SAFER-R involves stabilizing, acknowledgement, facilitating understanding, encouraging, and assisting the client in recovering to then offer a referral for further healing. ACT is comprised of seven stages, “assisting the affected person, establishing a relationship, understanding the problem, confronting emotions, exploring coping strategies, implementing a plan, and following up” (Wang & Gupta, 2020, para. 2). This text considers effective crisis intervention as reduction of injury to the effected person and those around them, and reduced risk of further illness or damage to their physical or mental health. Humor, social and emotional support, planning, acceptance and problem solving are named as just a few modes of effective coping mechanisms while recovering from and assisting a person in crisis. These skills are found to assist staff and clients in crisis situations, promoting positive engagement and handling of crises. Wang and Gupta go on to express that crisis intervention techniques should be accessible to all Healthcare staff, as recognizing and assisting those in crisis can promote less utilization of hospitalization, and less risk to those in crisis.

Mindfulness-based Crisis Intervention

Mindfulness-based crisis Intervention (MBCI) is made up of three components: utilizing guided practice mindfulness skill building, using mindfulness models to make sense of a crisis, and identifying values of patients and setting goals (Jacobsen et al., 2020). This understanding of the process of Mindfulness-Based Crisis Intervention is through the lens of short-term treatment in an inpatient are setting, in which there would only be 1 to 5 sessions. This practice could be modified to better suit long term care. The first MBCI session is focused on “crisis-focused formulation,” (Jacobsen et al., 2020, p. 3) which determines what the provider and the client

believe brought them to being in crisis and more specifically into the hospital on the occasion in which they are meeting. This information is used to guide future sessions, identifying critical events leading to the crisis which could be helpful to understanding future actions or behaviors. Subsequent sessions are to be utilized to identify values and discuss behavioral goals which align with these values. The end of each session would be marked by patients setting a small, achievable goal for homework which would later be followed up about in the next session. Finally, in preparation for discharge longer-term goals would be determined and shared with those assisting the clients in the community to bridge treatment from in facility, to in the community (Jacobsen et al., 2020).

In a study conducted in the United Kingdom, finding how effective MBCI is in reducing the admission and stay time of patients experiencing psychosis in inpatient care, Jacobsen et al. (2020) created a parallel group randomized control trial in which inpatient treatment as usual and MBCI were utilized for 1-5 sessions with qualifying patients. This study focused on three components: how feasible it is for clinicians and staff to implement MBCI, assess the effectiveness of MBCI for clients experiencing psychosis and psychotic symptoms warranting inpatient level of care, and to collect data on re-admission rates at 6- and 12-months post-discharge while utilizing self-report symptom measures to indicate long term effectiveness. This study found that MBCI was very effective to treating psychosis in an inpatient setting. Evidenced by a low drop-out rate, and high satisfaction ratings at follow-up, MBCI was determined not only to be effective, but acceptable treatment for clients. This study also found a low re-admission rate among those who participated in MBCI.

It is my opinion and belief that crisis intervention techniques created to support those experiencing mental health crises, contain multiple congruent themes such as : How the

environment impacts and supports those in crisis, the power of inter-personal connection in grounding those in crisis, the importance of returning the person in crisis to their baseline functioning, and the ability for crisis to be an opportunity for learning and growth of new skills. I believe that if handled correctly, a mental health crisis can empower clients, making them more confident in their ability to self-regulate and cope with triggering stimuli and trauma responses. Moving forward these themes in crisis intervention techniques will be explored through the lens of expressive arts theory. Utilizing Expressive Arts in acute care settings can be a glimpse into how Expressive Art are already utilized for those in crisis. Finally, subjects such as focusing and mindfulness will be explored to ground the understanding of the mind/ body connection and look at ways to biologically help regulate a body in crisis utilizing the Expressive Arts.

Expressive Arts and Crisis

Within the context of the Expressive Arts, Knill, Levine, Levine (2005) consider crisis situations as a necessary process of reformulation, breaking down the original order to create a new form. Moreover, they write: “the intensity of these situations, if responded to properly, can provide an impetus to see things in a new way and, thus, for change” (Knill, Levine, Levine, 2005, p.176). These ideas written in the context of emerging therapists crystalizing and immersing in the Expressive Arts process with others, draws an important parallel to crisis intervention: having a container allows for processing to learn and grow from the moment of crisis and the stressors which precipitated the event. This aligns with one of the primary concepts of TCI, crisis is an opportunity for growth. While still understanding crisis as a somatic and embodied experience, I feel inclined to also identify where crisis would be considered in terms of the expressive arts continuum.

The Expressive Arts Continuum is a method in which Expressive arts methods, materials and intervention are connected to different levels of cognition and neural integration. Based primarily on the research of Lusebrink (2010), Hintz (2009) organizes the way people interact with different expressive mediums and how images are formulated and processed. The three levels of processing are sensory/kinesthetic, perceptual/ affective, and cognitive/symbolic. Each level aligns with different parts of the brain and offered different opportunities for healing through engagement with the entire level. For example, if a client is in the sensory/kinesthetic level a client may be more aligned with sensory based exploration and products, which can be shifted to kinesthetic to help provide perspective and healing. Hintz (2009) states, “art expression can be a means of facing emotions previously conceived of as daunting or dangerous” (p. 104). The sensory/kinesthetic levels relate to simple motor expression with artistic materials and how much energy or movement is put into the art making process. Lusebrink (2010) emphasizes that each of these processes distract from each other: if one is immersed in the sensory experience their kinesthetic movement slows, while in the kinesthetic experience movements are so rapid and agitated the there is little to no sensory experience. In the perceptual/affective components the perceptual focuses on the visual processing of information and boundaries, whereas the affective focuses on creating and the expression of affect. Hintz (2009) also states the perceptual and affective component of the ETC relates to how clients relate to, present, and understand their emotions in respect to their perceptions of their environment, social cues, and somatic information. Lusebrink (2010) explains cognitive level “emphasizes global processing involving input from affective resources and autobiographical processing” (p.171). The symbolic is characterized by the symbolic relationship and meaning made of affective images. With this added understanding I will now explore where this aligns with crisis intervention.

Hintz (2009) expresses the thought that: “emotions are elemental to human experience because they are signals about inner experiences and events in one’s surroundings: Emotions indicate that people must act on something in their environment” (p. 102). This speaks to how by managing a person’s environment or the stimuli they are exposed to can assist in de-escalating and assisting a client in crisis. Hintz goes on to state: “clients can be taught that they can experience their emotions like waves that rise, peak, crest, and recede” (p.102). Caretakers can assist clients in feeling as though they are capable of coping with their emotions. Reminiscent of caretakers assisting in de-escalating a client in crisis “Creativity can be a companion on a difficult journey to reclaim appropriate affect” (Hintz, 2009, p. 104). Transitioning clients from cognitive/symbolic understanding to a more sensory/kinesthetic experience, can bring the client to the here and now, grounding the client to assist in de-escalating. Moving forward, the neuroscience supporting use of the creative arts will be discussed to explore the potential of utilizing expressive arts in crisis intervention.

Perryman, Blisard, and Moss (2019) focus their research on the relationship between creative arts as healing and trauma therapy through the lens of neuroscience of trauma. They begin by explaining: “creative arts activities offer a nonthreatening avenue for the discovery and processing of an embedded traumatic experience” (p. 81). They suggest that there are three primary ways people cope with trauma: through a fight response, through a flight response and removing themselves from any potentially threatening situation, and through repressing all feeling associated with trauma stressors i.e. an immobilization response. These responses may work well to protect one’s psyche, but long term will negatively impact a person’s interpersonal relationships and connection with others and themselves (Perryman et al., 2019). Here is where the authors suggest creative arts can be utilized to “enable clients to gain more awareness of

behavioral patterns and deeper understanding of themselves, while simultaneously fulfilling the human need for self-expression” (p.82-83). Perryman et al. (2019) suggest that the creative arts therapies offer a unique opportunity for the two hemispheres of the brain to connect and communicate with each other in a way that can be grounding for people who have experienced trauma. This more specifically relates to the function of each hemisphere of the brain “the right hemisphere, where images and negative unconscious emotions are stored, and the left hemisphere, which houses logic and language” (p.92). The writers go on to state that the creative arts therapies are ideal for treating those who are likely to experience unconscious or repressed materials coming to consciousness as the arts offer a less threatening way to process these memories and the emotions associated with them. To further explore how the expressive arts can be applied to crisis intervention, the body-mind model will be explored next.

The body-mind model developed by Czamanski-Cohen and Weihs (2016) take the Expressive Arts Continuum a step further, integrating the triangular relationship between client, therapist and art making process as well as considerations for what is physically happening for the client. This model suggests that the sustained nature of the art making process works toward not just calming the client, but also assisting them in regulating their physical body. The writers suggest that the sustained relaxation the is engaged while using the art making process can benefit a client’s long term ability for healing and emotional processing. Within the body-mind model there are multiple specific mechanisms which are pertinent to crisis intervention. First of these is tactile engagement, which allows for client self-assessment and observation of client’s movements while artmaking to derive the arousal of the client. The next process relates to Heart rate Variability or (HRV), which utilized how a person’s heartrate relates to their emotional state and regulation. Research on the body-mind connection suggests that HRV regulation assists in

how emotions are processed, as HRV heavily impacts the central and peripheral nervous systems which then impact neural processing. Czamanski-Cohen and Weihs (2016) suggest:

“Mentalization requires prefrontal cortical function, which is impaired in the context of high emotional arousal” (p. 67). The authors go on to explain that utilizing tactile materials and processing can assist clients in achieving a general sense of soothing and calming which then can relate to feelings of safety. Here it is suggested that the sense of accomplishment, calming sensations and mindfulness which can be fostered during the use of art making can assist in slowing HRV. The writers go on to express that: “cognitive development occurs when knowledge is transferred from an implicit pattern, which involves sensorimotor or bodily information to patterns of explicit thought that include conscious processing through language or other symbolic formulations, such as visual art” (p.67). It is then suggested that the amount of externalization which can be accomplished while using visual arts can assist clients’ ability to accept and acknowledge their emotions as they arise. Further expanding their ability for emotional awareness. This leads into one’s ability to then accept their emotions by attending to, acknowledging, and responding to the emotions as they present. This is a trial by error process as the person tests what is a good or bad reaction to emotions. The authors state that this process is associated with the development of more positive skills and less negative emotional effects than suppressing one’s emotions. The final stages of this process that are pertinent to crisis intervention relate to reflective processing, and perspective taking. Each of these processes focus on the client developing the ability to gain insight and perspective from their emotions and the events following their emotional expression. Here it is suggested that mindfulness and mindfulness based exercises are beneficial to reflecting and learning from experiences in a non-judgmental way which promotes growth. The final component of the mind-body model which

could be helpful in circumstances of crisis intervention is meaning making and finding purpose. This consists of utilizing art therapy as a mirror, to find emotional authenticity and find purpose.

Czamanski-Cohen and Weihs (2016) build a substantial body of information as to how the arts can be utilized to calm the body, which subsequently helps calm the mind allowing for a wider ability to self-soothe, acknowledge emotions, and learn from the experiences of emotions. This mimics the process needed in crisis intervention work, and could be used to benefit clients prone to being in crisis. This aligns closely with how Gupta and Wang (2020) explain the impact of a client's perceived understanding of their ability to cope, and their likelihood to be in crisis once triggered which will be discussed in the following passage.

Wang and Gupta (2020) begin their introduction to crisis intervention techniques by explaining the necessity of building positive rapport with the client, obtaining important information about them, discussing events, and providing support, all principals and containing features which are established in therapeutic Expressive Arts practices. Within this container of support is the potential to de-escalate and learn from the moment of overstimulation and crisis, to hopefully expand the client's perception of their ability to cope.

Shore and Rush (2019) explain this process in their work in adolescent inpatient psychiatric hospitalization group work, stating:

utilizing art expression to foster organization and meaning, while providing empathy and containment are basic tools that maximize the benefits of hospitalization for patients. ... it is helpful to maintain a seemingly simple and obvious approach that emphasizes supporting stabilization of acute symptoms, providing controllable experiences, individualized methods and modest short-term goals (p.13).

Stabilization and return to baseline functioning is one of the most important components of crisis intervention (Wang and Gupta, 2020, O'Reilly, Embar-Seddon, Pass, 2019, Shore and Rush, 2019). Shore and Rush (2019) explore the use of Art Therapy in an acute care setting establishing the goal of short-term stabilization for a wide range of diagnostic presentations, acuity, and symptomology. In a vignette on stabilization, the researchers discuss two clients who actively experience psychosis. These clients would become agitated when working with images of people and animals as indicated by laying down on the floor, running in circles, or writing inappropriate material on boards around the room. Shore and Rush (2019) managed this by changing the materials available to the clients to be less stimulating, here by helping the clients become more grounded and effectively able to self-regulate. This vignette was intended to highlight the value of under-stimulating to assist in stabilization. This highlights a benefit to the Expressive Arts in the respect to the power of materials, and flexibility of intervention options when a therapist understands how materials can interact with the expressive art continuum. Here, stabilization was distraction from the stimulus and interrupting obsessive thoughts with sensory material. In this scenario, removing the client and or stimulus from the environment allowed for the client to re-regulate their behaviors. Similarly, deep breathing or validation and presence with the person in crisis can allow the same opportunity, giving the client tools and support in knowing they have the tools needed to stay in control of their bodies (Shore and Rush, 2019). By utilizing the flexibility of Expressive arts in this vignette, Shore and Rush also display being able to attend appropriately to the group with presence, containing and holding the group and intervening while a client is unable to self-regulate. Shore and Rush also discuss the importance of utilizing reality testing in therapeutic groups, identifying patterns and copying as reality-based anchors. They go on to elaborate that

through a stable and non-threatening therapeutic relationship, participants can also use facilitators as grounding objects when there is enough trust, showing that even in short term relationships, provide the therapeutic support for crisis intervention.

In their work with unaccompanied adolescent refugees, Meyer DeMott et al. (2017) explore the effects of utilization of expressive arts groups for refugee boys. Unaccompanied refugees are at a substantial risk for experiencing severe mental health adversities and high levels of stress due to the potential experiences they have had before fleeing, and the stress of having a temporary residence in a new country. In this study two randomized groups of unaccompanied refugee boys were exposed to either a life as usual group, or an Expressive Arts in Transition group. Over the course of the Expressive arts group visual arts, movement, and sound were utilized to foster connection with peers, and connect where clients came from to their new temporary homes. This was combined with some life skill training such as rituals which mimicked keeping documents, and focused on assisting clients with expanding their therapeutic toolkit for coping. The results of this study found that on a long-term scale, the clients who participated in the expressive arts group were better able to cope with their mental health symptoms long term. Meyer DeMott, et al conclude with: “Our experiences in the implementation of this study suggest that the five principles of trauma intervention in stage one, promoting safety, calming, self-efficacy, connectedness and hope, may be appropriately addressed through group intervention with Expressive Arts” (p. 516). These findings are pertinent to crisis intervention exploration, as the expressive arts group focused on many necessary elements of crisis intervention as preventive work. Here the findings were significant against the control group and offers an opportunity for more research as to how Expressive arts can work as crisis intervention prevention.

Wright and Andrew (2017) pilot a qualitative study of integrating art therapy into the work of Crisis Resolution/Home Treatment Teams (CRHTT). Created to reduce the number of people brought into hospitals for mental health crises, CRHTT operates under the principles that coping skills are best repeated in the context in which they were learnt, crisis usually entails social and emotional triggers and if this takes place in the home, therapy can immediately tend to those triggers, and the patient-professional relationship is less dominated by power dynamics when in the patient's home. In this study an art therapist would attend to clients in crisis in 90-minute sessions. Sessions were designed to be stand-alone visits due to fast clientele turnover, and in this design the art therapist brought writing utensils (pastel, pencil, pen and markers) and newspaper. Wright and Andrew (2017) do not propose a specific method or exercise which clients would be lead though, acknowledging that art therapy is not a "one size fits all" process. However, in service feedback most clients expressed using art materials helped manage symptoms and helped them understand what they were going through. All CRHTT clients stated they found art therapy in home was useful, and that it helped them express themselves. This study highlights that crisis treatment and expressive arts can be helpful to clients and it is challenging to formulate a streamlined method of utilizing the expressive arts in crisis, as all patient needs are different.

Discussion

As previously mentioned, the expressive arts align well with the base understandings and principles of crisis intervention: crisis can be an impetus for change and healing, and the therapeutic companionship and relationship between client and caretaker are integral to returning a client to baseline. At this point I believe it has been deduced clearly that the nature of the expressive arts and its versatility can be utilized with those in crisis. The Expressive Arts

have been established to be well designed to be trauma informed, and with the correct training, an Expressive Arts therapist can utilize that to their advantage by integrating mindfulness techniques and the Expressive arts continuum. Moving forward I will consider potential ways to help a client return to baseline functioning utilizing expressive arts processes.

After completing this review of literature, I have determined that although crisis intervention theories and the expressive arts have many concepts in common, it is my opinion that there is no concise way to utilize expressive arts in crisis intervention without further research. Crisis Intervention is comprised of three main components: provider education and comfort in being able to intervene in crisis; grounding or returning the person in crisis to baseline; and learning from the crisis at hand. Expressive arts theories align well with the needs of crisis intervention. Through the use of arts materials, and expressive techniques such as movement, externalization, and coregulation through provider/client relationship, Expressive Arts training offers many skills and resources that could benefit client and practitioners operating in Crisis Intervention scenarios. Expressive Arts based mindfulness techniques could potentially assist in utilizing facilitating client ability to self-regulate more effectively to deescalate in crisis, and prevent future crisis from happening. Considering that the expressive arts offer a less intimidating form of understanding emotions and situations, utilization of arts-based practices have a unique opportunity to offer clients new ways to cope with triggers. Improving a client's perceived ability to cope and making clients less sensitive to triggers is vital to long term crisis management and can help clients move past immediate feeling of being overwhelmed and to learn skills that help them process trauma.

Utilizing the resources that have been compiled about different crisis intervention techniques, I have determined that all interventions have three components: staff training and

confidence in ability to intervene; assisting the client in returning to baseline (grounding); and learning from the experience through debriefing with the client. Moving forward I hope to introduce possible Expressive Arts interventions which could benefit clients in crisis and staff members who need to intervene with those in crisis.

Grounding Clients in Crisis

When returning Clients to baseline, also referred to as grounding, the Expressive Arts can be utilized to explore and promote play and curiosity in a contained, and more externalized manner.

Therapy is a time out of time, a pause to everyday life in which habitual behaviors, attitudes and beliefs can be examined and transformed...for change to occur, there must be a deconstructing...old identity comes into question and is taken apart. (Knill, Levine, Levine, 2005, p.45)

Crisis is a state which occurs when a client does not believe they can or are capable of coping (O'Reilly, Embar-Seddon, Pass, 2019). In the process of de-escalation, processing, and supporting the client consistently, there is an opportunity to open the artistic space to play with potential ideas in a contained a fluid way (Knill, Levine, Levine 2005, p. 49). Play and transitional experience can be introduced to reduce stress and provide an outlet for catharsis, curiosity, and fluidity of thought to find what is aligned with the client's true needs. This is the process which could prevent future escalation (Knill, Levine, Levine, 2005, p.49.). Sherwood (2008) supports this sentiment stating: "expressive therapies have energetic resonances which can change the patterns of unhealthy experiences within the layers of the human being and restore healthier patterns." (p. 90)

To recommend a direction for future research I am including a review of why I believe mindfulness and embodiment-based practices could be beneficial to developing a method for Expressive Arts based crisis intervention.

In her work on mindfulness and the expressive arts, Rappaport (2014) explains: “present awareness of thoughts, emotions and sensations can facilitate a client’s awareness of what is happening in a current experience without feeling overwhelmed” (p. 96). Rappaport goes on to discuss the relationship between mindfulness and embodiment explaining that embodiment is “the enlivened expressive response to awareness of one’s present moment experience” (p.97). Further ingraining the connection between embodiment and mindfulness she states, “the mind does not direct the body, more does the body act without consciousness, but there is an integrated experience” (p. 97).

In regard to the body in crisis, Rappaport and Kalmanowitz (2014) acknowledge the mind-body disconnection which happened when there is severe trauma present. They go on to explore that by blocking out trauma clients also often block out an embodied experience, which in turn, removes some opportunity for healing and grounding. Before going on about the benefits to mindfulness based expressive arts for those in crisis, I would like to discuss the cultural implications of mindfulness-based practices.

Given that I am suggesting utilizing Expressive Arts mindfulness techniques, it is important to introduce the cultural roots of mindfulness practices. Mindfulness is grounded in Eastern religious traditions and is integrated into multiple practices of Buddhism. Taken on by eastern culture, mindfulness practices have become adapted for all psychotherapeutic, education, and work environments (Rappaport & Kalmanowitz, p. 25). Before utilizing aspects of mindfulness, it is important to note that mindfulness in this context is adapted from ancient

religious beginnings, which are deserving of respect. Rappaport and Kalmanowitz note the intersectionality of mindfulness practices noting in Hinduism in the form of utilizing mantra to access *saksin-* accessing inner wisdom; Christianity in the form of contemplative and centering prayer; Judaism in the utilization of *kavanah* (intention) to master one's own thinking to follow consciousness to have awareness of God's presence; and Islam, "acceptance and acknowledgement of positive and negative experiences, unlearning old habits and looking at the world with new eyes" (Mirdal, 2010, as cited in Rappaport & Kalmanowitz, 2014, p. 27). Mindfulness has deep cultural and spiritual roots.

Grounding, also described as "mindful distraction," is the process of shifting attention from trauma related memories or triggers to concentrate on another specific object or sensation or experience (Williston et al., 2020). Potential distractions or sensations to shift should be concrete, noticing either a body experience or something about the environment. Rappaport & Kalmanowitz (2014) suggest that when a client is having a difficult time turning inward or the inward sensations are destabilizing, draw their attention to their environment. Asking the client in crisis to name objects in the room, or look for objects of certain description, allows for the client to focus on where they are in that moment. This grounding could also be done by redirecting a client back to noticing their breath, how the floor feels under their feet, the temperature in the room, or by even offering them water or something of taste to integrate another strong somatic sensation. Williston et al. (2020) go on to express that with consistent support in grounding and continued mindfulness training, the person engaging may be able to:

- (a) broaden their attention and perspective related to a difficult situation or circumstance,
- (b) improve their ability to intentionally decide how and where to focus their attention,

and (c) gain wisdom and skill about when to apply short-term coping strategies (such as grounding) and longer-term coping strategies (such as emotional processing). (p. 7)

Sherwood (2008) looks specifically at how the Expressive Arts and mindfulness relate to each other when considering clients experiencing grief, loss, shock, or betrayal. Although the named populations of this study are not peoples in immediate crisis as defined by the focus of this thesis, Sherwood proposes a method for utilizing the Expressive Arts and mindfulness as an embodied approach to healing. Sherwood utilizes breath as the focal point for an expressive arts exploration. Opening with recognizing the breath and breath patterns, Sherwood leads the client in noticing what part of the body they hold their breath and invite them to explore it by “stepping into that part of their body” (p.88). Here Sherwood mentions the importance of being well trained in the somatic and expressive explorations, as this activity can bring a reminder of trauma or triggering memory to the surface. With clients who are already triggered or in crisis, this step may already be in play, and the companionship of the therapeutic alliance could be enough support in the moment. Now with the noticing of breath and knowledge of where it is being held in the body, Sherwood would then offer an artistic medium to then imprint what they discovered to visualize their breath in their body. Commenting on what these media have to offer, Sherwood (2008) states:

Clay, because of its density and its demanding input of bodily energy, is particularly successful in bringing the repressed emotional experience to consciousness in resistant and inarticulate clients...it provides three dimensional concrete gestures of one's inner experience, illuminating all that has been buried, denied, avoided, and pushed down into the bodily organism. (p. 89)

Sherwood then organizes the results of these “imprints” into two categories: those that communicate hollowness or emptiness in the present moment, and those that result from interpersonal conflict. Utilizing this information the exploration can then continue in a more cognitive or verbal space.

Conclusion

Although this literature review has determined that the Expressive Art offer an unique opportunity to attend to clients in crisis, there is not enough evidence to formulate an exact method which could work for expressive arts professionals and other mental health professionals alike. This work was an attempt to join what I learned in field experience in inpatient psychiatric settings and residential care settings, and what I learned in my academic studies. As there was a large learning curve going into settings in which I needed to quickly learn how to attend to those in crisis, I hoped to write a thesis which could assist other students and professionals in that same position. Moving forward I suggest that researchers focus on Crisis intervention utilizing the expressive arts with special populations in mind, to potentially create a method for each population in need. I would also suggest exploration into how mindfulness based Expressive arts and embodied practices can be utilized for those prone to being in crisis to promote healing.

References

- Czamanski-Cohen, J., & Weihs, K. L. (2016). The bodymind model: A platform for studying the mechanisms of change induced by art therapy. *The Arts in psychotherapy, 51*, 63-71. doi: 10.1016/j.aip.2016.08.006
- Hinz, L. D. (2009). *Expressive therapies continuum : a framework for using art in therapy*. Routledge.
- Hoff, L. A. (2014). *Crisis: How to help yourself and others in distress or danger*. ProQuest Ebook Central <https://ebookcentral.proquest.com>
- Holden, M. J., Mooney, A. J., Holden, J. C., Sockwell Morgan, C., Kuhn, I. F., Taylor, R., Bidleman, D., Pidgeon, N., Ruberti, M., Laddin, M., Wise, G., Endres, T., Stanton-Greenwood, A. Paterson, A., Bath, H., Gibson, J., Heresniak, R., Smith, Z., & Bailey, C. (2009). *Therapeutic crisis intervention: A crisis prevention and management system reference guide* (6th ed.). Family Life Development Center, College of Human Ecology, Cornell University.
- Jacobsen, P., Peters, E., Robinson, E. J., & Chadwick, P. (2020). Mindfulness-based crisis interventions (MBCI) for psychosis within acute inpatient psychiatric settings; a feasibility randomised controlled trial. *BMC Psychiatry, 20*(1), 1–12. <https://doi.org/10.1186/s12888-020-02608-x>
- Knill, P.J., Levine, E. G., & Levine, S. K. (2005). *Principles and practice of expressive arts therapy: toward a therapeutic aesthetics*. Jessica Kingsley Publishers.
- Lusebrink, V. B. (2010). Assessment and Therapeutic Application of the Expressive Therapies Continuum: Implications for Brain Structures and Functions. *Art Therapy: Journal of the American Art Therapy Association, 27*(4), 168–177.

- Meyer DeMott, M. A., Jakobsen, M., Wentzel, L. T., & Heir, T. (2017). A controlled early group intervention study for unaccompanied minors: Can Expressive Arts alleviate symptoms of trauma and enhance life satisfaction? *Scandinavian Journal of Psychology*, *58*(6), 510–518. <https://doi.org/10.1111/sjop.12395>
- O'Reilly, J.F., Embar-Seddon, A., Pass, A. (2019). Crisis intervention. *Salem Press Encyclopedia of Health*.
- Parad, H. J., & Parad, L. G. (2006). *Crisis intervention book 2: the practitioner's sourcebook for brief therapy*. Fenestra.
- Perryman, K., Blisard, P., & Moss, R. (2019). Using creative arts in trauma therapy: The neuroscience of healing. *Journal of Mental Health Counseling*, *41*(1), 80–94. <https://doi.org/10.17744/mehc.41.1.07>
- Rappaport, L., & Kalmanowitz, D. (2014). Mindfulness, Psychotherapy, and the Arts Therapies . In *Mindfulness and the Arts Therapies Theory and Practice* (pp. 24–36). essay, Jessica Kingsley Publishers.
- Rosenberg, S. (2017). *Accessing the healing power of the vagus nerve: Self-help exercises for anxiety, depression, trauma, and autism*. Berkeley, CA: North Atlantic Books.
- Sherwood, P. (2008). Expressive artistic therapies as mind-body medicine. *Body, Movement and Dance in Psychotherapy*, *3*(2), 81–95. doi: 10.1080/17432970802080040
- Shore, A., & Rush, S. (2019). Finding clarity in chaos: Art therapy lessons from a psychiatric Hospital. *The Arts in Psychotherapy*, *66*. <https://doi.org/10.1016/j.aip.2019.101575>
- van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

- Viederman, M. (2016). Psychodynamic intervention in crisis. *American Journal of Psychotherapy*, 70(4), 393-412.
<https://doi.org/10.1176/appi.psychotherapy.2016.70.4.393>
- Wang, D., Gupta, V. (2020). Crisis intervention. StatPearls Publishing LLC. [Internet]:
<https://www.ncbi.nlm.nih.gov/books/NBK559081/>
- Wharff, E. A., Ginnis K. M., Ross A. M. (2012). Family-based crisis intervention with suicidal adolescents in the emergency room: A pilot study. *Social Work*, 57(2), 133–143.
<https://doi.org/10.1093/sw/sws017>
- Williston, S. K., Grossman, D., Mori, D. L., & Niles, B. L. (2020). Mindfulness interventions in the treatment of posttraumatic stress disorder. *Professional Psychology: Research and Practice*. Advance online publication. <http://dx.doi.org/10.1037/pro0000363>
- Wright, T., Andrew, T. (2017). Art therapy in a crisis resolution/home treatment team: report on a pilot project, *International Journal of Art Therapy*, 22:4, 180-189, DOI:
10.1080/17454832.2017.1306572

