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Adolescent Group Therapy: A Gottman Relationship-Based Approach Using Art-Based Interventions

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ADOLESCENT GROUP THERAPY: A GOTTMAN RELATIONSHIP-BASED APPROACH USING ART-BASED INTERVENTIONS

By

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables</td>
<td>viii</td>
</tr>
<tr>
<td>Abstract</td>
<td>ix</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Overview of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Conduct Disorder: Clinical Diagnosis, Etiology, &amp; Clinical Presentation</td>
<td>3</td>
</tr>
<tr>
<td>Florida Department of Juvenile Justice Research Endeavors</td>
<td>4</td>
</tr>
<tr>
<td>Introduction to Gottman’s Research-Based Relational Approach</td>
<td>5</td>
</tr>
<tr>
<td>Rationale for Art-Based Activities Implemented with Gottman’s Approach</td>
<td>9</td>
</tr>
<tr>
<td>Purpose</td>
<td>13</td>
</tr>
<tr>
<td>Research Questions</td>
<td>13</td>
</tr>
<tr>
<td>Research Hypotheses</td>
<td>13</td>
</tr>
<tr>
<td>Assumptions</td>
<td>14</td>
</tr>
<tr>
<td>Definitions</td>
<td>15</td>
</tr>
<tr>
<td>Limitations</td>
<td>15</td>
</tr>
<tr>
<td>Delimitations</td>
<td>16</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>16</td>
</tr>
<tr>
<td>Summary</td>
<td>17</td>
</tr>
<tr>
<td>2. LITERATURE REVIEW</td>
<td>18</td>
</tr>
<tr>
<td>Gottman’s Findings Regarding Unsuccessful Marital Interventions</td>
<td>19</td>
</tr>
<tr>
<td>Gottman’s Core Triad of Balance</td>
<td>21</td>
</tr>
<tr>
<td>Introduction to Gottman’s Sound Marital/ Relationship House Theory</td>
<td>24</td>
</tr>
<tr>
<td>Introduction to Group Therapy</td>
<td>31</td>
</tr>
<tr>
<td>Adolescence: Developmental, Clinical, and Treatment Considerations</td>
<td>33</td>
</tr>
<tr>
<td>Overview and Benefits of Art Therapy and Art Materials</td>
<td>37</td>
</tr>
<tr>
<td>Adolescent Individual Art Therapy</td>
<td>42</td>
</tr>
<tr>
<td>Adolescent Group Art Therapy</td>
<td>47</td>
</tr>
<tr>
<td>Introduction to Family Art Therapy</td>
<td>60</td>
</tr>
<tr>
<td>Adolescent Family Art Therapy</td>
<td>63</td>
</tr>
<tr>
<td>Summary</td>
<td>68</td>
</tr>
<tr>
<td>3. METHODOLOGY</td>
<td>69</td>
</tr>
<tr>
<td>Purpose of the Study and Research Hypotheses</td>
<td>69</td>
</tr>
<tr>
<td>Research Study Site</td>
<td>70</td>
</tr>
<tr>
<td>Research Study Population and Sampling Mechanism</td>
<td>70</td>
</tr>
<tr>
<td>Current Services Provided at the DJJ Residential Program</td>
<td>70</td>
</tr>
<tr>
<td>Overview of the Delinquency Process and Residential Commitment Programs</td>
<td>70</td>
</tr>
</tbody>
</table>
Overview of the Research Intervention 71
Training of Therapist/Researcher to Promote Treatment Fidelity 72
Quantitative Mental Health Research Measures 72
Quantitative Parent-Child/Relational Research Measures 73
Qualitative Verbal and Nonverbal Observational Research Measures 74
One-Sample Statistical Test Analysis 75
Expected Outcome of Study 75

4. RESEARCH RESULTS 77

Sample Characteristics 77
Discussion of Session Summary 78
Discussion of Session One- Exploring Communication Patterns and Feelings 79
Discussion of Session Two- Building Love Maps 82
Discussion of Session Three- Enhancing a Fondness and Admiration System 83
Discussion of Session Four- Accepting Influence 84
Discussion of Session Five- Regulation of Conflict 85
Summary of the Group and Drawing Activities 87
Results for the Mental Health Research Measures 89
Results for the Parent-Child Research Measures 95
POSIT Correctional Measures 98
Summary of the Quantitative and Qualitative Findings 99

5. SUMMARY AND DISCUSSION 101

Summary of Methodology and Response to Research Questions 101
Response to the Research Questions and Hypotheses 104
Findings Related to the Current Gottman-Based and Art-Based Literature 109
Limitations of the Study 111
Implications for Future Research 113
Implications for Clinical Practice within the Department of Juvenile Justice 116
Conclusion 118

APPENDICES 120

Appendix A: Art-Based Group Therapy Interventions 125
Appendix B: Sound Relationship House Theory 125
Appendix C: Creating Your Child’s Love Map 126
Appendix D: State of Florida Juvenile Delinquency Process 129
Appendix E: Overview of the DJJ Residential Commitment Programs 131
Appendix F: FSU Institutional Review Board Approval Letter 132
Appendix G: DJJ Institutional Review Board Approval Letter 133
Appendix H: Youth Assent Form Ages 12-14 134
Appendix I: Youth Assent Form Ages 15-17 136
Appendix J: Youth Assent form Age 18 and Over 138
Appendix K: Parental/Guardian Consent Letter for Minors 140
Appendix L: Art Therapy Informed Consent 142
Appendix M: Problem Oriented Screening Instrument for Teenagers (POSIT) 143
Appendix N: Symptom Checklist (SCL-90) 147
Appendix O: Parent-Child Closeness Questionnaire (PCC) 149
Appendix P: Quality of Relationship Inventory (QRI) 150
Appendix Q: Representation of Unhealthy Communication Patterns 151
Appendix R: Representation of Feeling Happy, Sad, Angry, & Excited 153
Appendix S: Representation of Feeling Anxious, Peaceful, Afraid, & Confident 155
Appendix T: Symbolic Family Drawings 157
Appendix U: Family Kinetic Drawings 159
Appendix V: Prospective Kinetic Family Drawings 161
Appendix W: Joint Puzzle Drawing 163
Appendix X: Problem and Solution Drawings 164
Appendix Y: Deep Breathing Painting 166

REFERENCES 168

BIOGRAPHICAL SKETCH 176
## LIST OF TABLES

1. Adolescent Group Session Outline 71
2. Sample Characteristics including the Youth’s Age and Clinical Diagnosis 77
3. Problem Oriented Screening Instrument for Teenagers (POSIT) Risk Level 90
4. POSIT Wilcoxin Signed Ranks Test 91
5. POSIT Wilcoxin Signed Rank Test Results 92
6. Symptom Check List SCL-90 Clinically Significant Subscales 93
7. Symptom Checklist (SCL 90) Wilcoxin Signed Ranks Test 94
8. SCL 90 Statistical Results 95
9. Parent-Child Closeness (PCC) Wilcoxin Signed Ranks Test 96
10. PCC Mother and Father Statistical Results 96
11. Quality of Relationship Inventory (QRI) Wilcoxin Signed Ranks Test 97
12. QRI Mother and Father Statistical Results 98
13. POSIT Correctional Measures 98
ABSTRACT

This study investigated the effectiveness of providing a Gottman-based group therapy using art-based interventions to adjudicated male adolescents ages 14-18. The group provided structured interventions based on Gottman’s Sound Relationship House Theory for five consecutive weeks at a Department of Juvenile Justice residential program. The first hypothesis was that by attending the group, the adolescents would experience a change in their communication, social, self-regulatory, and problem-solving skills. If these self-regulatory skills were improved, the adolescents would report a decrease in mental health symptoms. The second hypothesis was that by attending the group and completing art-based interventions, the adolescents would report a change in the parent/child relationship.

Two mental health measures were collected at pretest and posttest: the Problem Oriented Screening Instrument for Teenagers (POSIT), which has 10 subscales and the Symptom Checklist-90 (SCL-90), which has nine subscales. Three outcome measures for the parent-child relationship were administered. These were the POSIT, the Parent-Child Closeness (PCC) questionnaire with two scales for mother and father, and the Quality of Relationships Inventory (QRI), which has three subscales for the mother and father. All measures were analyzed utilizing a Wilcoxin Signed Ranks test.

Based on the 10 subscales measured by the POSIT, adolescents reported fewer family, vocational, social, and leisure problems. Based on the nine subscales measured by the SCL-90, adolescents reported fewer symptoms of depression, anxiety, and obsessive-compulsive behaviors. Parent-Child Closeness measures for mother and father were significant, indicating a closer parent-child relationship with fewer parent-child conflicts. No statistical significance was found for the QRI measure. The results of the study offer a preliminary finding to support the use of a Gottman relationship-based adolescent group therapy, utilizing art-based interventions within a Department of Juvenile Justice residential program.
CHAPTER 1
INTRODUCTION

This research study explored the effectiveness of a five week art-based group therapy intervention based on Gottman’s Sound Relationship House Theory. Participants were adjudicated delinquent adolescent males from age 14 to age 18. Information regarding juvenile delinquents, the clinical definition and criteria for the diagnostic category of Conduct Disorder, and the etiology and prognosis of Conduct Disorder are addressed within this chapter. Information regarding the current research endeavors of the Florida Department of Juvenile Justice, an introduction to Gottman’s research-based relationship approach, and a discussion of the use of this theory within an adolescent art-based intervention group also are provided. This chapter concludes with a discussion of the research purpose, questions, and hypotheses; the assumptions and definitions of terms; the limitations and delimitations of the study; the clinical and measurement abbreviations; and the research summary.

Overview of the Problem

According to the Florida Department of Corrections, as of September 1, 2005 under the Florida’s Criminal Punishment Code, nearly thirty percent (29.8%) of the offenders sentenced were considered youthful offenders under the age of eighteen at the time of sentencing. Of the 2,357 juveniles sentenced, 843 (35.4%) were age sixteen or younger. Over eighty percent (80.3%) were male. Charges for the offenders included: murder/ manslaughter (2%), sexual offenses (4.2%), robbery (16.1%), violent personal offenses (18.9%), burglary (23.8%), theft, forgery, or fraud (11.5%), drugs (16.7%), weapons (3.1%), and other offenses (3.8%) (Florida Department of Corrections, 2006).

Many adolescents who were sentenced to residential programs also presented with both mental health and substance abuse issues. Three out of four juveniles admitted to having a problem with alcohol or drug use; 29% of the adolescents were deemed emotionally disturbed, and 20% of the adolescents were diagnosed as having a serious mental illness (Department of Juvenile Justice, 2006). Further, adolescents entering DJJ programs were also diagnosed with Conduct Disorder due to inappropriate behaviors. Additional comorbid conditions, including Attention Deficit Hyperactivity Disorder and possible learning disabilities, also existed.

Burke, Loeber, and Birmaher (2002) discussed a model of developmental sequences in
symptoms with adolescents. These researchers proposed that the disruptive behavior disorders, such as Oppositional Defiant Disorder (typically diagnosed in younger children), Conduct Disorder (diagnosed in early childhood to later adolescence), and Antisocial Personality Disorder (diagnosed in adults age 18 and over), depend on the youth’s age and developmental level. The onset of less severe symptoms tended to precede the onset of moderate symptoms, followed by the onset of serious behavioral symptoms.

Loeber and colleagues (2002) reviewed the developmental pathways to serious conduct and delinquent problem behaviors. They discussed three different pathways including: 1) overt pathway, 2) covert pathway, and 3) authority conflict pathway. The overt pathway resulted in the individual progressing from minor aggression to physical fighting and then to physical violence. The covert pathway began before the age of fifteen and resulted in the minor’s covert behaviors of property damage, such as vandalism or fire setting, later leading to more moderate to serious forms of delinquency. The authority conflict pathway began before the age of twelve. Within this pathway the individual progressed from stubborn behaviors to defiance and authority avoidance, such as truancy, running away, and staying out past curfew. The pathways represented different lines of development and developmental tasks. Children and adolescents may vacillate between different levels or pathways, possibly resulting in multi-problem issues.

Chung and Steinberg (2006) reported a correlation between low parental support and adolescents’ involvement with deviant friends. The more peer deviance the adolescents were associated with, the more the adolescents committed violent and non-violent offenses, leading to more serious forms of antisocial activity. Adolescents whose parents exhibited a combination of strong supervision and positive involvement reported fewer delinquent behaviors.

For the purpose of this research study, the adolescents’ behaviors will be referred to as delinquent behaviors. All of the adolescents at the research site, a moderate risk male adolescent Department of Juvenile Justice program in Tallahassee, Florida, were diagnosed with Conduct Disorder, according to the American Psychological Association Diagnostic Statistical Manual Text Revised (APA, 2000). This guide was used as a diagnostic tool to provide a common language to practitioners regarding mental health and substance problems for children, adolescents, and adults. Additional information regarding the diagnostic category and description of behaviors is discussed below.
Conduct Disorder: Clinical Diagnosis, Etiology, and Clinical Presentation

Definition and Criteria for Conduct Disorder

Many adolescents entering a residential juvenile delinquency commitment program present with a clinical diagnosis of Conduct Disorder (CD). This section discusses the definition of Conduct Disorder and describes the two subtypes, childhood-onset (inappropriate behaviors occurring prior to age 10 years), and adolescent onset (inappropriate behaviors presenting after 10 years of age). Other cognitive and psychological issues, including co-occurring mental health disorders and behavioral problems, are also discussed (Shapiro, Friedberg, and Bardenstein, 2005).

According to the Diagnostic Statistical Manual IV- Text Revised (APA, 2000), Conduct Disorder is classified as a disorder usually first diagnosed in childhood or adolescence. The diagnosis of Conduct Disorder includes the presence of three or more of the following criteria in the past 12 months, with at least one criterion present in the past six months: aggression to people (bullies, initiates physical fights, uses a weapon to harm others, steals property while confronting a victim, forces someone to have sexual activity, or being physically cruel to people); destruction of property (engages in fire setting or destroys other’s property); deceitfulness or theft (breaks into someone’s house, business, or car; lies to obtain goods or favors; or steals items of nontrivial value without breaking and entering); and a serious violation of rules (stays out past curfew before age 13, truant from school before age 13, or runs away from home overnight at least twice while living at home). This disturbance in behavior causes a clinically significant impairment in school, academic, or occupational functioning. If the individual is 18 years or older, criteria for Conduct Disorder must not also be met for Antisocial Personality Disorder. If the behaviors occurred prior to the age of 10, the youth are diagnosed as having a childhood-onset type. For youth with an absence of behaviors prior to the age of 10, the youth are diagnosed as having an adolescent-onset type (APA, 2000).

Adolescents diagnosed with the child-onset subtype of Conduct Disorder were more likely to experience severe psychopathology, neuropsychological deficits, rejection by their peers, and a poor prognosis in terms of continued mental health problems and criminal activity. The adolescent-onset subtype of Conduct Disorder was considered to be more common and less severe. It was associated with antisocial and aggressive behavior most commonly associated
with antisocial peers and possible gang affiliations. This subtype’s behavior was described as an exaggeration of developmentally normal adolescent rebellion and experimentation with forbidden or illegal activities (Shapiro et al., 2005).

**Etiology, Clinical Presentation, and Prognosis of Conduct Disorder**

Conduct Disorder was associated with a number of risk factors, etiological processes, and skill deficits. No one risk factor was identified as a precursor to Conduct Disorder; instead, the likelihood of disturbance was based on the accumulation of risk factors. Regarding behavioral-systemic etiologies, family dysfunction, conflict, and a lack of family cohesion were strongly associated with Conduct Disorder. Ineffective parenting practices, including maladaptive patterns of reinforcement, cycles of coercive behavior, and inconsistent disciplinary practices were largely associated with disturbed conduct. A lack of parental supervision was found to be an important etiological factor, as was family socioeconomic disadvantage and social adversity (Shapiro et al., 2005).

Youth diagnosed with Conduct Disorder tended to have lower academic and overall intellectual functioning, possibly scoring around 8 points lower than the average youth on IQ tests. Further, the youth’s verbal IQ’s were significantly lower than their performance IQ’s. Many youth who were diagnosed with Conduct Disorder were also diagnosed with additional leaning disabilities and Attention-Deficit Hyperactivity Disorder (ADHD), which is characterized by marked symptoms of inattention, hyperactivity, and/or impulsivity. These co-occurring conditions resulted in impairments in language and heightened deficits in self-control, emotional regulation, problem-solving, and social skills. Youth diagnosed with Conduct Disorder also tended to be under-responsive to negative consequences (lack of concern about being punished), but had a heightened sensitivity to rewards (willing to take greater risks to obtain small rewards). They also exhibited higher rates of depression and anxiety with around one-third of the population meeting the criteria for a clinical diagnosis. Some youth also experienced problems into adulthood, including: criminality, continued psychiatric problems, marital difficulties, alcoholism, unemployment, and medical illnesses (Shapiro et al., 2005).

**Florida Department of Juvenile Justice Research Endeavors**

Currently at the Florida Department of Juvenile Justice, the department has implemented a program called the DJJ What Works Initiative (WWI). This is a comprehensive program
designed to increase the effectiveness of juvenile justice services. The goals of the WWI include: reducing youth recidivism rates and examining research-based assessments, interventions, treatment, and management practices that result in reducing the risk of youthful re-offenses. The core of the DJJ What Works Concept is based on five principles, including: 1) the risk principle which focuses on targeting high risk offenders; 2) the need principle which focuses on the risk factors associated with offending behavior; 3) the treatment principle which mandates evidenced-based treatment approaches; 4) the responsivity principle which tailors treatments to meet the youth’s special needs; and 5) the fidelity principle which monitors the implementation of the quality and treatment fidelity of the services being offered (Department of Juvenile Justice, 2006).

This research study was designed to respond to the needs of adjudicated adolescents by offering a five-week structured adolescent art-based group therapy, focusing on interpersonal and family dynamics based on Gottman’s Sound Relationship House Theory. This project offered a manualized relational approach which is empirically based on Gottman’s Sound Relationship Theory. The goals for this study were to: 1) evaluate the use of Gottman’s Sound Relationship House Theory with adolescents; 2) evaluate the combined use of the theory with art-based directives; and 3) determine if the theory is deemed effective with adolescents through the use of pretest and posttest mental health and relational measures. It was hypothesized that enhancing the client’s self-regulatory skills, including communication, social, and problem-solving skills, would allow the following results: a decrease in mental health issues/problems, an improvement in the parent-adolescent relationship, and the prevention of escalating academic, occupational, and family problems which could reach into adulthood.

**Introduction to Gottman’s Research-Based Relationship Approach**

In 1986 with assistance from the National Institute of Mental Health, Gottman joined the University of Washington’s Department of Psychology and started the Family Relationship Lab. This lab was the site for numerous studies in marriage, gay and lesbian couples, transition to parenthood, domestic violence, and parenting and child development (The Gottman Institute, 2006). Gottman’s approach became known as the Sound Marital House Theory (SMHT) and addressed components of what works and what does not work for satisfying relationships. Due to Gottman’s focusing on all types of relationships, in 2002 he renamed the approach the Sound
Relationship House Theory (SRHT) (Gottman, Murray, Swanson, Tyson, and Swanson, 2002). Gottman has further broadened his work by investigating the relationship of parents with newborn infants, children, and adolescents (The Gottman Institute, 2006). For this literature review both theories will be discussed, depending on the original literature citation, and will be treated as one theory.

Gottman has primarily focused on the effects of separation and divorce for adults and the effects of marital distress, conflict, and disruption for children. In adults, Gottman noted an increased risk/incidence of psychopathology, automobile accidents, physical illness, suicide, violence, homicide, significant immuno-suppression, mortality from diseases, decreased work productivity, poverty, and impaired parent-child relationships. In children and adolescents, Gottman found an increase in depression, withdrawal, poor social competence, health problems, poor academic performance, and conduct-related problems/juvenile delinquency (Gottman, 1998; Hicks, McWey, Bendon, & West, 2004).

In couples, Gottman found that the more negativity present in one’s relationship, the lower the amount of positive interaction in the relationship. A higher level of negativity, therefore, resulted in less empathy and nurturance in the relationship. Gottman asserted that there were four toxic communication patterns/behaviors which were found to be the most harmful in the relationship. These detrimental communication behaviors included: criticism, contempt, defensiveness, and stonewalling and were termed “The Four Horseman of the Apocalypse” (Gottman, 1999, p.41; Hicks et al., 2004). Gottman asserted that there were two “staples” of marriages that made them work: an overall level of positive affect and the ability to reduce negative affect during a conflict resolution (Gottman, 1999, p.105; Hicks et al., 2004). Gottman also found that in every marriage, couples established a “steady state” and that the “system” of the relationship was repeatedly drawn to this “stable steady state” and was capable of repair when needed (Gottman, 1999, p.33).

In What Predicts Divorce? The Relationship between Marital Processes and Marital Outcomes (1994), Gottman proposed a theory referred to as the core triad of balance. This theory was based on Gottman’s investigation of the three domains of human experience, including perception, behavior, and physiology. This theory suggested a bi-directional linkage between the three. The perception component was described as the sense of well-being and
safety in the relationship and referred to as the Q-space. The perception component could balance feelings of hurt/perceived threat or hurt/anger-contempt if a sense of well-being was present. The behavior component was described as the flow over time of positive and negative behaviors referred to as the P-space. The behavioral flow was measured as the sum of positive behaviors minus negative behaviors over time. The physiology component was described as one’s physiological responses such as heart rate, vascular constriction, and respiratory pattern. Physiological responses linked to negative affect could lead to increased reactivity and diffuse physiological arousal. Physiological responses linked to positive affect have the potential to buffer arousal through physiological soothing. Each component in the core triad of balance could affect the other in a bi-directional means and has the potential for balance. In his laboratory, Gottman referred to this theory as the Q-P-Phy theory.

**Integrating Gottman’s Approach with Art Therapy**

Gottman’s principle that the establishment of a stable steady state for couples is based on the core triad of balance (the interplay between one’s perception, behavior, and physiology in the relationship) should also apply to families, especially those with adolescents diagnosed with Conduct Disorder and those dealing with issues of poor communication, problem-solving, self-regulatory, and social skills (Arrington, 2001; Hughes-Brand, 2007). Art therapy with adolescents and families has expanded its research base to address these three domains of human behavior and has been found effective in school settings, juvenile justice programs, and hospitals.

Rosal (1993) evaluated the changes in the locus of control in behavior disordered children in the fourth, fifth, and sixth grades. She posited that art therapy could assist children in gaining control over their behavior and could change their perceptions of power and control. Rosal assigned 36 subjects to a cognitive-behavioral art therapy group, an art as therapy group, and a control group. She utilized three measures including the Children’s Nowicki-Strickland Internal-External Locus of Control (CNS-IE), the Connors Teacher Rating Scale (TRS), and a Personal Construct Drawing Interview. Results indicated that the children in both treatment groups made greater gains toward the norm than did the control group according to the CNS-IE. The two art therapy treatment groups were also found to be more effective than the control group in helping the behavior disordered students improve. If art therapy can impact perception and behaviors of
children, art therapy could also impact the adolescent’s perceptions and behaviors within the family system.

Howard (2001) discussed the use of painting with a 15-year-old male who presented with problems of juvenile delinquency, including petty theft, burglary, and grand auto theft with alcohol use and gang involvement. The adolescent was involved in four months of art therapy in a hospital setting to address parent-child conflicts, delinquent behaviors, and self-exploration. Howard reported an improvement in the adolescent’s academic performance, a decrease in family conflicts, and an improvement in his self-esteem and ability to cope with emotional problems.

Bennink, Gussak, and Skowran (2003) discussed the use of art therapy in a juvenile justice residential program. They described their work in a juvenile justice setting as providing individual and group therapy to 24 males between the ages of 12-18 over a four to six month time frame. Goals for the art therapy sessions included improving the adolescent’s anger management, self-esteem, decision-making, coping, social, and communication skills and educating the adolescents regarding the dangers of substances. Bennink et al. (2003) stated that the art activities started with easy to use media, such as pencils, erasers, colored pencils, and markers, and gradually progressed to more difficult materials, such as acrylic and watercolor paints. By gradually increasing the complexity of the media so that the adolescents had control over the fluidity of the paint, the adolescents were able to obtain a higher level of frustration tolerance. The art therapists also utilized highly structured, complex, and directed activities to foster healthy coping, communication, social, and problem-solving skills.

Bornmann, Mitelman, and Douglas (2007) investigated the effectiveness of relaxation techniques paired with art therapy techniques with children ages five to thirteen. Study results indicated statistical significance for a decrease in property destruction, physical aggression, and total aggression. Decreasing the adolescents’ overall levels of aggression and increasing their ability to self-soothe, also decreased their physiological arousal and possibility for flooding.

Although there have been numerous studies evaluating the effectiveness of Gottman’s Sound Relationship House Theory with couples and with couples and newborns (The Gottman Institute, 2006), there are no adolescent/family studies exploring the application of Gottman’s approach with expressive therapies. Ricco (2005, 2007) has explored incorporating Gottman’s
approach using art therapy with couples to investigate pivotal moments in therapy. This current research study will be the first to bridge Gottman’s Sound Relationship House Theory to an adolescent population, incorporating verbal and nonverbal approaches using art-based interventions in a group setting.

Rationale for Art-Based Activities Implemented with Gottman’s Approach

Session One – Representation of Unhealthy Communication Patterns and Feelings

This research project considered an adolescent group which utilized art-based interventions for five weeks and integrated principles of Gottman’s Sound Relationship House Theory. The first session began with group introductions followed by general information about Gottman’s theory and a discussion of the four unhealthy communication patterns of criticism, defensiveness, contempt, and stonewalling. The adolescent then depicted these patterns and behaviors using lines, shapes, colors, and forms (Hughes-Brand, 2005, Hughes-Brand & Brand, 2007, and Hughes-Brand & Craven, 2007). Having the adolescent express both positive and negative feelings as discussed by Rhyne (2001), allowed the adolescents’ identification of and connection with their feelings.

Gottman and DeClaire (1997) discussed the role of being aware of one’s feelings in the steps to emotion coaching. The goal of emotional awareness is to be able to recognize and identify one’s feelings, grant oneself permission to experience the feeling, and become more aware and sensitive to other’s feelings. Gottman found differences in the ways that males and females express their feelings. He found that females tended to openly express their emotions through words, body language, and facial expressions. Males tended to hide their emotions, hold back, and discount their feelings. Gottman and DeClaire (1997) discussed additional ways of gaining emotional self-awareness, which included engaging in meditation, prayer, journal writing, listening to or playing a musical instrument, and exploring other forms of artistic expression through drawing. The authors stated that by labeling, writing, or processing an emotion through thoughts and images, the feeling can be defined, processed, and contained.

Rhyne (2001) described the development of her model, the Gestalt Art Experience which was based on her training with Fritz Perls at the Gestalt Institute of San Francisco, as humanistic and holistic. The central task of a Gestalt therapist is to assist the client in fully experiencing being in the here-and-now and in recognizing how the client prevents himself/herself from
feeling and experiencing in the present. Rhyne requested clients to make sequential abstract drawings representing the client’s responses to a series of eight primary feelings including: 1) fear, 2) anger, 3) joy, 4) sadness, 5) disgust, 6) acceptance, 7) anticipation, and 8) surprise. She observed the structure and form of the images, as well as the directional movements in the lines and shapes and the interactions of the forms. In the exercise for this current study group, the adolescents were requested to represent four positive and negative similar emotions, including feeling happy, sad, angry, excited, anxious, peaceful, afraid, and confident. After completing the drawings, the adolescents were requested to describe the images, associations, and personal interpretations of the images/feelings.

Session Two – Building Love Maps through Family and Kinetic Family Drawings

The second session of the intervention focused on creating the child and parent love maps described as the cognitive room. The goal of reviewing the love maps is to assist parents and their children in learning more about their child’s feelings, experiences, preferences, and interests. If adolescents connect emotionally with their family and friends, they may turn towards their support system for assistance and guidance (Gottman & DeClaire, 2001). Further, by encouraging peers to share personal and family information with one another, peers may have a greater sense of connection with one another and could offer assistance and support within the group (Gottman and DeClaire, 1997).

The art-based activity for building family love maps in this group required having the adolescent complete a family and kinetic family drawing to share and reflect upon family dynamics and family experiences. Many art therapy projective drawings/assessments involve drawing the family, members of the family, peers, and/or social environments or situations. According to Rubin (1999) examples of family based art directives include: the Family Drawing introduced by Appel (1931) and Wolff (1942), the Kinetic Family Drawing by Burns and Kaufman (1970, 1972), and the Prospective Kinetic Family Drawing (Burna, 1992). Other deviations included the Draw-A-Family (DAF) developed by Hulse (1951) and Harris (1963). For the purpose of this intervention, the art directives described below were used only for therapeutic purposes to engage the adolescent in addressing family dynamics and interactions. The drawings were not used for assessment purposes; however, the group members were encouraged to share information about the drawings to gain rapport with other group members.
and to share family activities, strengths, rituals, and traditions.

Appel in 1931 and Wolff (1942) first introduced the *Family Drawing* which included having the person draw a picture of his/her family (Rubin, 1990). Hulse (1951) and Harris (1963) later developed the *Draw-A-Family (DAF)* in which subjects were asked to “draw a picture of your family” using only a pencil and an eraser on a single sheet of paper. The subjects were then asked to identify different persons in the drawings, label them, and place the subject’s name and date on the drawing. The drawings were interpreted based on descriptive qualities (relative size of figures, proximity to one another, line pressure, and shading), as well as the affect and overall quality of the drawing. Wright and McIntyre in 1982 developed an objective scoring system that was useful in detecting signs of depression. This scoring system included a scale that was comprised of 15 items including diverse variables, such as organization of the drawing, size of the figures, size of self-portrait drawn to other figures, separation of self from others if present, level of detail, degree of sexual differentiation, energy expressed by self and the family, and amount of empty space (Groth-Marnat, 1990, p.391).

Burns and Kaufman (1970, 1972) later developed the *Kinetic Family Drawing (KFD)* which directs the person to “Draw a picture of everyone in your family, including you, doing something.” After completing the drawing, the subject may be requested to include him- or herself in the drawing, describe the drawing, or tell a story about the image. The goal of this assessment was to illuminate the subject’s perceptions and attitudes toward his or her ongoing family dynamics. The KFD has been utilized with diverse populations, including abused children, children with perceptual-motor delays, families, cross-cultural comparisons, and persons with medical conditions such as diabetes (Groth-Marnat, 1990, Rubin, 1999, p.186).

**Session Three – Building Emotional Connections through Family Drawings**

Rubin (1999) also discussed the *Prospective Kinetic Family Drawing (PKFD)* developed by Burns in 1992. The PKFD was a variation of the projective drawing, the Kinetic Family Drawing (KFD). The PKFD requested the subjects to draw “the family doing something after five to ten years” (p.186).

The goal of this study’s session three focused on building the emotional connection between parent and child and on building more positive sentiments toward the family in order to minimize blaming, criticizing, or attacking within the family. In the art activity, the adolescent
drew a prospective kinetic family drawing. Since the adolescents in this study were adjudicated to a residential commitment program, they were instructed to draw a picture of their family doing something after they returned home. The goal of the exercise was to promote healthy activities between the adolescents and their families with a focus on family strengths, traditions, and rituals. It was hypothesized that focusing on past and current positive traditions and rituals may lead to an increase in future family activities and positive connections.

**Session Four – Accepting Influence through a Joint Puzzle Drawing**

The focus of session four was to assist the adolescents in being able to work together, listen to another, and respect each other’s beliefs and differences. The art activity for this session required that the adolescents decorate a single piece of a puzzle cut from a larger piece of poster board. After the pieces were decorated with the adolescent’s choice of media, the adolescents were asked to assemble the pieces to form a larger image (Betts, 2003). The goal of this exercise was to have the peers work together while addressing healthy communication, social, self-regulatory, and problem-solving skills. The adolescents also processed individual differences while addressing the issues of accepting influence and respecting others during the activity.

**Session Five – Regulation of Conflict through Drawing and Painting**

The goal of the fifth and final session was to focus on the ability to address solvable and perpetual problems. The session focused on the skills needed for solvable problems and ways to self-soothe. Skills needed for addressing solvable problems include: 1) softened start-up; 2) repair and de-escalation; 3) accepting influence; 4) compromise; and 5) physiological soothing. After a discussion of problem-solving techniques, the group members were requested to draw an image of a problem, either real or abstract, followed by an image of the solution. After they completed these two images, the group drew the means necessary to accomplish the solution (Hughes-Brand, 2005; Hughes-Brand & Brand, 2007; and Hughes-Brand & Craven, 2007).

The second part of the final group focused on physiological soothing techniques. Gottman and DeClaire (1997) reported that benefits of self-soothing included an increase in one’s ability to regulate one’s emotions, to calm down, and to refocus attention after a conflict. Increased ability to self-sooth allows a greater ability to regulate involuntary physiological processes of the autonomic nervous system such as heart rate, respiration, and digestion. Self-soothing activities practiced by the group were progressive muscle tension techniques and deep breathing exercises.
The adolescents were requested to practice deep breathing while painting with watercolors. The goal of this exercise was to address ways to release tension and to regulate one’s breathing while painting. The painting exercises included painting lines, shapes, colors, and forms with watercolors while focusing on lowering one’s heart rate and blood pressure (Rosal, 2003).

**Purpose**

The purpose of this study was to:

a) provide research to explore the use of Gottman’s Sound Relationship House Theory with adolescents, incorporating the use of art to explore interpersonal and family dynamics;

b) determine the effectiveness of a five week adolescent art-based group intervention based on Gottman’s Sound Relationship House Theory, as determined by pretest and posttest mental health and relational measures, and

c) integrate both verbal and nonverbal approaches, including art-based directives to encourage adolescent group interactions and to focus on personal and family strengths.

**Research Questions**

This study addressed the following research questions:

1. Does participating in a five week manualized adolescent treatment group based on Gottman’s Sound Relationship House Theory and using art-based interventions influence the adolescents’ self-regulatory skills in the areas of communication, social, and problem-solving skills?

2. Does participating in this intervention result in a change in the parent-child relationship?

3. Is there a relationship change according to the nine subscales of the POSIT: substance abuse, family, peer, educational, vocational, social, leisure, delinquency, and health as determined by the posttest measure?

4. Do art-based activities assist the adolescent to explore his feelings and communication patterns and to explore his family dynamics and relationships, as indicated through clinical observations of the group and the content of the individual adolescent’s drawings?

**Research Hypotheses**

This study was guided by two research hypotheses:

1. Adolescents participating in a manualized five week group based on
Gottman’s Sound Relationship Theory utilizing art-based interventions will experience a change in their self-regulatory skills in the areas of communication, social, and problem-solving skills.

The results were determined by a difference in the pretest and posttest mental health measures using the POSIT and the SCL-90. The ten subscales of the POSIT included: substance abuse, health status, mental health, family, peer, educational, vocational, social skills, leisure, and delinquency. The nine subscales of the SCL-90 included: somatization (perceptions of bodily dysfunction), obsessive-compulsive, interpersonal sensitivity (feelings of inadequacy and inferiority), depression, anxiety, anger-hostility, phobic anxiety, paranoid ideation, and psychoticism (experiencing false body sensations). The null hypothesis was that if the adolescents participated in the intervention, there would be no change in the adolescents’ self-regulatory skills. Because this theory has never been applied solely to this clinical population, the hypothesis regarding self-regulatory skills was two tailed to assess for an increase or decrease in self-regulatory skills as measured by the POSIT and SCL-90.

2. Adolescents participating in a five week manualized group based on Gottman’s Sound Relationship House Theory utilizing art-based interventions will experience a change in the adolescent/parent relationship.

The results were determined by considering the difference in the pretest and posttest measures using the POSIT, the PCC, and the QRI. The POSIT relational scales included the family and peer relationship measure. The Parent-Child Closeness (PCC) questionnaire measured the degree of closeness in parent-child relationships. The Quality of Relationships Inventory (QRI) examined three relationship factors, including social support, perceptions of relationships as positive, important, and secure (defined as the depth score), and the level of conflict and ambivalence resulting from the relationship. The null hypothesis was that if adolescents participated in the intervention, there would be no change in the parent-child relationship.

Assumptions

1. Adolescents involved with the Department of Juvenile Justice system were willing to participate in the study and to discuss their parent/child relationships and personal feelings and
beliefs.

2. The adolescents involved in the research project completed the questionnaires honestly and to the best of their ability.

3. All of the adolescents participating in the research study were present for all five of the weekly sessions and actively participated in group activities and discussions.

4. Due to a limited convenience sample, the Wilcoxin Signed Ranks nonparametric test was the most appropriate statistical test to evaluate the data so that all scores on the measures were ranked according to the pretest and post test measures to determine if a change in the scores occurred.

**Definitions**

Communication Skills - The ability to engage in healthy communications and avoid negative communication patterns/behaviors, such as being critical, contemptuous, defensive, and/or stonewalling.

Department of Juvenile Justice (DJJ) – The state agency which oversees adolescents who have been adjudicated due to committing a crime.

Media or Medium – Any art supply such as pencils, crayons, markers, paint, or clay.

Mental health problems/issues – Symptoms such as depression, anxiety, and anger as reported on a self-completed measure known as the Symptom Checklist -90 (Derogatis, 1983) and the Problem Oriented Screening Instrument for Teenagers (Rahdert, 1991).

Participant – A male adolescent between the ages of 12 through 18.

Problem-solving skills – The ability to regulate conflict and identify solvable and perpetual problems.

Self-regulatory Skills – Skills as defined by Gottman that include ways in which one deals or copes with stressful interpersonal, family, peer, or environmental situations or interactions.

Social Skills - The ability to interact with peers, adults, and family members in a healthy manner.

**Limitations**

The study was limited by the following:

1. The sample consisted of a convenience sample. Adolescents who were over the age of 18 were allowed to consent to participate in the study; or minors under the age of 18 were granted personal assent if consent was obtained from their family/guardian. Due to several
parents’ relocating, some parents could not be contacted to obtain consent for participation in the study, and some parents did not consent for their child to participate.

2. Because of the small sample size and the limited sample parameters (adolescent males age 14 to 18 from one residential program in Leon County, Florida), the results from the sample are not generalizable to the greater population.

3. Researcher bias is possible because the researcher implemented the groups. The researcher implemented a five week structured group manual to assist with treatment fidelity. The researcher also requested statistical assistance from an outside person to assist with the statistical analysis.

**Delimitations**

The researcher limited the study to the following:

1. The study consisted of males only because the facility is a male residential Department of Juvenile Justice program in Tallahassee, Florida.

2. The criteria for the research study sample consisted only of adolescents between the ages of 12 to 18 because this was the commitment age allowed by the Department of Juvenile Justice residential programs. Adolescents who commit crimes after the age of 18 are redirected to the adult Department of Corrections. The actual sample consisted of adolescents between the ages of 14 to 18; either the parent/guardian or the adolescent over the age of 18 consented to treatment.

**Abbreviations**

AATA: American Art Therapy Association, Incorporated
ADHD: Attention Deficit Hyperactivity Disorder
APA: American Psychological Association
CD: Conduct Disorder
DJJ: Department of Juvenile Justice
DPA: Diffuse Physiological Arousal
ED: Emotionally Disturbed
ETC: Expressive Therapies Continuum
MDV: Medium Dimension Variables
Summary

Many adolescents who are adjudicated to the Department of Juvenile Justice present with deficits in emotional regulation, self-control, and self-regulatory skills. Adolescents may also present with prior parent/family conflicts, as well as possible symptoms of depression and anxiety. By introducing an adolescent therapy group based on the principles of Gottman’s Sound Relationship House Theory and utilizing art-based interventions, this study applied to adolescents a theory researched with an adult population and introduced healthy self-regulatory skills to aide in the development of more positive peer, family, and community interactions. A Gottman-based treatment group incorporating art-based interventions may also facilitate adolescents to become more involved in the treatment process. If the adolescents become more engaged in treatment through an integrative approach with didactic and experiential modalities, enhanced treatment outcomes may result. This in turn may decrease the recidivism rates for adolescents. Enhancing the treatment approaches for adolescents may further prevent significant problems in adulthood.
CHAPTER 2
LITERATURE REVIEW

Over the past 35 years, John Gottman, a mathematician, psychologist, and premier researcher, has studied relationships in the context of the family and marriage. Gottman’s background as a psychologist planted the seed for the use of observational methods, for evaluating the design and implementation of programs, and for an optimism for studying marriages. Psychology marital researchers first posed the question: “What makes some marriages happy, but others miserable?” (Gottman et al, 2002, p.13) For the past 30 years Gottman has studied two lines of research in the laboratory regarding children’s friendships and children’s peer relations and the social interaction processes related to marital satisfaction. Gottman has provided behavioral observations as to characteristics of what makes marriages succeed and what makes them fail. His research has focused on human experience and has included studying one’s perception, behavior, and physiology within the context of the relationship. Importantly, he also identified the antedotes for perceptions, behaviors, and physiology that were identified as harmful to the marriage. Gottman collected large amounts of data from the University of Washington Family Research Laboratory and created a theory which he called the Sound Marital House Theory. At some point in his research, it became clear to him that the principles that he developed were applicable to all relationships. Therefore, the approach was renamed the Sound Relationship House Theory in 2002 (Gottman et al., 2002; Gottman, Murray, Swanson, Tyson, and Swanson, 2005).

After reviewing the characteristics of happily and unhappily married couples, this researcher believed that the characteristics present in happily married couples should also be applicable to healthy functioning families. This study aimed to combine Gottman’s Sound Relationship House Theory with art-based interventions in a therapeutic group setting with adjudicated delinquent adolescent males. Because the identified adolescents presented with poor communication, social, self-regulatory, and problem-solving skills, using art may assist the adolescents in developing these skills and in exploring their family relationships. To combine these approaches, it was necessary to first review Gottman’s work with couples and families, to determine how this approach can be applied with adolescents in a group format, and to review the current literature on art therapy concerning its effectiveness in an individual, group, and family setting. After the
review of the art therapy literature, this report states a rationale for the combination of the two approaches.

The literature review mainly focused on adolescent art therapy and adolescent family therapy based on Gottman’s Sound Relationship House Theory. Literature focusing on children under the age of 12 was not included, nor was literature focusing on individuals ages 18 and over. Initial key words of the search included: adolescent art therapy, adolescent family art therapy, adolescent group art therapy, adolescent group therapy, Gottman, Sound Marital House Theory, and the Sound Relationship House Theory. Specific dates for the literature topics were broad, focusing on the years 1985 to present; the literature review will be presented in chronological order. The search engines utilized included: Cambridge Abstracts, ERIC, First Search, Gale Net, Infotrac, Lexus-Nexus, PsychLit, Science Direct, and Wilson Web. These databases accounted for research and literature addressing diverse areas such as the arts, art therapy, counseling, education, marriage and family therapy, nursing, psychology, sociology, and social work. It was difficult to find research articles meeting the criteria for the literature search; some journals were searched by hand due to keywords not being detected in the initial search or were located in the reference list of prior articles.

Primary journals utilized for the art therapy section included: American Journal of Art Therapy, Art Therapy: Journal of the American Art Therapy Association, and the The Arts in Psychotherapy. The literature search focused on general art therapy interventions consisting of drawing, painting, and constructing murals. Specific art therapy literature that was based on other media (clay, photography, video, and other art forms) and specific environments (such as museums) were excluded from the search. Further, literature focusing only on art therapy diagnostics and assessments were also excluded. Only individual, group, and family art therapy research and literature were considered for adolescents ages 12-17 in schools, residential, in-patient, out-patient, hospital, and in-home settings. Also, expressive therapies such as drama, journaling/writing, music, play, and poetry therapy were excluded from the literature search.

Gottman’s Findings Regarding Unsuccessful Marital Interventions

Before describing Gottman’s principles of the Sound Relationship House Theory, Gottman first described the five myths of marital research that were found to be unsuccessful. Gottman reported that the “active listening model” of therapy was rarely used and did not predict happy
couples. Research showed that couples were often not summarizing their partner’s feelings or the content of their statements. Further, active listening was found to decrease negative interaction, but not to increase positive interactions between partners. For couples that did utilize the active listening skills model, the couples relapsed to pretreatment levels and remained in the “unhappy” relationship range. The second myth of couple’s counseling believed that anger was destructive in relationships and was deemed a dangerous emotion. After reviewing research in marital therapy, Gottman found that the suppression of anger was related to physical violence in couples in the United States. He also found that anger in marital interactions did not predict divorce; however, contempt and defensiveness did so reliably (Gottman, 1999, p.8).

Gottman (1999) also discovered that the “quid pro quo” theory in relationships known as “contingency contracting” characterized unhappy marriages (p.12). Unhappy couples were keeping tabs or counting positive exchanges by their partner; happy couples had positive interactions unconditionally. The fourth myth of marital therapy was the myth of “noncontingent positivity” (p.13). It was believed if couples were nicer to one another, regardless of the partner’s response, eventually the other partner would be nice to their spouse as well. When couples were nicer to one another, many partners underestimated the amount of positivity. Gottman also discussed the myth of the “harmony model” (p.14). This model posited that avoiding conflict and bickering about trivial issues was dysfunctional and indicative of underlying symbolic conflict. Gottman found that conflict-avoiding and volatile, bickering couples could both have happy marriages.

**Gottman’s Approach and Its Impact on Relationships**

The original family systems theorists were inspired by the work of von Bertalanffy (1968) who published *General System Theory*. He suggested that every system (biological, organizational, or interactive), acts to maintain its homeostatic balance or optimal steady state. Feedback mechanisms are present which guide the system back to a state of homeostasis. This led to the idea of “circular causality” which implies that each person’s behavior is affected by the other. In families, this point of view was referred to as “patterns of interactive behavior.” Families may maintain a pathological pattern through unhealthy feedback mechanisms (Gottman, 1999, p.31).

In 1994 Gottman met the world-famous mathematician and biologist, James Murray, to
further investigate a model of marital interactions first envisioned by von Bertalanffy. Gottman was trained in mathematics with an undergraduate and master’s degree in mathematics and had sought to explore a mathematical equation to marriages (Gottman et al., 2005). Gottman found that this model of interactions was not circular, but linear. Couples were found to have their own mechanisms for self-correction and repair when interactions became too destructive. Gottman, after further investigating the nature of homeostasis, suggested that there were two, not one, homeostatic stages for couples (one positive and one negative). Better establishing of repair attempts in relationships would influence the relationship to be more positive than negative. The two staples of the marriage discussed earlier included the ability to: 1) maintain a level of positive affect in the relationship, and 2) reduce the negative affect during the conflict resolution stage. To create a lasting change in the relationship, couples had to: a) maintain a positive affect level in both non-conflict and conflict contexts, and b) learn how to reduce negative affect during a conflict by accepting another’s influence (Gottman, 1999).

**Gottman’s Core Triad of Balance**

Gottman also investigated three domains of human experience: 1) behavior, 2) perception, and 3) physiology. These three domains were not defined as independent, but as linked in a relationship. Gottman refers to them as the “core triad of balance.” This idea was that every marriage establishes a steady state, and the “system” of the relationship is then drawn to that “stable steady state.” Each marital system is also capable of repair when needed. Gottman found that to have a successful stable steady state, the positive to negative ratio in interactive behavior during conflict resolution was at least 5 to 1 in stable, happy marriages. In unhappy marriages, the positive to negative ratio was .8 to 1 so that there were 1.25 negative interactions as positive interactions (Gottman, 1999, p33).

**Core Triad of Balance: Interactive Behavior**

During Gottman’s research in his laboratory, he utilized many observational measures to evaluate couples. Gottman devised a system called the “Specific Affect Coding System” that trained observers to measure and code couples’ voices and gestures and the content of what people were saying. The observers also coded positive and negative emotions and behaviors displayed by the couples. The coding was administered with the assistance of a computer so that each person’s actions were synchronized to the video time code. Two observers coded
independently to ensure the reliability of the observers. Gottman found that the best correlate of marital satisfaction and dissatisfaction across research laboratories in the United States and overseas was a construct referred to as the “negative affect reciprocity.” This term referred to the increased probability that a person’s emotions will be negative right after his or her partner has exhibited negativity. Negative affect reciprocity was found to be the most consistent discriminator between happily and unhappily married couples. Women were found to be more critical, and men were found to stonewall or withdraw emotionally from the relationship (Gottman, 1999, p.37).

Gottman further identified four behaviors that were corrosive to the relationship: criticism, defensiveness, contempt, and stonewalling. These behaviors are discussed in detail in the next section of this report. Many couples were also found to be pervasively emotionally disengaging with an absence of positive affect resulting in no humor, affection, or active interest in one another. Other negative interactions identified in unhappy relationships included: a low ratio of positivity versus negativity, harsh start-ups (a topic of disagreement is broached with negative affect), failure to initiate repair attempts (any attempt for the partner to support his or her spouse), and a husband’s escalation via his unwillingness to accept influence from his wife (Gottman, 1999).

**Core Triad of Balance: Perception**

Gottman (1999) defined perception as the partner’s ability to perceive and interpret positive and negative actions of one another. In a happy marriage, if one spouse does something negative, the other partner tends to evaluate the negativity as fleeting and situational. The negativity is viewed as *unstable* and fluctuating, and the cause is viewed as situational with external motivators. In an unhappy marriage, the same negative behavior is likely to be interpreted as *stable* and unchanging and internal to the partner. Further, in an unhappy marriage, a positive behavior may be seen as fleeting and situational. The positive behavior is viewed as unstable, and the cause of the behavior is viewed as situational and fleeting with external motivators. There also exists for couples the *fundamental attribution error* whereby each spouse interprets their marital problems as the result of their partner’s defective character traits. The spouse is seen as being defective and needs to be fixed for the marriage to improve.

Gottman also identified the *distance and isolation cascade* where unhappy couples process
immediate perceptions of negativity and transform them into negative and lasting narratives that lead to the relationship’s decay. The first element of the cascade was termed flooding whereby the person becomes emotionally overwhelmed. The problems are then seen as severe and the partner may believe it is best to work out the problems alone. The partner may believe they will get “nowhere by talking things over with their spouse” so that they turn away from the marriage and develop parallel lives. The partner arranges the household schedule so that it limits time with the spouse, leading to a sense of loneliness. Also, Gottman found that some couples set a lower threshold for negativity so that negative behaviors were ignored and not addressed immediately until the problems escalated (Gottman, 1999, p.73).

**Core Triad of Balance: Physiology**

Gottman (1999) further explored the physiology of happy and unhappy couples and investigated the two branches of the autonomic system, the sympathetic and the parasympathetic nervous system. The sympathetic nervous system is responsible for activating the body to respond to emergency situations, and the parasympathetic nervous system restores the body to calm. Gottman focused on the diffuse physiological arousal (DPA) which serves as the body’s general alarm mechanism. The mechanism is mediated by the sympathetic branch of the autonomic nervous system which signals the adrenal medulla to secrete the catecholamines such as dopamine, norepinephrine, and epinephrine, and activates the hypothalamic-pituitary-adrenocortical axis to produce cortisol. Accelerated functions of the sympathetic system are measured by the heart rate reactivity or stress-related endocrine responses. As the heart rate increases and the body enters into the stress response, the body experiences difficulty processing information, greater difficulty accessing new information, and greater access to habitual behaviors or cognitions.

Couples’ experiences of chronic physiological arousal lead to the suppression of the immune system and, in turn, to poorer cellular immunity. Further, it was believed that if the couple were in distress and in a state of DPA, the couple would need to learn how to self-soothe and to soothe one another in order to reduce states of DPA. Gottman further discussed the role of strong emotions as being state-dependent in nature. To be able to learn about anger, as well as learn to self-soothe, the spouse has to be in the state of anger. Gottman recommended initiating a withdrawal ritual so that couples will take a specific amount of time away from a conflictual
discussion. Because of the slow decay of sympathetic neurotransmitters such as norepinephrine and epinephrine, Gottman suggested at least a 20 minute break to allow the body to calm down. He further suggested an ideal heart rate for couples of around 95 beats per minute for adults ages 20 to 55 (Gottman, 1999).

**Introduction to Gottman’s Sound Marital/Relationship House Theory and Research**

**Overview of Gottman’s Sound Marital/Relationship House**

Gottman conducted long-term research based on over 3000 couples to determine what works in marriages and what does not work. The findings of his research led to the development of his approach originally called the Sound Marital House Theory (SMHT). Gottman placed much of his focus on toxic communication patterns that he called “The Four Horsemen of the Apocalypse” (p. 41). These four unhealthy behaviors included: criticism, defensiveness, contempt, and stonewalling. *Criticism* includes any statement that implies that there is something globally wrong with one’s partner, may include a personal attack on one’s character and/or personality, and may elicit defensiveness from the partner. Critical statements may include phrases such as “you always,” “you never,” or “why questions” (Gottman, 1999, p.42; The Gottman Institute, 2007).

*Defensiveness* is any attempt to defend one’s character from a perceived attack. It is a general stance of warding off a perceived attack and usually includes denying responsibility for the problem. *Contempt* is any statement either verbal or nonverbal that asserts oneself on a higher plane than one’s partner, such as mocking or correcting the partner’s behaviors or speech, or nonverbal expressions, such as eye rolling and looking away. *Stonewalling* is a behavior in which a person withdraws from an interaction with another person and may include activities such as leaving the room, ignoring the other person, or providing a brief vocalization such as a grunt, “yeah,” or “uh-huh.” Other examples are looking away from the speaker, maintaining a rigid stance (having arms crossed, stiff neck, tightened jaw or chin), or responding minimally while not providing the listener with nonverbal cues that one is tracking the conversation. Stonewalling occurs when a spouse shuts down or emotionally cuts off the partner. Generally, men are more likely to stonewall or withdraw emotionally (Gottman, 1999, p.46). Addressing these patterns with adolescents may strengthen the family relationships, as well as prepare the
male adolescent with sound self-regulatory skills to carry into future relationships.

Gottman and Silver (1999) further found that these communication patterns predicted divorce, along with five other patterns: harsh startups, flooding, body language, failed repair attempts, and bad memories. **Harsh startups** are the understanding that beginning a communication negatively only renders a negative exchange that will end negatively. **Flooding** occurs when couples’ emotional exchanges became overwhelming to the point of affecting their physiology, such as heart rate and cortisol (stress hormone) levels. **Body language** is the awareness that although a partner may not be verbally expressing anything that is negative, the body communicates a negative message anyway. **Failed repair attempts** are those that occur when a partner asserts a positive sentiment override, and either it goes unheard because of flooding or the message becomes negative, leading to negative sentiment override instead. An example of **bad memories** occurs when the couple becomes so entrenched in negativity that they re-write their pasts as negative.

Gottman (1999) provided his seven principles to fostering a successful marriage as being a sort of house that requires a strong foundation called the “Sound Marital House Theory” (SMHT) (p.105). The first three levels of the house focused on the couple’s friendship and included: love maps; nurturing a culture of fondness and admiration; and turning towards versus turning away. These levels made the emotional bank account of the marriage. The house’s foundation was known as the **love map**, which measures the amount of the cognitive room partners have for one another in which the partner knows the other’s psychological world and periodically updates this information. In Gottman and DeClaire’s later work (2001), they developed a Child’s Love Map focusing on ways for parents and children to know each other more fully. The second floor was composed of the *fondness and admiration system* that reflected the amount and accessibility of respect and affection felt and expressed for one another. This was also considered the antidote for contempt (Gottman, 1999). The third floor was turning toward versus turning away, reflecting the emotional connection versus distance in the marriage and including everyday activities which adds to the *emotional bank account*. Gottman and DeClaire (2001) also developed exercises for parents to look for opportunities to turn towards their children by finding things parents can do for and with their child.

The fourth floor was the **sentiment override**, described as either being negative or positive.
Negative sentiment override meant that the partner attacked the other partner and often blamed or criticized the partner for his/her mistakes. Positive sentiment override meant that any negativity expressed by the partner was interpreted as informative rather than as a personal attack. The fifth level reflected the couple’s ability to regulate conflict. The regulation of conflict was described as either skills needed for solvable problems or perpetual problems. Skills needed for solvable problems included: 1) softened start-up, 2) repair and de-escalation, 3) accepting influence, 4) compromise, and 5) physiological soothing (Gottman, 1999).

For perpetual problems it may be necessary to create a dialogue to overcome gridlock and better assist one another in understanding each partner’s feelings, thoughts, and behaviors. The goal was to move from gridlock by creating dialogues concerning the symbolisms behind one’s positions or dreams within the conflict. The last two levels were based on meanings in the marriage and included helping the couple honor one another’s dreams and aspirations. The last level of the house, considered to be the attic, included assisting the couple to create shared meanings in the marriage, such as dreams, narratives, rituals of connection, myths, and metaphors (Gottman, 1999).

Gottman’s Research with Couples

Gottman and Katz (1989) examined the role of the body’s response to stressful events through the sympathetic branch of the autonomic nervous system, the endocrine system, the immune system, and the interconnections of these three systems. Basing their study on the work of Henry and Stephens (1977), these researchers proposed that specific emotional states were connected to two adrenal endocrine systems, the sympathetic-adrenomedullary system and the pituitary-adrenocortical system. The sympathetic adrenomedullary system is activated during active coping and the affective responses of anger and hostility. This biological system is responsible for the acceleration of the metabolic rate and the expenditure of energy in the body through the secretion of catecholamines, including norepinephrine, epinephrine, and dopamine.

The pituitary-adrenocortical system was proposed to be activated during chronic stressors that engage a passive coping response, such as depression, helplessness, or withdrawal. This biological system is responsible for regulation of the glucose metabolism and the maintenance of metabolic processes through the secretion of the glucocorticoid cortisol. Chronic activation of the systems may lead to tissue damage such as the plaque formation in the arteries related to
atherosclerosis. Chronic marital tension may also lead to the activation of one or both of the
endocrine stress systems, as well as to feelings of chronic sadness, helplessness, or anger in both
of the parents and the children. If males tend to have more difficulty regulating their
physiological arousal, they are also at greater risk of continued medical and mental health
problems. Focusing on ways to assist males in dealing with physiological arousal in a healthy
manner may improve the male’s emotional and physical health, as well as improve their
relationships with family, friends, and later offspring.

While at the University of Washington Family Research Laboratory, Gottman collected data
on couples’ interactions through the use of videotapes and physiological data. During these
studies, Gottman requested that a couple discuss a major area of disagreement in their marriage
and then try to come to a resolution. While the couples discussed the conflict, physiological data
were collected including the couple’s heart rates, blood velocity and amplitude, skin
conductance, and gross motor movement (Gottman, 1991).

The results of the first study indicated that the physiological arousal, especially that of the
husband, predicted the longitudinal deterioration of marital satisfaction. For couples who had a
faster heart rate and blood flow, increase in perspiration, and increase in body movement during
marital interactions or anticipated marital conflict, the marriages deteriorated in satisfaction over
the next three years. This correlation was .92 indicating a 95% accuracy level of marital
satisfaction based on physiological data. For couples who were physiologically calmer,
marriages tended to improve over time (Gottman, 1991).

Gottman (1991) explored the separate expressions and behaviors associated with separation
and divorce utilizing a coding system to measure the rate of particular facial expressions of
emotions, including happiness, surprise, anger, and sad-miserable smiles. Miserable smiles were
defined as a partner raising the lip corners without the eye involvement (trying to display a
happy face). Gottman found that couples who were more likely to separate exhibited more of the
following facial expressions: wife’s disgust, husband’s fear, husband’s miserable smile, and
wife’s miserable smile. To counter balance the detrimental effects of the negative affects, the
ratio of positive to negative affects needed to exceed 10:1 so that the relationship could remain
healthy.

Gottman (1991) also explored the behaviors of couples. He found that husbands and wives
tended to be more defensive (made excuses and denied responsibility), wives complained and criticized more, husbands disagreed more, and both husbands and wives “yes-butted” more. Gottman further found that husbands’ tendency to stonewall and the wives’ tendency to display more verbal expressions of contempt predicted divorce.

Gottman (1991) further focused on gender differences in the marriage which may have accounted for emotional and physical health. He found that husbands’ tendency to stonewall predicted feelings of loneliness. Stonewalling was also associated with the male’s deterioration of physical health over a 4-year time period. Additionally, men who did housework were less overwhelmed by their wife’s emotions, were less avoidant of marital conflict, and had lower heart rates during marital conflict than men who did not share in household chores. Gottman proposed a gender difference in the physiological response to conflict in that men take longer than women to recover from physiological arousal.

Gottman’s Research with Families: Infants, Children, and Adolescents

In 1986 after Gottman began his work at the Family Research Lab, he later focused his research endeavors to include determining the effects of marital discord on young children’s health and peer interactions (Gottman and Katz, 1989). In both the laboratory and home setting Gottman and Katz studied a sample of 56 families who exhibited a wide range of marital satisfaction and who had children aged four to five. They hypothesized that the ability to regulate emotion would be disrupted in children from martially distressed homes and that disruption would also impact the child’s ability to interact with peers. They defined emotional regulation as the child’s ability to: a) inhibit inappropriate behavior as related to the strong negative or positive affect, b) self-soothe any physiological arousal that the strong affect has induced, c) refocus attention, and d) organize the self for coordinated action in the service of an external goal.

The goal of the research was to establish a multi-method database (self-report, observational, and physiological measures) to examine if marital discord affected the preschool child’s peer social relationships and physical health. The first criterion variable was peer interaction as measured by the child’s level of play, such as parallel play (children play at the same time with low involvement with one another) or play with more social involvement and social attention. The second peer-interaction criterion variable was the amount of negative peer
interaction (aggression with possible peer rejection). The third criterion variable was the child’s physical health, as assessed by the mother’s report of childhood health problems. It was found that children from homes with more marital distress tended to play at a lower level with peers, to display more negative peer interactions, and to have more health problems with a higher level of catecholamines. For these children, any negative affective experience may increase hypervigilance; trigger feelings of sadness, anger, or feeling flooded; and decrease the child’s ability to regulate negative affects (Gottman & Katz, 1989).

Gottman has also focused on applying his approach with children and families and has encouraged parents to become emotion-coaching parents. The goal of becoming an emotion-coaching parent is to assist children in learning how to regulate their emotions. Children can regulate themselves by self-soothing in order to focus attention, improve concentration, and learn to read other’s body language to assist in understanding social cues. They can also develop a sense of empathy for others by becoming more attuned to others’ feelings. The five steps to becoming an emotion-coaching parent as discussed by Gottman and DeClaire (1997) include: 1) becoming aware of the child’s emotions (assist the child in recognizing and identifying the feeling while granting permission to experience the feeling); 2) recognizing the emotion as an opportunity for intimacy and teaching (allowing children to talk about their emotions before they escalate); 3) listening empathetically and validating the child’s feeling (paying attention to the child’s body language, facial expressions, and gestures); 4) helping the child label emotions (by talking about emotions, the child can refocus and gain composure); and 5) setting limits with children while helping them problem-solve (parent establishes a system of rules, boundaries, and consequences).

Gottman’s most recent research studies with families have focused on the transition of couples to parenthood. The Relationship Research Institute in Seattle, Washington sponsors Gottman’s current research interest, the research project Bringing Baby Home, which explores that transition (The Gottman Institute, 2006, 2007). The goal of this research project is to decrease parental stress, expressed hostile affect towards the partners, and symptoms of post-partum depression and to improve the overall marital quality, resulting in the couples’ successfully transitioning to parenthood. The psycho-communicative-educational two-day manualized workshop used in this study focused on three goals: a) strengthening the couple’s
relationship and preparing them for the marital difficulties associated with parenthood; b) facilitating both parents’ involvement with the family; and c) providing the parents with basic information about infant psychological development. The workshops consisted of lectures, demonstrations, role plays, and watching video tapes, and they focused on nine areas including: 1) basic questions regarding the transition to parenthood and possible complications that may arise; 2) understanding marital communication through exploring the Sound Relationship House Theory; 3) maintaining friendship, romance, and passion, 4) developing a positive sentiment override instead of a negative one, 5) conflict management and regulation of solvable and perpetual problems, 6) physiological self-soothing during conflict, 7) knowing and honoring your partner’s life dreams, 8) building and maintaining a shared meaning system, and 9) interacting with new infants (Shapiro & Gottman, 2005).

Shapiro & Gottman (2005) conducted a randomized clinical trial for couples experiencing the transition to parenthood. Couple participants were either expecting a baby or had a baby born within three months of the first interview. In addition, the couples were required to be married and over the age of 18. The sample consisted of 38 couples that were randomly assigned to the experimental and control group (wait-list to be enrolled after the completion of the study three years later). The experimental group consisted of 18 couples; the control group consisted of 20 couples. The families were followed over a three-year period to assess the impact of the intervention. The outcome measures included the Locke-Wallace Marital Adjustment, the SCL-90 to evaluate post-partum depression, and observational data such as the interactive marital behaviors. The Specific Affect Coding system was used to code the couple’s conflict interactions; a short demographic inventory was administered at the beginning of the study (Shapiro & Gottman, 2005).

The results indicated that post-partum depression for both partners decreased in the workshop group and increased in the control group as measured by the SCL-90. Marital hostility was lower at one year for both spouses in the experimental group than for those in the control group. Marital quality as measured by the Locke-Wallace Marital Adjustment Test stayed stable in the workshop group, but declined steadily in the control group. The overall data suggested that the Bringing Baby Home preventive intervention, using a psycho-communicative-educational format, was found to be effective over a three-year time period as compared to the control group.
(Shapiro & Gottman, 2005).

The Family Health Project sponsored through the University of Washington is currently exploring the level of stress affecting families as children transition from childhood to adolescence (The Gottman Institute, 2006). This study is scheduled to last five years and is one of the first studies to explore Gottman’s Sound Relationship House Theory with adolescents and their family members. Currently, there are no Gottman research studies that focus primarily on improving the adolescent/parent relationship using expressive therapies. This study explored the adolescent/parent relationship with the hope of contributing to a decrease in parent/child conflicts and juvenile delinquency. The goal of the study was to enhance adolescents’ communication, problem-solving, social, and self-regulatory skills through the use of art-based interventions.

**Introduction to Group Therapy**

**Group Therapy Considerations (Setting, Format, Time and Size)**

Yalom and Leszcz (2005) discussed elements to consider when providing group therapy including the place (physical setting), format (open or closed group), time (duration and frequency of meetings), and size (number of the group members present). These authors recommended that the group meeting be held in any room that afforded privacy and freedom from distractions. The authors also suggested considering the advantages and disadvantages of open versus closed groups. Open groups maintain a consistent size by replacing members as they leave the group. Open groups welcome new members; however, previous members may have difficulty building rapport in the group if it is constantly changing. A closed group accepts no new members except possibly for the first two to three sessions and meets for a predetermined length of time. The closed group may provide a sense of stability to the group members, especially in a long term setting such as a juvenile delinquency setting, prison, military base, or long-term psychiatric hospital. Disadvantages of a closed group include the possible attrition of the group members. As the number of group members diminishes, the efficacy and cohesion of the group as a whole is affected.

An ideal size for an interactional group is seven or eight members with an acceptable range of five to ten members. Yalom and Leszcz (2005) reported that up to 16 members may benefit from group therapy. The optimal group size was defined as a function of the duration of the
group meeting. Duration and frequency of group meetings varied based on the client population and setting. It was reported that for some therapists, sixty minutes was required for the warm-up interval to address major themes of the session; however, after about two hours, the session may be less effective due to fatigue of the clients and the therapist. An average group therapy time was reported to be between eighty to ninety minutes meeting once weekly; however, some groups were reported to meet from one to five times a week. The authors also discussed the importance of the preparation needed to begin the group such as the establishment of group goals and the institution of a system of preparation (Yalom and Leszcz, 2005).

**Common Therapeutic Factors**

Yalom and Leszcz (2005) defined therapeutic factors as an intricate interplay of human experiences which make up crucial aspects in the process of change. The authors discussed 11 primary factors including: instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. The *installation and maintenance of hope* were reported as being crucial to keeping the client in therapy, as well as to having faith that the treatment mode could be therapeutically effective. *Universality* was defined as the client’s ability to connect with other group members after hearing similar concerns from others. The third factor, that of *imparting information*, included didactic information about mental health, mental illness, and general psychodynamics, as well as providing advice, suggestions, or direct guidance from the therapist or other group members. Many group members learn information about mental health symptoms/illness, interpersonal and group dynamics, and the process of psychotherapy through the partnership and collaboration of the group members and the therapist. The process of giving advice, rather than the advice itself, conveys a mutual interest and caring for the other group members.

The concept of *altruism* defined the group members’ help and support of other group members. Altruism also encouraged role reversal so that the clients shifted between receiving help and providing help. The concept of the *corrective recapitulation of the primary family group* referred to the group members’ interacting with the other group members and the therapist in modes similar to how the client interacted with their own families-of-origin (their parents and siblings). In the *development of socializing techniques*, group members may be asked to role play
certain scenarios; thereby, developing their social skills and providing open feedback for others while also reflecting on their participation and the feedback received from others. Clients may imitate the therapist or other group members through modeling positive behaviors and problem-solving skills through *imitative behaviors* (Yalom and Leszcz, 2005).

The last therapeutic factors Yalom and Leszcz (2000) discussed were interpersonal learning, group cohesiveness, catharsis, and existential factors. *Interpersonal learning* was described as the process of gaining insight, working through transference and the corrective emotional experience, developing interpersonal relationships, and exploring the group as a social microcosm. *Group cohesiveness* was broadly defined as the result of all of the forces acting on all of the group members so that the clients remained in the group. Members in a positive cohesiveness group experienced a sense of warmth, comfort, belongingness, and acceptance. *Catharsis* was described as the ability to experience an emotional discharge which may lead to an interpersonal change. The last therapeutic common factor was called *existential factors* and was comprised of tenets relating to our human existence, including recognizing that: 1) life can be unfair and unjust, 2) people will experience pain and the death of a loved one, 3) people will face life alone, even if they’re close to others, 4) people must face issues of life and death and hopefully live life honestly and fully, and 5) people must take ultimate responsibility for how they live their life.

**Adolescence: Developmental, Clinical, and Treatment Considerations**

**Adolescent Emotional, Social, and Moral Development**

Development is defined as the process of “orderly, cumulative, directional, age-related changes in a person.” Pathology is defined as any “marked deviation from a normal, healthy state” (Stepney, 2001, p. 3). Many adolescents diagnosed with Conduct Disorder present with developmental delays in several areas. By identifying the normal developmental stages of adolescence, as well as the deviations from normal development, areas of concern for at-risk youth can be identified and addressed to assist the adolescent in continuing his or her emotional, social, and moral development. Gottman discussed several developmental issues that adolescents encounter, including questions of personal identity, developing a healthy sense of judgment while integrating emotion and reason, and exploring one’s sexuality and self-acceptance. Questions of identity include: “Who am I?” “What am I becoming?” and “Who should I be?”
Adolescents may become very self-absorbed and may distance themselves from family members becoming closer to their peers. Adolescents’ friendships serve as a vehicle for exploring personal identity outside of the family. Through friendships adolescents explore new identities, new realities, and new aspects of self (Gottman, 1997, p. 208). Another developmental milestone is the integration of reason and emotion. Adolescents must balance their feelings with logic to develop a healthy sense of judgment (Gottman and DeClaire, 1997).

Moon (1998) also discussed how the adolescent processes information, explores abstractions, examines values, questions authority, reconsiders ethical and moral issues, and plans for the future. According to Moon, adolescents tend to be more egocentric focusing more on the needs of self than the needs of others. Further, adolescents begin to question their identity so that they can develop a sense of identity other than their parents’. To develop a sense of self, the adolescent must explore his/her beliefs, values, morals, talents, abilities, and potential. Adolescents often will experiment with their peer group and may acquire an oppositional stance with their parents and authority. Due to experimentation with peers and family members, the adolescent’s peer group may appear to be more vital in the adolescent’s development; therefore, the peer group may provide a sense of security for the process of separation-individuation. Adolescents may also change their peer group so that they associate more with peers of the opposite sex. Academic environment also changes as adolescents move from middle to high school. Adolescents may request more privacy and pull away from family traditions, spending less time with the family and sharing less information with the family, and seemingly becoming more secretive and withdrawn.

Adolescent Physical Development

Adolescence is defined as a period of growth from puberty to maturity from around age 12 to 19 years old. The production of sex hormones brings about the beginning of puberty when the adolescent undergoes a major physical transformation by developing secondary sex characteristics. By becoming sexually mature, the adolescent is now capable of reproduction and has many choices to make regarding becoming sexually active or abstaining (Stepney, 2001). These decisions greatly affect the adolescent’s role within his or her peer group and family, as well as the adolescent’s self-concept. Adolescents explore these issues of sexuality and self-acceptance with the goal of working towards autonomy and individuation. Further challenges
with adolescents include hormonal changes that may account for uncontrollable and rapid mood changes. The adolescent’s emotional instability may put them at risk for substance use, violence, gang activity, or unsafe sexual activity (Gottman and DeClaire, 1997). Introducing Gottman’s Sound Relationship House Theory to at-risk adolescents with the hopes of improving their communication, social, self-regulatory, and problem-solving skills may prevent or discontinue unhealthy behaviors, such as using substances, associating with peers with unhealthy behaviors, and not regulating their negative feelings, behaviors, or impulses.

**Adolescent Artistic Development: Seven Areas of Growth**

Lowenfeld and Brittain (1987) discussed the different characteristics of children’s and adolescents’ art work. Every drawing can be evaluated in seven areas of growth and represents the expression of the total child or adolescent at the time of the drawing or painting. The seven areas of growth include: emotional, intellectual, physical, perceptual, social, aesthetic, and creative growth. The emotional growth of a child or adolescent is evaluated by the range or intensity of involvement of the drawing from low levels with stereotyped repetitions to high levels of involvement where there are personal meanings and feelings attached. The intellectual growth is described as how attentive the child or adolescent is to the environment, the amount of knowledge that is used, and the ability to portray a relationship to the surroundings. The use of details and awareness of the environment both change with age as the child or adolescent intellectually matures.

Physical growth is measured by the children’s or adolescents’ visual and motor coordination, such as the way in which they control their bodies and perform skills and daily tasks. Children may struggle with the scribbling stage to make controlled lines or scribbles; whereas, adolescents may refine drawings to add detail in their self-representations or environment or to express their changing physical and emotional growth. The projection of the self into the picture is usually referred to as a body imagery; this portrayal will vary based on physical characteristics, active physical motions, and emotional states. The perceptual growth is measured by visual observation of the child or adolescent and includes a variety of perceptual experiences such as developing sensitivity toward color, form, and space. Perceptual growth also refers to the growing sensitivity to tactile sensations, such as experiencing different media on different levels (kneading clay or painting with finger paints) or working with different surfaces
or textual qualities (Lowenfeld and Brittain, 1987).

The social growth can be evaluated as the degree of identification the children or adolescents have with their own experiences and the experiences of others. Relationships with others and social activities are often drawn as a means of communicating one’s thoughts, feelings, and behaviors. As well, the act of drawing or creating art becomes a way to socially connect with others. Aesthetic growth refers to the means of organizing thinking, feeling, and perceiving into an expression that communicates one’s thoughts, feelings, and behaviors to others. The organization of the lines, shapes, colors, and forms make up art that is influenced by one’s culture, individual preferences, type of artwork, and the purpose behind the art form. The creative growth can be defined as the children’s or adolescents’ ability to imagine, create, explore, and engage in diverse art experiences which expresses the inner self. The creative growth is reflected in both the process of art making and the final product created (Lowenfeld and Brittain, 1987).

**Adolescent Artistic Development: Three Child and Adolescent Stages**

The artistic developmental level for children between the ages of seven to nine years is termed the Schematic Stage or the Achievement of a Form Concept. In this stage, elements of the drawing characteristics include the development of a form concept which is repeated often. The schema is altered only to convey special meaning; the drawings are bold, direct, and have a flat representation, and the drawings reflect the child’s active knowledge of the environment.

Elements of the spacial representation include the establishment of a base line, multi-base lines, or a sky line, and two dimensional organization of objects. The environment becomes symbolized; no or little overlapping, x-ray drawings, the fusion of time and space, or a simultaneous representation of plane and elevation are present. Elements of the human figure representation include a repeated schema for a person. The body is usually made up of geometric shapes. The arms and legs show volume and are usually correctly placed; there is an exaggeration, omission, or change of schema that shows the effect of experiences, and the proportions depend on emotional values (Lowenfeld and Brittain, 1987).

The artistic developmental level for adolescents between the ages of 12 to 14 years is termed the Pseudo-Naturalistic Stage or the Age of Reasoning. In this stage elements of the drawing characteristics include being able to focus upon selected parts of the environment, emerging
details in the drawings such as wrinkles and folds, and the adolescent projection of personal meanings into the objects and events. Elements of the spacial representation include developing an awareness of depth and attempting to gain perspective. Action can occur within the picture plane, and there is a greater awareness of the environment. Elements of the human figure representation include: drawings closer to proportions, a greater awareness to the joints and the body’s actions, and variation in facial expressions for meaning. Cartooning also becomes popular. A person can be represented by less than a total figure, and sexual characteristics may be over-emphasized (Lowenfeld and Brittain, 1987).

The artistic developmental level for adolescents between the ages of 14 to 17 years is termed the Adolescent Art Stage or the Period of Decision Stage. In this stage, elements of the drawing characteristics include: control of purposeful expression and development of a mastery of material. Adolescents develop an extended attention span with possibly visual detailing such as using shading. Drawings may show subjective interpretations and the adolescent gains a conscious development of artistic skills. Elements of the spacial representation include the development of perspective with awareness to the atmosphere. There is attention to the non-naturalistic representation, and there is a portrayal of mood with a shift in space or distortion. Elements of the human figure representation include naturalistic attempts with awareness of proportions, actions, and visible details, as well as an exaggeration of details and imaginative use of satire with the figures (Lowenfeld and Brittain, 1987).

Overview and Benefits of Art Therapy and Art Materials

Definition of Art Therapy and the Benefits of Using Art

To first discuss combining art therapy with Gottman’s SMHT, it is essential to define the role of art therapy, as well as the benefits of art and art therapy with an adolescent population. Further, the general benefits of art therapy will be addressed with adolescents in individual, group, and family art therapy. Literature citing the combination of both individual and group art therapy is reviewed in the Adolescent Individual Art Therapy section. Because there is a limited number of empirical studies validating the use of art therapy utilizing an experimental and control group, the literature review was very broad and addressed the overall benefits of art therapy through case studies and narratives.

According to the American Art Therapy Association, Inc., art therapy is defined as:
“A human service profession that uses art media, images, the creative process, and patient/client responses to the created products as reflections of an individual’s development, abilities, personality, interests, concerns, and conflicts. Art therapy practice is based on the knowledge of human development and psychological theories which are implemented in the full spectrum of models of assessment and treatment including educational, psychodynamic, cognitive, transpersonal, and other therapeutic means to reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, and increasing self-esteem (AATA, 2001, p.1).

Benefits of Using Art in Therapy

According to Rubin (2005), there are many benefits of using art in therapy. Rubin discussed the role of art as being a natural way to communicate. Historically, prior forms of communication included pictograms and hieroglyphics, as well as ancient carvings in caves at Lascaux and Altamira. Children also naturally make shapes and marks as a form of communication before their development of verbal language. Art can also serve as a form of relaxation and can assist in reducing tension and anxiety, thereby assisting the client to become more comfortable in therapy. By enhancing relaxation, art activities may enable verbalizations for many and reveal unknown thoughts and feelings.

Art can also assist individuals in enhancing their problem-solving skills. Much of our thought processes are made up of visual thinking. Thinking in images is also a way to conceptualize working in art. When a person makes a drawing, he or she is engaged in what is called “visual thinking” by psychologist Rudolph Arnheim. Creating art is a way of “externalizing ideas so that they can be viewed” and can then stimulate and process new thoughts and feelings. Images, drawings, or sculptures can also express a certain thought, feeling, or behavior symbolically or literally that cannot be expressed in words. Images can also have a magical power in that individuals feel a greater sense of control over natural forces as seen in fertility figures or protective symbols on mummy cases. This has been referred to as the “magic power of the image” (Rubin, 2005, p.23).

Rubin (2005) also discussed the benefits of art in that some feelings and ideas are better conveyed through art than words. Some individuals may experience an intense sense of grief,
anguish, anger, or distress that cannot be adequately articulated verbally. When individuals are allowed to express their thoughts and feelings through images, they are able to discharge “the affect in the physical activity of drawing” or art making, thus relieving their intense emotions. Further, “colors and expressive designs” give form to emotions to prevent the client from being flooded by emotion (p.25). Art is also helpful in expressing preverbal memories, events and images that are encoded in the body and occurred before the individual developed language. Examples might include an individual’s processing of sexual abuse that occurred before the child developed the language to process the trauma. The art also promotes the individual’s expression of thoughts and feelings through a tactile means, such as pounding clay to release frustration. Individuals can express disowned aspects of self and can process unacceptable thoughts, feelings, and impulses that may be seen as unacceptable. Further, complex feelings and situations can be represented by art. Different times and places in the same pictorial space can occur so that the events can be simultaneous explored, and events, places, and people can be represented sequentially. Also, incompatible affective states such as love and hate can be expressed, synthesized, and processed in one work of art work or art activity.

Rubin (2005) also reported that with art everyone in a group or family can express his or her thoughts or feelings at once, either independently or jointly. While the group or family works on an art task, conversation tends to become more natural and spontaneous, thereby providing a more accurate depiction of the group or family dynamics. Also, the addition of art to group or family activities allows ideas and feelings to be expressed visually which may not be successfully interpreted or portrayed verbally. Art can also accelerate the therapy process or overcome treatment impasses by limiting self-censorship and allowing the individual to view an existing problem from a different or symbolic viewpoint.

Art can reduce one’s self-consciousness in that the art allows for symbolic disguise with hidden meanings in a less direct and personal manner than do verbal statements. The focus of the session may be turned to the art product and not the person, allowing the individual some distance to process the session if needed. The art work is also concrete and lasting so that the individual can refer to the art piece weeks later and can reflect upon prior topics discussed. Finally, art enhances neurological integration in that both cerebral hemispheres of the brain are activated in the creative process (Rubin, 2005).
Benefits of the Art Materials

Lusebrink (1992) described a systems oriented approach to the expressive therapies called the Expressive Therapies Continuum (ETC). The ETC consists of three hierarchical levels, including the kinesthetic/sensory (K/S), the perceptual/affect (P/A), and the cognitive/symbolic level (C/S). These levels are based on “the sequence of increased complexity in cognitive and emotional development.” The fourth level is that of creativity which can cross all of the levels. Each level of the ETC is characterized by a reflective distance that “denotes the time span between the impulse or stimulus and the reaction to it.” The reflective distance increases with the consecutively higher levels of the ETC from the first level of the kinesthetic/sensory to the cognitive/symbolic level (p.395).

The kinetic component focuses on releasing energy and expressing it through bodily action such as pounding clay or scribbling on paper. The sensory component focuses on inner sensations and tactile experiences, including interacting with different media such as exploring finger-paints. The perceptual component focuses on the formation of schematic forms and representational images. Examples might include focusing on the formal elements of a form, color, or pattern. Experimenting with different media, such as highly structured media (pencils and markers) versus fluid media (watercolors and paints), allows the person to perceive the media differently and to enhance the affective component by applying intense color or using fluid media, thereby enhancing the expression of one’s affect. The cognitive component emphasizes the analytical and logical thought required for information processing. The symbolic component emphasizes the metaphorical and intuitive nature of the art process whereby one can view problems differently and enhance problem solving and decision-making skills. The creative expression can be experienced on all three levels and can enhance all three components, thus encouraging new experiences though perceptual openness and enhanced receptiveness to inner and outer stimuli (Lusebrink, 1992).

Landgarten (1987) discussed the benefits of the use of art materials. The medium based on more controlled or least controlled properties can heighten or lower the client’s affective state, influence the freedom of expression, and can circumvent defenses. More controlled mediums include lead pencils, colored pencils, felt markers, hard plasticene, and collage materials as compared to the least controlled materials including wet clay, watercolors, soft plasticene, oil
pastels, and thick felt markers. The continuum of least controlled media to most controlled media is referred to as the Media Dimension Variables (MDV).

Benefits of Art Therapy and the Art Therapy Process

According to Riley (1999), general benefits of art therapy are that techniques offer a non-threatening way for individuals to express their feelings both verbally and non-verbally. Art therapy also serves as a tool to assess verbal and visual interpretations of self, as well as interpersonal and family problems/concerns. Techniques allow clients to express themselves via multidimensional and visual means, especially if clients cannot express themselves verbally due to developmental delays. Art therapy can also address complex issues such as depression, anxiety, abuse, and neglect, and family functioning. Also, for many adolescents art therapy allows the youth to address conscious and unconscious material/issues.

Linesch (1993) discussed three benefits of the art therapy process. The art process offers a means for affective self-expression. The art experience can bypass defense mechanisms and allow one to express thoughts and feelings on a conscious and unconscious level. The second advantage of the art therapy process is that it facilitates communication that is not influenced by traditional dynamics, behaviors, and patterns so that new conversations can occur to enhance relationships. The third advantage of art process is that it facilitates a sense of energy and empowerment. Art making is a creative and productive process; therefore, it promotes a sense of self and of accomplishment. Further, the art process helps to empower the family members to acknowledge, take responsibility for, and hopefully modify their roles within the family system.

Art therapy can also assist in the problem-solving process and the expression of affect. Creating artwork promotes the individual’s ability to symbolize, to think, and to think about thinking in order to aide in problem-solving abilities. During the art making experience, the individual must make choices and decisions about the art making process and weigh the pros and cons of decisions. The art experience can also facilitate the individual’s process of making choices and expanding perception. Further, visual representation “offers a means to express multiple layers of meaning in a condensed format.” Art therapy can also assist the individual to ventilate feelings through the manipulation of the media, such as pounding clay to provide a cathartic release of feelings and also provide a means so that individuals can reflect upon artwork from a distance to discover his or her feelings (Linesch, 1993, p.26).
Hinz (2003) discussed the use of art therapy with unbonded or conduct-disordered adolescents as an adjunctive therapy to enhance treatment. Hinz reported six benefits of using art therapy with youth that included: 1) helps the youth increase trust with the therapist and others; 2) allows for a safe engagement with others and engagement with the world; 3) gives the youth a limited amount of control over his or her behaviors; 4) allows for the appropriate expression of affect; 5) increases the youth’s self-esteem; and 6) illustrates problematic defense mechanisms and teaches new ones.

**Adolescent Individual Art Therapy**

Steinberger (1987) discussed the role of art therapy over a period of three years with a 15-year-old female diagnosed with autism. The author discussed art therapy sessions in which the client drew images of models in an art studio using crayons, colored pencils, thin point felt tip pens, magic markers, acrylic paints, and watercolors. When the client was 18 years-old, her mother reported improved artistic abilities, self-esteem and self-concept, and communication and social skills. She was able to draw for two hours with minimal distractions. These improvements lead to an improved academic placement for the client.

Conger (1988) discussed his work with suicidal adolescents and adults. He identified five common emotional themes in art work that may indicate risk including: isolation, hopelessness, helplessness, anger, and a sense of failure or guilt. He further developed an approach to address specific art objectives to explore each feeling. Art directives and interventions to address feelings of *isolation* included: having the client draw a bridge and to describe the two shores it joins; asking the client to take turns describing a picture for another group member and then drawing what the other person described; developing a scribble jointly with another client; commenting about the client’s or another’s artwork; and encouraging the client to help plan and execute a group mural. Art directives to address feelings of *hopelessness* included: having the client draw a personal goal for the future and the steps necessary to achieve that goal; drawing an activity that the client wishes to learn; and drawing three wishes for the future. Art directives and interventions to address feelings of *helplessness* included: having the client use an unfamiliar art medium such as clay to foster a sense of empowerment; drawing a kinetic drawing of the client doing something; or asking the client to draw a four-panel progressive dialogue between a person and an obstacle such as a stone, box, or wall. Art directives to address feelings of *anger*
included: wedging clay; using clay or paper to act out a conflictual situation involving the client and another person; and drawing one action that would change the client’s life. Art directives to overcome a sense of humiliation and failure included: using clay to symbolize an important gift given to another person; drawing at least four personal strengths; and drawing images of an achievement that the client is proud of.

Stanley & Miller (1993) provided short-term art therapy with a 15-year-old male in a residential group home; the adolescent had been removed from his parents due to unlivable conditions. The adolescent was referred for therapy because of behavioral problems including: verbal aggression, temper outbursts, destruction of property, refusing to attend class, and refusing to participate in school activities. The client participated in weekly art therapy activities for 45 minutes over eight weeks addressing anger management techniques and the benefits of appropriate behaviors. The client was administered a pretest and posttest using the School form of the Coopersmith Self-Esteem Inventory (CSEI), a self-report measure of self-esteem for school age students.

For session one, the therapist engaged in feelings and discussed the different kinds of defense mechanisms, such as masking one’s feelings. The goal of this session was to assist the client in understanding what the client allowed others to see of him. The tasks included completing an “inside/outside” painting representing how the client felt on the inside and how he thought others saw him. In session two, the client was requested to create a mask using different creative materials to represent his internal and external feelings. The discussion focused on how “we use masks to hide our true feelings.” For session three, the client was asked to “draw something” using different art materials. The discussion revolved around the client’s family. In session four, the client drew a picture of his family doing something together. The discussion was focused on the family members who were missing, which included himself and his parents. For session five, the client was asked to “draw something.” The topic of the discussion was on the client’s feeling as though he had “lost his mind” without control of his behaviors. In session six, the client was requested to “draw something.” The client drew pictures of flowers and discussed his placement with his brother in a foster home, as well as the importance of his relationship with his brother. For session seven, he was requested to “draw something” again. The client drew a picture of a beach and discussed being able to spend time and do activities with his brother. In session eight,
the client was asked to draw a picture using colored markers to express his current feelings for that day. The client drew a picture of a tree and ground and assigned different colors to represent his feelings. The client discussed his uncertainty about returning home or staying in foster placement, as well as issues of trust with the client’s care givers. The client also discussed control issues and taking responsibility for his behaviors (Stanley and Miller, 1993, p.398-399).

The authors reported a significant change in the pretest and posttest scores of the CSEI for this client. For the Total Self Score, the overall measure of self-esteem, the score increased from 56 to 78, the higher score being indicative of a higher level of self-esteem. The General Self subscale score increased 16 points; the Home-Parents subscale increased by 8 points, the School-Academic subscale increased by 2 points, and the Social Self-Peers subscale decreased by 4 points. The last two subscales were not found to be significant; however, the first two subscales were found to be clinically significant. The teachers at school and the program director reported that the client made more positive comments about himself and his family members; had a decrease in maladaptive behaviors, such as a decrease in destructiveness at the group home with a reduction in verbal and physical aggression at the group home and at school; and an increase in school attendance and participation in school activities. The client also reported an increased understanding and acceptance of himself and his family members, and he stated that he hoped to be reunited with his brother (Stanley and Miller, 1993).

Milia (1996) described the use of individual art therapy with a 15-yr-old adolescent who was hospitalized for two months due to several suicide attempts. After the adolescent was released from the hospital, she entered a day treatment program to continue to address her symptoms of depression, trauma, prior suicide attempts and self-harming behaviors, family conflicts, and feelings of anger. The author provided individual art therapy using drawings, pastel drawings, painting, and clay sculpture. She reported that the adolescent was able to express her feelings through her art imagery, substitute her self-mutilating behaviors through manipulating the art media, and gradually process prior traumatic memories through gradually working with more tactile art medias such as the sculpting clay.

Morgan (1999) explored the question of whether a male adolescent’s relationship is a reflection of his relationship with self, and if shown, how art therapy may improve this relationship using a feminist, relational therapeutic method. The goal was to see how beneficial
such an approach would be in reducing self-alienation in an adolescent male experiencing behavioral and emotional difficulties. Two posttest screening measurements were used, the Piers-Harris Children’s Self-Concept Scale and an original art directive designed especially for this study. The case study was a 14-year-old boy who attended a day treatment facility due to his diagnosis of Post-Traumatic Stress Disorder and Oppositional Defiant Disorder. Art materials utilized included clay, rocks, moss, leaves and other natural objects found. The assumption was that if an individual is alienated from the self, the individual may be alienated from the world. This proved to be not necessarily so in this study.

Howard (2001) discussed a case study with 15-year-old male described as a middle-class juvenile delinquent presenting with symptoms of delinquent behaviors (stealing from homes, stores, and other’s property/ automobiles; becoming the leader of a gang, and engaging in excessive alcohol use) and parent-child conflicts. The adolescent was committed to the hospital by the juvenile court system for four months and received daily to weekly art therapy sessions. The client worked on several paintings and drawings and discussed personal and family conflicts during the art therapy sessions. The author did not discuss in detail all of the art therapy sessions, nor use any form of instrumentation to measure the client’s interpersonal, family, and academic functioning.

The author reported that the client later was released from the hospital and was admitted to a private boarding school; improved his school attendance and grades; continued with outpatient counseling and successful visitations with his family, and had begun dating. The author reported that art therapy helped the client learn about himself and cope with his emotional problems, as well as foster an interest in art and proficiency in artistic skills (Howard, 2001).

Druckenmiller (2002) discussed the use of individual art therapy with a 15-year-old male in a middle school setting referred for problems of narcissism, anger, anxiety with prior psychotic features and night terrors and nightmares. The author reported that art therapy provided the adolescent control over his feelings by learning ways to gain mastery of the art materials through drawing and painting. During the academic school year, the adolescent attended art therapy sessions. The author reported that the adolescent was able to appropriately express his feelings, improve his social skills, demonstrate empathy, and increase his tolerance for separating from others.
Bennink et al. (2003) discussed the use of individual and group art therapy in a Department of Juvenile Justice setting with adolescent males from the ages of 12 to 18 in a 24 bed residential facility. The authors discussed possible individual directives to address anger management; medication monitoring; self-esteem; substance abuse education; decision-making skills; and coping, social, and communication skills. Individual drawing directives included: a) draw a House-Tree-Person, b) draw your family, c) draw your lifeline, d) and draw what it’s like to be locked up. The adolescents were first given more structured activities and started with the use of more controlled media such as pencils, erasers, colored pencils, and markers. As the sessions progressed, the directives were less structured, and the adolescents were encouraged to use more complex and fluid materials, such as papier-mâché, cardboard, collage, found objects, oil pastels, acrylic, and water color paints. The group activities included: a) draw a volcano showing your anger today, b) draw different anger states, c) draw what different feelings look like, d) draw what it’s like to have very little control, and e) draw a bridge illustrating your life. After completing the assessment and intervention techniques, the group discussed the art process and the art product. Benefits of the group included empowering the adolescents to make decisions, such as what media to use, and interacting appropriately and working together with others, thereby enhancing the adolescent’s social skills.

Harnden, Rosales, & Greenfield (2004) discussed a case study utilizing art therapy with a 14-year-old female experiencing suicidal ideations. The client reportedly had been abandoned by her mother at age seven, witnessed domestic violence, and had been the victim of physical violence and sexual molestation resulting in symptoms of post-traumatic stress disorder. The authors reported that the client was in therapy for one year and described her sessions in three phases of treatment: beginning, middle, and the final phase of treatment. The authors reported that in the first phase of treatment, from approximately sessions one through nine, the client focused on representing her feelings of hopelessness, despair, and mistrust.

The authors reported that in the middle phase of treatment (approximately sessions 10-23), the client focused on processing her feelings of anger, rage, mistrust, isolation, and fear. In the final phase of treatment (approximately sessions 24-33), art therapy interventions addressed improving the client’s self-esteem and self-concept. The counselor also scheduled the treatment team at the facility to meet bi-monthly with the client’s foster mother to address relationship and
safety issues. The authors reported that after the client attended the sessions, the client reported experiencing a decrease in depression and feelings of hopelessness, an increase in her self-esteem, and a discontinuation of suicidal ideations and symptoms of post-traumatic stress disorder, such as experiencing nightmares, insomnia, lethargy, emotional numbing, feelings of depersonalization, and intrusive thoughts of traumatic events (Harnden et al., 2004).

Art therapy utilized in individual therapy with adolescents was discussed in several different settings addressing diverse issues and problems. The topics addressed included: improving academic performance/engagement (Steinberger, 1987, and Howard, 2001); appropriately expressing one’s anger and improving one’s communication skills (Steinberger, 1987; Conger, 1988; Stanley & Miller, 1993; Druckenmiller, 2002; Bennink et al. 2003; and Harnden et al., 2004); improving one’s coping skills (Howard, 2001 and Bennink et al. 2003); decreasing symptoms of depression (Conger, 1988 and Harnden et al., 2004); addressing and decreasing family conflict (Stanley & Miller, 1993; Howard, 2001; and Harnden et al., 2004); decreasing symptoms of PTSD/trauma (Milia, 1996 and Harnden et al., 2004); improving one’s self-esteem/self-concept (Steinberger, 1987; Stanley & Miller, 1993; Howard, 2001; Bennink et al. 2003, and Harnden et al., 2004); improving one’s social skills (Steinberger, 1987; Howard, 2001, Druckenmiller, 2002; and Bennink et al. 2003); and decreasing suicidal ideations (Conger, 1988; Milia, 1996; and Harnden et al., 2004). All authors reported a decrease overall in mental health problems.

**Adolescent Group Art Therapy**

Hume and Hiti (1988) explored the efficacy of group art therapy with adolescents diagnosed with mental retardation and emotional impairments. The authors developed a group treatment model for adolescents enrolled in a Transitional Employment Program housed in a high school. The sample consisted of 13 adolescents aged 14-17. The adolescents were divided into two groups according to the levels of social and intellectual functioning to maximize the opportunities for mutual understanding. The group met for one hour weekly for 16 weeks and emphasized expressive and social skills, vocational training, and problem-solving and study skills.

The groups were described in three stages including *early* (more structured art activities and discussion), *middle* (adolescent chose their own themes), and *late* (adolescent processed their
thoughts and feelings, reviewed their artwork, and prepared for group closure). Examples of
more directed themes included: a) Week one- “Draw something that makes you happy and
something that makes you mad or sad,” b) Week three – “Draw a picture about your sibling(s),”
c) Week four – “Draw the house you live in now and the house you would like to live in when
you grow up,” d) Week six – “Choose an animal and draw an environment you can imagine for
it,” and e) Week seven- “Draw a place you would like to go, the companion you would like to
bring along, and the supplies you would need.” Information was not provided for the second and
fifth week (Hume and Hiti, 1988, p. 4).

Although no formal measures were utilized, the authors observed that the group members
did initially benefit from structured activities serving as behavioral models with leader-directed
activities. The art media were limited to various kinds of paper, drawing media, and collage
materials due to space and time constraints. It was believed that the materials were easy to use
and encouraged the adolescents to explore their feelings verbally and nonverbally. Adolescents
were found over time to become more confident, gain a level of trust in the group, become less
dependent on the adults, and turn more to their peers for emotional support and feedback on their
artwork. Social themes were explored, such as conflicts with family and friends, through the
artwork and group discussion. The adolescents also improved their social judgment and
cognitive abilities through practicing reasoning skills. The adolescents were able to express their
ideas and feelings through the fluid integration of art and discussion. Drawing permitted them to
articulate thoughts and feelings which they may not have been able to put into words because of
delayed social and communication skills. The adolescents were also able to channel their
disruptive impulses and explore personal meaning associations among the group members.
These activities affected levels of attachment and a sense of belonging (Hume and Hiti, 1988).

Tibbetts and Stone (1990) conducted a short-term art therapy group with seriously
emotionally disturbed adolescents. The study consisted of subjects randomly selected from a
population of 130 adolescents in a Los Angeles County Office of Education Special Class
Alternative (SCA) setting. Twenty subjects were randomly assigned into two separate groups: an
experimental group (ages between 14-16) and a comparison group (ages between 14-15). The
authors reported having an experimental and control group; however, the control group was
described as having “….weekly socialization sessions by the same professional, with individual
sessions lasting 45 minutes.” This appears to a comparison group, not a control group, because of the intervention present. The authors reported that the groups were matched for age, level of cognitive functioning as measured by IQ test, and sex. It is unclear as to the sampling techniques utilized since over 60% of their sampling pool was lost. Four of the subjects failed to complete the study (two subjects from both the experimental and comparison group) due to expulsion, running away, and attempted suicide, resulting in 18 subjects being present in both groups. The subjects were evaluated using pretest and posttest measures including the Burks Behavior Rating Scales (BBRS) and the Roberts Apperception Test (RATC), standardized projective test of personality (p. 141).

The authors described the art therapy approach as based on the principles of gestalt therapy. The goal of the sessions was to increase the subjects’ sense of personal power and responsibility by becoming aware of how they block their feelings and experiences, especially anger. The approach was non-interpretative with the subjects finding their own meanings in the individual artwork. The authors did not provide specific art directives; therefore, the intervention could not be replicated. The results of the study indicated that there were two significant within-group differences found for the experimental group. This group demonstrated improvement in the adolescent’s attention span and positive sense of identity. No within-group differences were found for the control group. Further, no significant pretest score differences between the control and experimental group on the BBRS were present (Tibbetts and Stone, 1990).

A significant pretest score difference between the two groups on the RATC was present. The experimental group measured by the RATC demonstrated significant score reductions in the Reliance Upon Others subscale, the degree of perceived support available from others in the environment as measured by the Support/Others subscale, and the positive expressed feelings about themselves measured by the Support/Child subscale. Significant reductions were also found in levels of the Depression, Rejection, and Anxiety subscales. The across-group differences were found for two variables. The experimental group demonstrated a significantly greater reduction in its degree of perceived support available from others in the environment (the Support/Child subscale), as well as a reduction in the Depression subscale. Both the control and the experimental groups demonstrated positive changes in the behavioral and emotional level of functioning (Tibbetts and Stone, 1990).
Walsh (1993) investigated the effectiveness of an art future-image intervention (AFI) which was designed to increase self-esteem, improve future time perspective, and decrease depressive symptoms in hospitalized suicidal adolescents. A pretest and posttest time series design was utilized with two groups, an experimental group and an attention placebo group to measure self-esteem and future time perspective. A purposive, convenience sample was obtained from one 16-bed private psychiatric facility in the Southern United States. Thirty-nine hospitalized suicidal adolescents, age ranging from 13 to 17 years old, were divided into a group of 21 subjects for the experimental group and 18 subjects for the placebo group. Treatment was offered to the placebo group after the study. The effectiveness of the intervention in enhancing self-esteem, improving future time perspective, and depressive symptom reduction was determined using several measures in the study. The experimental group showed a greater improvement at the three-month follow-up on measures of self-esteem, depression, and future perspectives of themselves.

Epping and Willmuth (1994) discussed the use of art therapy with a 13-year-old female admitted to inpatient rehabilitation because of a spinal cord injury resulting in quadriplegia. This adolescent also experienced symptoms of anxiety manifested through nausea and dizziness and levels of low motivation. She was able to draw through the use of a Wanchik writer, an adaptive device that allowed her to write and draw. The adolescent addressed issues of her self-esteem and self-concept, as well as the relationships with her family members, through drawing self-portraits and other free drawings. The author noted that the adolescent portrayed herself with a full body image (prior images omitted body parts), was more motivated in her physical and occupational therapy, and improved her general grooming and daily choices and involvement.

Gerber (1994) discussed the use of art therapy in a juvenile sex offender program. The author discussed three case studies of a 12, 16, and 17-year-old male. The first case study instructed the males to draw a picture representing before the sexual offense, during, and after the sexual offense. The author also focused on having the 16 year-old categorize his feelings including one’s most pleasant feelings, most unpleasant feelings, and the most commonly felt feelings. The 17-year-old male used mythology and metaphor to discuss his experiences. The author reported that art therapy was effective because it allowed the males’ internal processes to be externalized through the artwork. The author also reported that maladaptive patterns can be illustrated in art work and confronted and processed by the therapist and peers in the group.
treatment setting. Further, new patterns of thought and behavior can be practiced and reinforced through the group art tasks.

Graham (1994) discussed a drawing program for adolescents diagnosed as emotionally disturbed (ED) in a high school setting. The author described the use of art and art therapy to address coping and integrating past traumatic experiences. Graham stated that allowing students to draw violent or traumatic imagery may help the student overcome feelings of inadequacy and powerlessness, may move the students past the stage of feeling victimized, and may enhance self-control skills and sense of identity. The students may also develop an appreciation of art so that he or she may develop a sense of empathy or, at the least, tolerance for others.

The author reported that violent imagery may be a manifestation of an unfocused impulse such as general rage towards others. Finding a healthy way of expressing violent emotions may allow the student to process his or her feelings either verbally or nonverbally with others. Graham discussed possible reasons for students to draw violent imagery: 1) guarantees responses from others, 2) can be shocking and elicit an emotional response from others, as well as establish the artist’s power, and 3) it distinguishes the artist from others. The author recommended three features of a drawing program with students diagnosed as ED: a) discuss the art work and the purpose of art, b) provide an opportunity for the student to view, evaluate, and discuss the artwork made by the student, his or her peers, and other artists, and c) provide an opportunity for the student to demonstrate artistic skills (Graham, 1994).

Viscardi (1994) provided an adolescent art therapy group in a private, state-supported facility designed for educating children and adolescents who have severe physical and orthopedic impairments. The group members were allowed to choose their choice of art materials and decide on their art projects. For the first group, the youth decided to work with clay and build a family sculpture. The students were requested to make a clay model to represent their earliest relationships. The adolescents also used foam-core board that was light enough to enable the students who may have limited mobility to handle large pieces. The adolescents attached and built objects with the foam-core board using hot glue guns.

During the groups, the adolescents made more eye contact with the other students and the adults. The author also reported more verbal comments from the youth and stated that the youth asked for help from others and talked more to their peers. The group also discussed their feelings
towards their family members, their support system, other peers, and their personal feelings. As the adolescents discussed their feelings, the group as a whole reportedly became more encouraging, empathetic, and compassionate. Students with physical disabilities were able to experience “getting outside themselves, outside their wheelchairs, outside their disability, outside feelings of loneliness, alienation, and reluctance to discuss their situation” (Viscardi, 1994, p.68).

Appleton and Dykeman (1996) discussed the use of art in group counseling with Native American youths ages seven to 17. The group met once a week for 50 minutes for seven weeks. The sample consisted of 10 male and female students attending a north-western public school located on an Indian reservation. The authors described the goals and outlined the seven group sessions. The first session focused on introducing the group members, developing the group rules, and building rapport with the group members through having the youth work on a family drawing. The directive included: ‘Draw yourself and your family.’ The goal of the family drawing was to provide information as the levels of intimacy or distance, the emotional tone in the family, pleasantness or unpleasantness in the home setting, and the feelings of who is the closest to whom. The second session focused on exploring the youth’s feelings of security and safety within the home. The directive included “Draw a picture of a house.” The goal of the directive was to represent symbolic representations of maturity, adjustment, accessibility to others, one’s contact with reality, and one’s general emotional stability. The third session focused on the promotion of self-knowledge through the use of collage as a symbolic path to self-understanding. The art directive included “Make a picture about you in your world.” The goal of this exercise was to use collage as a form for the youth to integrate self and the environment through structured techniques (sorting pre-made images) and unstructured techniques (having the freedom to create a personal collage).

The fourth session focused on encouraging the youth to express their feelings through spontaneous drawings. The instruction included: “On one side of the paper, draw things you like; on the other side draw things that you do not like.” The goal of the session was to assist the youth in focusing on affective themes. For the fifth session, the goal was to assist the youth in focusing on cognitive themes through symbolic representation. The art directive included: “With your eyes closed, scribble for 30 seconds.” After the 30 seconds, the counselor stated, “Now find
a shape, image, or symbol within the scribble and make it look more like what you see.” The goal of the session was to gain a sense of mastery through the drawing and to develop a framework for drawing meaning from the emotional experience. The sixth session focused on affective themes by having the youth explore the feelings through the use of clay. The directive included “Create something you have imagined or dreamed.” After the adolescents created a clay symbol, the counselor requested that they process working with the clay, the clay product, and the feelings associated with the clay creation. The seventh session focused on bringing closure to the group and sharing one’s feelings with others through a whole-body tracing on paper. The counselor directed the youth to work in pairs and to trace each other’s body. While making the tracings, the youth were instructed to “Say something about your experience in group.” The goal was to build trust with the group members to have the youth bridge their feelings, thoughts, actions, and insights (Appleton and Dykeman, 1996, p.226-227).

The authors found that warm-up exercises were helpful due to some of the youth’s feeling threatened by the art media. Also, the authors recommended that the group start with a highly controlled medium such as pencils and then slowly build toward the use of a less controllable media such as watercolors. The authors also recommended that group members have the same level of respect and confidentiality toward art products as verbalizations since the art products represented the youth’s internal processes, their thoughts, and feelings. Further, the group also allowed the youth to discuss and represent racial and societal themes within a safe environment through verbal and nonverbal means (Appleton and Dykeman, 1996).

Rosal, McCulloch-Vislisel, and Neece (1997) performed a pilot study that investigated the effectiveness of a combined art therapy and English curriculum in improving the attitudes of ninth-grade students. Fifty (50) students, 53% male, and 47% female, ages ranging from 13 to 15, from two ninth-grade English classes at an urban public school participated in the study. The three goals of the study were to improve attitudes concerning school, family, and their sense of self; to improve failing grades; and to decrease their school drop out rates.

The research design of the study was a one group pretest-posttest quasi-experimental design using the Jefferson County Public School Student Attitude Inventory (SAI), 52 item questionnaire. Two art therapists joined the English teacher one Friday morning each month to provide four interventions in the fall semester and five in the spring semester for a total of nine
art therapy interventions. The t-test indicated significant changes in the attitudes of students from the pretest to the posttest. The analysis of the overall data made evident that art therapy in conjunction with the English curriculum had a positive effect on the ninth-graders (Rosal et al., 1997).

Ter Maat (1997) explored a 10-week art therapy group experience for two groups of eight Spanish speaking students at one suburban middle school. The assumption was that experiences of depatriation increased feelings that inhibited self-awareness and social assimilation. The hope was to increase cultural sensitivity and awareness, as well as to illustrate how art therapy could assist with adjusting to a new culture. Although there were no measures in this study, it was reported that the students were enthusiastic towards the tasks and showed overall progress toward self awareness and reconciliation.

Taylor, Kymissis, and Pressman (1998) addressed the use of family drawings with adolescents with mental health and substance abuse issues. The adolescents were requested to draw their families without using stick figures. Upon completion of the drawings, adolescents were requested to label their family members. After completion of the second drawing, the clients were asked to draw their families in ten years and to label the members afterwards. The clients were also requested to draw a person and a person of the opposite sex following the same protocol for the first two drawings. The purpose of this study was to determine the use of drawings in assessing the family’s dynamics.

McGann (1999) discussed the use of individual, group, and family art therapy with a 15-year-old female in an adolescent day treatment program over one-and-a half-years. The client received weekly individual art therapy, weekly verbal therapy, group art therapy, and monthly family therapy. The client worked on two dimensional drawings and three dimensional clay constructions and addressed ongoing suicidal and homicidal ideations, as well as family conflict. The author reported that through the client’s manipulating clay, she was better able to tolerate her negative feelings, presented with less defense mechanisms, and increased her level of trust with her peers and other staff. The author also reported that the client was able to return home with her family and work towards obtaining her GED with no physical assaults at home.

Riley (1999) discussed the developmental and clinical advantages of having adolescents attend a group art therapy setting, as well as the advantages of residential closed groups. Due to
many youth having limited communications with their parents, the youth may confide more with their peers and ask for their peers’ advice and support. Grouping one’s peers together may encourage the youth to discuss difficult topics and to be more receptive to treatment in a group format than in an individual setting. The art therapy group format also offers four possible advantages for adolescents including: 1) control over their expressions so that they only revel in the art product what they choose to visually or verbally reveal, 2) use of the media as an outlet for creativity, 3) gain pleasure from the art activities, and 4) utilization of personal and age-group metaphors and symbols. Group treatment versus individual treatment may reflect the adolescents’ desire to utilize the peer group as a replacement for parental influence and structure. The overall goal of adolescent group art therapy is to provide a safe environment for the adolescent to interact with his/her peers and discuss his or her thoughts and feelings both verbally and nonverbally through the use of art (Riley, 1999).

Several considerations regarding conducting a residential group therapy were discussed by Riley (1999). The first consideration was the developmental maturity of the group members. Many of the group members may not be functioning at the same developmental level. Having a small group size may allow more individual attention to the adolescent if needed. Benefits of a same sex group are that it eliminates the additional stimulus of dealing with the opposite sex members; however, the same sex group does not have the opportunity to practice social skills with the opposite sex. Group members may also draw images of substances or sexual content. Discussing art/drawing boundaries before the group started would minimize possible conflicts and hopefully foster a healthy dialogue.

Vick (1999) utilized pre-structured art elements in brief group art therapy with adolescents in a partial hospital program ranging from age 12 to 18 years. This author explored strategies for using six different pre-structured art elements, including magazines pictures, magazine words, photocopied images, cut and torn paper, traced shapes, and partial drawings. Vick used images in general categories, including people together, people alone, animals, environments, and objects. Words and phrases from magazines could be transformed into titles, poems, labels, stories, and dialogue in speech bubbles. Photocopied images and words could also be manipulated through cut-and-paste methods using scissors, glue, correction fluid, and other drawing materials to portray thoughts and feelings. Cut and torn construction, tissue, and other forms of paper also
allowed the adolescent to manipulate an image. Tracing geometric shapes on paper also served as a starting point for artwork, as well as partial drawings of lines, shapes, and scribbles which may foster the adolescent’s imagination and creativity.

Four advantages of using pre-structured art elements in group therapy with adolescents were discussed. The group provided freedom within structure in that the adolescent could explore their own personal issues by allowing the art material itself to serve as the framework with little verbal directive tasks. The group also created an environment of psychological safety in that the adolescent could explore their thoughts and feelings in a safe physical and psychological space through the art product itself and the discussion of the process. The group also provided an opportunity for the adolescent to make connections with the other peers and the group leader through verbal and nonverbal (shared visual and content themes) interactions. Finally, the group provided a here-and-now stance in which the adolescent could process the content of the group discussions itself, as well as the process of the treatment group (Vick, 1999).

Hanes (2000) presented a case study of a 16-year-old female in a psychiatric hospital who was admitted for two weeks due to symptoms of depression, suicidal ideations, and a history of sexual abuse by her step-father. The author reported that the client depicted an image of her step-father in group art therapy and then stabbed the image with pencils; therefore, providing her the opportunity to release pent-up emotions stemming from her abusive past. The adolescent also found a safe and assertive manner to express her anger through verbal and nonverbal means rather than acting on thoughts of harming herself or others.

Robertson (2001) discussed an art therapy program created to help adoptees “explore and integrate their unique life experiences into their maturing identities” (p.74). The program consisted of eight weeks of a planned art therapy group focusing on the adoptees’ origins and early experiences through their current perceptions of self, family, and the world. The group consisted of eight components including: 1) portray the adoption story the adolescents were told growing up; 2) explore information about the birthparents and their circumstances before the adoption occurred; 3) explore the loss of connection to their birthparent; 4) explore the adoptees’ inherited traits from their biological parents through a self-portrait; 5) portray a time that the adoptee was singled out for special attention because of being adopted, either positive or negative attention; 6) create an adoptive family portrait including adoptive family relationships.
and significant life events; 7) portray a person who is an “ally” within (p.78) such as a known person, famous person, or a peer who is truly supportive; and 8) draw a bridge joining two shores to represent a bridge into the future depicting new connections such as leaving the adoptive home. This approach was described as helping the adoptees recognize and resolve internal conflict regarding being adopted, as well as building a connection between their biological parents and their adoptive family.

Testa and McCarthy (2004) presented a weekly art therapy group provided to three male inpatients, ages 11 to 12, who were being treated in a state psychiatric hospital for children. The three clients had experienced multiple traumas such as early neglect, parental abandonment, multiple foster home placements, and extreme aggression with violence, suicidal ideations, and self-harming behaviors. The art therapy group consisted of 12 weekly sessions that were 1.5 hours long. After the September 11, 2001 terrorist attack on the World Trade Center, the group chose to paint a memorial mural about the incident. The authors reported that the youth completed the mural and experienced a heightened sense of feelings of sadness about the incident. The authors also reported that the youth became attached to the artwork and wanted to take pictures of the artwork. The counselor suggested that the youth assemble an album to contain their drawings, writings, and photographs of the mural. The albums served as a means of documenting their progress and enhanced their ability to work collaboratively together on one project. The authors reported that by creating the mural, this empowered the group members to tolerate the presence of traumatic memories and process their feelings in a safe environment. The mural also reportedly gave the youth a voice and means of self-expression to allow others to respond to their thoughts and feelings.

Hartz and Thick (2005) conducted an exploratory, quasi-experimental study which compared the impact of two art therapy approaches addressing self-esteem. The sample was comprised of 27 female juvenile offenders ages 13 to 18 who received ten 90-minute sessions during a 12-week period. The study used pretest and posttest self-esteem measures and a posttest measure to focus on the specific aspects of the art therapy treatment. The study sought to explore the efficacy of an art psychotherapy approach versus an art as therapy approach. The art psychotherapy approach incorporated a brief psychoeducational presentation emphasizing personal awareness and insight through the use of abstraction, symbolization, and verbalization.
The *art as therapy approach* focused on design components, technique, and the creative problem-solving process. That approach emphasized artistic expression and accomplishment.

The authors found no significant difference between the two treatment groups; the majority of the participants reported the groups to be helpful in developing mastery, connections to others, and an increased self-approval. The participants were also able to identify their feelings and to experience a sense of safety and comfort in self-expression, lending to a greater sense of self-awareness and self-approval. The authors postulated that the psychotherapy group approach may encourage the adolescent to share more personal feelings through both verbalizations and self-disclosure in the art work. However, for newly formulated groups, using an *art as therapy approach* may be more beneficial if there is a low trust level, if the group has poor social skills collectively, or if conflict is present among the group members or the program/agency. This approach may lead to the development of a sense of belonging and group cohesion through an increase in social interactions fostered by sharing art materials, techniques, and observation of peer’s art. The group participants may also be able to sublimate anger through the manipulation of the art materials (Hartz and Thick, 2005).

Wadeson and Wirtz (2005) conducted an eight week art therapy group with sixteen 13-year-old males enrolled in a hockey team in order to develop a sense of respect for one another, to increase problem-solving skills, and to improve the adolescents’ social skills. The group worked on building a city using carved wood pieces, colored tissue papers, and tiles. The groups were held for 1.5 hours and followed the Wirtz Three Level system. The *first level* of the system focused on building trust, teamwork, and developing self-respect and respect for others. The *second level* focused on facilitating expression in art and words by the adolescents’ describing their artwork and the feelings associated with their work, and the *third level* focused on making the connection between art and feelings and applying the group learning to life outside the groups.

During the first session, the group developed rules, such as respecting self and others, being honest with others, not criticizing others, staying within healthy boundaries, and staying on task for the group. The rules were incorporated into a four point system: one point for coming to the session, one point for making art, one point for following the rules during the group, and one point for following the rules during the ice hockey practice and games. Adolescents who earned
a total of 32 points for eight sessions were rewarded at the end of the series with a skybox dinner and party at a professional hockey game. The authors reported that the adolescents experienced less conflict with peers and adults; decreased school truancy and behavioral problems at home; and improved cooperation, teamwork, and respect for others. The authors also reported that the hockey team won their league trophy and division trophy due to their improved teamwork and cooperation. The authors conducted a second art therapy group with the same team the following year. That group worked on making a photo-collage book of team photographs, self-portraits, and a self-collage, using images and comments from others. The authors reported the same gains as the first group with a greater show of emotion towards the other teammates and coaches. The researchers did not utilize any formal pretest and posttest measures; however, they reported that they have developed measures for their upcoming project (Wadeson & Wirtz, 2005).

Bornmann et al. (2007) conducted a controlled study to determine the effectiveness of a psychotherapeutic relaxation group (combination of a creative arts therapy and progressive muscle relaxation) to a comparison group with children ages 5-13 admitted to an inpatient child psychiatric unit at a state hospital. These researchers enlisted a control group of 23 subjects between the ages of 5-12. This group received treatment as usual (TAU), which does not qualify as an experimental control group. The experimental group consisted of 25 subjects aged 6-13 who received the TAU and also received up to 13.5 hours of relaxation training. The psychotherapeutic relaxation group protocol included art activities, mental imagery, progressive muscle relaxation, and drama therapy. Mental imagery consisted of having the youth imagine a relaxing scene to deepen the relaxation experience. Participants were then requested to draw their interpretations of the images. Both groups were rated daily by the Modified Overt Aggression Scale (MOAS).

The two groups were analyzed utilizing a two-tailed t-test and univariate analysis of covariance (ANCOVA) with the length of stay as a co-variate. Results were statistically significant for the youth presenting with problems of property destruction, physical aggression, and total aggression. Results for verbal aggression and auto aggression were found to be non-significant. This study’s results supported the hypothesis that children receiving additional psychotherapeutic relaxation techniques would demonstrate a diminished aggression compared to children who did not receive the intervention (Bornmann et al., 2007).
Art therapy utilized with adolescents in group therapy has been provided in diverse settings to address diverse mental health issues. Topics addressed by art therapy have included: improving academic performance/engagement (Hume & Hiti, 1988; Stanley & Miller, 1993; Rosal et al., 1997; McGann, 1999; Wadeson & Watz, 2005); appropriately identifying and expressing feelings such as anger/aggression (Hume & Hiti, 1988; Stanley & Miller, 1993; Gerber, 1994; Viscardi, 1994; Appleton & Dykeman, 1996; McGann, 1999; Hanes, 2000; Hartz & Thick, 2005; Wadeson & Watz, 2005; Bornmann et al., 2007); decreasing symptoms of anxiety (Tibbetts & Stone, 1990); improving coping skills (Graham, 1994; Viscardi, 1994; Hanes, 2000; Bornmann et al., 2007); decreasing symptoms and feelings of depression/sadness (Tibbetts & Stone, 1990; Walsh, 1993; Hanes, 2000; Testa & Mc Carthy, 2004); exploring family dynamics, relationships, and decreasing family conflict (Hume & Hiti, 1988; Stanley & Miller, 1993; Epping & Willmuth, 1994; Viscardi, 1994; Appleton & Dykeman, 1996; Rosal et al., 1997; Taylor et al., 1998; McGann, 1999; Hanes, 2000; Robertson, 2001; Testa & Mc Carthy, 2004); addressing grief and loss issues (Testa & Mc Carthy, 2004); addressing medical illness/disabilities (Epping & Willmuth, 1994; Viscardi, 1994); improving problem-solving (Hume & Hiti, 1988; Viscardi, 1994; Hartz & Thick, 2005; Wadeson & Watz, 2005); improving self-esteem and self-concept (Tibbetts & Stone, 1990; Stanley & Miller, 1993; Walsh, 1993; Epping & Willmuth, 1994; Graham, 1994; Viscardi, 1994; Appleton & Dykeman, 1996; Rosal et al., 1997; Hartz & Thick, 2005); addressing sexual abuse issues (Gerber, 1994; Hanes, 2000); improving social skills (Hume & Hiti, 1988; Stanley & Miller, 1993; Viscardi, 1994; Appleton & Dykeman, 1996; McGann, 1999; Vick, 1999; Testa & Mc Carthy, 2004; Hartz & Thick, 2005; Wadeson & Watz, 2005); decreasing suicidal ideations and self-injury (Milia, 1998; McGann, 1999; Hanes, 2000); and addressing and decreasing symptoms of Post Traumatic Stress Disorder and trauma (Graham, 1994; Hanes, 2000; Testa & Mc Carthy, 2004). Group art therapy has been proven successful in addressing diverse mental health issues and offered a promising approach paired with Gottman’s Sound Relationship House Theory.

**Introduction to Family Art Therapy**

Family art therapy was developed by Hanna Kwiatkowska, working closely with Lyman Wynne, M.D. in the Family Studies Section of the Adult Psychiatry Branch of the National Institute of Mental Health. Wynne was interested in family studies regarding schizophrenia to
investigate links between family interaction and the development of schizophrenic offspring. Kwiatkowska developed modes of art therapy evaluation and treatment of families being studied by Wynne and noted that many patients in the hospital improved, but soon decompensated after returning home. She turned to the systems theory approach applied to families by Don Jackson, M.D. and later modified by Murray Bowen, M.D. in the 1950’s. In a systems approach, the family is conceptualized as a homeostatic system; therefore, change in one family member affects the rest of the family. Often when problems arise in the family, one member becomes designated as “the problem” and is often blamed for the family’s problems (Wadeson, 1980, p. 281).

Many art therapists have devised clinical batteries/ interventions that have focused on working with children and their families. Rubin and Magnussen devised assessment batteries for children in 1974 known as the Family Art-Based Assessment (FABA), followed by Kwiatkowska’s art assessment battery known as the Family Art Evaluation (FAE) in 1978. In 1984, Rubin developed another assessment which she called the Family Art Evaluation. Assessment batteries for children and adolescents known as the Family Art-Based Assessment (FABA) included the work of Rubin and Magnussen in 1974 developed at the Pittsburgh Child Guidance Center. These assessment techniques involved four tasks including: 1) Scribble drawings – used to assist individuals feel at ease with the artwork and the process, 2) Family portraits – two-or three-dimensional drawings, either abstract or realistic, with a choice of media and location of workstation, 3) Family joint mural – family decides together on topic and then works together on large mural paper taped to the wall, and 4) Free picture if time remained in the sessions – client can create any drawing using any medium (Rubin & Magnussen, 1974; Kwiatkowska, 1978; Rubin, 1984; Anderson, 2001).

Kwiatkowska (1978) also developed an art assessment battery known as the Family Art Evaluation (FAE) with six tasks including: 1) Free picture, 2) Picture of your family, 3) Abstract family portrait, 4) Scribble drawing, 5) Joint Family Drawing, and 6) Free drawing. In the first task, each member of the family is requested to “draw a picture of whatever comes to mind.” There is no suggested topic, and it is emphasized that the drawings do not have to be elaborate because there will be many drawings to follow. For the second drawing task, each member of the family is requested to draw a family portrait. The instructions are as follows: “Draw a picture of
your family, each member of the family including yourself. We do not expect you to make very elaborate photographic portraits. Do the best you can; there is no right or wrong. We would also like you draw the whole person.” If questions are posed as to whom to draw in the family, the answer is, “Whatever way you choose to do it.” (Kwiatkowska, 1978, p. 87).

The third art task includes developing an abstract family portrait. In this task each family member is asked to draw an abstract image of the family (may include lines, forms, colors, shapes, and/or symbols). After the drawing is completed, the members are requested to give a general title for the artwork and sign and date the images. The fourth task is drawing a scribble drawing. Family members are invited first to practice relaxing body exercises which include standing up and doing arm exercises with a piece of pastel to relieve tension, to physically loosen up, and to enhance the freedom of motion in the scribbles. The exercises include drawing in the air straight vertical and horizontal lines; swinging the arms up and down from the shoulder; making big circles in the air using the whole body, and making a broad free-floating scribble in the air. After completing the exercises, each member of the family is requested to close his/her eyes and draw a scribble based on the movements practiced earlier. Family members are then asked to look at the image from all angles, use the scribble as a stimulus for choosing a subject to develop, and develop the scribbles into an image. Members can either add lines and shapes or ignore scribbles to develop the image (Kwiatkowska, 1978).

The fifth drawing task requests each member to compose a joint family scribble with same instructions as the individual scribble. Each member draws a scribble. All members look at the images, describe what they see in the drawings, and then choose one picture as the basis for a joint picture. The family then works on drawing the image together and must jointly decide on a title for the piece. The final task is to complete another free drawing with no subject assigned and later to discuss the images (Kwiatkowska, 1978).

The first stage of Rubin’s Family Art Evaluation (FAE) included having the family members develop an individual picture from a scribble. The directive was to draw a continuous scribble with one’s eyes either open or closed, using drawing materials such as pencils, crayons, chalk, makers, or pens. After the scribble was drawn, the family members were requested to examine the scribble from all directions, to select an image, and to elaborate on that image. Afterwards, the participants were asked to name the image and to describe the artwork while the other family
members responded. The second art task required the family members to create a representation of the family on a two or three dimensional level using drawing or painting materials, clay, wood scraps, or construction paper. The art pieces were either taped on the wall or displayed so that the artwork could be described by the artist and the other family members could ask questions. The third task included having the families create a family mural with three by six feet paper that was taped on the wall. The group was then requested to discuss the piece and the art-making experience. The final task was a free art production in which members of the family could create an image using any of the art materials provided if they had completed any of the previous tasks before the other group members. During these sessions, the therapist had the opportunity to observe verbal and nonverbal interactions; to examine the art work according to the form, content, use of color, process, and style of execution; and to compare the family artwork for commonalities and differences due to the presence of multiple data (Rubin, 1984).

**Adolescent Family Art Therapy**

Keyes in 1983 developed a technique called the Family Sculpt Technique (FS) using modeling clay, paper, and pencils. The technique consisted of seven tasks. The first task requested the clients to think about their family of origin at a time between 3 and 10 years of age. On a sheet of paper the clients were requested to “write three adjectives for each member in the family at that time,” including the client. The second task requested the clients to “construct a clay sculpture of the adjectives describing each family member.” The third task requested the clients to place “the sculptures on the paper in relationship to each other” such as those family members closest to one another versus those most distant. The fourth task directed the clients to “write a question or comment that the client may have felt (probably non-verbally) from each family member” and what his or her reply may have been. The fifth task requested the therapist to review the family sculpt, focusing first on the “family of the past” and then compare the adjectives to the family members in the current relationships. The sixth task requested that the “client gestalt each term and the sculpture” so that the client expressed how he/she was feeling. The last task requested the client to change, bend, or blend the modeling clay in any manner without throwing any of the sculpture away (Arrington, 2001, p. 196).

Langarten (1987) also practiced family art psychotherapy and reported that her work was based on the art task that guides the diagnosis and treatment of the family. Two goals of family
therapy were described: the resolution of the presenting problems and the facilitation of family tasks that paralleled the developmental phases in the family life cycle. Landgarten reported that art tasks could address diverse issues in family therapy. The family system was examined through the way in which the family functioned as a unit while creating art together. The art task provided information about three different areas including the process, product, and the content. The process is the manner in which the family interacts and provides diagnostic and interactional information. The product refers to the artwork itself and serves as the physical manifestation of the family’s dynamics and efforts. The content refers to the topics discussed by the family.

Landgarten (1987) also developed a *Family Art Diagnostic (FAD)* procedure with three tasks. This task delineated communication patterns which were viewed primarily through the process and secondarily through the content of the session. The tasks included nonverbal team art tasks, nonverbal family art tasks, and verbal family art tasks.

The first procedure requested that the family divide into two teams to determine family alliances. Everyone in the family was requested to “select a color marker that is different from the others and is to be used for the entire session.” The family team was then instructed to “work together on a single piece of paper.” The family was informed that they were “not permitted to speak, signal, or write notes to each other while working on the art, and when finished, they are merely to stop.” After completing the task, the teams are instructed to title their pieces and write the title on the art piece (Landgarten, 1987, p. 14).

The second procedure required that the entire family work together on a single sheet of paper. The family was instructed not to communicate verbally or nonverbally. The family was allowed to title their piece after completing the art task. The third procedure requested the family to “make a single piece of artwork.” Talking was permitted during this exercise. The therapist should observe the family as they complete the three art tasks for levels of participation in the activity (Landgarten, 1987, p. 15).

Landgarten (1987), also known for her work as a family art psychotherapist, completed a case study consisting of 24 weekly sessions with a family who had an adolescent acting-out male. The adolescent male was unable to attend the sessions because he was attending an out-of-state school. Family art therapy techniques included: splitting the family members into teams and having them create drawings nonverbally, switching family teams and creating a joint drawing.
verbally, creating a family mural with colored markers nonverbally, drawing another joint picture with all of the family members while permitting verbal interactions, and creating a photo collage which focused on past family fun, choosing an image of the present, and choosing an image that represents wishes for the future. The family was then requested to paste the images into a separate page and to include their meanings under each photo.

Other family art directives included: cutting out a construction paper symbol that represented thoughts and feelings about the previous family session; creating a construction paper sculpture together; creating a symbol of what each family member would like to have from their family currently; creating a symbol to give to the parents, children, and themselves; creating art and an collage based on the family’s feelings; and creating a collage in which every member choose one picture, arranged the pictures, and then added a story to the images. Other techniques with the family included: drawing a house, tree, person, and picture of the family; creating a collage to represent one’s role in the family; and creating a piece of artwork to describe a problem area, another image to portray goals for therapy, and a final image to represent how one will be affected if other family members reach their treatment goals. The family also worked on creating a family sculpture; creating an image as to how the family believed the therapist could assist the family and a symbol representing one’s individual contribution to the treatment process; creating an image to portray dissatisfied home scenes through art; and representing feelings about the process and termination of therapy (Landgarten, 1987).

Linesch (1988) discussed the role of a female adolescent in family art therapy. First identified were the stages of development the adolescent encounters, including working towards separation, individuation, and identity. Addressing the family in treatment may involve both therapy with the adolescent present and family therapy without the adolescent present. The process of treatment resided in a balance between the individual and the family intervention. The author discussed a two-month case with a 15-year-old who presented with problems of school truancy, failing grades, negative attitude, and family conflict. Art activities utilized in the sessions included: having the adolescent create a collage that depicted the adolescent’s understanding as to why she had entered counseling, family members’ creating individual family collages, creating a nonverbal dual drawing done jointly by the daughter and mother, and
drawing with the daughter and her mother regarding messages they wanted to share with each other. The adolescent also created a collage of what she had learned from the family sessions and a “goodbye” collage (p. 182) to depict changes she had undergone. Treatment issues addressed included family and marital conflicts and the adolescent developmental issues of identity and separation.

Riley (1993) explored family therapy with an alcoholic mother and a 14-year-old daughter. The daughter was removed from the home because of the mother’s alcohol and drug use. The family addressed the mother’s substance use and parent-child conflicts through the use of drawings and collage. The author discussed the importance of taking a social constructivist viewpoint so that the therapist can understand the family’s reality through their verbal and nonverbal expressions.

Lantz and Alford (1995) discussed the use of existential art therapy with families to explore their meanings and meaning potentials within their family. The authors discussed several family art therapy techniques including the “family shoebox,” drawing the family history, family clay sculpture, the “buried treasure technique,” and the “end of the rainbow drawing.” For the “family shoebox” technique, the family members were given a shoebox, magazines, tape, and scissors. They were instructed to “represent meanings and meaning potentials which they are not afraid to share with the other family members” on the outside of the box and to “represent the meanings and meaning potentials that they were afraid to share with the other family members” on the inside of the box (p. 336-337).

The “drawing the family history” technique consisted of drawing the family-of-origin followed by other information regarding the couple relationship, the parent-child relationships, changes in the family, and the family’s present situation. In the clay family sculpting technique the family was requested to “make a sculpture of their family as you see it” and then later discuss with the family what the clay sculpture suggested about the family’s problems, strengths, structure, and communication patterns. With the “buried treasure technique” the family was requested to draw a picture of a buried treasure. The family was then instructed to draw a buried treasure box that contained their hopes, dreams, and meaning potentials within the family and then to share this information (p. 339). The “end of the rainbow drawing” requested the family to draw the end of the rainbow and then reflect upon future goals, hopes, and meaning potentials.
within the family (Lantz and Alford, 1995, p. 340).

Kaiser (1996) discussed the use of a drawing assessment with the directive “Draw a bird’s nest.” The Draw a Bird’s Nest (BND) examined the drawing based on whether or not the subject included a parent or baby bird and if eggs were included in the nest. The goal of this assessment was to evaluate the attachment of children and their parents (Arrington, 2001, p. 199).

Arrington (2001) also adapted Rubin and Magnussen’s (1974) Family Art-Based Assessment (FABA) by incorporating only three steps which included having the family create a free picture, a family portrait by each of the family members, and a mural that members of the family completed together. The first art task was to “draw a free picture” for the purpose of reducing tension and helping the family members relax and be in control of the session (p. 11). The second art task directed the family members to “draw a family portrait” to help illustrate the family dynamics and relationships (p. 12). The third art task requested the family members to “create a joint mural” on a 3-by-5 foot piece of paper (p. 15). By observing the family members, researchers could gather information regarding how the family members work together.

Arrington (2001) further discussed the use of a Family Landscapes Drawings (FLD) which consisted of five tasks focusing on family boundary issues and the perceptions of each family member. The first task requested the client to “think of a specific time in the client(s) lives between 3 and 12 years old,” and the “psychological space” that the client grew up in (how the client felt emotionally growing up). The second task requested the client to “draw a symbolic landscape, seascape, or desert scape” of the psychological space. The clients were instructed to “include each member of the family that was in the family at the time, placing those emotionally close, close together, and those distant, distant.” The third directive requested the client “to place a legend on the landscape identifying each family member.” The fourth step was to note any significant changes that may have occurred from the ages of 3-12 such as death, divorce, remarriage, etc. The clients were then requested to “draw a different landscape that depicts the emotional climate” during that time and place and put a legend on the landscape for that event. The fifth and last directive requested the client to “draw, with the same intensity, a landscape from the viewpoint of the person that was the furthermost away” from the client. Afterwards, the clients were requested to “draw the view from the symbol of each family member in the family landscape and discuss what he or she experienced” (p. 197).
Summary

Combining Gottman’s Sound Relationship House Theory, a research-based approach, with art-based interventions for adolescents may provide adolescents with verbal and non-verbal means to discuss and explore their feelings and relationships, as well as possibly to expand their cognitive maps and friendships. Adolescents diagnosed with Conduct Disorder may tend to be very self-absorbed, may distance themselves from family members, and may present with ineffective communication, social, self-regulatory, and problem-solving skills. Adolescents may also have difficulty recognizing and regulating their emotions. Adolescents must learn to balance their feelings with logic to develop a healthy sense of judgment and develop effective self-regulatory skills. Incorporating Gottman’s Sound Relationship Theory with an adolescent population experiencing these difficulties may enhance their interpersonal skills and their parent/child relationships. Gottman’s research has illustrated what makes marital relationships work and what makes the relationships fail. It is hypothesized that these principles will also be applicable to these adolescents and their family members. Further, having a hands-on approach, such as art-based interventions, may assist the adolescent in being more engaged and expressive in treatment.

Art therapy has been cited as having many advantages for use with an adolescent population, such as allowing for a verbal and non-verbal means of communication, assisting in illuminating the conscious and unconscious thoughts and feelings, decreasing defense mechanisms, and exploring one’s emotional, behavioral, and cognitive domains through structured and unstructured art activities. Art therapy has also been found useful in many areas including: improving academic performance/engagement; appropriately identifying and expressing feelings such as anger/aggression; decreasing symptoms of anxiety, depression, PTSD/trauma; improving coping, social, and problem-solving skills; exploring and decreasing family dynamics/ conflict; and addressing grief and loss issues. Art therapy also has been found effective in addressing medical illness/disabilities, improving one’s self-esteem and self-concept, addressing sexual abuse issues, decreasing suicidal ideations and self-injury, and providing family and peer support. Improving the adolescents’ self-regulatory skills, including communication, social, and problem-solving skills, may assist the adolescent in having more positive family interactions and in improving the child-parent relationship.
CHAPTER 3
METHODS

This chapter provides an overview of the purpose of the study and the research hypotheses; description of the research study site, population, and sampling mechanism; and a description of the current treatment services provided at the research site. Additional information regarding an overview of the delinquency process within the Department of Juvenile Justice is described in the appendix (see Appendix E). An overview of the intervention is provided with a description of the research treatment manual, outline of the research treatment manual, and information regarding the training of the researcher to promote the treatment fidelity. Additionally, information regarding the pretest and posttest measures is provided, followed by a review of the statistical analysis and the expected outcomes.

Purpose of the Study and Research Hypotheses

The primary focus of this research study was to determine the effectiveness of a Gottman-based structured five-week art-based intervention for adolescents. The research hypothesis was that the adolescents participating in the group would experience a change in their self-regulatory skills. If the adolescents’ self-regulatory skills improved, the adolescents would report fewer mental health and substance abuse issues/problems as evidenced by a change in the pretest and posttest measures on the POSIT and SCL-90. Further, by addressing family dynamics through the group interventions, the adolescent would experience a change in family relationships as evidenced by a change in the pretest and posttest measures on the POSIT, the Parent-Child Closeness, and the Quality of Relationships Inventory. It was hypothesized that art-based interventions would assist the adolescent in exploring his feelings, communication patterns, and family dynamics. Three primary concepts of the theory using art-based activities included: 1) exploring unhealthy communication patterns and positive and negative feelings through the use of art, 2) enhancing peer and family relationships through exploring family activities, rituals, and dynamics through drawing, and 3) improving the ability to regulate conflict through problem solving and self-soothing art-based activities. General observations were made regarding the adolescent’s verbal and non-verbal group interactions, the content of the drawings/art work, and the adolescent’s group participation.
Research Study Site

The research site is known as Seminole Work and Learn Center (SWLC) in Tallahassee, Florida. This program offers services to male adolescents and their families who reside throughout the state of Florida. The males are adjudicated to the program for approximately three to six months; however, the adolescents may gain additional time in the program due to inappropriate behaviors at the facility. A large private room for group counseling sessions accommodated the adolescents and the program staff.

Research Study Population and Sampling Mechanism

The research sample consisted of 15 adolescent males from the ages of 12 to 18 who were adjudicated to this DJJ program in Tallahassee, Florida. The participants were a convenience sample. Adolescents who were age 18 gave their consent to participate in the study. Parent(s) or guardian(s) of adolescents under the age of 18 consented first; then the adolescents assented to participation.

Current Services Provided at the DJJ Residential Program

At Seminole Work and Learn Center in Tallahassee, Florida, the counselors implement cognitive-behavioral individual and group therapy mental health services, focusing on improving the adolescent’s anger management, communication, decision-making, social, and coping skills. The mental health overlay provider also assesses all adolescents for possible mental health symptoms, such as symptoms of depression, anxiety, past trauma, substance use/abuse, and other mental health issues which might be addressed in individual and group therapy (Bennink et al., 2003).

Overview of the Delinquency Process and Residential Commitment Programs

To have an understanding of the research sample (male adolescents), state agency (DJJ), and local program (SWLC), it may be beneficial to the reader first to understand the process for being committed to an adolescent program and how the youth are placed in a residential delinquency program. The juvenile delinquency process in the state of Florida has nine steps: origin of the offense and the referral process; the intake process; non-judicial interventions; recommendations for court interventions; recommendations for court disposition; assessment of court fees and cost of care; supervision after residential commitment; DNA testing, and the possible referral of a juvenile to adult court (Department of Juvenile Justice, 2006).
According to the Department of Juvenile Justice (2007), adolescents are adjudicated to a residential juvenile program based on the severity of their charges. Further considerations include the county in which the adolescent resides, preferences of the judge and circuit office, and availability of the residential commitment program. Within the DJJ system adolescents are sentenced to either five levels of restrictiveness: minimum-risk nonresidential, low-risk residential, moderate risk residential, high-risk residential, and maximum-risk residential. For a more extensive description of the delinquency process and placement, see Appendix D and E.

**Overview of the Research Intervention**

The Gottman art-based group intervention using the Sound Relationship House Theory consisted of group therapy for two hours per week provided by the researcher for a total of 10 hours. The intervention consisted of five consecutive weeks of adolescent group therapy with art-based directives designed to address self-regulatory skills, including healthy communication, and social and problem-solving skills. In addition, family dynamics, interactions, traditions, and strengths were addressed.

**Research Treatment Manual**

The group interventions were structured so that each week a new topic was covered, and the prior week’s topic was reviewed. Art supplies included pencils, crayons, markers, paints, brushes, and paper for drawing and painting. For a more detailed description of the activities, please see additional information in chapter two and an outline of the sessions in Appendix A. An abbreviated description of the interventions is provided in Table 1 below.

**Table 1: Adolescent Group Session Outline**

<table>
<thead>
<tr>
<th>Session # And Focus</th>
<th>Group Therapy Intervention/ Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session 1:</strong></td>
<td></td>
</tr>
<tr>
<td>a. Name Drawing</td>
<td>a. Draw your name to represent your personality.</td>
</tr>
<tr>
<td>b. Represent 4 unhealthy behaviors using line, shape, color, and form</td>
<td>b. Draw a representation of criticism, defensiveness, contempt, and stonewalling.</td>
</tr>
<tr>
<td>c. Represent 8 feelings using lines, shapes, colors, and form</td>
<td>c. Draw a representation of feeling happy, sad, angry, excited, anxious, peaceful, afraid, and confident.</td>
</tr>
<tr>
<td><strong>Session 2:</strong></td>
<td></td>
</tr>
<tr>
<td>a. Family Drawing</td>
<td>a. Draw a picture of your family, either abstract or real.</td>
</tr>
</tbody>
</table>
Table 1: Continued

<table>
<thead>
<tr>
<th>Session 3: Prospective Family Kinetic Drawing</th>
<th>Draw a picture of your family doing something after you return home.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 4: Joint Puzzle Drawing</td>
<td>Decorate a single puzzle piece cut from a larger piece of poster board. After decorating the piece, assemble the pieces to form a larger image.</td>
</tr>
<tr>
<td>Session 5: a. Problem and Solution Drawing</td>
<td>a. Draw a representation of a problem, the solution, and the means to achieve the solution.</td>
</tr>
<tr>
<td></td>
<td>b. Practice deep breathing while painting with watercolors.</td>
</tr>
</tbody>
</table>

**Training of Therapist/ Researcher to Promote Treatment Fidelity**

The researcher provided the group interventions. The researcher is licensed as a Marriage and Family Therapist and as a Clinical Social Worker and is approved as a state licensed Mental Health, Marriage and Family Therapy, and Social Work Supervisor. The researcher is also approved as a Marriage and Family Supervisor, credentialed through the American Association for Marriage and Family Therapy (AAMFT). The researcher is further credentialed as a Registered Play Therapist Supervisor and as a Board Certified Art Therapist. The researcher has attended one graduate semester course in Gottman’s Sound Relationship House Theory at Florida State University under the supervision of a Gottman-Certified Therapist and Trainer; has attended a two-day training under Dr. John Gottman; and for the last three years has provided state and local workshops on Gottman’s Sound Relationship House Theory incorporating art and play therapy.

**Quantitative Mental Health Research Measures**

The pretest and posttest measures consisted of two mental health and substance abuse measures which were completed by the participant before the start of the first group and after the last group session. The adolescent completed the measures in the classroom at the program facility within three days of the first group session. The researcher administered the measures to the participants. If the participants had questions about the measures, the researcher answered the questions by defining any unknown words without
providing additional information or interpretations of the instrument’s questions. After the last group session the participants completed the posttest research measures within three days in the same setting, the program classroom.

The first measure was the Problem Oriented Screening Instrument for Teenagers known as the POSIT (Rahdert, 1991). This measure consisted of 139 items with nominal scoring (“yes and no”) that examined 11 areas including: substance use/abuse, physical health status, mental health status, family relationships, peer relationships, educational status, vocational status, social skills, leisure and recreation, and aggressive behavior/delinquency.

Knight, Goodman, Pulerwitz, and DuRant (2001) studied the internal consistency and one-week test-retest reliability of the POSIT among medical patients 15-18 years of age. Results indicated that four of the scales (Substance Use/Abuse, Mental Health, Educational Status, and Aggressive Behavior/Delinquency) had an adequate inter-item consistency (alpha coefficients were better then .70). For the one-week test-retest reliability, the alpha range was from .72 to .88.

The second mental health and substance abuse measure was the Symptom Checklist - 90 known as the SCL-90 (Derogatis, 1983). The SCL-90 consisted of 90 items with a Likert-type scale of 0 = not at all, 1 = a little bit, 3 = quite a bit, and 4 = extremely. This assessment was divided into nine areas including: somatization (perceptions of bodily dysfunction), obsessive-compulsive, interpersonal sensitivity (feelings of inadequacy and inferiority), depression, anxiety, anger-hostility, phobic anxiety, paranoid ideation, and psychoticism (experiencing false body sensations).

The alpha coefficients of the SCL-90 ranged from .79 to .90 (Derogatis, 1983). The test-retest interval for one week had a range of r = .78 to .90; a second study with a ten-week interval between tests had correlation coefficients ranging from .68 to .80 (APA, 2000).

Quantitative Parent-Child Research Measures

The subjects completed two additional assessments to measure the parent-child and family relationships. The parent-child relational measure was the Parent-Child Closeness (PCC) questionnaire. The second measure was a family relational measure
known as the Quality of Relationships Inventory (QRI). These two measures were administered at the same time as the first two measures under the same conditions.

The first parent-child relational measure included the Parent-Child Closeness questionnaire (Buchanan et al., 1991), a 9-item questionnaire based on a 5-point Likert-type scale (1 signifies “not at all” and 5 indicates “very”). A composite score ranging from 9 to 45 was created by summing responses to the nine items for both the mother and the father. The higher scores indicated more positive parent-child relationships. The alpha score was .89 for responses about mothers and .90 for those about fathers (Touliatos, Perlmutter, & Straus, 2001).

The second family relational measure included the Quality of Relationships Inventory (Pierce, 1994), a 25-item questionnaire based on a Likert-type scale from 1-4. A 1 signifies “not at all,” a 4 signifies “very much.” The questionnaire examined three specific dimensions of the relationship: 1) social support, 2) perceptions of relationships as positive, important, and secure, and 3) conflict and ambivalence resulting from the relationship. The QRI yielded three scores: a) social support described as the reliance on the other person for assistance in a range of situations, b) depth described as the level of commitment and positive value within the relationship, and c) conflict described as anger and ambivalence felt toward the other person. The subscales were determined by averaging the relevant response values. The alpha scores for the subscales across several samples were between .70 to .90’s. QRI scores for college students and their mothers and fathers had a one-year test-retest correlation ranging from .48 to .79 (Touliatos, Perlmutter, & Straus, 2001).

**Qualitative Verbal and Nonverbal Observational Research Measures**

The researcher observed the group interactions, including the adolescents’ verbal comments and overall participation in the group and reviewed all of the completed artwork. It was hypothesized that participation in the group would change not only the adolescents’ self-regulatory skills, but also would enhance the adolescents’ ability to recognize communication patterns and identify positive and negative feelings. The researcher/therapist observed the adolescents’ interactions and made observations based on three major concepts of the model: 1) ability to explore unhealthy communication patterns, as well as positive and negative feelings,
through the use of art, 2) ability to enhance peer and family relationships through exploring family activities, rituals, and dynamics through drawing, and 3) ability to regulate conflict through problem solving and self-soothing art-based activities.

**One-Sample Statistical Test Analysis**

The analyses of the data were performed using a Wilcoxin Ranks test. Due to the study’s having a two-sample case with related or matched samples (intervention with pre- and post-test measures), having a low sample size (n = 15), and utilizing a nominal (yes or no response) and an ordinal level of measurement (three Likert-type ordinal measures), a nonparametric statistical test was most appropriate. The statistical test included a one-sample statistical test involving two measures to determine the direction of the differences between pairs, as well as the relative magnitude of the differences within pairs. The Wilcoxin Signed Ranks test gave more weight to a pair which showed a larger difference between the two conditions. The Wilcoxin Signed Ranks test determined if a member of pairs was “greater than” and ranked the differences in order of absolute size. The difference between the pair’s scores under two treatments X and Y was examined so that $d_i = X_i - Y_i$. The null hypothesis was that treatments X and Y were equivalent. (Siegel & Castellan, Jr, 1988).

To determine if a correlation existed between the 11 scales on the posttest POSIT measure (substance use/abuse, physical health status, mental health status, family relationships, peer relationships, educational status, vocational status, social skills, leisure and recreation, and aggressive behavior/delinquency), the Spearman’s rank-order correlation coefficient $r$ was utilized to measure potential association between two variables by ranking two ordered series (Siegel & Castellan, Jr, 1988). To test the hypothesis in this research study, a significance level of .10 was used. This significance level was selected to reduce the possibility of making a Type II error (the failure to reject a false null hypothesis) and to account for an exploratory study with a small sample size (Rubin & Babbie, 1993). The data was considered significant at less than .10 so that 90 times out of 100 results would be found (Agresti & Finlay, 1997).

**Expected Outcome of the Study**

It was hypothesized that improving the adolescents’ self-regulatory skills would in turn improve communication, social, and problem-solving skills. Practicing healthy self-regulatory
skills may reduce mental health and substance abuse problems. Decreasing mental health problems and substance abuse rates among adolescents could serve as an investment in our youth and their families.

Further, focusing on family dynamics, interactions, traditions, and rituals may increase the adolescents’ connection with families and support systems and improve the parent-child relationship. Enhancing the adolescents’ relationships with families and support systems may, in turn, strengthen the family and the community. This pilot project may also expand avenues for continued research which focuses on adolescents’ using art-based interventions based on Gottman’s Sound Relationship House Theory. Finally, the exploration of adolescent communication patterns, feelings, family dynamics and activities, problem-solving skills, and self-regulatory skills could enable better articulation and regulation of adolescent feelings and improvement of adolescent problem-solving abilities.
CHAPTER 4
RESEARCH RESULTS

This project was an exploratory study aimed to assess the effectiveness of Gottman’s Sound Relationship House Theory with an adolescent therapy group which incorporated art-based interventions. The purpose of this study was to: 1) examine research to evaluate Gottman’s model using art therapy with adolescents to explore interpersonal and family dynamics, 2) determine the effectiveness of a five week adolescent group based on Gottman’s Sound Relationship House Theory as determined by pretest and posttest mental health and relational measures, and 3) to integrate both verbal and nonverbal approaches, including art-based directives to encourage healthy adolescent group interactions and to explore family dynamics and interactions.

The results section describes sample characteristics according to the age and diagnoses of the adolescents; the overview of the five week sessions with detailed information provided about three of the subjects; summary of the art-based activities; statistical analysis of the mental health and family/relational measures including the POSIT, SCL-90, PCC, and the QRI; and the POSIT correctional measures.

Sample Characteristics

The sample consisted of 15 adolescent males from the ages of 14 to 18. Seven were age 18, three were age 17, two were age 16, two were age 15, and one was age 14. The sample consisted of ten African-American youth and five Caucasian youth. Of the 15 youth, 6 were diagnosed with Conduct Disorder, Child Onset, and nine youth were diagnosed with Conduct Disorder, Adolescent Onset. Of the 15 youth, 13 presented with a dual clinical diagnosis based on the DSM IV-TR (APA, 2000), including Post-Traumatic Stress Disorder (3 youth), Attention Deficit Hyperactivity Disorder (3 youth), Cannabis Abuse (8 youth), Cannabis Dependence (1 youth), and Mild Mental Retardation (2 youth). For a more detailed description of the sample, see Table 2.

Table 2: Sample Characteristics including the Youth’s Age and Clinical Diagnosis

<table>
<thead>
<tr>
<th>Age of Youth</th>
<th>Conduct Disorder, Child Onset</th>
<th>Conduct Disorder, Adolescent Onset</th>
<th>Additional Mental Health Diagnosis</th>
<th>Additional Substance Abuse Diagnosis</th>
<th>Mental Retardation Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 14: 1 Youth</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

77
### Discussion of Session Summary

Session One began with an introduction of the researcher/therapist and the participants in the hopes of building rapport with and among the members. The participants introduced themselves by their first names and shared where they were from. The group also reviewed the rules of the group, which included respecting the other group members and staff, and refraining from using curse words and any inappropriate aggressive or sexual behaviors. These group rules were established by the residential program. The researcher also discussed the research project and reviewed the research informed assents and consents that were signed earlier by the participants and their parents prior to the beginning of the research study. Three art therapy tasks were completed including: 1) Drawing one’s name to represent one’s personality, 2) Representing four unhealthy behaviors using line, shape, color, and form including criticism, defensiveness, contempt, and stonewalling, and 3) Representing eight feelings using lines, shapes, colors, and form including a representation of feeling happy, sad, angry, excited, anxious, peaceful, afraid, and confident. The participants as a whole had difficulty representing their emotions and unhealthy communication patterns on a symbolic level using lines, shapes, colors, or forms; however, most were able to represent their feelings and behaviors using feeling faces and situational images. The participants discussed the four unhealthy communication patterns and discussed situations when they had experienced these patterns in their family or with other relationships. The participants varied in choice of media, using either pencil or markers. Some drew feeling faces; some drew dialogue between images/people, and some participants drew dialogue only depicting certain feelings and situations of unhealthy communication patterns.
Discussion of Session One – Exploring Communication Patterns and Feelings

Participant One (P1) – Images of Unhealthy Communication Patterns and Feelings

For the session discussions, three participants were chosen to discuss their drawings in detail. The first participant (P1) used a pencil and markers for his drawing with six colors included. Participant one drew an image of the classroom to describe his feelings of being criticized. The adolescent reported that he had difficulty in school and was assigned to an ESE class because he was diagnosed with mild mental retardation. Participant one reported that he was often criticized by teachers and peers and had difficulty successfully completing class assignments. Participant one’s second description of contempt included the participant’s taking a cookie from a cookie jar at his parents’ home. Participant one reported that he was “caught red handed” as described by an image of a red hand. Participant one stated that he felt as though he was being “put down” and “talked down to” for taking cookies at home. The third image of defensiveness included the adolescent’s getting into trouble at home because he was accused of scratching the television. Participant one stated that he did not scratch the television; however, his parents did not believe him. He then reported that he felt as though he had to defend himself. The last image of stonewalling was described as “when people are arguing, they see red and ball themselves up and close themselves off with other people.” The forms in the picture represented fourteen people “balled up” and pulling away from other people. See Appendix Q for examples of the participants’ artwork.

In Participant one’s second set of drawings he used one orange marker for all of the images. Participant one’s representation of feelings of happiness included a self-portrait of the adolescent smiling; the representation of the youth feeling sad included the youth crying. The third image represented P1 feeling excited. This image depicted P1 spending time with his girlfriend. The fourth image represented P1 feeling angry and was shown as the adolescent with a frown.

For P1’s third set of drawings he used marker, including five colors, and drew two feeling faces and two situational images. For the representation of feelings of anxiety, P1 drew an image with his “hair standing on end” and his mouth open. For the representation of feelings of peacefulness, P1 drew a picture of himself spending time in his backyard playing sports. For the representation of feeling afraid, P1 drew an image of jail because he stated that he was afraid of getting into trouble again and going to jail or prison. For the last image to represent feelings of
Confidence, P1 drew a picture of a playground and stated that he enjoyed “being able to swing real high” as a child. It is interesting to note that all of the images depicted the participant in the present except for the last two images (drawings of feeling afraid and confident). Participant one’s image of fear was based in the future as an adult (the participant was 18 years old and would be charged as an adult if he were to commit another crime). Participant one’s image of confidence was based in the past reflecting on feelings as a child. Participant one could not think of an example to represent a sense of confidence in the present. See Appendix R and S for examples of the participant’s drawings/images.

Participant Two (P2) – Images of Unhealthy Communication Patterns and Feelings

The second participant drew all feeling faces for the three sets of drawings, using one black marker throughout the images. Participant two drew an image to represent feelings of being criticized that included a self-portrait of the youth “smirking” due to being yelled at. Participant two reported that he was criticized often and reported symptoms of having low self-esteem and a poor self-concept. Participant two’s second description of contempt included “someone shoving their hand in his face and talking down to him.” The third image of defensiveness included the adolescent’s getting angry with his eyes, nostrils, and lips flared. The last image of stonewalling was described as himself “shooting down” and blocking out others. See Appendix Q for an example of the participant’s artwork.

The adolescent’s representation of feelings of happiness included a common representation of a happy face with eyes wide open with a smile. The second image represented P2 feeling sad represented by a face with dark eyes, open mouth, and tears. The third image represented P2 feeling excited. This image depicted the participant with open eyes, and a smiling face with his tongue sticking out. The fourth image showed P2 feeling angry represented by a face with dark eyes, flared nostrils, and flared lips.

For the representation of feelings of anxiety, P2 drew an image with dark squinting eyes and with a clinching moth. For the representation of feelings of peacefulness, P2 drew an image with highly arched eyebrows, dark eyes, and a smiling face. For the representation of feeling afraid, P2 drew an image of a face with an oscillating line for the mouth. For the last image representing feeling confident, the youth drew a face with dark eyes, arched eyebrows, and one side of the mouth turned upwards. The participant reported that he was trying to draw a “cocky look or
expression.” For these images P2 drew typical feeling faces with stereotypical expressions. He did not provide specific examples of these feelings and provided limited discussion during the activity. Participant two also completed the activity quickly with little additional written or verbal information. The use of typical feeling faces may have been indicative of defense mechanisms present or a lack of interest in the drawing exercises. See Appendix R and S for examples of the youth’s drawings/images.

Participant Three (P3) – Images of Unhealthy Communication Patterns & Feelings

The third participant drew an image to represent feelings of being criticized that included an image of the adolescent being “yelled at by his ex-girlfriend” with her pointing her finger at him. The adolescent stated that he felt as though he was being put down and treated like a child. Participant three reported that he had been criticized often and “put down” by many teachers and peers. Participant three’s second representation of contempt included “being put down by others” resulting in his wanting to leave the situation by driving off in his car. The third image of defensiveness included a representation of the adolescent experiencing conflicts with others and going on the defense. The adolescent drew a picture of two opposing shapes and described as two opposing viewpoints. The last image of stonewalling was described as the adolescent’s becoming angry and walking away from an argument. He also stated that he has had verbal and physical altercations other peers and ex-girlfriends. See Appendix Q for examples of the participant’s drawings.

The participant’s representation of feelings of happiness included a common representation of a typical smile without a face present. The second image showed P3 feeling sad represented by a typical frown without a face present. The third image represented P3 feeling excited. This image depicted the participant feeling happy, and he stated that he thought of receiving a gift from others. The fourth image represented P3 feeling angry by showing an image of a gun. The participant reported that when he is angry, he has thought of hurting others to “get back at them.” For the representation of feelings of anxiety, P3 drew an image of a person with a clinching moth. For the representation of feelings of peacefulness, P3 drew an image with a person “laying down and relaxing.” For the representation of feeling afraid, P3 drew an image of a stop sign. He reported that when he comes upset or afraid, he has a hard time setting limits and was afraid he would do something he would regret. For the last image representing feeling confident, the
participant drew an image of a happy person jumping up and down. For these images P3 drew some typical feeling faces with stereotypical expressions, but he also drew situations in which he experienced conflicts with his peers. Participant three did not provide extensive information about his drawings, but appeared to capture the essence of the feelings successfully. This participant was diagnosed with Mild Mental Retardation, ADHD, Conduct Disorder, and daily cannabis use since age 15 resulting in academic, family/interpersonal, and cognitive impairments. See Appendix R and S for examples of the youth’s drawings/images.

**Discussion of Session Two – Building Love Maps**

In Session Two this group focused on Gottman’s Love Maps and discussed family traditions, rituals, and activities while answering several of Gottman’s Love Map questions. Six questions were asked from Gottman’s Creating Your Child’s Love Map (Gottman & DeClaire, 2001, p. 249-250): 1) What are your two favorite foods? 2) What are you two favorite kinds of music, singer, or bands? 3) What are your two favorite videos or movies? 4) What are your two favorite television shows? 5) What are your favorite sport(s)? and 6) What would be your ideal vacation or getaway? The participants took turns answering the questions and discussing prior family trips/vacations, as well as possible future vacations. Many of the participants reported that they would like to take a road trip to the beach or a trip out of state after being released from the DJJ program.

After discussing the Love Maps, two tasks were completed (see Appendix T and U), including working on a Family Drawing (a picture of your family, either abstract or real) and a Kinetic Family Drawing (a picture of your family, either abstract or real doing something). For the symbolic family drawings, the participants drew pictures of symbols including hearts, geometric shapes (squares, triangles, and circles), and animals and insects using different colors and different media (pencils and markers). For the Kinetic Family Drawings activities drawn by the participants included the families playing basketball, football and soccer; having dinner and cook-outs; watching television and going to the theatre; going to the mall and shopping; dancing and spending time together at home; riding dirt bikes; going to the beach; and traveling/ taking road trips together. After completing the drawings, the participants discussed family traditions, rituals, and activities such as how the family celebrates birthdays, holidays, graduation, weddings, childbirth, and other celebrations in the family.
Participants One, Two, and Three – Family Drawing and the Kinetic Family Drawing

The first participant drew a symbolic drawing of his step-father as represented by an image of a snake. He reported that his step-father could be supportive, but was also a “snake in the grass” that was poisonous and could bite. Participant one did not draw an image of his mother, but reported that his mother was overprotective but supportive. For the kinetic family drawing, P1 drew an image an image of himself and his family sitting at home watching television. He reported that he likes to “stay at home and relax while watching T.V.” Participant one drew an image of his backyard as though he were looking out his window.

The second participant drew a symbolic image of his mother. Participant two drew an image of his mother enclosed in a heart. Participant two reported that he cared for his mother and felt supported by his mother. Participant two did not draw an image of his father; he stated that his father was not present, nor supportive. For the kinetic family drawing, P2 drew an image of his family dancing and hanging out together. The image was drawn with red markers only and was very simplistic showing movement with the members of his family exhibiting a positive affect. The image was titled “Platinum” and he stated the family was “keeping it real.”

The third participant drew a symbolic image of his mother as represented by a turtle. The participant reported that his mother procrastinated often, “moved slow,” but was supportive. The participant did not draw an image to represent his father; he reported that his father lived in the same town, but rarely visited, and there were prior parent-child conflicts. For the kinetic family drawing, the participant drew an image of a cook-out with his family represented by the family coming to the adolescent’s house with a grill in the front yard (see Appendix T and U for examples of the participant’s artwork).

Discussion of Session Three – Enhancing a Fondness and Admiration System

Session three focused on reviewing the fondness and admiration system and the concept of turning towards versus turning away. The group discussed ways to increase the binds of connection with their family members and how to build their emotional bank account. The group also focused on how Gottman’s four unhealthy behaviors destroy the emotional bank account and reviewed examples of criticism, defensiveness, contempt, and stonewalling. Four out of the 15 participants were able to identify examples of defensiveness and stonewalling. No participant was able to identify all four unhealthy behaviors. The art task (see Appendix V) included
drawing a Prospective Family Kinetic Drawing (a picture of your family doing something after you return home). Examples of the activities drawn included: going to the beach to go fishing and ride water vehicles; going swimming at the pool and in the ocean; playing sports with family and friends; going shopping and having dinner at home, at restaurants, and having cook-outs; watching television with family members; traveling with family members and spending time doing family activities; and riding four wheelers and dirt bikes.

**Participant One, Two, and Three – Prospective Family Kinetic Drawing**

Participant one drew an image of himself and his step-father playing basketball together. He stated that he would like to spend more time with his step-father, mother, and his younger brother. Participant one reported that he has been adjudicated for several months and was looking forward to going home and spending more time outside in his backyard.

Participant two drew an image of his family, including his mother, younger brother, and himself, going to have a family portrait taken. He reported that he his mother wanted to have pictures taken after his release from the residential program and to schedule an outing with his family. He stated that he was looking forward to returning home and wanted to spend more time with his family. He also reported that he missed his younger brother (image of a male pictured on the right with red dots representing freckles) and wanted to spend more time with him. Participant two drew the image with markers, including four colors, with the words written “Family Photo.”

Using a black marker P3, drew an image of his family having a picnic together. Participant three has four older brothers and two older sisters. He drew an image of his six siblings, himself, and his mother. He ported that he enjoyed having picnics and family cook-outs. His image included the family having a picnic with a table set with hamburgers and hotdogs.

**Discussion of Session Four – Accepting Influence**

Session Four focused on exploring both positive and negative sentiment override, the concepts of accepting influence, and identifying interpersonal and family strengths. The group also discussed ways the adolescent can work together to achieve a common goal. The art therapy task was to work on a joint puzzle drawing. The participants decorated a single puzzle piece cut from a larger piece of poster board. The piece of poster board was cut into 16 pieces (15 pieces for the group participants and 1 piece for the researcher/therapist). The group decorated/colored
the individual puzzle pieces and then put all of the pieces together to form a larger image. The group chose a leader to assist in assembling the pieces. After the participants found two matching pieces, they taped the pieces together (see Appendix W). After completing the task, the group processed the activity and discussed the skills needed to be able to work together to assemble the puzzle pieces. The group also discussed the diversity of the images (16 pieces colored in with crayon and marker with some of the pieces left in black and white).

**Participant One, Two, and Three – Joint Puzzle Drawing**

All of the participants appeared to enjoy the activity and took several minutes decorating the puzzle piece. Participant one colored in the image with 11 colors and chose to use crayons and markers; his puzzle piece consisted of the eyes and partial face of the dragon. On the back of his puzzle piece, P1 drew the number “211,” his favorite football jersey number. The second participant colored in the image with four colors using markers only; his puzzle piece consisted of the dragon’s neck. On the back of his piece, he drew his nickname. Participant two did take an active role in helping to put together the puzzle pieces. Participant three colored in the image with eight colors using markers, but left most of the space white. His piece consisted of the dragon’s mouth. On the back of his piece he wrote, “Pensacola, Sunshine State.” All three participants helped in taping the puzzle together. The group took approximately 25 minute to re-assemble the puzzle pieces.

**Discussion of Session Five – Regulation of Conflict**

Session Five focused on increasing the ability to regulate conflict, both with solvable and with perpetual problems. Skills discussed for regulating conflict include: practicing a softened start-up, learning repair and de-escalation techniques, accepting influence from others, being able to compromise with others, and learning physiological soothing techniques, such as deep breathing exercises. Two art therapy tasks were completed: a Problem and Solution Drawing (a representation of a problem, the solution, and the means to achieve the solution) and practicing deep breathing while painting with watercolors. Themes of the *problem drawings* included: emotionally and physically fighting with siblings and parents; feeling depressed and anxious; financial problems; running away from home and staying out past curfew; the participants’ being adjudicated to a residential program; and the parents’ being incarcerated. Themes of the *solution drawings* included: talking with family members without conflict, feeling happy with little
worries, spending time with the family at home; spending time doing family activities such as going to the theatre or to the mall; using substances such as cigarettes to relax; attending church with the family and praying together; or leaving home to avoid family conflicts.

The second part of the group included having the participants explore a deep breathing painting exercise. The participants practiced deep breathing exercises and painted with watercolors as they exhaled. The group discussed the importance of recognizing when one is feeling upset or angry and learning to regulate one’s anger, stress, or anxiety through self-soothing. The participants reported that they enjoyed the Deep Breathing Painting exercise, which assisted in regulating the physiological responses and self-regulatory skills. See Appendix X and Y for examples of the participants’ artwork and comments.

Participant One, Two, and Three – Problem & Solution Drawing and Deep Breathing

Participant one drew a picture of a problem which was his having an argument with his stepfather and walking away from the situation. This picture was drawn in pencil with a tree colored in marker with green and brown. The solution depicted showed P1 living in a calm, happy home. The means to reach the solution included the family (father, mother, and son) spending time together “doing fun activities outside” and “talking together.” The adolescent did have an incongruence in his affect. He reported that he felt angry, yet in his self-portrait he was smiling.

The second participant drew an image of feeling depressed and worrying about things. The image consisted of 10 colors using markers with words written on all three sections. The drawing was on a schematic drawing level with a stick man to present his self-portrait with a foreground and a sky present. The problem was depicted by P2’s being caught under rain clouds in a storm. The comments on this image included “Too many problems on my mind,” “A person full of bad dreams,” and “The grass aint green.” The solution was depicted as P2’s being surrounded by a rainbow with clear, sunny skies and next to a pot of gold. The comments on this image were, “clear sky, rainbows, riches, green grass and happiness.” The means to reach the solution showed P2’s becoming rich. The comments on this section were “money, more, more.” Participant two reported that if he had more money, he would feel happy with fewer worries. Participant two believed that money would repair his problems, and he had difficulty seeing other options or solutions to help him address symptoms of depression and anxiety.

The third participant drew an image physically fighting with his brother, using only pencil
with words written on all three sections. Participant three’s drawings were on the schematic level with a poorly developed body (stick people with gloves for hands and feet). Participant three did include facial expressions in one of the drawings, showing a male “crying with a black eye.” P3 reported several physical confrontations with his brother. The image of the solution showed a picture of money with the word written “missing money always(s).” The means to reach the solution was an image of his car. The words read “going home to get to the money.” This participant also believed that money would be the answer to his problems and was not able to think of solutions to resolve the conflict with his brother. See Appendix X for examples of the Problem and Solution Drawings.

For the second portion of the group activity, the participants were instructed to practice deep breathing and paint with watercolors while they were exhaling. Participant one chose 7 colors and practiced painting straight, serrated and wavy lines, circles, and dots. Participant two chose 6 different watercolors and practiced many shapes including straight, serrated, and wavy lines; spirals; and dots. Participant three chose one color, black, and painted small and large circles, spirals, small and large serrated and wavy lines. All participants appeared to enjoy the exercise as evidenced by their smiling and laughing. See Appendix Y for the deep breathing painting exercise examples.

**Summary of the Group and Drawing Activities**

**Relation of Art-based Interventions to Gottman’s Theory**

After completing the five group sessions, the researcher reviewed the group topics for the five prior weeks. Six group members were able to list four of Gottman’s identified unhealthy behaviors; eight group members were able to list both positive and negative feelings; two participants were able to define the term “love map;” four participants were able to discuss the emotional bank account; two participants were able to define the term accepting influence; nine of the participants were able to define flooding, and 15 of the participants were able to identify positive self-regulatory skills and ways to achieve physiological soothing. All participants completed all of the assignments and stayed on task throughout the group. No inappropriate behaviors occurred during the group sessions and all interactions with both peer and staff were positive in nature.

For the first session all participants were able to identify feelings for the four unhealthy
communication patterns and the eight positive and negative feelings. Participants were able to
discuss their feelings and discuss examples of the four unhealthy communication patterns within
the context of their family, as well as other relationships in their home, community, school, and
work setting.

For the second and third session the participants were able to draw images of themselves, of
their families, either real or symbolic, and of their families doing something. However, in many
of the drawings the participant or the entire family was absent from the image. Many participants
reported that they did not engage in family activities often and did not feel as though their family
was available for activities (e.g. parents were separated/ divorced, did not reside in the same area
as the participant, or were incarcerated). Further, for many of the drawings the participants drew
low level activities, such as watching television and sitting at home together with the family
members, or the participant was not included in the picture.

During the fourth session the participants were actively involved in working on the joint
puzzle drawing and successfully completed the task through working together with their peers. It
was hypothesized that improving the adolescent’s communication, social, self-regulatory, and
decision-making skills would allow the adolescents to be able to better regulate their feelings
and tolerate levels of depression and anxiety. Improving these self-regulatory skills may
decrease impulsive behaviors; therefore, the adolescent may be less at risk for criminogenic
behaviors.

In the fifth session the participants were successfully able to discuss their problems on a
symbolic level, as well as practice deep breathing skills through painting. Practicing self-
regulatory skills such as deep breathing may decrease the propensity for flooding, may decrease
verbal and physical aggressions, and may improve the adolescents’ ability to maintain
meaningful relationships with less conflict. The group members practiced deep breathing and
discussed the importance of allowing oneself enough time to relax after becoming flooded or
upset.

**Artistic Drawing Level, Media, and Themes**

Many of the images were drawn according to the artistic developmental levels of the
*Schematic Stage*, typically found in children from seven to nine years old, to the *Gang Age*,
typically found in children nine to twelve years of. In the schematic stage, the youth draws
images that tend to have a flat representation. There is an establishment of a base line with often a sky line present, and the human form representation is usually made up of geometric shapes with correctly placed arms and legs. In the Gang Age, the youth draws images with a greater awareness of details in the physical environment and human figures with more of a relationship between images (Lowenfeld & Brittain, 1987). Some participants used diverse media including many markers and colored pencils; whereas, other participants simplified their drawings using pencil only. Finally, in the problem and solution drawings many participants drew and discussed money as a way to solve their problems. They had difficulty visualizing other possible realistic solutions and focused on quick materialistic solutions.

**Results Regarding Mental Health Measures**

For the POSIT and the SCL-90 measures, fewer points accrued indicated fewer symptoms or problems. The POSIT pretest measure described the participants as being at low, moderate, or high risk for problems based on the 10 subscales. The results for the high risk category were as follows: 13 participants were identified as having vocational problems; 11 participants were identified as having problems in leisure activities; 6 participants were identified as having family problems; 5 participants were identified as having educational problems; 4 participants were identified as having health, mental health, and social skills problems; and 1 participant was identified as having substance abuse and delinquency problems.

The results for the moderate risk were as follows: 11 participants were identified as having problems with peers; 9 participants were identified as having delinquency problems; 8 youth reported health problems; 7 participants reported educational and social skills problems; 6 participants reported substance abuse problems; and 4 participants were identified as having mental health and family problems.

The results for the low risk category were as follows: 8 participants reported substance abuse problems; 7 participants reported mental health problems; 5 participants were identified as having family and delinquency problems; 4 participants reported social skills problems; 3 participants reported educational problems; 2 participants reported vocational and leisure activity problems; and 1 participant reported peer problems. Table 3 illustrates the number of participants found to be at low, middle, and high risk on the POSIT measure.
Table 3. Problem Oriented Screening Instrument for Teenagers (POSIT) Risk Level

<table>
<thead>
<tr>
<th>POSIT Group Totals</th>
<th>Low Risk</th>
<th>Middle Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse (0-17 points)</td>
<td>8</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Health Status (0-10 points)</td>
<td>3</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Mental Health (0-22 points)</td>
<td>7</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Family (0-11 points)</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Peer (0-10 points)</td>
<td>1</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Educational (0-26 points)</td>
<td>3</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Vocational (0-18 points)</td>
<td>2</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Social Skills (0-11 points)</td>
<td>4</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Leisure (0-12 points)</td>
<td>2</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Delinquency (0-16 points)</td>
<td>5</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>

Statistical Analysis for the POSIT

In order to exam changes in the participant’s substance abuse, mental health, health, family, peer, educational, vocational, social, leisure, and delinquency levels/ status after participating in a five-week Gottman art-based group intervention, participants’ POSIT scores were subjected to the nonparametric Wilcoxin Rank test because the small sample size of this study (15 participants) did not allow normal distribution present. The significance level was determined to be .10, so that 90 times out of 100 results will be found.

The Wilcoxin Rank test was computed to the presence of a statistical difference between pretest and posttest measures on the POSIT. To calculate the Wilcoxin Rank test statistic, all of the scores were placed in ascending order and then were given ranks. There were fifteen participants in this study. Of the ten subscales on the POSIT, the positive ranks for the subscales were as follows: Substance Abuse (3), Mental Health (4), Health (7), Family (1), Peer (3), Educational (4), Vocational (1), Social (3), Leisure (4), and Delinquency (5).

Of the ten subscales on the POSIT, the negative ranks for the subscales were as follows: Substance Abuse (5), Mental Health (9), Health (7), Family (10), Peer (6), Educational (10),
Vocational (11), Social (11), Leisure (10), and Delinquency (9). The higher the number of negative ranks indicated greater change in the posttest scores. Ties occurred when two scores of any pair were equal; in other words, no difference was observed between the two treatments for that pair. The mean for each group was calculated, and the sum of the ranks for each group was calculated (see Table 4).

Table 4. Problem Oriented Screening Instrument for Teenagers (POSIT): Wilcoxin Signed Ranks Test

<table>
<thead>
<tr>
<th>POSIT Substances Abuse</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
<td>5</td>
<td>5.70</td>
<td>28.50</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>3</td>
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<td>7.50</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POSIT Mental Health</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
<td>9</td>
<td>7.61</td>
<td>68.50</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>4</td>
<td>5.63</td>
<td>22.50</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>2</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POSIT Health</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
<td>7</td>
<td>8.36</td>
<td>58.50</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>7</td>
<td>6.64</td>
<td>46.50</td>
</tr>
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<td>Total</td>
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<table>
<thead>
<tr>
<th>POSIT Family</th>
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<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
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<td>6.30</td>
<td>63.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>1</td>
<td>3.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
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<table>
<thead>
<tr>
<th>POSIT Peer</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
<td>6</td>
<td>4.83</td>
<td>29.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
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<td>5.33</td>
<td>16.00</td>
</tr>
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<td>Total</td>
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<table>
<thead>
<tr>
<th>POSIT Educational</th>
<th>N</th>
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<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
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<td>7.20</td>
<td>72.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
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<td>8.25</td>
<td>33.00</td>
</tr>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>POSIT Vocational</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
<td>11</td>
<td>6.91</td>
<td>76.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>1</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POSIT Social</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
<td>11</td>
<td>7.36</td>
<td>81.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>3</td>
<td>8.00</td>
<td>24.00</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POSIT Leisure</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
<td>10</td>
<td>9.10</td>
<td>91.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>4</td>
<td>3.50</td>
<td>14.00</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POSIT Delinquency</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
<td>9</td>
<td>7.67</td>
<td>69.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>5</td>
<td>7.20</td>
<td>36.00</td>
</tr>
</tbody>
</table>
Results for the subjects pretest and posttest POSIT Substance abuse scores were analyzed using the Wilcoxon Signed Ranks Test. In Table 5 below shows the asymptotic significance for the non-directional hypothesis, that is, there was no difference between pretest and posttest, and substance abuse scores were retained (Z = -1.491, p = 0.136). Five additional subscales were determined not to be statistically significant including: Mental Health scores (Z = -1.613, p = .107); Health scores (Z = -0.381, p = 0.703); Peer scores (Z = -0.785, p = 0.432); Education scores (Z = -1.231, p = 0.218); and Delinquency scores (Z = -1.048, p = 0.295).

The participants’ pretest and posttest POSIT Family scores were analyzed using the Wilcoxon Signed Ranks Test. Table 5 shows the asymptotic significance for the non-directional hypothesis; that is, there was no difference between pretest and posttest, and family scores were rejected (Z = 2.697, p = 0.007). A significant difference was also found for two additional scales including: Vocational scores (Z = -2.972, p = 0.003); Social scores (Z = -1.824, p = 0.068); and Leisure scores (Z = 2.432, p = 0.015).

Table 5: POSIT Wilcoxin Rank Signed Test Results

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Z Asymp Sig. (2-tailed)</td>
<td>-1.491 -.136</td>
<td>-1.613 -.107</td>
<td>-0.381 .703</td>
<td>-2.697 .007</td>
<td>-0.785 .432</td>
<td>-1.231 .218</td>
<td>-2.972 .003</td>
<td>-1.824 .068</td>
<td>2.432 .015</td>
<td>-1.048 .295</td>
</tr>
</tbody>
</table>

Statistical Analysis for the SCL-90

Based on the scores of the SCL-90 subscales, up to nine participants were diagnosed as having clinically significant symptoms on the pretest measure. This determination was made when there was a mean that was equal to or higher than the clinical cut off for the subscale (see Table 6). Clinical significance included: Symptoms of Obsessive Compulsive Disorder and Anger/Hostility (9 participants); Anxiety, Paranoia/Paranoid Ideations, and Psychotism (6 participants); Interpersonal Sensitivity (feelings of inadequacy and inferiority) and Phobias (5 participants).
participants); and symptoms of Depression (4 participants). See Table 6 for a summary of the SCL-90 subscales.

**Table 6: Symptom Check List SCL-90 Clinically Significant Subscales**

<table>
<thead>
<tr>
<th>SCL-90 Subscales</th>
<th>Clinical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatization Questions</td>
<td></td>
</tr>
<tr>
<td>(0-48 points)</td>
<td>12</td>
</tr>
<tr>
<td>Mean=1.23</td>
<td></td>
</tr>
<tr>
<td>OCD</td>
<td></td>
</tr>
<tr>
<td>(0-40 points)</td>
<td>10 Questions</td>
</tr>
<tr>
<td>Mean=1.18</td>
<td>9</td>
</tr>
<tr>
<td>Interpersonal</td>
<td></td>
</tr>
<tr>
<td>(0-36 points)</td>
<td>9 Questions</td>
</tr>
<tr>
<td>Mean=.96</td>
<td>5</td>
</tr>
<tr>
<td>Depression Questions</td>
<td></td>
</tr>
<tr>
<td>(0-52 points)</td>
<td>13 Questions</td>
</tr>
<tr>
<td>Mean=1.50</td>
<td>4</td>
</tr>
<tr>
<td>Anxiety Questions</td>
<td></td>
</tr>
<tr>
<td>(0-40 points)</td>
<td>10 Questions</td>
</tr>
<tr>
<td>Mean=1.24</td>
<td>6</td>
</tr>
<tr>
<td>Anger</td>
<td></td>
</tr>
<tr>
<td>(0-24 points)</td>
<td>6 Questions</td>
</tr>
<tr>
<td>Mean=.83</td>
<td>9</td>
</tr>
<tr>
<td>Phobia</td>
<td></td>
</tr>
<tr>
<td>(0-28 points)</td>
<td>7 Questions</td>
</tr>
<tr>
<td>Mean=.69</td>
<td>5</td>
</tr>
<tr>
<td>Paranoid</td>
<td></td>
</tr>
<tr>
<td>(0-24 points)</td>
<td>6 Questions</td>
</tr>
<tr>
<td>Mean=1.32</td>
<td>6</td>
</tr>
<tr>
<td>Psychotism</td>
<td></td>
</tr>
<tr>
<td>(0-40 points)</td>
<td>10 Questions</td>
</tr>
<tr>
<td>Mean=.76</td>
<td>6</td>
</tr>
</tbody>
</table>

The Wilcoxin Rank test was computed to explore if a statistical difference between pretest and posttest measures on the SCL-90 was present. Of the nine subscales on the SCL-90, the positive ranks for the subscales were as follows: Somatization (5), OCD (1), Interpersonal (2), Depression (2), Anxiety (4), Anger (3), Phobia (2), Paranoid (4), and Psychotism (5). For the nine subscales on the SCL-90, the negative ranks for the subscales were as follows: Somatization (8), OCD (14), Interpersonal (12), Depression (12), Anxiety (8), Anger (10), Phobia (5), Paranoid (8), and Psychotism (4). The higher the number of negative ranks indicated a greater change in the posttest measures. Ties occurred when two scores of any pair were equal; therefore, no difference between the two treatments was observed for that pair. The mean for
each group was calculated and the total sum of the ranks for each group was calculated (See Table 7).

**Table 7: Symptom Checklist (SCL 90) Wilcoxin Signed Ranks Test**
Pretest and Posttest Mean Ranks & Sum of Ranks based on the Group Responses

<table>
<thead>
<tr>
<th>Scale</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SCL 90 Somatization</strong></td>
<td>8</td>
<td>7.50</td>
<td>60.00</td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>5</td>
<td>6.20</td>
<td>31.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SCL 90 OCD</strong></td>
<td>14</td>
<td>8.29</td>
<td>116.00</td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>1</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SCL 90 Interpersonal</strong></td>
<td>12</td>
<td>6.30</td>
<td>63.00</td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>2</td>
<td>9.33</td>
<td>28.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SCL 90 Depression</strong></td>
<td>12</td>
<td>6.96</td>
<td>83.50</td>
</tr>
<tr>
<td>Negative Ranks</td>
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<td>21.50</td>
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<tr>
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<td></td>
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<tr>
<td>Posttest-Pretest Ties</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SCL 90 Anxiety</strong></td>
<td>8</td>
<td>7.50</td>
<td>60.00</td>
</tr>
<tr>
<td>Negative Ranks</td>
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<td>18.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
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<td></td>
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<tr>
<td>Posttest-Pretest Ties</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SCL 90 Anger</strong></td>
<td>10</td>
<td>6.70</td>
<td>67.00</td>
</tr>
<tr>
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<td>Positive Ranks</td>
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</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SCL 90 Phobia</strong></td>
<td>5</td>
<td>4.30</td>
<td>21.50</td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>2</td>
<td>3.25</td>
<td>6.50</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SCL 90 Paranoid</strong></td>
<td>8</td>
<td>6.38</td>
<td>51.00</td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>4</td>
<td>6.75</td>
<td>27.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SCL 90 Psychotism</strong></td>
<td>4</td>
<td>5.25</td>
<td>21.00</td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>5</td>
<td>4.80</td>
<td>24.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Wilcoxon Signed Ranks test was used to test if there was any difference between pretest and posttest SCL 90 subscale scores (see Table 8). A significant difference was found on the following subscales: OCD (Z = -3.200, p = 0.001); Depression (Z= -1.948, p = 0.051); and Anxiety scale (Z = -1.651, p = 0.099). No statistical difference was found on the Somatization (Z=-1.015, p=0.310); Interpersonal (Z=-1.226, p=0.220); Anger (Z=-1.509, p=0.131); Phobia (Z=-1.272, p=0.203); Paranoid (Z=-.944, p=0.345); and Psychoticism (Z=-.178, p=0.859).

**Table 8: SCL 90 Statistical Results**

<table>
<thead>
<tr>
<th>SCL 90</th>
<th>Somatization Post-Pretest</th>
<th>SCL 90 OCD Post-Pretest</th>
<th>SCL 90 Interpersonal Post-Pretest</th>
<th>SCL 90 Depression Post-Pretest</th>
<th>SCL 90 Anxiety Post-Pretest</th>
<th>SCL 90 Anger Post-Pretest</th>
<th>SCL 90 Phobia Post-Pretest</th>
<th>SCL 90 Paranoid Post-Pretest</th>
<th>SCL 90 Psychotism Post-Pretest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z</td>
<td>Asymp.</td>
<td>Sig (2-tailed)</td>
<td>Z</td>
<td>Asymp.</td>
<td>Sig (2-tailed)</td>
<td>Z</td>
<td>Asymp.</td>
<td>Sig (2-tailed)</td>
<td>Z</td>
</tr>
<tr>
<td>-1.015</td>
<td>.310</td>
<td>.001</td>
<td>-3.200</td>
<td>-1.226</td>
<td>.220</td>
<td>-1.948</td>
<td>.051</td>
<td>.099</td>
<td>-1.651</td>
</tr>
</tbody>
</table>

**Results for the Parent-Child Research Measures**

A higher score on the PCC indicated a more positive relationship. For the first two scales the QRI (social and depth scales), a higher score indicates a more positive relationship. On the QRI’s conflict scale a higher score indicates more family conflict. See Tables 9 and 10 below for the group pretest and posttest median ranks and statistical results for the PCC measure and Table 11 and 12 for the group pretest and posttest median ranks and statistical results for the QRI measure.

**Statistical Analysis for the PCC**

The Wilcoxin Rank test was computed to explore if a statistical difference between pretest and posttest measures on the PCC was present. Of the two subscales on the PCC, the positive ranks for the subscales were as follows: Mother (9) and Father (10). For the two subscales on the PCC, the negative ranks for the subscales were as follows: Mother (0) and Father (0). The mean for each group and the total sum of ranks for each group were calculated. The sum of the positive ranks for the mother and father scale (45 versus 0 and 55 versus 0 respectively) showed that the posttest scores were much higher than the pretest scores, indicating a significant change in the measures (see Table 9).
Table 9: Parent-Child Closeness (PCC) Wilcoxin Signed Ranks Test
Pre and Posttest Mean Rank & Sum of Ranks based on the Group Responses

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCC Mother</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>0</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>9</td>
<td>5.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PCC Father</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>0</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>10</td>
<td>5.50</td>
<td>55.00</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Wilcoxon Signed Ranks Test was used to test the difference between the pretest and posttest scores on Father's and Mother's PCC scores. Table 10 shows that there were only two subscales which were significant. On the Mother's PCC and Father's PCC there was a significant difference between pretest and posttest scores (Mother's Z = -2.677, p = .007, Father's Z = -2.812, p = 0.005).

<table>
<thead>
<tr>
<th></th>
<th>Mother PCC Posttest-Mother PCC Pretest</th>
<th>Father PCC Posttest-Father PCC Pretest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z</td>
<td>-2.677</td>
<td>-2.812</td>
</tr>
<tr>
<td>Asymp. Sig (2-tailed)</td>
<td>.007</td>
<td>.005</td>
</tr>
</tbody>
</table>

Table 10: PCC Mother and Father Statistical Results

Statistical Analysis for the QRI

The Wilcoxin Rank test was computed to explore if a statistical difference between pretest and posttest measures on the PCC was present. Of the six subscales on the QRI, the positive ranks for the subscales were as follows: Mother Social (5), Mother Depth (5), Mother Conflict (7), Father Social (6), Father Depth (7), and Father Conflict (4). For the three subscales for mother and father on the QRI, the negative ranks for the subscales were as follows: Mother Social (4), Mother Depth (2), Mother Conflict (4), Father Social (2), Father Depth (1), and Father Conflict (6). The higher the number of positive ranks indicated a greater change in the posttest measures. Ties occurred when two scores of any pair were equal; therefore, no difference between the two treatments was observed for that pair. The mean for each group was
calculated, and the total sum of the ranks for each group was calculated (see table 11).

Table 11: Quality of Relationship Inventory Wilcoxin Signed Ranks Test

Social Support (Reliance on parent for assistance): Higher Score, Closer Relationship
Depth (Level of commitment and positive value): Higher Score, Closer Relationship
Conflict (Level of anger and ambivalence): Lower Score, Closer Relationship

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>QRI Mother Social</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>4</td>
<td>6.25</td>
<td>25.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>5</td>
<td>4.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QRI Mother Depth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>2</td>
<td>6.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>5</td>
<td>3.20</td>
<td>16.00</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QRI Mother Conflict</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>4</td>
<td>5.63</td>
<td>22.50</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>7</td>
<td>6.21</td>
<td>43.50</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QRI Father Social</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Ranks</td>
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<td>5.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Positive Ranks</td>
<td>6</td>
<td>4.33</td>
<td>26.00</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QRI Father Depth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Ranks</td>
<td>1</td>
<td>7.00</td>
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<td>Positive Ranks</td>
<td>7</td>
<td>4.14</td>
<td>29.00</td>
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<tr>
<td>Posttest-Pretest Ties</td>
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<td></td>
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</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QRI Father Conflict</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Ranks</td>
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<td>.00</td>
<td>26.50</td>
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<tr>
<td>Positive Ranks</td>
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<td>5.50</td>
<td>28.50</td>
</tr>
<tr>
<td>Posttest-Pretest Ties</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Wilcoxon Signed Ranks Test was used to determine the presence of difference between the pretest and posttest scores on Father's and Mother's QRI scores. Table 12 shows that there were only two subscales that were significant. No statistical significance was found for any of the QRI measures for the mother or father (see Table 12) including: Mother’s and Father’s Social score respectively ($Z=-.297$, $p=0.766$ and $Z=-1.560$, $p=0.262$); Mother’s and Father’s Depth score ($Z=-.339$, $p=0.735$ and $Z=-1.560$, $p=0.119$); and the Mother’s and Father’s Conflict score respectively ($Z=-.936$, $p=.349$ and $Z=-.102$, $p=0.919$).
Table 12: QRI Mother and Father Statistical Results

<table>
<thead>
<tr>
<th></th>
<th>Mother QRI Social Posttest-Pretest</th>
<th>Mother QRI Depth Posttest-Pretest</th>
<th>Mother QRI Conflict Posttest-Pretest</th>
<th>Father QRI Social Posttest-Pretest</th>
<th>Father QRI Depth Posttest-Pretest</th>
<th>Father QRI Conflict Posttest-Pretest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z Asymp. Sig (2-tailed)</td>
<td>-.297</td>
<td>.766</td>
<td>-.936</td>
<td>-1.122</td>
<td>-1.560</td>
<td>-.102</td>
</tr>
<tr>
<td></td>
<td>.339</td>
<td>.735</td>
<td>.349</td>
<td>.262</td>
<td>.119</td>
<td>.919</td>
</tr>
</tbody>
</table>

POSIT Correctional Measures

On the POSIT subscales there were nine positive correlations and one negative correlation that were statistically significant. Spearman’s Rho correlation was computed on the POSIT posttest subscale scores; one negative correlation and nine positive correlations were found. A significant negative correlation was found between POSIT Vocational subscale and POSIT Health subscale ($r = -0.557, p = 0.031$). A significant positive correlation was found between the POSIT Education subscale and POSIT Substance Abuse subscale ($r = 0.702, p = .004$); Education subscale and the Peer subscale ($r = 0.654, p=0.008$); Social subscale and the Peer subscale ($r = 0.698, p=.004$); Social subscale and the Education subscale ($r = 0.698, p=.004$); Leisure subscale and the Substance abuse subscale ($r = 0.787, p=.000$); Leisure subscale and the Education subscale ($r = 0.707, p=.004$); Delinquency subscale and the Peer subscale ($r = 0.558, p=.031$); Delinquency subscale and the Education subscale ($r = 0.670, p=.006$); and the Health subscale and the Delinquency subscale ($r = 0.545, p=.036$). See Table 13 for the POSIT subscale correlations.

Table 13: POSIT Correlation Using the Spearman’s Rho Test

<table>
<thead>
<tr>
<th></th>
<th>POSIT SA Posttest</th>
<th>POSIT FAM Posttest</th>
<th>POSIT Peer Posttest</th>
<th>POSIT ED Posttest</th>
<th>POSIT VOC Posttest</th>
<th>POSIT Social Posttest</th>
<th>POSIT Leisure Posttest</th>
<th>POSIT DEL Posttest</th>
<th>POSIT Health Posttest</th>
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</thead>
<tbody>
<tr>
<td>POSIT SA Posttest</td>
<td>1.000</td>
<td>.302</td>
<td>.429</td>
<td>.702*</td>
<td>.101</td>
<td>.322</td>
<td>.787*</td>
<td>.428</td>
<td>.402</td>
</tr>
<tr>
<td></td>
<td>.274</td>
<td>.111</td>
<td>.004</td>
<td>.721</td>
<td>.242</td>
<td>.000</td>
<td>.112</td>
<td>.138</td>
<td></td>
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<tr>
<td>POSIT FAMILY Posttest</td>
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<td>1.000</td>
<td>.215</td>
<td>.405</td>
<td>.388</td>
<td>.377</td>
<td>.591*</td>
<td>.469</td>
<td>-.072</td>
</tr>
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<td></td>
<td>.274</td>
<td>.441</td>
<td>.134</td>
<td>.153</td>
<td>.166</td>
<td>.020</td>
<td>.078</td>
<td>.798</td>
<td></td>
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<tr>
<td>POSIT PEER Posttest</td>
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<td>.215</td>
<td>1.000</td>
<td>-.142</td>
<td>.698*</td>
<td>.372</td>
<td>.558*</td>
<td>.241</td>
<td></td>
</tr>
<tr>
<td></td>
<td>.111</td>
<td>.441</td>
<td>.008</td>
<td>.613</td>
<td>.004</td>
<td>.172</td>
<td>.031</td>
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</tr>
</tbody>
</table>
### Summary of Quantitative and Qualitative Findings

Using the quantitative mental health and substance abuse measure, the Problem Oriented Screening Instrument for Teenagers (POSIT), four subscales were found to be statistically significant for the POSIT including the family, vocational, social, and leisure subscales. Using the Symptom Check List (SCL-90), three subscales were found to be statistically significant: the OCD, depression, and anxiety subscales. As to the relational measures, statistical significance was found for both Mother and Father Parent-Child Closeness questionnaire.

Six subscales of the POSIT were analyzed and deemed not statistically significant: substance abuse, mental health, health, peer, education, and delinquency. Six subscales of the SCL-90 were found to be not statistically significant: somatization, interpersonal, anger, phobia, paranoid, and psychoticism. No statistical significance was found for the Quality of Relationship Inventory.

In the images drawn, all participants were able to represent successfully the four unhealthy communication patterns and the four positive and negative feelings. Regarding the kinetic family drawing and the prospective kinetic drawing, the first drawing for two of the three participants discussed (P1 and P3), did not include the adolescents or their family members. However, in the

<table>
<thead>
<tr>
<th>POSIT EDU Posttest</th>
<th>.702*</th>
<th>.405</th>
<th>.654*</th>
<th>1.000</th>
<th>.047</th>
<th>.698*</th>
<th>.707*</th>
<th>.670*</th>
<th>.367</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.004</td>
<td>.134</td>
<td>.008</td>
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<td>.868</td>
<td>.004</td>
<td>.003</td>
<td>.006</td>
<td>.179</td>
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<td>POSIT VOC Posttest</td>
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<td>.388</td>
<td>-.142</td>
<td>.047</td>
<td>1.000</td>
<td>.058</td>
<td>.107</td>
<td>-.014</td>
<td>-.557*</td>
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<td></td>
<td>.721</td>
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<td>.613</td>
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<td></td>
<td>.837</td>
<td>.703</td>
<td>.960</td>
<td>.031</td>
</tr>
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<td>.698*</td>
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<td>.339</td>
<td>.343</td>
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<td>.210</td>
<td>.881</td>
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<tr>
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<td>.591*</td>
<td>.372</td>
<td>.707*</td>
<td>.107</td>
<td>.339</td>
<td>1.000</td>
<td>.413</td>
<td>.243</td>
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<td></td>
<td>.000</td>
<td>.020</td>
<td>.172</td>
<td>.003</td>
<td>.703</td>
<td></td>
<td>.126</td>
<td>.382</td>
<td></td>
</tr>
<tr>
<td>POSIT DEL Posttest</td>
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<td>.469</td>
<td>.558*</td>
<td>.670*</td>
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<td>.343</td>
<td>.413</td>
<td>1.000</td>
<td>.545*</td>
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<td></td>
<td>.112</td>
<td>.078</td>
<td>.031</td>
<td>.006</td>
<td>.960</td>
<td></td>
<td>.126</td>
<td></td>
<td>.036</td>
</tr>
<tr>
<td>POSIT HEALTH Posttest</td>
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<td>-.072</td>
<td>.241</td>
<td>.367</td>
<td>-.557*</td>
<td>.042</td>
<td>.243</td>
<td>.545*</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>.138</td>
<td>.798</td>
<td>.387</td>
<td>.179</td>
<td>.031</td>
<td></td>
<td>.382</td>
<td>.036</td>
<td></td>
</tr>
</tbody>
</table>

*Correlation is significant at the .10 level (2-tailed); N=15
second set of drawings two participants did include themselves and the family or parent, possibly indicating a change in the parent-child relationship.
CHAPTER FIVE
SUMMARY AND DISCUSSION

This study investigated the effectiveness of providing a Gottman-based group therapy using art-based interventions to adjudicated male adolescents ages 14-18. According to Gottman’s Sound Relationship House Theory, this research study focused on enhancing the adolescents’ communication, social, self-regulatory, and problem-solving skills, as well as improving the parent-child relationship. The results of the study offer a preliminary finding to support the use of Gottman’s Sound Relationship House Theory with adolescents who have been diagnosed with behavioral problems and adjudicated to a Department of Juvenile Justice program.

The intervention was based on the first five levels of Gottman’s Sound Relationship House; the treatment plan consisted of a five week manualized group provided weekly for two hours. Sessions one through five focused on identifying feelings and unhealthy communication patterns, enhancing love maps, nurturing a culture of fondness and admiration to develop a positive sentiment override, and developing the skills necessary to regulate conflict to address solvable and perpetual problems. The next section will discuss an outline of the verbal and nonverbal components of the intervention in more detail.

The methodology and research questions are reviewed, as are the results for each objective of the research study. Based on the results of the pretest and posttest measures, interpretations are presented about the outcomes of this five-week manualized Gottman-based adolescent group therapy which utilized art-based interventions. The limitations of the study addressed in Chapter One are explored in more detail in this chapter, and current and future relational art therapy approaches utilizing Gottman’s Sound Relationship House are reviewed. Implications for future research are presented as are suggestions for clinical practice within the Department of Juvenile Justice.

Summary of Methodology and Response to Research Questions

This research project was initiated in order to explore the possibilities of an intervention that might provide more intensive interpersonal and family therapy to adolescents adjudicated to a Department of Juvenile Justice program and to determine if Gottman’s theory would be applicable to adolescents. The next section reviews the research questions and hypotheses; research sample, sampling mechanism, and setting; outline of the adolescent group therapy based
on Gottman’s Sound Relationship House Theory using art-based interventions; pretest and posttest mental health and relational measures, and response to the research questions and hypotheses.

**Research Questions**

This study addressed the following research questions:

1. Will participating in a five week adolescent group based on Gottman’s Sound Relationship House Theory using art-based interventions influence the adolescents’ self-regulatory skills in the areas of communication, social, and problem-solving skills?
2. Will participating in this group result in a change in the parent-child relationship?
3. Is there a relationship in the change in the nine subscales of the POSIT: substance abuse, family, peer, educational, vocational, social, leisure, delinquency, and health?
4. Will art-based activities assist the adolescents in exploring feelings, communication patterns, and family/relationship dynamics, as well as lend support to the quantitative findings?

**Research Hypotheses**

This study was guided by two research hypotheses:

1. Adolescents participating in a manualized five week group based on Gottman’s Sound Relationship Theory utilizing art-based interventions will experience a change in their self-regulatory skills in the areas of communication, social, and problem-solving skills.
2. Adolescents participating in a five week manualized group based on Gottman’s Sound Relationship House Theory utilizing art-based interventions will experience a change in the adolescent/parent relationship.

**Research Sample, Sampling Mechanism, and Setting**

This research study consisted of a convenience sample of 15 adolescent males ranging from the age of 14-18 who were recruited from a Department of Juvenile Justice moderate-risk residential program. The adolescents were adjudicated to a DJJ program in Tallahassee, Florida for approximately three to six months. The intervention included five weeks of adolescent group therapy for two hours each week with art-based interventions designed to address communication, social, self-regulatory, and problem-solving skills. The intervention also addressed family dynamics, interactions, traditions, and strengths based on Gottman’s Sound
Relationship House Theory.

**Adolescent Group Therapy Outline with Art-Based Interventions Discussed**

All the adolescents in the study attended a manualized weekly group for two hours per week with drawing interventions incorporated. The adolescents completed the art-based interventions after discussing the group topic. For the *first session*, the group focused on recognizing feelings and unhealthy communication patterns. The adolescents drew images to represent Gottman’s four unhealthy communication patterns (criticism, defensiveness, contempt, and stonewalling). The adolescents also drew images to represent four negative (sad, angry, anxious, and afraid) and four positive feelings (happy, excited, peaceful, and confident) using lines, shapes, colors, and forms. For the *second session*, the group focused on creating child and parent love maps. The adolescents completed a family drawing, either abstract or real, and a kinetic family drawing, an image of the family including the adolescent “doing something.”

For the *third session*, the group focused on nurturing a culture of fondness and admiration and turning towards one’s family versus turning away. The adolescents completed a prospective family kinetic drawing in which the adolescent was instructed to draw a picture of the family “doing something” after he returned home from the residential program. For the *fourth session*, the group focused on developing a positive perspective and learning to accept influence. The adolescents worked on decorating and putting together a two-sided puzzle cut from a large piece of poster board paper to foster working together and listening to one another. For the *fifth session*, the group focused on learning the skills to regulate conflict for solvable and perpetual problems. The adolescents created problem and solution drawings and discussed either symbolic or real avenues to reach the solution. The adolescents also practiced a deep breathing painting exercise and processed all of the artwork after completion of the activities. For a more detailed description of the intervention, see Table 1 and Appendix A, as well as the rationale for the art-based interventions discussed in Chapter One.

**Pretest and Posttest Mental Health and Relational Measures**

Four pretest and posttest measures were used in this study. Two mental health and two relational measures were completed by the adolescents at the beginning of the intervention and after the last group session. An overview of the measures is presented with additional information about the measures discussed in detail in Chapter 3. Outcomes for these measures
will be discussed in the next section.

The first measure used was the Problem Oriented Screening Instrument for Teenagers (POSIT). This measure consisted of 139 items examining 11 areas: substance use/abuse, physical health status, mental health status, family relationships, peer relationships, educational status, vocational status, social skills, leisure and recreation, and aggressive behavior/delinquency. The second mental health measure was the Symptom Checklist-90 (SCL-90) which included 90 items that assessed nine areas: somatization (perceptions of bodily dysfunction), obsessive-compulsive, interpersonal sensitivity (feelings of inadequacy and inferiority), depression, anxiety, anger-hostility, phobic anxiety, paranoid ideation, and psychoticism (experiencing false body sensations).

Two pretest and posttest relational measures were used to evaluate the parent-child relationship. The first parent-child relational measure was the Parent-Child Closeness questionnaire. This measure used a composite score ranging from 9 to 45. The score was created by summing the responses to the nine items for both the mother and the father. The higher score indicated more positive parent-child relationships. The second family relational measure was the Quality of Relationships Inventory, a 25-item questionnaire that examined three specific dimensions of the relationship: 1) social support, 2) perceptions of relationships as positive, important, and secure, and 3) conflict and ambivalence resulting from the relationship. The QRI yielded three scores: a) social support described as the reliance on the other person for assistance in a range of situations, b) depth described as the level of commitment and positive value within the relationship, and c) conflict described as anger and ambivalence felt toward the other person. The subscale scores were determined by averaging the relevant response values.

Response to the Research Questions and Hypotheses

Response to the First Research Question and Hypothesis

In response to the first research question regarding adolescent group therapy influencing the adolescents’ self-regulatory skills, changes were noted based on the results of the POSIT and the SCL-90; therefore, the hypothesis was rejected. The analyses of the data were performed using a Wilcoxon Signed Rank test. Four subscales of the POSIT, the Family, the Vocational, the Social, and the Leisure subscales, showed statistical significance.

According to the analysis of data from the POSIT, adolescents who participated in the
intervention reported fewer vocational, leisure, and social problems. It is speculated that the aspects of intervention that emphasized working together as a team and learning to “accept influence” with peers and staff, as well as working cooperatively with the art media, in a new and appropriate manner may have contributed to these findings.

The change in vocational scores may have occurred due to the efforts of the residential program and the school system, a confounding variable in the study. Because several adolescents dropped out of school, had excessive absences, or were suspended or expelled from school, this may have been the first time that some of the adolescents were able to focus on educational and/or vocational goals. Many of the adolescents may not have had a positive experience in the classroom or in the work setting. The adolescents at the DJJ program attend classes with a smaller student number on a daily basis. Many of the students have an Individualized Education Plan (IEP) to address learning disabilities or other mental health or academic challenges. The residential program further requires the adolescents to complete chores at the program and provides training in diverse areas such as horticulture and the culinary arts. These factors may support the adolescents’ exploration of their vocational endeavors and may assist their obtaining a GED or high school diploma. This intervention did not address vocational problems; however, a qualitative investigation could provide information to determine if this group assisted in decreasing vocational problems through verbal or nonverbal methods.

Improvement in leisure and social skills may be attributed to the group format itself, as well as to the overall verbal and nonverbal approaches. The group encouraged positive interactions among the adolescents and staff members and encouraged team building activities, such as the joint puzzle exercise. Adolescents reported that they enjoyed drawing, painting, completing the activities, sharing comments about the group topics, and processing the artwork in the group. During the intervention, the researcher observed the adolescents smiling and laughing often, working together with one another, and sharing comments and asking questions of other peers and staff members. The group also discussed family rituals and traditions, drew pictures of family activities, and shared stories about being with their family and friends.

Statistical significance was not found for six of the subscales including the Substance Abuse, the Mental Health, the Health, the Peer, the Educational, and the Delinquency subscales. This intervention focused on enhancing the adolescent’s self-regulatory skills and the
parent/child relationship; issues of substance use, academics, and delinquency were not addressed. Because the adolescents had been adjudicated to the residential program for one to six months, they had not been able to expand their peer support in the community. Results were not statistically significant for the Mental Health subscale; however, changes were noted for the SCL-90 measure.

Three subscales on the SCL-90 were found to be statistically significant: the OCD, Depression, and Anxiety subscales. Adolescents participating in the intervention, according to the analysis of data from the SCL-90, appeared to be less anxious and depressed with less obsessive–compulsive behaviors. It is speculated that aspects of the intervention that emphasized regulating “flooding” may have contributed to this finding. Components of the intervention which addressed the adolescents’ self-regulatory skills and communication skills included having the adolescents: explore feelings and effective communication patterns through art-based activities; enhance self-regulatory skills through the deep breathing painting with an emphasis on relaxation skills, and regulate feelings of depression, anxiety, and stress to avoid becoming flooded. The adolescents may have further benefited from talking about feelings and from expressing feelings though the art media. The process of making artwork itself could have presented opportunities for insights to occur either during the group or afterwards during the adolescent’s personal time of reflection.

Statistical significance was not found for the remaining six subscales of the SCL-90 including the Somatization, Interpersonal, Anger, Phobia, Paranoid, and Psychotism subscales. The intervention did not specifically address issues of somatization, paranoia, or psychotic features such as hallucinations. These symptoms are not characteristic for the diagnosis of Conduct Disorder; therefore, a decrease in symptoms was not expected to be clinically or statistically significant. It was believed that the adolescent’s level of anger may be decreased; however, no change occurred based on the SCL-90 subscale. Because many adolescents in residential programs have difficulty appropriately expressing and regulating their anger, adolescents experience verbal and physical altercations often; thereby, increasing their chances of becoming flooded.

Response to the Second Research Question and Hypothesis

In response to the second research question regarding a change in the parent-child
relationship, a change was noted in the parent-child relationship according to the POSIT Family subscale and the PCC mother scale and father scale. The POSIT showed statistical significance on the Family subscale and on both the mother scale and the father scale on the Parent Child Closeness measure. The hypothesis was rejected because a change was determined (improvement in the parent/child relationships) with mixed results. No statistical significance was found for any of the subscales (Social, Depth, or Conflict) on the QRI measure. This result is not congruent with the results of the other measures; however, by adding a qualitative component, this might could have provided additional information as to the effectiveness of the intervention and provide information about the validity and reliability of the measure.

Adolescents who participated in the intervention, according to the analysis of data from the POSIT and the PCC, reported an improvement in their parent-child relationships. It is speculated that aspects of the intervention that emphasized building parent-child friendships through expanding “love maps,” focusing on the family strengths, enhancing family rituals, and learning skills needed for solvable problems, such “accepting influence,” may have contributed to the findings.

The intervention that addressed family dynamics and interactions was formulated around exploring and enhancing the parent-child relationship. By addressing the love maps in the intervention and discussing the family strengths, traditions, and activities, the adolescents may have been able to focus more on positive characteristics of the family and not on prior conflicts. Further, Gottman posited that once a couple becomes involved in a negative perspective, it is difficult to focus on the strengths of the relationships. Remembering back to positive interactions with the family members may have assisted the adolescents in moving towards a positive perspective, as well as toward increasing the adolescents’ bids in the relationship.

Additional questions regarding the effectiveness of the Gottman’s Sound Relationship House are presented. Can talking about or drawing family activities be just as helpful as actually doing something such as scheduled activities with family members? If so, this idea offers hope that adjudicated delinquent adolescents and incarcerated parents might build the parent-child relationship within a confined environment. Further, can rituals of family connection be instituted in confined environments such as juvenile justice programs, jails, prisons, or psychiatric hospitals, even if the family members are not present? Examples might include
initiating mealtime, bedtime, or holiday rituals which could be continued after the adolescent or adult returns home. This action could offer hope to adolescents that have been adjudicated to several programs due to inappropriate behaviors or re-offenses committed, as well as to parents who are incarcerated and are unable to spend time at home with their children and family.

**Response to the Third Research Question**

In response to the third research question regarding a relationship in the change of the POSIT subscales, correlations were found among the POSIT measure. A Spearman Rho correlation computed on the POSIT posttest subscale scores showed ten positive correlations among eight subscales of: Substance Abuse, Family, Peer, Education, Social, Leisure, Delinquency, and Health. The ten positive correlations included: 1) As the adolescents’ substance abuse and peer problems decrease, so do their educational problems decrease. 2) As the adolescents’ peer and educational problems decrease, so do the adolescents’ social problems decrease. 3) As the adolescents’ substance abuse, family, and educational problems decrease, so do the adolescents’ leisure problems. 4) As the adolescents’ peer and educational problems decrease, so do the adolescents’ delinquency problems decrease, and 5) As the adolescents’ delinquency problems decrease, so do the adolescents’ health problems decrease. One significant negative correlation was found between the POSIT Vocational and Health posttest subscale scores. As the adolescents’ vocational problems increase, the adolescents’ health problems decrease. Based on the POSIT correlations, it appears that as one problem is addressed, other issues are, in turn, affected, thereby reinforcing a systemic therapeutic approach.

**Response to the Fourth Research Question**

In response to the fourth research question regarding whether or not art-based activities would assist the adolescent in exploring feelings, communication patterns, and the adolescent’s family and relationship dynamics, the adolescents successfully completed the tasks and processed their images and the activities during the art-based interventions. The adolescents may have benefited from drawing images to represent their thoughts, feelings, behaviors, families, family dynamics, rituals, and strengths. They may also have benefited from completing the tasks and processing the artwork afterwards, as compared to traditional verbal counseling and psychoeducational groups. The participants did interact appropriately with others throughout the intervention, stayed on task through-out the group, and did successfully complete every weekly
art-based intervention. Based on the adolescents’ participation in the group and the content of the group drawings, the adolescents discussed family activities such as taking family vacations; traveling to the beach to swim, fish, and ride water vehicles; having dinner and cook-outs; attending sporting events and playing sports; going to the cinema to watch movies and television at home; going to the mall to go shopping; and dancing and spending time together. While discussing the family activities, the adolescents appeared to enjoy discussing their artwork as evidenced by them laughing and sharing family stories with the group. For additional information on the content of the adolescents’ drawings, see Chapter Four’s discussion on the second and third session of the intervention.

No qualitative measure, such as interviewing the adolescents regarding their perception of the art-based interventions, was used to evaluate the participants’ use of the art-based interventions or to determine if they found the interventions to be helpful. A qualitative measure might be the next step in further investigating the efficacy of art-based interventions. Additional research would be helpful to identify what aspect of the art-based interventions, if any, were instrumental in improving the parent-child relationship. By adding a questionnaire after each session to explore the helpfulness of the art-based activities, this may have offered much valuable information.

**Findings Related to the Current Gottman-Based and Art-Based Literature**

As discussed in Chapter Two, several studies explored the effectiveness of Gottman’s Sound Relationship House Theory with couples and newborns and the efficacy of art therapy with adolescents. Results that emerged from this study correlated to several research studies in marriage and family therapy and art therapy. The most recent Gottman study with families explored the transition of couples to parenthood. This newer project is called *Bringing Baby Home* and focuses on: exploring the transition to parenthood, decreasing parental stress, decreasing expressed hostile affect towards partners, decreasing symptoms of post-partum depression in both partners, and improving the overall marital quality of the relationship, resulting in a successful transition to parenthood (The Gottman Institute, 2006). Shapiro and Gottman (2005) explored the effectiveness of a psycho-communicative-educational two-day manualized workshop with three research/clinical goals including: a) strengthening the couple’s relationship and preparing the partners for the marital difficulties associated with parenthood, b)
facilitating the father’s, as well as the mother’s, involvement with the family, and c) providing the parents with basic information about infant psychological development.

The results of Shapiro and Gottman’s (2005) study indicated: a decrease in post-partum depression for both members of the couples after they attended the workshop with a 3-year follow-up, lowered marital hostility in both spouses at 1 year, and stable marital quality after attending the workshop group. The overall data suggested that the Bringing Baby Home preventive intervention using a psycho-communicative-educational format was found to be effective over a 3-year time period with couples age 18 and over. The results of the study regarding a decrease in levels of depression were consistent with this current study with adolescents and utilized the same measure to assess levels of depression, the SCL-90. If principles of the project could be implemented with families, parents and adolescents may also report an improvement in the family relationship.

Gottman and DeClaire (1997) focused on the role of regulating emotions with children and parents. They found that if children can learn how to regulate their emotions through self-soothing, this may assist children in focusing attention, improving their concentration, and learning to read other’s body language thereby enhancing their social cues. Children then become proficient in recognizing their feelings, experiencing the feelings immediately, and then talking about the feelings so that children can refocus and gain composure so that their feelings do not escalate. Children can also learn problem-solving skills through a system of rules, boundaries, and consequences established by the parent. Results from this study were congruent with the findings of Gottman and DeClaire (1997). By allowing the adolescents the opportunity to express their feelings verbally and nonverbally through discussion and art-based interventions, the adolescents reported fewer symptoms of depression and anxiety and were better equipped to recognize and express their feelings while avoiding the unhealthy communication patterns such as the criticism, defensiveness, contempt, and stonewalling. It is posited that if children can apply the principles of Gottman’s theory through their parents becoming emotion-coaching parents, the same results will hold true for adolescents in that they will also be able to improve their communication, social, self-regulatory, and problem-solving skills.

In reviewing the art therapy literature, this study’s findings were consistent with the prior art therapy literature citing an improvement in adolescent’s social skills and a decrease in symptoms
of anxiety, depression, and family conflict. It is believed that the adolescents were also able to improve their communication, problem-solving, and self-regulatory skills through the use of art-based interventions. Several authors found individual and group art therapy with adolescents to be effective in improving the adolescent’s communication skills and feeling expression (Steinberger, 1987; Conger, 1988; Hume & Hiti, 1988; Tibbetts & Stone, 1990; Stanley & Miller, 1993; McGann, 1999; Hanes, 2000; Druckenmiller, 2002; Bennink et al., 2003; Harnden et al., 2004; Wadeson & Wirtz, 2005; and Bournmann et al., 2007), coping skills (Viscardi, 1994; Hanes, 2000; Howard, 2001; Bennink et al., 2003; and Bormann et al., 2007); problem-solving skills (Hume & Hiti, 1988; Viscardi, 1994; and Hartz & Thick, 2005); and social skills (Steinberger, 1987; Hume & Hiti, 1988; Stanley & Miller, 1993; Viscardi, 1994; Appleton & Dykeman, 1996; Vick, 1999; Howard, 2001; Druckenmiller, 2002; Bennink et al., 2003; Testa & McCarthy, 2004; and Hartz & Thick, 2005).

Several authors also found a decrease in symptoms of anxiety (Tibbets & Stone, 1990); symptoms of depression and sadness (Conger, 1988; Tibbetts & Stone, 1990; Walsh, 1993; Hanes, 2000; Harnden et al., 2004; and Testa & McCarthy, 2004) and family conflict (Hume & Hiti, 1988; Tibbetts & Stone, 1990; Stanley & Miller, 1993; Viscardi, 1994; Appleton & Dykeman, 1996; Hanes, 2000; Howard, 2001; Robertson, 2001; Harnden et al. 2004; and Testa & McCarthy, 2004).

**Limitations of the Study**

The limitations of this study were briefly presented in Chapter One and are explored in this section in detail. The study was first limited by having a convenience sample in which either the adolescents over the age of 18 were allowed to consent to participate in the study, or minors under the age of 18 were granted personal assent if consent was obtained from their parent/guardian. Due to several parents’ relocating or not having a current address/telephone number on file, not all of the parents were contacted regarding the research group; therefore, consent for participation in the study, could not be obtained. Some parents contacted did not provide consent for treatment because they either stated that they did not believe that the group would be helpful or felt that the adolescent had more important problems to focus on (such as academic or vocational) than family and interpersonal problems.

Due to the small sample size of 15 youth from one adolescent residential program in one
In Florida, the results from the sample can not be generalized to the greater population. This limit results in threats to the external validity of the study. Further, because the sample consisted of males only from the ages of 14 to 18, the results of the study could not be generalized to all adolescents. The results of the study can be applied only to this study setting, population, and study conditions. Further, due to the researcher’s implementing the groups, researcher bias is possible. The researcher implemented a five week structured group and devised a manual to assist with treatment fidelity outlining the tasks of the session, the art therapy interventions, and the goals for the session. The researcher hired an outside statistical consultant to assist with the statistical tests in an effort to decrease researcher bias.

Six threats to internal validity as described by Campbell and Stanley (1963) were present. These threats included history, maturation, testing and instrumentation, selection biases, and diffusion/ imitation of treatments. Because the program is a residential treatment program which lasts for approximately three to six months, extraneous events may have occurred with the adolescent or the program to confound the results. An example of a history threat might include an adolescent’s receiving positive or negative news from home; having a positive or negative family visitation while at the program, or having a change at the facility, including absconding from the program, or a change at the school, such as being suspended or expelled. The adolescents’ maturation which may naturally occur over time could create change not related to the treatment intervention.

The third and fourth threats to internal validity were the effects of testing and instrumentation. Because the participants completed the same pretest and posttest measures, scores may be enhanced due to familiarity with the measures. Further, the participants may have believed that the second measures were easier to complete since they were now familiar with the test questions and the format. Selection bias also may have occurred. The participants that were age 18 and consented for treatment may have been more motivated for treatment and ready to address interpersonal and family problems. The family members who provided consent for their child to participate in the intervention may have also been more motivated for treatment; in turn, the family members who did not provide consent may have been less motivated and accepting of treatment. The final threat to internal validity may have been the presence of an additional treatment, including group and individual therapy based on Cognitive-Behavioral approaches.
All participants at the program receive institutional-based task groups which focus on completing chores and following the rules at the facility.

Two additional limitations were present because of two possible measurement errors, systematic and random measurement error. Systematic error occurs when information collected through measures reflects a false representation of the variable being measured. Two forms of systematic measurement error include the acquiescent response set and the social desirability bias. The acquiescent response set involves a subject’s agreeing or disagreeing with most or all of the statements, regardless of the content. Because many of the participants had difficulty reading, staying on task, and sitting still (13 of the participants from the sample were diagnosed with ADHD, PTSD, Mental Retardation, or a prior substance abuse problem), the participants may have marked the surveys quickly to finish the measures. The social desirability bias may have occurred due to the subjects’ purposefully answering the surveys to convey a favorable impression of themselves (Rubbin & Babbie, 1993).

Another limitation of this study included the difficulty of selecting instruments to measure the participants’ self-regulatory skills. Gottman included in his manual and texts many surveys to assess a couple’s strengths and level of functioning. However, many of the surveys measure couples’ intimacy level and sexuality and are not appropriate for adolescents and families. If these surveys were revised to assess more family/relational functioning, they may be used to provide more valid and reliable measures in assessing the effectiveness of the model with adolescents and families.

Implications for Future Research

This study served as the first research project to explore the effectiveness of group therapy with adolescents utilizing art-based interventions based on Gottman’s Sound Relationship House Theory. The researcher’s first goal was to investigate the effectiveness of a parent-child family art therapy group; however, no families agreed to participate in the weekly group. Family members reported that they could not attend the group because they could not take time off from work, could not afford the travel expenses or have the time to travel out of town, did not have transportation, or lacked supervision or day care for their other children. If a group using the intervention model of this study could be replicated with family members present, it could be beneficial to further understanding of what might help improve parent-child relationships within
the juvenile justice population.

Only eight parents consented for their child to participate in this group (seven of the participants were 18 and did not require parental consent). If the sample size were to be increased, a more robust research design could be utilized to test the efficacy of this intervention. A control group/experimental group design could be used wherein participants are randomly assigned to one of the two conditions and threats to internal validity could be limited. Also, if a larger sample size could be obtained with a broader sampling parameter (varied sex and age at multiple adolescent treatment programs), a truer representation of the adolescent population may be obtained. Having a triangulation of measures (Different measures have different potential sources of information such as the information from the youth, teacher, program, and parent/guardian, based on self-report and observational measures.) could limit possible systematic measurement errors.

**Linking Art Therapy with Empirically-Based Interventions**

In the field of art therapy, having more quantitative studies may be helpful in exploring the effectiveness of individual, family, and group interventions with adolescents. Many art therapy studies tend to rely on qualitative measures or case studies with a need in the field of art therapy for more quantitative data (Rosal, 1989). This study utilized quantitative mental health and relational measures with qualitative observations of the adolescents during the intervention and information gathered from their art-work to explore the effectiveness of Gottman’s research-based theory. Increasing the number of empirical quantitative studies combined with vital qualitative information may enhance the field of art therapy and promote the most clinically efficacious treatment for adolescents with conduct-related problems, their peers, and their family members. Further, by having more collaboration between marriage and family therapists and art therapists, adolescents and adults may benefit from traditional and non-traditional verbal and non-verbal approaches. Recommendations for future studies examining Gottman’s theory would include adding a qualitative component to assess the helpfulness of the art-based interventions such as incorporating surveys or visual or audio recording. Because the adolescents were adjudicated in a DJJ program, recording was not permitted; however, a questionnaire would have provided information as to the adolescents’ perception of verbal and nonverbal approaches.

**Merging Gottman-Based Theory with Art Therapy Approaches**
Arrington (2001) discussed Gottman’s model for positive affect between couples and advocated for the use of Gottman’s model with couples and families. Exploring Gottman’s model with expressive therapies such as art therapy may support the use of art therapy with manually guided treatments such as Gottman’s Sound Relationship House Theory and may possibly enhance the treatment effectiveness of using verbal and nonverbal treatment approaches. It may also support the use of Gottman’s theory with adolescents and families.

A Florida State University colleague has investigated the effectiveness of art therapy with couples based on Gottman’s Sound Relationship House approach, focusing on pivotal moments using quantitative and qualitative methods (Ricco, 2005, 2007). Rico developed an eight-week manualized intervention based on Gottman’s Sound Relationship House Theory using art therapy with adults. The eight interventions included: 1) develop a genogram to represent family of origin dynamics, 2) draw an emotional marital landscape of the marriage, either abstract using color, line, and form or representational using manmade or natural structures, 3) draw a lifeline representing birth to present followed by images or symbols to represent one’s life events, 4) create a have/need collage using images and words to express the things that one person provides in the marriage, 5) develop one joint picture together without verbal communication, 6) create a torn paper solvable problem collage to represent a problem in the marriage, 7) draw or paint one’s ideal house of the future, and 7) draw a bridge individually of a couple “crossing a bridge going from some place to some place” (p.145).

Rico (2007) investigated the pivotal moments in three couples and identified pivotal moments as when “core issues tied to the presenting problem were discussed.” Pivotal moments with couples also “followed sessions that were emotionally charged and when cognitions relating to these emotions were reframed in a more positive light” (p. 120). The pivotal moments tended to build on one another and occurred within or relating to a particularly powerful session. The Dyadic Adjustment Scale (DAS) was administered as a pretest and posttest measure. Results indicated that the DAS scores increased in reported marital adjustment from the beginning to the end of the marital art therapy intervention. The couples also reported an improvement in their family relationships. These results are congruent with this study’s findings of a decrease in parent-child conflicts.
Implications for Clinical Practice within the Department of Juvenile Justice

Because 13 of the 15 adolescents were dually diagnosed with additional mental health and substance abuse issues, the researcher believes that the current treatment for delinquency within the Department of Juvenile Justice programs must prioritize the mental health needs of the adolescents and encourage the enhancement of the parent-child relationship. For the 15 research participants, two adolescents reported no contact with their mother and five adolescents reported no or little contact with their father. The adolescents reported a lack of parental involvement due to the parents’ using substances, being incarcerated or relocating and not staying in contact with the adolescent. Many of the adolescents reported that they wished to have more parental contact with their mother or father; however, they have not had contact since birth to their early childhood years. Further, 13 adolescents on the POSIT questionnaire reported that their parents either do not know their true feelings, their interests, or their whereabouts or daily activities (questions number 68, 114, 36, and 89 respectively). Focusing more on family relationships may assist the adolescent in re-connecting their family ties, as well as their ties with their peers and their community.

One recommendation for the Department of Juvenile Justice might be to place adolescents in a residential or aftercare program or facility closer to their homes. Many parents reported that they were interested in attending the group, as well as family visitation; however, due to the distance they could not take extended time from work for travel and could not afford the travel expenses. Due to rising gasoline prices and overall cost of living, many families stated that they could not afford the additional expenses. Further, if the parents or guardians could not attend family visitation, it may be helpful to arrange an additional telephone contact in lieu of their attendance. Currently at the program site, the adolescents are permitted to make one telephone call home per week for 10 or 15 minutes as determined by their level in the program. Further, the adolescents have to wait two weeks before they are permitted to call their family while they are on the orientation level at the program. The first two weeks at the facility may be the most difficult for the adolescent; however, most programs prohibit telephone contact for 30 days due to fear that the adolescent will try to abscond from the program. If the adolescents are allowed to contact their families, they may experience less stress and decrease their chances of absconding.

In addition to promoting family visitation and weekly telephone calls to family, home visits
consisting of the adolescent returning home for the weekend within the last two weeks of his program stay would provide an opportunity for the adolescent to return home, spend time with family and friends, and determine if there are any unresolved conflicts or problems that ay need to be addressed in the last several weeks of the adolescent’s residential stay. Many DJJ residential programs are cautious about sending adolescents home before their scheduled release; however, it is vital that the adolescent has an opportunity to practice the newly learned skills at the program and determine if the necessary skills are in place to avoid unhealthy behaviors such as using substances and engaging in illegal behaviors.

Another suggestion is to include family traditions at the program, such as having a movie or game night per week, scheduling weekly team sports activities, scheduling mealtime rituals (preparing the meals and cleaning together) or bedtime rituals (watching a television show, reading a book, or journaling before bedtime). The adolescents do participate in daily exercise; however, it might be helpful to encourage more team sports with peers and staff to build rapport and positive interactions with others. Other suggestions are to have the adolescents participate in weekly group art, drama, music, team building, or journaling/writing exercises to foster creativity, healthy self-regulatory skills, and group cohesiveness.

Of the 15 participants in the sample, 10 adolescents reported cannabis abuse or dependency issues. Three additional adolescents reported substance abuse issues that had not yet reached the severity to meet the criteria for clinical diagnosis. Further, five adolescents that had been diagnosed with substance abuse or dependency issues based on their prior history, denied their substance use on the POSIT measure. Marijuana use with this sample population was both the primary and the secondary problem reported by the adolescents. Focusing more on substance abuse prevention and intervention may allow the adolescent to focus on other interpersonal and family problems so that the adolescent can resolve relational, academic, and vocational problems and can enhance self-regulatory skills and social skills, rather than using substances with their peers.

Adolescents in Department of Juvenile Justice programs also encounter major educational problems. Thirteen of the 15 adolescents reported that they had failed a grade level in school and all of the youth reported reading, math, and general academic difficulties. Two of the adolescents were diagnosed with Mild Mental Retardation, indicating an intelligence quotient (IQ) level of
50-55 to approximately 70 (APA, 2000). Also, based on the artistic developmental level of the adolescents, many adolescents were artistically and cognitively delayed.

Due to adolescents also presenting with educational, family, mental health, and substance abuse problems, using a more expressive therapies approach such as art, dance, music, play, poetry, and psychodrama therapy, may assist the adolescent in accessing his or her thoughts, feelings, and behaviors. Verbal and nonverbal approaches allow the adolescent to access information on different levels of the Expressive Therapies Continuum starting with kinesthetic/sensory, perceptual/affective, and the cognitive/symbolic level fostering creativity throughout the three hierarchical levels (Lusebrink, 1992). Specific benefits of art therapy are that it provides an alternative form of symbolic or literal communication which can serve as a form of relaxation and can assist in reducing tension and anxiety through working with the media itself. Art therapy promotes visual thinking that can externalize ideas to allow enhanced processing of thoughts and feelings. It allows expression of preverbal memories and complex feelings and ideas that are difficult to verbalize. Art therapy also allows the adolescent to access conscious and unconscious thoughts and feelings without verbal censorship (Rubin, 2005).

Conclusion

After attending the five week adolescent group based on Gottman’s Sound Relationship Theory using art-based interventions, four subscales on the POSIT showed statistical significance utilizing a Wilcoxin Signed Ranks Test that included the Family, Vocational, Social, and Leisure subscales. The adolescents did experience a decrease in family, vocational, social, and leisure problems and were able to improve their communication, social, and problem-solving skills. Three subscales on the SCL 90 were found to be statistically significant: the OCD, the Depression, and the Anxiety subscales. After attending the five-week intervention, the adolescents reported fewer symptoms of anxiety and depression with less obsessive-compulsive behaviors. Based on the results of the measures, the adolescents were able to improve their self-regulatory skills.

No statistical significance was found for the QRI measure; however, both scales for the PCC mother and father scales showed statistical significance. There was also a statistical significance for the participants’ pretest and posttest POSIT Family subscale score using the Wilcoxin Signed Ranks test. The adolescents reported fewer parent/child conflicts and were able to discuss their
family and relationship dynamics after completing the art-based interventions. Additional research is needed to evaluate the use of Gottman’s theory with adolescents incorporating art-based interventions; however, a preliminary finding is that adolescents were able to improve their parent/child relationship.

The results of this exploratory study lend support to the use of a Gottman-based art therapy group with this sample (adolescent males from the ages of 14-18 in a local residential Department of Juvenile Justice program). Although the results of the study cannot be generalized to the greater population due to the limited sample size and limited parameters of the research site and sample population, this study offers a preliminary effort to incorporate current empirical research on adult healthy and unhealthy relationships and test its viability on the adolescent population. It would further be beneficial to explore this intervention with both the adolescent and the family members present. Extending traditional services with adolescents to incorporate relational models such as Gottman’s Sound Relationship House Theory with verbal and nonverbal approaches such as art therapy may provide additional support to the adolescents, their families, and their community, with the hope of reducing recidivism rates for delinquent youth and decreasing mental health and substance abuse symptoms for adolescents.
APPENDIX A

ART-BASED GROUP THERAPY INTERVENTIONS

Group Therapy Interventions Session 1A

I. Tasks for the session: Incorporate the introduction of group members into the group, as well as emphasize the rules of the group.

II. Art-based Intervention(s): **Introduction and Name Drawing**
The group will draw their name in a decorative manner to display aspects of their personality. Other variations might include having the members draw their initials and/or nicknames. The group will also come up with their own rules for the group sessions.

III. Goals of the session: The youth will be able to introduce one another and hopefully become more comfortable with the group. This will assist in establishing healthy boundaries and will allow for healthy communications and feedback in a facilitative manner with both the group members and the group leader.

Introduction to the four unhealthy communication patterns/behaviors that includes:

- **Criticism** - Any statement that implies there is something globally wrong with another person which may include a personal attack on one’s character and may elicit defensiveness from the other party.
- **Defensiveness** - Any attempt to defend one’s character from a perceived attack. It is a general stance of warding off a perceived attack and usually includes denying responsibility.
- **Contempt** - Any statement either verbal or nonverbal that asserts oneself on a higher plane than another. This may include mocking or correcting one’s behaviors or speech, or nonverbal expressions such as eye rolling and looking away.
- **Stonewalling** – A person withdrawing from interactions with another person.

Group Therapy Interventions Session 1B and 1C

I. Tasks for the session: To provide a drawing contrasting both positive and negative feelings.

II. Art-based Intervention(s): **4 behaviors and 8 feelings using lines, shapes, colors, and form**
Youth will be asked to draw different lines, shapes, colors, or form to represent their reaction to the four communication patterns discussed earlier: criticism, defensiveness, contempt, and stonewalling. Youth will fold a 15x22 piece paper into four squares and will be given time to work on the feelings/behaviors. The youth will also fold another 15x22 piece of paper into eight squares to represent 8 feelings including: happy, sad, angry, excited, anxious, peaceful, afraid, and confident. The youth will then be asked to share their images with the group.

III. Assessment of the session: Youth will discuss their art work with other members. The group will share the similarities and differences between the feelings and behaviors. The youth will have the opportunity to share his beliefs about different feelings and past experiences.
Session 2: Creating Child and Parent Love Maps

Defined as the house’s foundation. The term “love maps” measures the amount of the cognitive room a person has for one another where the person knows the other’s psychological world and periodically updates this info. In Gottman and DeClaire’s later work (2001), they developed a Child’s Love Map focusing on ways for parents and children to better get to know each other. The youth will review the family love map questions and will process their responses.

Art Therapy Interventions

I. Tasks for the session: Youth will discuss their family Love Maps and their current family relationships.

II. Art-based Intervention(s): Family Drawing and Kinetic Family Drawing

Youth will be requested to draw a picture of their family, either abstract or real. The youth will also draw a kinetic family drawing of the family doing something together. During processing they will be given time to share the pictures and their feelings and thoughts associated with their drawings.

III. Goals of the session: Youth will be able to get to know the other peers, as well as what are the perceptions each member of the family has of one another. The youth will have the opportunity to discuss the pictures, as well as ways to connect with one’s family including interests, hobbies, and family traditions and rituals.
Session 3: Nurturing a Culture of Fondness and Admiration/
       Turning Towards versus Turning Away

Defined as the second and third floor of the house.

_Fondness and admiration system_ - reflects the amount and accessibility of respect and affection felt and expressed for one another that is also considered the antidote for contempt. Review Love Maps and focus on the family strengths, perceptions, and family activities.

_Turning toward versus turning away_ - reflects the emotional connection versus distance in the relationship including everyday activities that adds to the “emotional bank account”. Gottman and DeClaire (2001) also developed exercises for parents to look for opportunities to turn towards their children by finding things parents can do for and with their child.

Explore healthy options for the youth and family members/guardians.

**Art Therapy Intervention**

I. Tasks for the session: To provide an understanding of where the clients feel they are in respect to the program, their recovery/ family treatment, and their developmental stage of life. Youth will address different perspectives of their lives including possibly their hopes, fears, dreams, and aspirations. Clients will also address their hopes for the family in the future.

II. Art-based Intervention(s): **Prospective Family Kinetic Drawing**
Youth will draw a picture of his family doing something together in the next month after the youth has been discharged from the program. Youth will discuss the images, as well as other family activities, traditions, and rituals of the family.

III. Goals of the session: To allow the youth to gain insight into their present, past, and future. This picture is important in assessing where the clients are and where they want to go. This also allows the client to focus on the role of his behaviors and how his actions have affected the client's present situation, past, and future. By completing the prospective family drawing, this promotes the client and his support system in developing and building rituals of emotional connection.
Session 4: Positive Sentiment Override

Defined as the fourth floor of the Sound Relationship House.

*Sentiment override* is described as either being negative or positive. Negative sentiment override means that the person attacks another person and often blames or criticizes that person for his/her mistakes. Positive sentiment override means that any negativity expressed by one person is interpreted as informative, rather than as a personal attack.

Address the concepts of accepting influence – being able to work together, listen, and respect one another’s different beliefs.

Focus on family and interpersonal strengths

**Art Therapy Intervention**

I. Tasks for the session: Youth and his peers will decorate a puzzle piece with diverse media including crayons, pencils, and markers. The youth will process working on the images and then will piece the images together to form a larger image.

II. Art-based Intervention(s): **Joint Puzzle Drawing**

III. Goals of the session: For the youth and his peers to be able to practice working together as a team and listening to each as they piece together the pieces to form a larger image. Also, to create a dialogue regarding differences in opinions so that the youth can better understand and discuss these differences. Further, all members have the opportunity to reflect upon the activity from a different perspective and process the peer and group interactions as a whole.
Session 5: Regulation of Conflict

The fifth level of the relationship house includes the family’s ability to regulate conflict.

Regulation of conflict - includes the ability to address solvable problems or perpetual problems. Skills needed for solvable problems includes the: 1) softened start-up; 2) repair and de-escalation; 3) accepting influence; 4) compromise; and 5) physiological soothing

For perpetual problems, it may be necessary to create a dialogue to overcome gridlock and better assist one another in understanding each person’s feelings, thoughts, and behaviors. The goal is to move from gridlock by creating dialogues concerning the symbolisms behind one’s positions or “dreams with the conflict”.

Art Therapy Intervention

I. Tasks for the session: To provide an understanding of the process of regulating conflict and to complete a problem-solution drawing. For the relaxation component, the youth can also practice healthy coping and relaxation skills.

II. Art-based Intervention(s): Problem and Solution Drawing and Deep Breathing Painting

The clients are asked to draw a picture of a problem, the solution to the problem, and what it would take to solve the problem. The youth will process the drawings afterwards. Afterwards, the youth will practice deep breathing and muscle tension techniques. The youth will also paint while practicing the deep breathing techniques and will discuss the benefits of learning healthy coping and relaxation skills.

III. Goals of the session: To allow the youth to gain insight into solvable problems and to focus on the healthy skills necessary to solve these problems. By learning to self-soothe, the youth will be better able to regulate his emotions.
APPENDIX B

GOTTMAN'S SOUND RELATIONSHIP HOUSE THEORY

THE SOUND RELATIONSHIP HOUSE

CREATING
SHARED MEANING:
Rituals of Emotional Connection

HONORING DREAMS AND ASPIRATIONS

REGULATION OF CONFLICT
1: Skills for Solvable Problems
   1) Softened Startup
   2) Repair & De-escalation
   3) Accepting Influence
   4) Compromise
   5) Physiological Soothing

2: For Perpetual Problems
   Create a Dialogue to Overcome Gridlock

POSITIVE SENTIMENT OVERRIDE “POSITIVE VIBES”

EMOTIONAL BANK ACCOUNT

TURNING TOWARDS VS. TURNING AWAY
The “BIDDING” Process
Making Emotional Connections

NURTURING A CULTURE OF
FONDNESS AND ADMIRATION

LOVE MAPS

Areas of Strength
APPENDIX C

CREATING YOUR CHILD’S LOVE MAP

1. What are your child’s two favorite foods?
2. What two foods does your child most dislike?
3. What are your child’s two favorite kind of music?
4. Who are your child’s two favorite singers?
5. What are your child’s special hobbies and out-of-school interests?
6. Name all of your child’s friends.
7. Name all of your child’s enemies?
8. Who are two of your child’s heroes and heroines?
9. Name two of your child’s favorite videos or movies.
10. Name two of your child’s favorite TV shows.
11. What two animals does your child like, and what two does your child dislike?
12. What would be your child’s ideal vacation getaway?
13. Name two of your child’s favorite bands.
14. What sports does your child especially like to play?
15. What sports does your child especially like to watch and follow?
16. Name one person your child has had a crush on.
17. What sports does your child find interesting?
18. If your child had a sizable sum of money to spend and could go shopping anywhere, what three things would he or she buy?
19. What is one thing your child would like to change about you?
20. What types of clothing does your child prefer to wear and hate to wear?
21. Who is your child’s least favorite relative?
22. Name two people your child would pick for wall posters in his or her room.
23. Who is your child’s most favorite relative?
24. What would be your child’s ideal birthday party this year?
25. What are your child’s favorite types of dessert?
26. If your child could design the ideal family, what would it look like?
27. What is one thing you would like to change about your child?
28. Name three preferences your child has about evenings at home. (For example, does you child prefer to spend time alone reading?)
29. What would be your child’s least favorite kind of birthday party?
30. What would be your child’s idea of a good way to spend a rainy day indoors at home?
31. Name three of your child’s recent favorite books.
32. Name your child’s three favorite and three least favorite teachers.
33. Name three preferences your child has about weekends. (For example, would your child like to go to a museum? A ball game?)
34. Name two of your child’s favorite songs or pieces of music.
35. What are the main problems your child will have to overcome to have a successful and happy life?
36. What are two of your child’s favorite musical instruments?
37. Describe are two of your child’s dreams that have yet to be fulfilled?
38. What occupations has you child seriously considered having when grown up?

126
39. What are two occupations that your child definitely would not want to have when he or she grows up?
40. What are your child’s two favorite colors?
41. What three games does your child like to play, if any?
42. What color are your child’s eyes?
43. Where would your child most like to travel and why?
44. Name two of your child’s favorite restaurants.
45. How does your child feel about reading?
46. Name two places or events that your child would find uncomfortable.
47. What does your child like for you to do when he or she is sick?
48. What are your child’s comfort foods?
49. What was the saddest event in your child’s life?
50. How does your child feel about mathematics?
51. What was the worst time your child ever had?
52. How does your child feel about writing?
53. What is your child’s attitude towards crime?
54. What would be your child’s ideal bedtime routine?
55. What are two of your child’s favorite ways to exercise?
56. What would be your child’s ideal birthday present?
57. Name two things your child fears.
58. How does your child feel about war?
59. What would be your child’s ideal weekend?
60. Describe one great day your child recently had. What happened that day?
61. What two things make your child most angry?
62. How does your child feel about travel?
63. Does your child know the real difference between good and evil? How do you know this about your child?
64. Describe one heart-to-heart talk you recently had with your child.
65. Describe your child’s ideal sack lunch. What would he or she like least?
66. What are two of your child’s current stresses?
67. Name two lies your child has told.
68. What does your child think about hunting animals?
69. How does your child feel about the police?
70. Name three of your child’s personality weaknesses that you worry about.
71. What are the worst and best parts of your child’s current school year?
72. List your child’s three favorite books.
73. What is your child’s attitude toward money?
74. How does your child feel about politics?
75. How does your child feel about popular animals like cats, dogs, horses, or whales? Why does your child feel this way?
76. How does your child feel about school tests?
77. How does your child feel about teasing?
78. What is your child’s attitude toward poor people?
79. Describe one time when your child felt ashamed or humiliated.
80. What was the best time your child ever had, and why?
81. Name two things that your child is really worried about.
82. Who are your child’s favorite painters?
83. What would be your child’s idea of the “coolest” car in town?
84. What are your child’s attitudes toward violence?
85. What is one thing you could do to improve your relationship with your child?
86. What would your child describe as the best experience he or she ever had?
87. What does your child most like to do with friends?
88. How does your child get over being sad?
89. What have been some of your child’s ideal and worst summer experiences?
90. How would your child ideally like to decorate his or her room?
91. How does your child try to get attention?
92. What is your child’s attitude toward homework?
93. What are two things your child is proudest of about himself or herself?
94. Describe one bad day your child recently had. What happened that day?
95. What would your child choose to give you as a birthday gift?
96. Who was your child’s favorite teacher, and why?
97. Describe one nightmare your child has had.
98. What are your child’s feelings about nature?
99. How does your child feel about charity?
100. What would your child describe as the worst experience he or she ever had?

APPENDIX D

STATE OF FLORIDA JUVENILE DELINQUENCY PROCESS

Step 1: Referral Based on the Origin of the Offense

When a youth commits a crime, the law enforcement agency charges the youth with the law violation. After the youth is charged, there are four possible considerations for a referral based on the seriousness of the offense, community resources, and the enforcement officer’s recommendation. For more serious offenses, the youth is transported to the Juvenile Assessment Center (JAC) for an intake screening to further assess the youth’s risk to the community and to determine if juvenile detention placement is necessary. For communities without a JAC, an “on call screener” is contacted to evaluate the youth’s risk and determine if detention is necessary. For less serious offenses, the youth is released to the parent or guardian and the charges are forwarded to the local clerk of the court and the Department of Juvenile Justice Probation office. The last option includes the release of the youth to the parent or guardian with a direct referral to a diversion program.

Step 2: Intake Session

The Intake Juvenile Probation Officer (JPO) receives a copy of the charge from the law enforcement agency or the clerk of the court. The JPO will then contact the youth and the youth’s family to conduct the interview that entails gathering information about the youth and his or her family. Information gathered in the intake include: nature of the offense, the risk the youth presents to the community, damages incurred to the victim by the youth’s actions, and other possible medical and mental health needs of the youth. The JPO then makes a recommendation of a plan to address the delinquent offense to the State Attorney’s Office based on the information gathered. The goal of the plan is to ensure adequate protection of the community, accountability of the youth to the victim, and a rehabilitative plan to address the youth’s needs to prevent the occurrence of any further delinquent behaviors.

Step 3: Non-judicial Intervention

This recommendation is presented by the JPO to the state attorney and may recommend a non-judicial diversion program. If it approved by the state attorney, the youth and guardian may be required to sign a “waiver of speedy trial” agreement so that the youth and family agree to waive their rights to a speedy trial with the understanding that the youth will complete all of the requirements of the diversion program. If the youth successfully completes the program, no further judicial action will be pursued by the state attorney. If the youth fails to complete the program, the state attorney will file a petition with the juvenile diversion of the circuit court which will result in formal charges of the delinquent offense.

Step 4: Recommendation for Court Intervention
This recommendation is presented by the JPO to the state attorney. The state attorney may recommend filing a petition in the juvenile division of the circuit court resulting in formal charges the youth with the delinquent offense.

Step 5: Recommendation for the Court Intervention

If a petition is filed in court, the JPO will present a recommendation to the court that considers risk accountability and individual needs. This recommendation may range from a court ordered diversion or plan to probation for residential commitment.

Step 6: Calculation of the possible Court Fees and/or Cost of Care

If there is a deposition that results in a diversion or any court ordered sanction or program, the youth and family may be responsible for the costs. This recommendation may include court fees and a per diem charge if the youth was held in the custody of the Department of Juvenile Justice detention center or a commitment program.

Step 7: Placement on Supervision after the Release from a Residential Commitment Program

Upon completion of the residential commitment program, the youth may have some form of “aftercare” supervision with a Conditional Release Supervisor. This is similar to probation with the exception that the youth may still be technically committed to the department and could be administratively returned to a residential commitment facility for violation of the supervision without further order from the court.

Step 8: DNA Testing of the Youth

If a youth is found guilty of certain offenses, this may result in a court order for the youth to cooperate with DNA testing. The results are kept on file with the Florida Department of Law Enforcement (FDLE).

Step 9: Possible Referral of the Youth to an Adult Court

With certain felony offenses, there is the possibility that the jurisdiction of the youth’ charges may be sent to the adult criminal division of the court by direct file, waiver, or indictment. In this instance, the youth may be tried as an adult for the offense and receive an adult sentencing. The Department of Corrections (DOC) then becomes involved with the youth’s case giving a recommendation to the adult division of court. In some circumstances, the youth may be found guilty in an adult court, but is sentenced back to the Department of Juvenile Justice for implementation of juvenile sanctions or programs (Department of Juvenile Justice, 2006).
APPENDIX E

OVERVIEW OF THE DJJ RESIDENTIAL COMMITMENT PROGRAMS

A. Minimum-Risk Nonresidential - Programs or program models at this commitment level work with youth who remain at home and participate at least 5 days per week in a day treatment program. Youth assessed and classified for programs at this commitment level represent a minimum risk to themselves and public safety and do not require placement and services in residential settings. Youth in this level have full access to, and reside in, the community.

B. Low-Risk Residential - Youth classified for placement in programs in this restrictiveness level are assessed as low risks to public safety, yet require 24-hour supervision. Currently, most placements result from first and second-degree misdemeanors to third degree felonies. Patterns of offending are infrequent and non-violent and are oriented toward property crimes rather than crimes against people. These youth have usually performed unsuccessfully in prevention and diversion programs, and typically have weak family and community support structures. With the court’s concurrence, low-risk programs may allow supervised and unsupervised access to the community contingent upon the youth’s assessed risk to the public and demonstration of positive behavior.

C. Moderate-Risk Residential - Youth classified for placement in this restrictiveness level have been assessed as moderate risks to public safety and require 24-hour awake supervision. Moderate-risk facilities are either environmentally secure, staff secure, or hardware-secure with walls, fencing, or locking doors. The majority of these youth have generally committed serious property offenses and their offending is characterized by frequent and repeated law violations. Moderate-risk programs, with the court’s concurrence, may allow supervised and unsupervised access to the community contingent upon the youth’s assessed risk to the public and demonstration of positive behavior.

D. High-Risk Residential - Youth classified for placement in this restrictiveness level have been assessed as high risks to public safety and require close supervision in a structured residential setting that provides 24-hour secure custody and care. Placement in a high-risk program is prompted by a concern for public safety that outweighs placement in a program at lower restrictiveness levels. High-risk facilities are hardware-secure with perimeter fencing and locking doors. Community access for youth in high-risk programs is restricted primarily to necessary off-site activities such as court appearances and health-related events. However, with the court’s concurrence, unsupervised home visits for purposes of facilitating their transition may be granted toward the end of a youth’s stay if the youth is assessed as a minimum risk to the community and has demonstrated positive behavior.

E. Maximum-Risk Residential - Youth classified for placement in this restrictiveness level have been assessed as serious risks to public safety and require 24-hour custody, care, and close supervision in a maximum-security setting. They are chronic offenders with committing offenses consisting of violent and other serious felony offenses. Placement in a maximum-risk program, with a minimum length of stay of 18 months, is prompted by a demonstrated need to protect the public. Therefore, maximum-risk facilities are hardware-secure with perimeter security fencing and locking doors. These facilities are comprised of single cells, except that youth may be housed together during their pre-release transition phase. Except for necessary off-site supervised activities such as court appearances and health-related events, youth in maximum-risk programs are prohibited from having access to the community.
APPENDIX F

FSU IRB APPROVAL LETTER

Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2742
(850) 644-8633 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 3/23/2006

To:
Nicola Brand
2276 Hartsfield Way
Tallahassee, FL 32303

Dept: FAMILY & CHILD SCIENCE

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
Family Art Therapy: A Gottman-Based Approach

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Human Subjects Committee at its meeting on 3/15/2006. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.

If the project has not been completed by 3/14/2007 you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. The principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHEC regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc: Dr. Mary Hicks
HSC No. 2006.0127
APPENDIX G

DJJ IRB APPROVAL LETTER

FLORIDA DEPARTMENT OF JUVENILE JUSTICE
Governor Jeb Bush               Secretary Anthony J. Schembri

March 21, 2006

Shea Hughes-Brand
2276 Hartsfield Way
Tallahassee, FL 32303

Dear Shea Hughes-Brand:

RE: Family Art Therapy: A Gottman Based Approach

I am pleased to inform you that the Florida Department of Juvenile Justice Institutional Review Board has approved your proposed study. This approval covers only the study identified in your proposal.

The following conditions apply to this approval:

- DJJ would like a report of the findings with a discussion of the practical application of these findings for the programming needs of youth in the Florida Juvenile Justice System.
- All information obtained from DJJ is confidential. It may not be disclosed to any person, business, government agency, or other entity unless the disclosure is authorized in writing by DJJ.
- You may not disclose any information that could reasonably lead to the identification of any individual youth. All data resulting from this research project must be published in aggregate form.
- Any person working on this research project must agree to be bound by these conditions concerning confidentiality of information.
- We require that you provide the DJJ with a review copy of the final publication with a reasonable comment period prior to publication of the study findings. Please send to the IRB in the address listed below.
- Please complete and sign the following security agreement and send it back to us at Florida Department of Juvenile Justice, 2737 Centerview Drive, Suite 100, Tallahassee, Florida 32399 to the attention of Susan Quinn. The study shall not begin until the security agreement has been signed and received by the Department.

Cordially,

[Signature]

Ted Tollett
Institutional Review Board
Dear Youth,

I am a student at Florida State University. I am starting a research study on a five week family art therapy group based on Dr. Gottman’s Sound Relationship House Model.

**Title of Research Study:** Family Art Therapy: A Gottman Based Approach

**Procedures for this Research:** I have been told that my parent (mom or dad) or guardian (foster parent or other family member) has given permission for me to participate, if I want to, in this study about helping children and families improve their relationship. I will be asked to fill out surveys before the beginning and at the end of the groups. The groups will last five weeks for two hours each. My participation would also include talking about my family’s strengths. Art therapy activities will be planned to also talk about communication, coping, and problem-solving skills.

**Withdrawal From this Research Study:** I know that I can stop at any time and it will be okay. If I choose to not go to group or want to stop going to group at any time, I will not be punished (it will not change my stay while at Seminole Work and Learn Center).

**Confidentiality:** The results of this study may be published, but my or my family’s name will not be used. Information such as how old I am, my racial/ethnic background, my school grade, and information about my family will be gathered. All information collected will be confidential (it won’t be discussed with others) to the extent allowed by law. All surveys and artwork will be placed in my mental health chart and will be locked in the locked filing cabinet in the mental health office. This information will be kept by the Henry and Rilla White Foundation in a locked facility for seven years as allowed by the Florida law.

**Potential Financial Risks:** My family/guardian will have to pay for all travel costs to come for the groups and visitation.

**Potential Financial Benefits to You or to Others:** My family/guardian will be able to come to the groups at no charge to them.

**Compensation for Research Related Injury:** In the event that I get hurt physically or emotionally while going to the groups, professional medical or counseling services will be provided by Seminole Work and Learn Center and/or the Henry and Rilla White Foundation without charge to myself or my family/guardian.

**Potential Health Risk or Discomforts:** There are possible risks if I agree to attend the groups. The possible risks...
are that I may choose to discuss difficult topics. Possible discomforts include discussing topics that I may find
difficult which may lead to a disagreement or may be stressful. If I or my family request to meet with a counselor,
one will be provided to me.

**Potential Health Benefits to You or to Others:** The groups may not help me, but if they do, I may improve my
communication, coping, problem-solving skills, and relationship with my family.

**Conflict of Interest:** The researcher, Ms. Shea, is employed by the counseling agency, the Henry and
Rilla White Foundation, to meet weekly with my counselors.

If I have any questions about this study, I can call Ms. Shea at (850) 575-8954 Monday through Friday
between the hours of 12 p.m. to 5 p.m. or ask to speak with one of my counselors
If I have any questions about my rights in this study, or if I feel I have been placed at risk, I can contact
the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for
the Office of Research at (850) 644-8633.
If I have any questions or complaints about the youth assent or the research study, I may also contact the
Department of Juvenile Justice Institutional Research Board (IRB), the committee that protects research
participants, at (850) 414-2238.

Sincerely,

Shea Hughes-Brand

**Signatures:**

_______________________________________________________________
Participant’s Name (Youth)

The Principal Investigator or representative has explained the nature and purpose of the above -described procedure and the benefits and risks that are involved in this research protocol.

_______________________________________________________________
Signature of Principal Investigator                                    Date

If a representative signs and if appropriate, the participant of this research should indicate assent by
signing below.

_______________________________________________________________
Youth’s Signature                       Date

_______________________________________________________________
Signature of Witness                                                          Date
APPENDIX I

YOUTH ASSENT FORM AGES 15-17

Family Art Therapy: A Gottman Based Approach
Youth Assent Form Ages 15-17

Dear Youth,

I am a graduate student in the Department of Family and Child Sciences at Florida State University. I am conducting a research study on a five week family art therapy group based on Dr. Gottman’s Sound Relationship House Model.

**Title of Research Study:** Family Art Therapy: A Gottman Based Approach

**Procedures for this Research:** I have been informed that my parent/guardian has given permission for me to participate, if I want to, in this study. I will be asked to complete surveys before the beginning of the first group and at the last group. The groups will be scheduled for five weeks lasting two hours each. My participation would also include sharing information about my family’s strengths during the first hour. Art therapy activities will be planned for the second hour to explore communication, coping, and problem-solving skills.

**Withdrawal From this Research Study:** My participation in this study is voluntary and I have been told that I may stop my participation in this study at any time. If I choose to not participate or to withdraw from the study at any time, there will be no penalty (it will not affect my treatment or stay while at Seminole Work and Learn Center).

**Confidentiality:** The results of the research study may be published, but my or my family’s name will not be used. Demographic information such as how old I am, my racial/ethnic background, my school grade, and information about my family will be gathered. All information collected will be confidential (it won’t be discussed with others) to the extent allowed by law. All surveys and artwork will be placed in my mental health chart and will be locked in the locked filing cabinet in the mental health office. This information will be kept by the Henry and Rilla White Foundation in a locked facility for seven years as allowed by the Florida law.

**Potential Financial Risks:** My family/guardian will be responsible for all travel costs to attend the family art therapy groups and visitation.

**Potential Financial Benefits to You or to Others:** My family/guardian will receive group art therapy at no expense to them.

**Compensation for Research Related Injury:** In the unlikely event that I sustain a physical or emotional injury which may be caused by this study, professional medical or counseling services will be provided by Seminole Work and Learn Center and/or the Henry and Rilla White Foundation without charge to myself or my family/guardian.

**Potential Health Risk or Discomforts:** There are possible risks or discomforts if I agree to participate in the
study. The possible risks are that I may choose to discuss difficult topics or conflictual information. Possible discomforts include discussing topics that I may find difficult which may lead to a disagreement or may be stressful. If I or my family request to meet with a counselor, one will be provided to me.

**Potential Health Benefits to You or to Others:** Although there may be no direct benefit of attending the groups, the possible benefit of my participation may include improving my communication, coping, problem-solving skills, and relationship with my family.

**Conflict of Interest:** The researcher, Ms. Shea, is employed by the counseling agency, the Henry and Rilla White Foundation, to provide clinical supervision with my counselors.

If I have any questions about this research study, I can call Ms. Shea at (850) 575-8954 Monday through Friday between the hours of 12 p.m. to 5 p.m. or speak with one of my counselors.

If I have any questions about my rights as a participant in this study, or if I feel I have been placed at risk, I can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at (850) 644-8633.

If I have any questions or complaints about the youth assent process or the research study, I may also contact the Department of Juvenile Justice Institutional Research Board (IRB), the committee that protects research participants, at (850) 414-2238.

Sincerely,

Shea Hughes-Brand

**Signatures:**

____________________________________________________________________
Participant’s Name (Youth)

The Principal Investigator or representative has explained the nature and purpose of the above-described procedure and the benefits and risks that are involved in this research protocol.

____________________________________________________________________
Signature of Principal Investigator                                  Date

If a representative signs and if appropriate, the participant of this research should indicate assent by signing below.

____________________________________________________________________
Youth’s Signature                                                  Date

____________________________________________________________________
Signature of Witness                                                 Date
Dear Youth,

I am a graduate student under the direction of Professor Mary Hicks in the Department of Family and Child Sciences at Florida State University. I am conducting a research study on the effectiveness of a five week family art therapy group based on Dr. Gottman’s Sound Relationship House Model.

**Title of Research Study:** Family Art Therapy: A Gottman Based Approach

**Procedures for this Research:** Your participation will involve completing surveys and assessments before the beginning of the first group and at the last group. The groups will be scheduled for five consecutive weeks lasting two hours each. Your participation would also include sharing information about your family’s strengths and interactions during the first hour. Art therapy activities will be planned for the second hour to explore communication, coping, and problem-solving skills.

**Withdrawal From this Research Study:** Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty (it will not affect your treatment/mental health care).

**Confidentiality:** The results of the research study may be published, but your name will not be used. Demographic information will be gathered for yourself and your family regarding age, race, education level, and your parent/guardian’s family status (single, married, widowed, or divorced). All information gathered will be confidential to the extent allowed by law. All surveys and artwork will become property of the mental health chart and will be locked in the mental health office, as well as a locked filing cabinet. This information will be kept for seven years as allowed by the Florida statutes.

**Potential Financial Risks:** All families/guardians will be responsible for all travel costs to attend the family art therapy groups and visitation.

**Potential Financial Benefits to You or to Others:** All families/guardians will receive group art therapy at no expense to the parent/guardians.

**Compensation for Research Related Injury:** In the unlikely event of you sustaining a physical or psychological injury which is proximately caused by this study: 
_X_ professional medical; or_X_ professional consultative care will be provided by Seminole Work and Learn Center and/or the Henry and Rilla White Foundation without charge to the family/guardian.
**Potential Health Risk or Discomforts:** There are foreseeable risks or discomforts if you agree to participate in the study. The possible risks are that you may choose to discuss difficult topics or conflictual information. Possible discomforts include discussing topics that you or your family may find difficult which may lead to a disagreement or may be stressful. If you request to meet with a counselor individually or with your family present, one will be provided to you to offer counseling services at your request.

**Potential Health Benefits to You or to Others:** Although there may be no direct benefit of attending the group, the possible benefit of your participation may include an improved relationship with your family, improved communication, coping, problem-solving, and decision-making skills.

**Conflict of Interest:** The researcher is employed by a mental health overlay provider to provide clinical supervision to all mental health employees.

If you have any questions concerning this research study, please call me at (850) 575-8954 Monday through Friday between the hours of 12 p.m. to 5 p.m. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at (850) 644-8633. If you have any questions or complaints about the informed consent process or the research study, you may also contact the Department of Juvenile Justice Institutional Research Board (IRB), the committee that protects research participants, at (850) 414-2238.

Sincerely,

Shea Hughes-Brand

**Signatures:**

____________________________________________________________________________________
Participant’s Name

The Principal Investigator or representative has explained the nature and purpose of the above-described procedure and the benefits and risks that are involved in this research protocol.

____________________________________________________________________________________
Signature of Principal Investigator Date

You have been informed of the above-described procedure with its possible benefits and risks and you have received a copy of this description. You have given permission for your participation in this study.

____________________________________________________________________________________
Signature of Participant or Representative Date

____________________________________________________________________________________
Signature of Witness Date
APPENDIX K

PARENT/GUARDIAN CONSENT LETTER FOR MINORS

Family Art Therapy: A Gottman Based Approach
Parental/Guardian Consent Letter for Minors

Dear Parent/Guardian,

I am a graduate student under the direction of Professor Mary Hicks in the Department of Family and Child Sciences at Florida State University. I am conducting a research study on the effectiveness of a five week family art therapy group based on Dr. Gottman’s Sound Relationship House Model.

Title of Research Study: Family Art Therapy: A Gottman Based Approach

Procedures for this Research: Your child’s participation will involve completing surveys and assessments before the beginning of the first group and at the last group. The groups will be scheduled for five consecutive weeks lasting two hours each. Your child’s participation would also include sharing information about your family’s strengths and interactions during the first hour. Art therapy activities will be planned for the second hour to explore communication, coping, and problem-solving skills.

Withdrawal From this Research Study: You and your child’s participation in this study is voluntary. If you or your child chooses to not participate or to withdraw from the study at any time, there will be no penalty (it will not affect your child’s treatment/mental health care while at Seminole Work and Learn Center).

Confidentiality: The results of the research study may be published, but your name or your child’s name will not be used. Demographic information will be gathered for yourself and your child regarding age, race, education level, and family status (single, married, widowed, or divorced). All information gathered will be confidential to the extent allowed by law. All surveys and artwork will become property of the mental health chart and will be locked in the mental health office, as well as a locked filing cabinet. This information will be kept by the Henry and Rilla White Foundation in a locked facility for seven years as allowed by the Florida statutes.

Potential Financial Risks: All families/guardians will be responsible for all travel costs to attend the family art therapy groups and visitation.

Potential Financial Benefits to You or to Others: All families/guardians will receive group art therapy at no expense to the parent/guardians.

Compensation for Research Related Injury: In the unlikely event of you or your child sustaining a physical or psychological injury which is proximately caused by this study:

_X_ professional medical; or__X___ professional consultative care will be provided by Seminole Work and Learn Center and/or the Henry and Rilla White Foundation without charge to your child, the family, and/or guardian.

Potential Health Risk or Discomforts: There are foreseeable risks or discomforts if you or your child agree to participate in the study. The possible risks are that your child may choose to discuss difficult topics or conflictual information. Possible discomforts include discussing topics that you or your child may find difficult which may
lead to a disagreement or may be stressful. If you or your child request to meet with a counselor individually or with your child present, one will be provided to you or your child to offer counseling services.

**Potential Health Benefits to You or to Others:** Although there may be no direct benefit of attending the group, the possible benefit of your or your child’s participation may include an improved relationship with your family, improved communication, coping, problem-solving, and decision-making skills.

**Conflict of Interest:** The researcher is employed by a mental health overlay provider to provide clinical supervision to all mental health employees.

If you have any questions concerning this research study, please call me at (850) 575-8954 Monday through Friday between the hours of 12 p.m. to 5 p.m. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at (850) 644-8633. If you have any questions or complaints about the informed consent process or the research study, you may also contact the Department of Juvenile Justice Institutional Research Board (IRB), the committee that protects research participants, at (850) 414-2238.

Sincerely,

Shea Hughes-Brand

**Signatures:**

Participant’s Name (Youth)

The Principal Investigator or representative has explained the nature and purpose of the above-described procedure and the benefits and risks that are involved in this research protocol.

__________________________  ________________________
Signature of Principal Investigator                                    Date

You have been informed of the above-described procedure with its possible benefits and risks and you have received a copy of this description. You have given permission for your child’s participation in this study.

__________________________  ________________________
Signature of Participant or Representative       Date

If you are not the participant, please print your name: _________________________________

____ Participant’s parent  ____ Participant’s guardian  ____ Department representative as guardian

__________________________
Signature of Witness                                                          Date
APPENDIX L

ART THERAPY INFORMED CONSENT

Family Art Therapy: A Gottman Based Approach
Art Therapy Informed Consent Form

I freely and voluntarily consent to have slides/pictures taken of my or my child’s artwork to be used in case presentations for academic or research presentations, workshops, and/or publishings.

I understand that my participation is totally voluntary and I may stop participation at any time. Every effort will be made to ensure confidentiality and my name will not appear on my artwork or any written information that may accompany it.

I have the right to ask any questions concerning my artwork and the presentation or research involved with it. I may contact Shea Hughes-Brand for answers to questions I have. I have read, or have had read to me, this consent form and understand its contents.

____________________________
Client/Parent/Guardian

____________________________
Date

____________________________
Witness

____________________________
Date
APPENDIX M

PROBLEM ORIENTED SCREENING INSTRUMENT FOR TEENAGERS

1. Do you have so much energy you don't know what to do with it?
2. Do you brag?
3. Do you get into trouble because you use drugs or alcohol at school?
4. Do your friends get bored at parties when there is no alcohol served?
5. Is it hard for you to ask for help from others?
6. Has there been adult supervision at the parties you have gone to recently?
7. Do your parents or guardians argue a lot?
8. Do you usually think about how your actions will affect others?
9. Have you recently either lost or gained more than 10 pounds?
10. Have you ever been intimate with someone who shot up drugs?
11. Do you often feel tired?
12. Have you had trouble with stomach pain or nausea?
13. Do you get easily frightened?
14. Have any of your best friends dated regularly during the past year?
15. Have you dated regularly in the past year?
16. Do you have a skill, craft, trade or work experience?
17. Are most of your friends older than you are?
18. Do you have less energy than you think you should?
19. Do you get frustrated easily?
20. Do you threaten to hurt people?
21. Do you feel alone most of the time?
22. Do you sleep either too much or too little?
23. Do you swear or use dirty language?
24. Are you a good listener?
25. Do your parents or guardians approve of your friends?
26. Have you lied to anyone in the past week?
27. Do your parents or guardians refuse to talk with you when they are mad at you?
28. Do you rush into things without thinking about what could happen?
29. Did you have a paying job last summer?
30. Is your free time spent just hanging out with friends?
31. Have you accidentally hurt yourself or someone else while high on alcohol or drugs?
32. Have you had any accidents or injuries that still bother you?
33. Are you a good speller?
34. Do you have friends who damage or destroy things on purpose?
35. Have the whites of your eyes ever turned yellow?
36. Do your parents or guardians usually know where you are and what you are doing?
37. Do you miss out on activities because you spend too much money on drugs or alcohol?
38. Do people pick on you because of the way you look?
39. Do you know how to get a job if you want one?
40. Do your parents or guardians and you do lots of things together?
41. Do you get A's and B's in some classes and fail others?
42. Do you feel nervous most of the time?
43. Have you stolen things?
44. Have you ever been told you are hyperactive?
45. Do you ever feel you are addicted to alcohol or drugs?
46. Are you a good reader?
47. Do you have a hobby you are really interested in?
48. Do you plan to get a diploma (or already have one)?
49. Have you been frequently absent or late for work?
50. Do you feel people are against you?
51. Do you participate in team sports which have regular practices?
52. Have you ever read a book cover to cover for your own enjoyment?
53. Do you have chores that you must regularly do at home?
54. Do your friends bring drugs to parties?
55. Do you get into fights a lot?
56. Do you have a hot temper?
57. Do your parents or guardians pay attention when you talk with them?
58. Have you started using more and more drugs or alcohol to get the effect you want?
59. Do your parents or guardians have rules about what you can and cannot do?
60. Do people tell you that you are careless?
61. Are you stubborn?
62. Do any of your best friends go out on school nights without permission from their parents or guardians?
63. Have you ever had or do you now have a job?
64. Do you have trouble getting your mind off things?
65. Have you ever threatened anyone with a weapon?
66. Do you have a way to get to a job?
67. Do you ever leave a party because there is no alcohol or drugs?
68. Do your parents or guardians have rules about what you really think or feel?
69. Do you often act on the spur of the moment?
70. Do you usually exercise for a half hour or more at least once a week?
71. Do you have a constant desire for alcohol or drugs?
72. Is it easy to learn new things?
73. Do you have trouble with your breathing or with coughing?
74. Do people your own age like and respect you?
75. Does your mind wander a lot?
76. Do you hear things no one else around you hears?
77. Do you have trouble concentrating?
78. Do you have a valid driver's license?
79. Have you ever had a paying job that lasted at least one month?
80. Do you and your parents or guardians have frequent arguments which involve yelling and screaming?
81. Have you had a car accident while high on alcohol or drugs?
82. Do you forget things you did while drinking or using drugs?
83. During the past month have you driven a car while you were drunk or high?
84. Are you louder than other kids?
85. Are most of your friends younger than you are?
86. Have you ever intentionally damaged someone else's property?
87. Have you ever stopped working at a job because you just didn't care?
88. Do your parents or guardians like talking with you and being with you?
89. Have you ever spent the night away from home when your parents didn't know where you were?
90. Have any of your best friends participated in team sports which require regular practices?
91. Are you suspicious of other people?
92. Are you already too busy with school and other adult supervised activities to be interested in a job?
93. Have you cut school at least 5 days in the past year?
94. Are you usually pleased with how well you do in activities with your friends?
95. Does alcohol or drug use cause your moods to change quickly like from happy to sad or vice versa?
96. Do you feel sad most of the time?
97. Do you miss school or arrive late for school because of your alcohol or drug use?
98. Is it important to you now to get or keep a satisfactory job?
99. Do your family or friends ever tell you that you should cut down on your drinking or drug use?
100. Do you have serious arguments with friends or family members because of your drinking or drug use?
101. Do you tease others a lot?
102. Do you have trouble sleeping?
103. Do you have trouble with written work?
104. Does your alcohol or drug use ever make you do something you would not normally do - like breaking rules, missing curfew, or breaking the law?
105. Do you feel you lose control and get into fights?
106. Have you ever been fired from a job?
107. During the past month, have you skipped school?
108. Do you have trouble getting along with any of your friends because of your alcohol or drug use?
109. Do you have a hard time following directions?
110. Are you good at talking your way out of trouble?
111. Do you have friends who have hit or threatened to hit someone without any real reason?
112. Do you ever feel you can't control your alcohol or drug use?
113. Do you have a good memory?
114. Do your parents or guardians have a pretty good idea of your interests?
115. Do your parents or guardians usually agree about how to handle you?
116. Do you have a hard time planning and organizing?
117. Do you have trouble with math?
118. Do your friends cut school a lot?
119. Do you worry a lot?
120. Do you find it difficult to complete class projects or work tasks?
121. Does school sometimes make you feel stupid?
122. Are you able to make friends easily in a new group?
123. Do you often feel like you want to cry?
124. Are you afraid to be around people?
125. Do you have friends who have stolen things?
126. Do you want to be a member of any organized group, team, or club?
127. Does one of your parents or guardians have a steady job?
128. Do you think it's a bad idea to trust other people?
129. Do you enjoy doing things with people your own age?
130. Do you feel you study longer than your classmates and still get poorer grades?
131. Have you ever failed a grade in school?
132. Do you go out for fun on school nights without your parents' or guardians' permission?
133. Is school hard for you?
134. Do you have an idea about the type of job or career that you want to have?
135. On a typical day, do you watch more than two hours of TV?
136. Are you restless and can't sit still?
137. Do you have trouble finding the right words to express what you are thinking?
138. Do you scream a lot?
139. Have you ever had sexual intercourse without using a condom?
# APPENDIX N

## SYMPTOM CHECKLIST (SCL-90)

Your name ___________ Case Number _______ Session No. ______ Date ____________ Male/Female

SCL – 90

Please read and answer the following questions, utilizing the number description scale below. Circle the number in the box that best describes how much discomfort that problem caused you during the past week.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>1. Headaches</td>
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<tr>
<td>2. Nervousness or shakiness inside</td>
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<td>3. Repeated unpleasant thoughts that won’t leave your mind</td>
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<td>4. Faintness or dizziness</td>
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<td>5. Loss of sexual interest or pleasure</td>
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<td>6. Feeling critical of others</td>
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<td>7. The idea that someone else can control your thoughts</td>
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<td>8. Feeling others are to blame for most of your troubles</td>
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<td>9. Trouble remembering things</td>
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<td>10. Worried about sloppiness or carelessness</td>
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<td>11. Feeling easily annoyed or irritated</td>
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<td>12. Pains in heart or chest</td>
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<td>13. Feeling afraid in open spaces or on the streets</td>
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<td>14. Feeling low in energy or slowed down</td>
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<td>15. Thoughts of ending your life</td>
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<td>16. Hearing voices that other people do not hear</td>
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<td>17. Trembling</td>
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<td>18. Feeling that most people cannot be trusted</td>
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<td>19. Poor appetite</td>
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<td>20. Crying easily</td>
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<td>21. Feeling shy or uneasy with the opposite sex</td>
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<td>22. Feelings of being trapped or caught</td>
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<td>23. Suddenly scared for no reason</td>
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<td>24. Temper outbursts that you could not control</td>
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<td>25. Feeling afraid to go out of your house alone</td>
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<td>26. Blaming yourself for things</td>
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<td>27. Pains in lower back</td>
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<td>28. Feeling blocked in getting things done</td>
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<td>29. Feeling lonely</td>
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<td>30. Feeling blue</td>
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<td>31. Worrying too much about things</td>
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<td>32. Feeling no interest in things</td>
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<td>33. Feeling fearful</td>
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<td>34. Your feelings easily being hurt</td>
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<td>35. Other people being aware of your private thoughts</td>
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<td>36. Feeling that others do not understand you or are unsympathetic</td>
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<td>37. Feeling that people are unfriendly or dislike you</td>
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<td>38. Having to do things very slowly to insure correctness</td>
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<td>39. Heart pounding or racing</td>
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<td>40. Nausea or upset stomach</td>
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<td>41. Feeling inferior to others</td>
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<td>42. Soreness of your muscles</td>
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<tr>
<td>No.</td>
<td>Statement</td>
<td>Score</td>
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<tr>
<td>43</td>
<td>Feeling that you are watched or talked about by others</td>
<td>0</td>
<td></td>
<td></td>
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<tr>
<td>44</td>
<td>Trouble falling asleep</td>
<td>0</td>
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<tr>
<td>45</td>
<td>Having to check and double-check what you do</td>
<td>0</td>
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<tr>
<td>46</td>
<td>Difficulty making decisions</td>
<td>0</td>
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<tr>
<td>47</td>
<td>Feeling afraid to travel on buses, subways, trains</td>
<td>0</td>
<td></td>
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<td>48</td>
<td>Trouble getting your breath</td>
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<td>49</td>
<td>Hot or cold spells</td>
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<tr>
<td>50</td>
<td>Having to avoid certain things, places, or activities because they frighten you</td>
<td>0</td>
<td></td>
<td></td>
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<tr>
<td>51</td>
<td>Your mind going blank</td>
<td>0</td>
<td></td>
<td></td>
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<tr>
<td>52</td>
<td>Numbness or tingling in parts of your body</td>
<td>0</td>
<td></td>
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<tr>
<td>53</td>
<td>A lump in your throat</td>
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<tr>
<td>54</td>
<td>Feeling hopeless about the future</td>
<td>0</td>
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<tr>
<td>55</td>
<td>Trouble concentrating</td>
<td>0</td>
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<td></td>
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<tr>
<td>56</td>
<td>Feeling weak in parts of your body</td>
<td>0</td>
<td></td>
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<tr>
<td>57</td>
<td>Feeling tense or keyed up</td>
<td>0</td>
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<tr>
<td>58</td>
<td>Heavy feelings in your arms or legs</td>
<td>0</td>
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<tr>
<td>59</td>
<td>Thoughts of death or dying</td>
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<td>60</td>
<td>Overeating</td>
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<td>61</td>
<td>Feeling uneasy when people are watching or talking about you</td>
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<tr>
<td>62</td>
<td>Having thoughts that are not your own</td>
<td>0</td>
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<tr>
<td>63</td>
<td>Having urges to hurt, injure, or harm someone</td>
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<tr>
<td>64</td>
<td>Awakening in the early morning</td>
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<tr>
<td>65</td>
<td>Having to repeat the same actions, such as touching, counting, washing</td>
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<tr>
<td>66</td>
<td>Sleep that is restless or disturbed</td>
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<tr>
<td>67</td>
<td>Having urges to break or smash things</td>
<td>0</td>
<td></td>
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<tr>
<td>68</td>
<td>Having ideas or beliefs that others do not share</td>
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<tr>
<td>69</td>
<td>Feeling very self-conscious with others</td>
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<td>70</td>
<td>Feeling uneasy in crowds, such as shopping or at a movie</td>
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<tr>
<td>71</td>
<td>Feeling everything is an effort</td>
<td>0</td>
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<td></td>
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<tr>
<td>72</td>
<td>Spells of terror or panic</td>
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<td></td>
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<tr>
<td>73</td>
<td>Feeling uncomfortable about eating or drinking in public</td>
<td>0</td>
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<tr>
<td>74</td>
<td>Getting into frequent arguments</td>
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<tr>
<td>75</td>
<td>Feeling nervous when you are left alone</td>
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<td>76</td>
<td>Others not giving you proper credit for your achievements</td>
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<tr>
<td>77</td>
<td>Feeling lonely even when you are with people</td>
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<tr>
<td>78</td>
<td>Feeling so restless you couldn’t sit still</td>
<td>0</td>
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<tr>
<td>79</td>
<td>Feelings of worthlessness</td>
<td>0</td>
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<tr>
<td>80</td>
<td>The feeling that something bad is going to happen to you</td>
<td>0</td>
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<tr>
<td>81</td>
<td>Shouting or throwing things</td>
<td>0</td>
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<td></td>
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<tr>
<td>82</td>
<td>Feeling afraid you will faint in public</td>
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<tr>
<td>83</td>
<td>Feeling that people will take advantage of you if you let them</td>
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<tr>
<td>84</td>
<td>Having thoughts about sex that bother you a lot</td>
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<tr>
<td>85</td>
<td>The idea that you should be punished for your sins</td>
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<tr>
<td>86</td>
<td>Thoughts and images of a frightening nature</td>
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<tr>
<td>87</td>
<td>The idea that something serious is wrong with your body</td>
<td>0</td>
<td></td>
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<tr>
<td>88</td>
<td>Never feeling close to another person</td>
<td>0</td>
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<tr>
<td>89</td>
<td>Feelings of guilt</td>
<td>0</td>
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<tr>
<td>90</td>
<td>The idea that something is wrong with your mind</td>
<td>0</td>
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</tbody>
</table>
APPENDIX O

PARENT-CHILD CLOSENESS QUESTIONNAIRE

PARENT-CHILD CLOSENESS (PCC)
C. M. Buchanan, E. E. Maccoby, & S. M. Dornbusch

Instructions: The questions about mother assume a minimal amount of continuing contact with mother; the questions about father assume a minimal amount of continuing contact with father. Use the following scale:

Not at all 2 3 4 Very
1 5

1. How openly do you talk with your (mother/father)?
2. How comfortable do you feel admitting doubts and fears to your (mother/father)?
3. How interested is your (mother/father) in talking to you when you want to talk?
4. How often does your (mother/father) express affection or liking for you?
5. How well does your (mother/father) know what you are really like?
6. How close do you feel to your (mother/father)?
7. How confident are you that your (mother/father) would help you if you had a problem?
8. If you needed money, how comfortable would you be asking your (mother/father) for it?
9. How interested is your (mother/father) in the things you do?


Scoring instructions: A composite score is created for each parent by summing the responses to the nine items. The possible range of scores for the composite is 9 to 45.
### QUALITY OF RELATIONSHIP INVENTORY

**Instructions:** Please use the scale below to answer the following questions regarding your relationship with ____________.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>Quite a bit</th>
<th>Very much</th>
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<tbody>
<tr>
<td>1</td>
<td></td>
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<td></td>
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<tr>
<td>2</td>
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<tr>
<td>3</td>
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<tr>
<td>4</td>
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</tr>
</tbody>
</table>

1. To what extent could you turn to this person for advice about problems?  
2. How often do you need to work hard to avoid conflict with this problem?  
3. To what extent could you count on this person for help with a problem?  
4. How upset does this person sometimes make you feel?  
5. To what extent can you count on this person to give you honest feedback, even if you might not want to hear it?  
6. How much does this person make you feel guilty?  
7. How much do you have to “give in” in this relationship?  
8. To what extent can you count on this person to help you if a family member very close to you died?  
9. How much does this person want you to change?  
10. How positive a role does this person play in your life?  
11. How significant is this relationship in your life?  
12. How close will your relationship be with this person in 10 years?  
13. How much would you miss this person if the two of you could not see or talk with each other for a month?  
14. How critical of you is this person?  
15. If you wanted to go out and do something this evening, how confident are you that this person would be willing to do something with you?  
16. How responsible do you feel for this person’s well-being?  
17. How much do you depend on this person?  
18. To what extent can you count on this person to listen to you when you are angry at someone else?  
19. How much would you like this person to change?  
20. How angry does this person make you feel?  
21. How much do you argue with this person?  
22. To what extent can you really count on this person to distract you from your worries when you feel under stress?  
23. How often does this person make you feel angry?  
24. How often does this person try to control or influence your life?  
25. How much more do you give than you get from this relationship?
APPENDIX Q

REPRESENTATION OF UNHEALTHY COMMUNICATION PATTERNS
APPENDIX R

REPRESENTATION OF FEELING HAPPY, SAD, ANGRY, & EXCITED
Happy

Sad

Angry

Excited
APPENDIX S

REPRESENTATION OF FEELING ANXIOUS, PEACEFUL, AFRAID, & CONFIDENT
Anxious

Fearful

Stop

Afraid

Confident

Jumping
APPENDIX T
SYMBOLIC FAMILY DRAWINGS
APPENDIX V

PROSPECTIVE FAMILY KINETIC DRAWINGS
APPENDIX W

JOINT PUZZLE DRAWING
APPENDIX X

PROBLEM AND SOLUTION DRAWINGS
me and my brother fighting

going home to get the money

missing money always
REFERENCES


Betts, D. (2004, Fall). Introduction to art therapy. Course presented at Florida State University, Tallahassee, FL.


BIOGRAPHICAL SKETCH

Shea Hughes-Brand, LCSW, LMFT

Curriculum Vita

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Tallahassee, Florida 32303
Home Phone: (850) 383-3156
Office Phone: (850) 575-8954
Office Fax: (850) 575-9445
Email: nsh7242@garnet.acns.fsu.edu

Education

PhD, Interdivisional Program of Marriage and the Family - August, 2007
Florida State University, Department of Family and Child Sciences, College of Human Sciences, Tallahassee, Florida - Dissertation: Adolescent Group Therapy: A Gottman Relationship-Based Approach Using Art-Based Interventions

Master of Science, Specialization: Art Therapy and Art Education - August, 2005
Florida State University, Department of Art Education, College of Visual Arts, Theatre, and Dance, Tallahassee, Florida

The University of Alabama, School of Social Work, Tuscaloosa, Alabama

Bachelor of Science, Psychology - May, 1994
The University of Alabama, Tuscaloosa, Alabama

Associate of Science, Psychology - May, 1992
Walker College, Jasper, Alabama

Teaching Experience

Visiting Instructor – Spring 2005
Valdosta State University, Valdosta Georgia – Provided lectures for Psychopathology and Psychopharmacology, MFTH 7400, to advanced graduate level students in the Marriage and Family Therapy Program.

Guest Lecturer – Fall 2004
Valdosta State University, Valdosta, Georgia – Provided multiple guest lectures for the course Treatment Issues in Families, Couples, and Children, MFTH 7601, to graduate level students in the Marriage and Family Therapy Program.
**Guest Lecturer – Fall 2003**
Tallahassee Community College, Tallahassee, Florida – Provided multiple guest lectures for the course *College Success, SLS 1501*, for undergraduate students focusing on career planning and development.

**Instructor – Fall and Spring 1998-1999**
Child Abuse Prevention Services of Tuscaloosa, Incorporated, Tuscaloosa, Alabama
Responsible for teaching a 15 week parenting program known as the *Nurturing Program* which included both volunteer and mandated clients through the Department of Human Resources.

**Instructor – Spring 1997**
Family Counseling Service, Tuscaloosa, Alabama
Responsible for co-facilitation of a 12 week *Domestic Violence Intervention Program (DVIP)* which was ordered by the court in the state of Alabama for clients with Domestic Violence charges.

**Graduate Teaching Assistant – Fall and Spring 1996-1997**
The University of Alabama, Tuscaloosa, Alabama – Provided lectures for *Career Development and Planning, BCE 280*, to undergraduate students sponsored through the Career Resource Center.

**Professional Presentations**


Hughes-Brand, N. S. (2007, April). *Play and Art Interventions for Families and Couples*. Invited to present at the South Georgia Regional Marriage and Family Therapy Student Conference, Valdosta State University, Valdosta, GA.


Barlow, S. & Hughes-Brand, N. S. (2005, May). *Play Therapy with Traumatized Children and Their Families.* Invited to present at the Florida Association for Marriage and Family Therapy Annual Conference (Infant Mental Health Plenary), Ft. Lauderdale, FL.

Hughes-Brand, N. S. (2005, April). *Clinical Interventions for Family and Couple Play Therapy.* Invited to present at the Georgia Association of Play Therapy Annual Conference sponsored by Valdosta State University, Valdosta, GA.

Hughes-Brand, N. S. (2005, April). *Clinical Interventions for Family and Couple Play Therapy.* Invited to present at the Tallahassee Area Chapter of the Florida Association for Play Therapy, Tallahassee, FL.


Publications

Work in Progress:


Research Activities

Graduate Research Assistant, Fall 2006 – Present, Florida State University, Department of Family and Child Sciences, Tallahassee, Florida: Research is currently being conducted with adolescent males ages 12-18 in a Department of Juvenile Justice residential program. This project addresses the transportability of Gottman’s Sound Relationship House model using art therapy interventions under the supervision of Dr. Mary Hicks, a Gottman Certified Therapist and National Trainer.

Graduate Research Assistant, Fall 1996- Spring 1997, The University of Alabama, School of Social Work, Tuscaloosa, Alabama: Prepared surveys for the National Association of Social Workers (NASW) research study regarding the diverse roles of the social work profession and coded the data from surveys to be used for statistical analysis under the supervision of Dr. Robert Teare.

Licensure

Florida Licensed Clinical Social Worker
Florida Licensed Marriage and Family Therapist
Registered Florida State Board LCSW, LMHC, and LMFT Clinical Supervisor
American Association for Marriage and Family Therapy Approved Supervisor

Certifications and Training

Registered Art Therapist Board Certified (ATR-BC)
Registered Play Therapist/ Supervisor (RPT-S)
Board Certified Diplomate in Clinical Social Work
Clinically Certified Alcohol, Tobacco, and Other Drug Social Worker
Clinically Certified Forensic Counselor with Specializations: Forensic Assessment & Evaluation, Criminal Offender and Youthful Offender Counseling, and Addictions & Domestic Violence
Red Cross Disaster Mental Health Services Training
CPR, First Aid, Infection Control Training, and Non-Violent Crisis Intervention
Children’s Functional Assessment Rating Scale (CFARS) and FARS
Substance Abuse Subtle Screening Inventory (SASSI-3)
Domestic Violence Intervention Program Implementation Training
Defensive Driving, Self-Defense, and High Risk Training
Adult Case Management and Supervisory Case Management Training

Clinical Experiences

Clinical Director, January 2001 – Present, Henry and Rilla White Foundation,
Tallahassee, Florida: Provide clinical assessments for male and female adolescents in
Leon, Liberty, and Gadsden counties. Provide clinical supervision to all counselors/case
managers, as well as internship supervision to students in the Department of Educational
Psychology and Learning Systems Mental Health Counseling Program and the Art
Therapy Program at Florida State University.

Associate Therapist, September 2000 – Present, Psychological and Family Consultants,
Tallahassee, Florida: Provide individual, family, and couples counseling to children,
adolescents, and adults. Provided supervision for interns in the FSU Department of
Educational Psychology and Learning Systems Mental Health and School Counseling
Program.

Clinical Director, February 2004 to November 2005, North American Family Institute,
Monticello, FL: Provided clinical supervision to all agency counselors and provided
clinical assessments/ interventions for adolescent female adjudicated youth. Provided FSU
Art Therapy and FAMU Social Work internship supervision.

Clinical Director, May 2003 – May 2004, Correctional Services Corporation, Greenville,
Florida: Provided clinical supervision to all counselors and provided clinical assessments.
Provided NOVA Substance Abuse Counseling and Education internship supervision.

PhD Student Practicum, August 2001 – December 2003, Marriage and Family Therapy
Clinic, Florida State University, Tallahassee, Florida: Provided individual, family, and
couples counseling. Provided supervision to first and second year doctoral students at the
FSU MFT Clinic.

School Mental Health Counselor, February 2001 - August 2002, Community
Intervention Center, Tallahassee, Florida: Provided mental health assessments and
individual counseling for at-risk children in the school system at Oak Ridge Elementary.

Residential Mental Health Counselor, September 1999 - December 2000, Henry and
Rilla White Foundation, Inc., Tallahassee, Florida: Provided individual and family
counseling within the Department of Juvenile Justice. Provided internship supervision for
the FSU Department of Educational Psychology and Learning Systems Career Counseling
and the Art Therapy Program.
Continuous Care Team Leader/Supervisor, January 1999 - August 1998, Indian Rivers Mental Health Center, Tuscaloosa, Alabama: Provided individual & family counseling with high risk clients diagnosed with a severe mental illness and dual diagnosis.

Contractual Outpatient Substance Abuse Counselor, December 1998 – August 1999, Bradford Health Services, Northport, Alabama: Provided individual and family counseling with substance abusing adolescents.


Professional Activities and Development

Garry Landreth: Filial Therapy: Child-Parent Relationship Training, Savannah, GA, - August 2005
Salvador Minuchin: Structural Systematic Family Therapy, Advanced Summer Intensive - at The Minuchin Center for the Family, New York City, NY, July, 2005
Garry Landreth: Healing the Hurting Child: The Necessary Dimensions of Play Therapy, - University of North Texas, Center for Play Therapy, Denton, TX, July, 2003
Salvador Minuchin: New Developments: 40 Years Later in Family Therapy, Orlando, FL, - April, 2005.
John Gottman: Marital Therapy: A Research-Based Approach, Orlando, FL, April, 2002
Daniel Wile: Collaborative Couple Therapy: Turning Fights into Intimate Conversations, - Tallahassee, FL, February, 2002
Albert Ellis: Treating Anxiety, Depression, and Anger Effectively, Jacksonville, FL, - February, 2001

Professional Affiliations and Service
American Art Therapy Association – 2007 to present
National Association of Christian Social Workers- 2006 to present
National Association of Social Workers 1995- present
American Association for Marriage and Family Therapy- 2003 to present
Florida and Georgia Association for Marriage and Family Therapy – 2003 to present
Tallahassee Association for Marriage and Family Therapy – 2005 to present
Marriage and Family Therapy Graduate Association: Professional Committee Member
- Organized and provided local clinical trainings for the community and university
Association for Play Therapy Incorporated - 2002 to present
Florida and Georgia Association of Play Therapy – 2002 to present
Tallahassee Area Chapter of the Florida Association for Play Therapy – 2006 to present
National Association of Forensic Counselors- 2001 to present
American College of Certified Forensic Counselors- 2001 to present

**Honors and Awards**

Ruth Dales Scholarship (College of Human Sciences FSU Doctoral Award)
Florida State University Nomination and Certificate of Appreciation of Service to the
- Graduate Student Colleagues and Academic Community at FSU, 2003-2007
Hortense Glen Honor Society (Upper 1% of the FSU College of Human Sciences Award)
Chancellor’s List (National Graduate Honor Society)
Kappa Omicron Nu National Family and Consumer Science Honor Society
Phi Alpha National Social Work Honor Society
Florida State University Dean’s List
University of Alabama Social Work Honor Society
The National Dean's List and Multiple Year Award
Psi Chi National Psychology Honor Society
Sigma Tau Delta National English Honor Society
Achievement Award for Service to Indian Rivers Mental Health Center
Certificate of Appreciation for Service to Indian Rivers Mental Health Center
Certificate of Appreciation for Outstanding Volunteer Contribution for
- Child Abuse Prevention Services, 1998 and 1999
The University of Alabama and Walker College Dean's List
Phi Theta Kappa National Junior College Honor Society
Who's Who Among American Students in American Junior Colleges
Walker College Outstanding Student Award in Social Science