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A Modified DBT-Informed Art Therapy Group Curriculum with a Focus on Neurodiversity Acceptance

Megan Moyer

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CHAPTER I

INTRODUCTION

Disability as an aspect of diversity has made significant strides within the past several decades. However, individuals with disabilities have faced a history of oppression from individuals who have meant well but have done more harm than good. This practice dates back many centuries and, unfortunately, still maintains poor practices in the twenty-first century (e.g., Kindlon et al., 2006).

In 1880, Alexander Graham Bell had started the initiative to establish boarding schools for deaf children across the nation (Hott, 2007). The ultimate goal of these schools was to teach deaf children to speak. Developing this skill gave deaf people opportunities they wouldn't have otherwise. It helped them communicate with others, navigate the world around them, and helped them get jobs. In the process of teaching deaf people the skills to communicate, the efforts of Alexander Graham Bell's initiative almost eradicated an entire culture and forced a language to go extinct (Hott, 2007). In these schools, it was forbidden to use sign language. Teachers, professionals, and other experts in the field at the time had believed that the usage of sign language would discourage the learning process (Bell, 1898). If the children in the school had obeyed the rules, American Sign Language would have been forgotten to time. However, the children at these schools didn't always do so. They had used sign language during recess, in the student dorms, or anywhere that was out of the sight of the staff (Bell, 1989). Because these kids disobeyed the rules and regulations of the school, they kept a language and culture alive. Over one hundred years later, American Sign Language is recognized as a foreign language and taught in academic institutions around the country (Hott, 2007). The Deaf community is a culture that celebrates deafness instead of lamenting the loss of hearing and holds ASL as the cornerstone of its values and practices (Hott, 2007).

When I started learning American Sign Language in undergraduate school, it prompted me to consider my own disability, autism spectrum disorder. Ever since autism was first documented in 1943 by Leo Kanner, efforts have been made on how to best integrate people on the spectrum into society (Kanner, 1943). Professionals and experts developed techniques, schools, and therapies claiming that, similar to education in deaf schools in the 1800's, developing these skills would give these people with autism opportunities they wouldn't have otherwise. It can help them communicate with others, navigate the world around them, and help them get jobs. It prompts us to think about what these skills actually do? Are they for the benefit of the individual or for the comfort and benefit of society around them? It also makes me wonder, if we continue to "fix" or "cure" development or cognitive disabilities, what will be lost? What kind of unique language would become extinct? What kind of culture would be snuffed out?

The events from the late 19th century in Deaf culture would be one of the earliest examples of an ongoing debate between the medical model and social model of diversity, occurring 90 years before this conflict was even named by Mike Oliver in 1983 (Oliver, 2013). The medical model is one that proposes disabilities are disorders or conditions that must be cured or treated in order for the individual to fit into society. It focuses on changing characteristics, traits, or behaviors of the individual. In contrast, the social model proposes that people with disabilities should not be changed to fit society but society must change in order to accommodate for people with disabilities. For many decades in the United States, the medical model has had a stronger influence on how society approaches disability-related issues in part because the U.S. is an individualistic-centered culture that values the individual changing to overcome challenges as opposed to society changing in order to eliminate the need for challenges to be overcome.

In the twenty-first century, the social model has expanded to include cognitive and developmental disabilities, becoming recognized as aspects of diversity instead of conditions that

must be cured. This category of diversity has been coined “Neurodiversity” by Judy Singer in 1998, marking a change that would continue to transform the definition of diversity. Though change is evident, there are still many areas that do not recognize neurodivergence as an aspect of multicultural diversity and continue to teach skills that encourage assimilation rather than integration (Shkedy, Shkedy, & Sandoval-Norton, 2021). However, this does not have to be the case for neurodivergent and neurotypical people to live and work together.

In the face of neurodiversity, the decision of how to approach the topic of cognitive disabilities have, once again, been in a back-and-forth debate between the medical and social models. Medical models aim to treat or cure cognitive disabilities through medicine or therapeutic techniques. The social model often focuses more on policy changes. However, this poses the question of how therapeutic techniques can change to support the social model instead of the medical model. If a medical model therapeutic technique focuses on teaching the individual how to conform to their environment, what if a social model therapeutic technique focuses on empowering the individual to change their environment and teaching skills to do so? In other words, instead of forcing clients to learn what works for society, what if we encourage them to learn what works for themselves?

In addition to alternative skill building, professionals can also address mental health concerns from a multicultural perspective. Many neurodivergent individuals do experience high rates of oppression, abuse, and emotional turmoil that affect their social-emotional well-being and may require treatment for depression, anxiety, or trauma (Harrel 2017; Kindlon et al., 2006; Sobsey & Doe, 1991). A therapeutic treatment that recognizes neurodivergence as an aspect of diversity instead of a disorder in need of fixing can address these mental health concerns effectively. As the landscape for what defines multicultural diversity changes, so too must treatment methods transform in order for therapists to maintain multicultural competence as is

ethically mandated in their practice. The group art therapy curriculum in this paper poses as one such possibility for a change in practice.

The aim of this paper is to create a new treatment course that focuses on building skills, autonomy, and self-acceptance using dialectal behavioral therapy and art therapy tailored for people with cognitive and developmental disabilities. This is not a paper that aims to treat developmental or cognitive disabilities. These are aspects of neurodiversity and, therefore, do not need to be treated. Instead, this paper aims to build an effective treatment method for mental health issues, encourage neurodivergence as an aspect of positive identity that capitalizes on strengths, and building skills to adapt and interact with one's own environment.

Dialectal behavioral therapy (DBT) is a type of therapy that focuses on four core skills: mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness (Linehan, 1997). These skills are intended to help the client develop an awareness of their own thoughts and emotions and address them using various coping strategies. The client can practice these skills both inside and outside of therapy. The theory also emphasizes the importance of radical acceptance in order to accept reality and the self so the client can move forward (Linehan, 1997). The treatment was initially developed for individuals with borderline personality disorder, but has rapidly grown to be effective in treating many other mental health issues such as depression and anxiety (Lynch et al., 2003).

The Centers for Disease Control and Prevention (CDC) state that developmental disabilities represent an expansive spectrum of disabilities that include, but are not limited to, autism spectrum disorder (ASD), down's syndrome, attention deficit disorder (ADD), dyslexia, Tourette's syndrome, cerebral palsy, and cognitive disabilities (CD), otherwise known as intellectual disabilities. The one characteristic that all these conditions have in common is that they become evident during childhood. Cognitive disabilities, in most circumstances, are a subcategory of developmental disabilities except for when the cognitive disability emerges

during adulthood (CDC, 2021). Historically, cognitive disabilities are characterized by an IQ below 70. However, the CDC identifies CD as individuals who have difficulty in tasks related to cognitive functioning that interfere with everyday life. On the other hand, many individuals with CD have unique strengths in other areas called positive niches (Armstrong, 2010). These niches draw from other dimensions of multiple intelligences that are not measured by a traditional IQ test such as spatial, social, kinesthetic, linguistic, etc., as well as creativity (Armstrong, 2010; Gardner, 1993).

Neurodiversity is defined as ways in which people have brains that function differently on a neurological level (Singer, 1998). Neurotypical individuals are people whose brain functionality aligns with the majority of the population. Widespread social norms and constructs have traditionally been built with neurotypical people in mind. Neurodivergent individuals are people whose brain functionality is different or does not align with the majority of the population. Individuals with developmental or cognitive disabilities make up the majority of the neurodivergent population. Historically, social norms and constructs have not been built with neurodivergent individuals in mind (Singer, 1998).

Art therapy is a type of therapy that uses art in the counseling process. Depending on the technique, this has many applications. Art can be used as a medium to communicate and express oneself without words. It can also help the client discover more about themselves through processing and observing their art. The art-making process can also provide a somatic medium of communication and insight (Rubin, 2010). Art therapy has a flexible framework that allows itself to become intertwined with many different theories, including DBT.

The combination of DBT skills and art therapy has been conceptualized and practiced before (Drass, 2015), but there is very little literature focused on adapting this cross-disciplinary approach for people with cognitive and/or developmental disabilities. Due to this gap in the literature, I propose to integrate DBT and art therapy into a group curriculum tailored for

neurodivergent individuals. This proposed approach could support effective treatment of social-emotional well-being among neurodivergent clients.

CHAPTER II

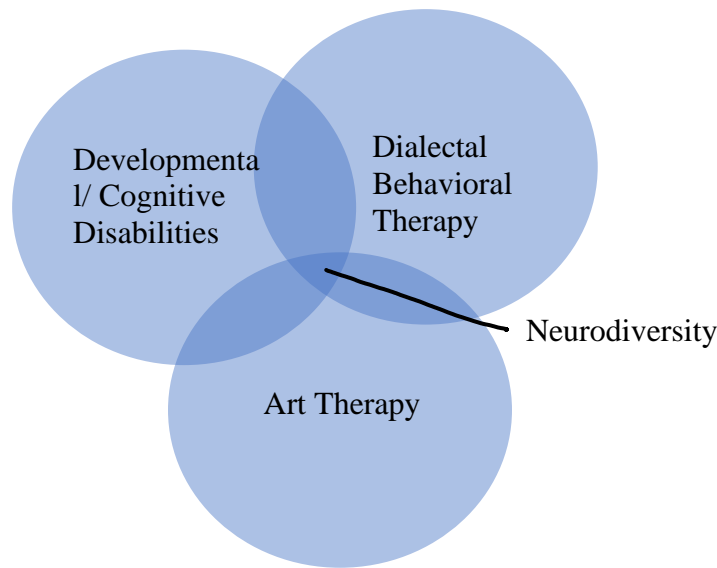
LITERATURE REVIEW

In this chapter, I will introduce a brief overview of well-known psychotherapies that have been attempted and studied for their effectiveness in serving neurodivergent populations with mental health concerns. Then, I will analyze the research topics by focusing on content shared between two of the three topics: therapy for neurodivergent individuals, art therapy, and dialectal behavioral therapy. Finally, a brief description of the vision of the proposed technique will be discussed. Research consisted of finding articles associated with developmental and cognitive disabilities, neurodivergence, DBT, and art therapy (see Figure 1). Each search consisted of two terms from different categories. For example, the terms “art therapy” AND “cognitive disabilities” were searched. Many of the articles used in this paper were found by searching in the references of sources found using the search terms in Table 1.

Table 1.
Search Terms and Databases

DD/ID/Neurodivergence	Dialectal Behavioral Therapy	Art Therapy	Search Engines
-Cognitive Disabilities	-Dialectal Behavioral Therapy	-Art	PsychINFO
-Intellectual Disabilities	Behavioral Therapy	-Art Therapy	Eric
-Neurodivergent	-Cognitive Behavioral Therapy	-Creative Therapies	ResearchGate
-Disabilities	Behavioral Therapy	-Expressive Therapies	ScienceDirect
-Developmental Disabilities	-DBT Skills System		Wiley Online Library
			WorldCat
			Google Scholar
			Lovejoy Library Catalogue

Figure 1.
Main Topics



Psychotherapy for People with DD and CD

Many different forms of therapy had been implemented and assessed in treating individuals with CD and DD with varying degrees of success. Applied behavioral analysis (ABA) has been acclaimed as a successful treatment method in reducing maladaptive behaviors as the methodology aims to control and manage behavior (Baer et al., 1987). However, this method faces much criticism because it can discourage an individual's autonomy and free expression by conditioning the "appropriate" response in them. It also does not address intense emotions felt in the wake of oppression, abuse, and mental health difficulties nor other mental health concerns like depression and anxiety (Gilroy, 2014). These criticisms are true even for the most harmless and beneficial cases. ABA has an unfortunate history of also being linked to aversive methods of "therapy" that involve discouraging inappropriate responses with unfavorable consequences. These consequences may range from mildly unpleasant to severely abusive. The Judge Rotenberg Educational Center, for example, is among the most notorious treatment centers for using aversive methods in the form of food and sleep deprivation, solitary confinement, restraint, and electric shocks through a device called the graduated electronic decelerator (Kindlon et al., 2006). These aversive methods have been known to cause acute

stress disorder and trauma in individuals. With ABA's questionable methods, many therapists have renounced their support of ABA in favor of other methods.

Cognitive behavioral therapy (CBT) has been adapted and attempted with individuals with CD and DD. CBT is a structured, goal-oriented approach to psychotherapy that places a great deal of focus on identifying maladaptive thoughts and changing them to be constructive. It also involves teaching various coping strategies to help the client deal with distressing situations in the moment (Society of Clinical Psychology, 2017). The straight-forward approach characteristic of CBT has shown some promising results. However, cognitive difficulties are oftentimes a barrier to treatment as CBT techniques often require a great deal of insight that may be challenging for some (Gilroy, 2014). As a result, the efficacy of the method ranges from mild to moderate success (Prout & Nowak-Drabit, 2003).

DBT, a technique based on CBT, teaches clients to use mindfulness-based techniques to manage distress and express emotions in constructive, objective ways. It also encourages clients to use interpersonal effectiveness skills to advocate for themselves. This can be surmised in the four core skills of DBT: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Finally, DBT encourages radical acceptance of reality and the self. This is because shame can be detrimental to an individual's mental well-being and pose as a barrier to treatment (Linehan, 1997). DBT has been effective in treating Borderline Personality Disorder, mood disorders, and anxiety disorders (Linehan, 2015). In the present day, people with DD and CD are often taught self-monitoring and relaxation techniques that bear some resemblance to DBT techniques. This is effective in interrupting distress brought on by intense emotions, but ineffective in learning to understand and express that emotion in constructive ways and can instill shame in the individual (McClure et al., 2009). This is where DBT can directly address emotional regulation in a constructive way and encourage the acceptance of the self.

DBT for Neurodivergent Individuals

The potential for Dialectical Behavioral Therapy (DBT) for neurodivergent individuals with CD and DD has been debated. Some critics claim that individuals with disabilities might have too much difficulty accurately identifying their own emotions (Reif, 2015). However, several studies have been done in the past showing that individuals with CD and DD can accurately and reliably identify emotions within themselves (Lindsay et al., 2004; Lindsay et al., 2008; Rose & West, 1999) differentiate between thoughts, feelings, and behaviors (Sams et al., 2005), and link specific events to emotions (Dagnan, 2001; Gilroy, 2014; Joyce et al., 2006, Oathamshaw & Haddock, 2006).

In 2013, Dr. Julie Brown had adapted a series of DBT skills into a group therapy program tailored for people with CD. This program has shown moderate success over the years and holds a lot of promise as well as creating more options for treatment for individuals with CD (Brown, 2013). The program has an organized structure that makes the material easy to follow and allows for emotional expression while also encouraging self-advocacy, pursuing one's own goals, and tolerance of distress (Brown, 2016).

DBT and Art Therapy

Art fits well into the context of DBT due to several elements inherent in art making that also align with the core skills present in DBT. In a study by Heckwolf et al. (2014), the authors coordinated the DBT core concepts to various concepts and characteristics found in art therapy: awareness, sublimation, containment, and intrapersonal effectiveness. This identified many similarities and established a foundation for building an art therapy-DBT practice.

Mindfulness - Awareness

Mindfulness is a practice that involves bringing a non-judgmental awareness to the present moment (Linehan, 2015). Oftentimes, distress involves a person thinking about the past or the future which causes anxiety in the present. The practice of mindfulness focuses on

noticing the current environment and bodily sensations. This is an important grounding exercise that provides a foundation for other skills to function (Linehan, 1993). Heckwolf et al. (2014) had associated the DBT practice of mindfulness with the art therapy practice of awareness. Awareness, in the context of art therapy, is rooted in psychoanalytic theory where uncomfortable internal processes are brought to light through creative expression (Naumberg, 1966). According to Heckwolf et al. (2014), “Parallel to the meeting ground of conscious and unconscious achieved in awareness, mindfulness involves coming into full contact with a moment and finding a home in divergent thoughts and feelings” (p. 331). Mindfulness can be demonstrated in the therapy room by objectively observing the client’s process, associated emotions, and final artwork. By naming characteristics in the artwork in a non-judgmental manner, the client is actively practicing mindfulness techniques and radical acceptance of their own work.

Distress Tolerance - Containment

Distress tolerance is a series of skills the client learns that help de-escalate distress during crisis (Linehan, 2015). It involves learning several strategies that the client picks from in order to construct a personalized and effective distress tolerance plan. Skills include self-soothing activities, pre-determined thought exercises, sensory skills, a safety plan to ensure the physical safety of the individual, and many more (Linehan, 2015). Containment involves keeping emotional distress within the confines of the art-making process and allows the individual to express themselves and relieve distress in a safe way. Rubin (2010) describes art-making as a “framework for freedom” (p. 76) as it allows clients to freely explore their own distress without fear of judgement or harm to anyone (2010). In addition, art can provide a temporary distraction from distressing events as somatic symptoms of distress de-escalate over time (Heckwolf et al., 2014).

Emotion Regulation – Sublimation

The key to emotion regulation is understanding one's own emotions from a non-judgmental stance and reducing suffering from said emotion. That is, emotion regulation does not involve the complete abolition of negative emotions as they are part of the natural human experience. Rather, emotion regulation is about capitalizing on the strengths emotions bring and controlling the challenges faced from emotions (Linehan, 2015). Sublimation originates from Freud's descriptions of defense mechanisms and refers to the act of transforming emotional energy from a socially taboo action to a socially acceptable action (Freud et al., 1946). Sublimation, in art therapy, involves the free expression of emotion and transformation of destructive behaviors to a socially acceptable form (Heckwolf et al., 2014). Art can give physical form to emotions which aids in understanding it and helps control challenges of intense emotions by employing sensory techniques inherent to the art-making process to reduce intensity and suffering (Heckwolf et al., 2014).

Interpersonal Effectiveness – Intrapersonal Effectiveness

Interpersonal effectiveness skills involve communicating effectively with others including asking on behalf of one's own needs, saying "no", and handling conflicts (Linehan 2015). Marsha Linehan theorizes that, though many individuals may possess interpersonal skills as they are able to identify what to do in a proposed scenario, carrying out such skills is where the issue lies. Therefore, Linehan proposes techniques that emphasize self-compassion and self-efficacy (Linehan, 2015). Intrapersonal effectiveness focuses on self-exploration and getting to know oneself. Through art, individuals can turn incorporeal desires, needs, and goals into a concrete object (Ulman & Dachinger, 1996). The identification of hopes, dreams, needs, and goals can help individuals with interpersonal skills as they navigate relationships using the deeper understanding of their own intrapersonal desires (Heckwolf et al., 2014).

By identifying how DBT skills are represented in art therapy, many have developed DBT-informed techniques and art interventions in art therapy. For example, Drass (2015) discussed an example where individuals may create a “save-it-for-later” box where they place troubling memories, uncomfortable thoughts, or issues they are working on in treatment on the inside. On the outside, they depict their own strengths, positively-affirming words, or reminders of coping strategies they find helpful. This way, clients can open the box when they feel ready to address what is inside and close it when they want (Drass, 2015).

Art Therapy for Neurodivergent Individuals

Using art synergizes well with neurodivergent people as they can take advantage of the medium to achieve therapeutic objectives in ways other therapies cannot. Art-making is a way of directing the client’s focus towards a task. For many individuals that encounter difficulties staying focused or feel distressed around social interaction, art can facilitate the therapeutic process by providing an additional stimulus to concentrate stress onto or act as a source of stimming. Stimming, or self-stimulation, is a repetitive physical action done by a person, most often in order to ground or calm oneself or express emotions (Kapp et al., 2019). There are several art activities that involve a repetitive physical action such as knitting, drawing lines, pounding clay, painting strokes on a canvas, etc. In addition, instead of using worksheets like many cognitive behavioral techniques use in the current era, art provides an interesting and engaging substitute to practice the same skills conveyed in worksheets (Clark, 2016). Also, many neurodivergent individuals with DD or CD may have limited vocabularies, but art can convey meaning in ways words cannot. Neurodivergent individuals often have unique worldviews that often go unspoken or misunderstood (Kaye-O’Connor, 2021). Art capitalizes on this creativity and unique worldview through creative expression of ideas, allowing what was once misunderstood to be comprehended by others (Allan, 2005).

For neurodivergent individuals with DD and ID, art therapy has facilitated emotional regulation through the art-making process and promotes an improved understanding of oneself and their relationship to others. Got & Cheng (2008) identified that using art therapy as a means to facilitate social communication improved social interaction and language expression overall in individuals with Down Syndrome.

For many years, art therapy has been closely linked to social justice as art has its own history of identifying pain and hardship in a marginalized population or calling for change by sending a visual message to the masses. Disability Art, works created by people with disabilities, has stood as a way they can make their voices heard and define their own individuality (Allan, 2005). Therefore, art is also a way in which neurodivergent individuals communicate their own experiences to others and make themselves heard. The Art of Autism is one such example of a non-profit organization that accomplishes this, emerging as a response to the rise in neurodiversity acceptance (Muzikar, 2022).

Group Approach

Dr. Marsha Linehan describes an ideal DBT program to be comprised of a DBT skills group, individual therapy to debrief, practice, and explore those skills, and a therapeutic consultation. The proposed group therapy curriculum in this paper will fulfil the DBT skills group part of her ideal treatment plan. A group format also introduces many benefits to the client. According to the Bureau of Justice Statistics, people with disabilities have higher rates of being subjected to abuse than any other population in the US (Harrell, 2017). Another source states the majority of people with cognitive disabilities will face sexual abuse and/or assault at some point in their lifetime (Sobsey & Doe, 1991). Being in a shared space or group space as opposed to the therapist and the client being in a secluded room alone can help the client feel more comfortable. Many individuals with ID also thrive among communities of people where disability culture and belonging exist (Miller et al, 2020).

The Proposed Vision

One of the objectives of this group therapy curriculum is to approach mental health treatment from a neurodiverse perspective. If one were to think about neurodivergence as its own culture, one with different behaviors, customs, and traditions separate from what is well-known, one may gain a new perspective on what sort of “therapy” can be offered that would be beneficial. What would a therapist do to help someone with a different culture live and thrive in the culture of the majority? We may explore ways in which we communicate and come to agreements with each other. We would respect each other’s culture and customs as long as they are not hurting anyone. As counselors, we would allow them opportunities to explore their identities, find how they can navigate the popular culture but still be true to themselves. Counselors can help them learn skills that the individual can choose to use when and how they deem necessary.

Therefore, the vision for this project is to create a DBT skills group therapy that adapts art therapy approaches and is tailored for people with DD and CD who are facing mental and emotional distress while taking on a neurodiverse perspective. To do this, therapists who carry out the plan will assume several core principles.

1. A person has a right to create, accept, or deny goals (Wampold, 2015).
2. Every “diagnosis” in neurodivergence, including developmental disabilities and cognitive disabilities, have their own unique strengths, challenges, and ways of observing the world (Kaye-O’Connor, 2021).
3. A diagnosis does not dictate what someone is or is not capable of (Kaye-O’Connor, 2021).
4. Most of the “challenge behaviors” people with DD or CD present with result from a lack of effective communication, unjustified restriction, discrimination, and trauma (Miller et al., 2020).

5. There is no possibility of creating a “one-size-fits-all” technique to treat neurodivergent people facing emotional distress (Kaye-O’Connor, 2021).

Though the last core principle rings true and we cannot create a “one-size-fits-all” solution, we can develop a framework that is flexible enough to be altered as needed, but structured and developed enough for feasible use by therapists. These core principles aim to instill a sense of autonomy and self-efficacy in neurodivergent individuals and encourage effective communication with the community around them. It is the unfortunate reality that many neurodivergent individuals with DD or CD are in service programs that undermine their independence, human rights, and identity (Miller et al., 2020). This therapeutic intervention will not be one of them.

Cultural Competency and Humility

The proposed curriculum and program contains benefits that it shares with other supported techniques as well as unique benefits that set it apart from other successful curriculums and programs. One of its strengths is respecting disability as a component of multiculturalism. It is the job of a therapist to be multiculturally competent and multiculturally humble (American Psychological Association, 2017). This is especially important for this population as, oftentimes, disability status and neurodiversity are forgotten as other dimensions to the multicultural spectrum. Therefore, in order for mental health professionals to maintain their multicultural competence and humility as part of their ethical obligation, they must recognize neurodivergence as its own culture and adjust their techniques as such. Cultural competency consists of understanding and appreciating differences, including differences in how people may interact, navigate, and communicate with the world (2017). The program achieves this by being mindful of different strengths through a wide variety of art activities. Cultural humility consists of being open to new perspectives (2017). One of the best ways this curriculum achieves cultural humility is treating the individual as the expert in themselves.

One of the ways this group will treat the individual as an expert on themselves is by letting the individual decide what constitutes as a problem in need of fixing. Many therapies, in the past and present, tailored for people with DD or CD have aimed to reduce “challenge behaviors” which is defined as “culturally abnormal behaviors” that put the individual’s or others’ safety at risk or behaviors that reduce the individual’s access to community facilities (Emerson, 1995). While “challenge behaviors” include risky behaviors like physical aggression, it also includes behaviors such as non-compliance, overactivity, swearing, or stimming (Emerson et al., 2001), behaviors that do not hurt anyone and may be situationally or culturally appropriate. Some of these “challenge behaviors” are not necessarily problematic but defined as such by people other than the client. This violates an individual’s autonomy to pursue their own goals in therapy. However, in this new DBT-informed art therapy group curriculum, the individual can decide what their own goals are. By allowing the individual to define what the issue in need of fixing is, therapists allow individuals to have a greater sense of autonomy on their own progress and respecting their own identity.

A significant benefit to having a neurodivergence-acceptance approach is that it keeps with upcoming shifts in how the general public views neurodivergent individuals. Already, within the past decade, there has been a shift in perspectives and stated missions by many large-scale organizations to abandon language pertaining to finding a cure for neurodivergent individuals and towards acceptance. An example of this is Autism Speaks, the largest non-profit organization pertaining to autism. Upon their foundation, their mission statement focused on finding treatments and cures for autism. In 2016, Autism Speaks changed their mission statement to leave the “cure” language in favor of identifying causes of autism while promoting acceptance (Muzikar, 2016). This is just one example of how goals and perspectives have shifted in the last decade and, as they continue to shift in the direction of acceptance-oriented approaches, therapeutic interventions will have to shift in turn.

The long-term hope is that this proposed DBT-informed group art therapy curriculum may be an example of how treatment may be changed from the original methods that focused on assimilation to methods that encourage autonomy, respect, and acceptance of the self. As the definition for what defines cultural differences are evolving in the professional counseling world, so too must our techniques evolve with it, not just to provide a quality service to our clients, but out of necessity as well.

CHAPTER III

CURRICULUM

The following new curriculum has been adapted from Brown's group therapy curriculum elaborated in her book, *The Emotion Regulation Skills System for Cognitively Challenged Clients: A DBT-Informed Approach* (2016). However, there will be several notable differences in the approach, group activities, assessment and goals of the curriculum to adapt it into an art therapy framework and maintains a multiculturally competent practice. Brown's curriculum was selected for its adaptability to many different abilities, comprehensive adaptation of the four core skills of DBT, and allowing the client the freedom to choose their own goals to work towards.

Julie Brown's (2016) research involves learning nine skills that correlate with the core DBT skills created by Marsha Linehan (1997). The skills function as a series of coping mechanisms that are chained together to form a strategy in the moment. The number of skills used depend on the severity of the situation. Art interventions will be used to augment and reinforce the skills learned in Brown's (2016) model and target self-growth by learning coping skills that have a positive effect on behavior, emotions, and thoughts. In addition, modifications will be made as needed to adhere to a neurodiversity-informed approach. As such, it is important to understand Brown's system and how it can be translated into an art therapy, neurodiversity-affirming practice. In the next section, I provide an overview of the skills system and what each skill entails.

Overview of the Skills System

The skills system is a set of nine skills that participants can use to cope with a situation in which they feel intense emotional distress.

1. Clear Picture:

Clear picture involves a person becoming aware of their surroundings, emotions, thoughts, and urges and is the first skill in every skill chain as the observations, emotions,

thoughts, and urges observed during this skill will guide which skills will be used next. People using the clear picture skill will first use several of the five senses to name and notice their surroundings. Next, they will identify their emotion and rate it on a scale of 0-5 with 0 representing no emotion and 5 representing an extremely strong emotion. A rating of 3 or lower signifies a “calm” rating, meaning that the individual can communicate effectively, make informed decisions, and will not harm the self or others. An “intense” rating of above 3 means the individual may have significant trouble communicating, making informed decisions, or may be at risk of bringing harm to the self or others. A “calm” rating means the individual can use both all-the-time skills (1-5) and calm-only skills (6-9). An “intense” rating means the individual can only use all-the-time skills (1-5) until their score on the rating scale lowers to a 3 or below. Next, the individual will identify any thoughts or urges they may have.

2. On-Track Thinking

On-track thinking involves focusing on the thoughts and urges identified during clear picture. A person using the on-track thinking skill will think about an urge they had and decide whether this urge brings them towards or away from their goal. If an urge moves a person away from their goal, they will decide on an opposite action from the initial off-track urge that moves them towards their goal.

3. On-Track Action

On-track action involves acting on urges or opposite actions that were on-track from the previous skill. It also involves accepting situations in which the individual has done all they can to move towards a goal in a specific situation.

4. Safety Plan

Creating a safety plan involves accounting for all kinds of risks, not just scenarios in which the individual may be at risk of getting hurt. A person using the safety plan skill will first assess the situation to determine if it is a low-risk, medium-risk, or high-risk situation. A low-

risk situation means a threat is far away or engaging with the “threat” could cause stress. A medium-risk situation means the threat is in the area or engaging with the “threat” could cause serious problems or distress for the individual or others. A high-risk situation means that the threat is nearby or engaging with the “threat” could cause significant harm to the self or others. Creating a safety plan involves deciding on what new-me activities an individual can do to cope with a situation, going to a place that is safe and/or seeking help from an individual they trust. The activities done, places gone to, or people sought out may vary depending on the situation and level of risk.

5. New-Me Activity

New-me activities involve doing various activities that serve different purposes and ways to cope. There are four different kinds of new-me activities: focusing, feel-good, distracting, and fun activities. Focus activities involve tasks that require logic or organizational skills such as sorting, counting, organizing, following directions, or completing a puzzle. Doing a focusing activity can help someone cope with a feeling of confusion or disorganization. Feel-good activities involve using one or more of the five senses to experience something pleasurable such as smelling perfume, tasting something sweet, touching a soft piece of cloth, etc. Feel-good activities can help people cope with a stressful situation. Distracting activities are activities done when the individual must wait or distract from a distressing situation until it can be resolved. Distracting activities are activities that can grab and keep an individual’s attention for a period of time. Fun activities are recommended when an individual feels they need some joy or happiness, generally involving activities that are pleasurable to the individual.

6. Problem Solving

Problem-solving involves directly addressing a problem that may be causing some distress. There are three ways to address a problem: fix it, change how they think about the

problem, or accept the situation as it is. The individual will make a “plan A, plan B, and plan C” and analyze the pros and cons of each plan before deciding on which course of action to take.

7. Expressing Myself

Expressing myself involves an individual sharing their thoughts, feelings, and experiences with others. The skill involves distinguishing if the topic the individual wants to share is “on my mind”(thoughts, concerns, needs) or “in my heart”(feelings, desires, hopes, dreams). It also involves determining who should hear what is “on my mind” and who should hear what is “in my heart”.

8. Getting it Right

Getting it right involves using interpersonal and assertiveness skills to ask for what an individual wants. An individual using this skill will “use sugar” by being respectful and polite, “explain” the situation, “ask” for what they want, “listen” to what the other person has to say, and “seal the deal” by reaching a mutual decision and/or compromise. These steps can be remembered through the acronym SEALS.

9. Relationship Care

Relationship care involves compromise, deciding when to give or take, and when to listen or talk. An individual using this skill will think about their relationship with a person and decide if the balance of give-and-take is equal and how to rectify the balance if it is not. This will likely also involve using other skills such as using “expressing myself” in a relationship in which the individual does not speak up much or using “problem-solving” or “getting it right” skills to find compromises or solutions.

The original twelve-week program was designed to teach clients the nine skills and how to apply them in their lives. This is done through psychoeducation techniques, experientials, and worksheets. The purpose of constructing this new group is to incorporate art-making into the program and modify it to become a more neurodiversity-affirming approach by making changes

such as how the material is presented, putting a greater emphasis on self-advocacy, and incorporating personal exploration through art and discussion. As art-making is an involved process, the curriculum will likely need to be extended from the original 60 minute sessions to 90 minute sessions. Moreover, this will allow more time to practice and solidify skills that can result in a more successful outcome.

Correlation of Skills, DBT, and Art Therapy

There is no current literature of art interventions that directly correlate to the skills in Brown's (2016) skills system model. However, there is literature that correlates to the four core concepts of DBT to core concepts of art therapy and specific art interventions. The table below illustrates what core concepts are used in each of the nine skills and how this, in turn, correlates to art therapy concepts.

Table 2.
Correlation of Skills System, DBT and Art Therapy Concepts

Skills System	Mindfulness / Awareness	Emotional Regulation/ Sublimation	Distress Tolerance/ Containment of Distress	Interpersonal/Intra-personal Effectiveness
Clear Mind	X	X		
On-Track Thinking	X	X		X
On-Track Action	X			X
Safety Plan			X	
New-Me Activities		X	X	
Problem-Solving				X
Expressing Myself			X	X
Getting it Right			X	X
Relationship Care	X	X		X

Theoretical Framework

By using the information above, accessing art interventions that correlate to the appropriate skills is much more feasible. Because of this correlation, identifying and planning potential art interventions is not just limited to studies that merge art therapy and DBT but rather any resource that utilizes several of the core features of art therapy, thus paving a clear path for the direction of this study.

Brown's model draws from the Interactive Behavioral Therapy (IBT) model of group therapy for individuals with cognitive disabilities (Brown, 2016). The IBT was the first model of group therapy built for people with CD, created in order to address a lack of empirically supported psychotherapy that addresses mental health issues among individuals with CD (Tomasulo & Razza, 2006). It draws from Moreno's conceptualization of psychodrama in group therapy, consisting of a warm-up, an enactment, and sharing (Blatner & Blatner, 1987). The IBT model consists of four stages that structure session progression: the orientation, the warm-up and sharing, the encounter, and the affirmation (Tomasulo & Razza, 2006).

The added segment, orientation, encourages participants to share and be heard by the other members of the group. The second segment of warm-up and sharing consist of a deeper level of personal disclosure as members of the group feel more comfortable in the setting. The third stage, enactment, increases the emotional engagement of each member of the group. The final stage affirms what has been learned from the previous stages by analyzing stories shared by the group (Tomasulo & Razza, 2006). Just as Brown used this model to construct her own curriculum, so too shall the group therapy established in this paper use the IBT model. This will be done by incorporating art interventions into daily activities and interventions that focus on the skills taught through Brown's model.

Session Format

Each week, the therapist will start the session with a brief group mindfulness exercise as is suggested in Brown's (2016) curriculum and helps orient members to the current moment. Suggestions for various mindfulness activities are provided. However, the therapist may also use recorded mindfulness audios, guided meditations, or other art-based exercises in order to orient the group.

After the mindfulness exercise, a brief discussion will follow consisting of what was reviewed the previous week. If homework was assigned, participants will discuss the homework at this time as well. This time of discussion allows to share and be heard by other members in the group as well as warming up for further group engagement. Then, the therapist will teach the skill or topic of the week using a combination of Brown's (2016) model and suggested teachings from the activity. Following this, participants will engage in the art activity for the week as directed in the following curriculum. The art activities aim to enact the skill learned and enhance understanding and allows participants to enact and explore skills. Each activity will be followed by a discussion. The therapist may choose to ask guiding questions as elaborated in each activity. The discussion allows for deeper exploration, a further development of emotional connection in the group, and the affirmation of skills learned. The therapist will briefly overview what had been covered that day in group and assign homework as directed.

Each activity consists of an explanation that notes its significance and how it relates or even modifies Brown's (2016) skills system to adhere to a Neurodiversity-affirming approach. At the end of the activities will be a series of suggestions to the therapist in case a difficult scenario arises.

Activities Overview

Mindfulness Activity A

Materials.

- Sheet of paper (8.5x11)
- Chalk Pastels

Procedure.

1. Ask participants to find a comfortable place to sit with their limbs uncrossed, feet flat on the floor if they are sitting in a chair, or laid straight out in front of them if they are sitting on the floor.
2. Prompt participants to bring their attention to their body, noticing any tension or clenching of muscles such as balled-up fists or clenched jaws. Invite them to briefly acknowledge it, then relax the tension.
3. Invite participants to use their senses to notice their surroundings. What do they hear? Smell? Taste? Touch? See?
4. Remind participants to keep an open mind by asking them to notice any thoughts, feelings, or judgements that come by, encouraging participants to briefly acknowledge the thoughts, feelings, or judgements, then let them float by.
5. Ask participants to key into their breathing, naming each inhalation as “breathe in” and each exhalation as “breathe out”. Encourage participants to say these words silently with their thoughts.
6. Ask participants to pick up the chalk pastel, encouraging them to feel the texture of the object, the edges and tip, to notice its weight and length.
7. Invite participants to make marks on the page without judging where the marks are going, encouraging the process of mark-making instead of creating an image.

This activity is adapted from Clark's (2016) book, *DBT-Informed Art Therapy* (pp.170-172).

The prompt may be repeated with different media.

Mindfulness Activity B

Materials.

- 18x12 Paper
- Markers

Procedure.

1. Encourage participants to find a comfortable spot to sit in. Then, read from the following script, making sure that, when starting the breathing exercise, the therapist will leave four seconds in between each inhalation and exhalation or when there is a (pause):

Introduction: We're going to be doing a mindfulness activity today. First, I'd like you to place the sheet of paper and the marker, uncapped, in front of you. Once they are placed, leave them alone for now. We will be using them soon. We'll start with a breathing exercise first. It's best to go into this exercise with an open and curious attitude. From time to time, you may find yourself making judgements and that's okay. Gently acknowledge the judgement or say "hi" to the thought before letting it go or telling it "goodbye" in your mind.

Orienting: First, I'd like you to get comfortable where you are. Place both feet on the floor/lay your legs out in front of you. If your hands are clenched or tense, gently open your fingers and allow them to rest. You may want to close your eyes if that feel comfortable. If not, you may pick an empty spot on the wall in front of you and focus on that spot. Take a deep breath in.

Notice the air going through your body, filling your lungs. Then, breathe out, noticing the air going out of your chest and through your throat. Breathe in again, picturing the air filling every part of your body, from the top of your head to the tips of your toes. Breathe out and feel the air being pulled from every corner of your body. Breathe in again, drawing the air into your

lungs(pause) and out, letting the air go free(pause). Breathe in, filling your body with fresh air(pause) and out, gently letting it go(pause).

Picking up the marker: Breathe in again and pick up the marker. As you continue breathing at an even, steady pace, notice how the marker feels in your hand. Notice the texture of the object, first along the side. Is it smooth or rough, maybe soft or hard? Identify what the texture is. Now, notice what the ends of the marker feel like? Is it pointed or round or somewhere in between? Take in another breath, holding the marker in your hand(pause), breathe out and place the tip to the paper(pause).

Making marks on the page: As you take in your next breath, make your first mark on the page without picking up your marker. Breathe out and let your hand move again, letting your hand flow like your breath. You may have the urge to look at what your hand is doing. Gently acknowledge that urge. You may give it a nod or say “hi” to it in your head, then let the urge go. As you keep your marker flowing with your hand and your hand flowing with your breath, you may feel curves or the direction of the marks changing as you take a new breath in or let another breath out. Notice these changes and know that they are how the air moves through your body. Continue to breathe and make marks with the marker, keeping the steady rhythm of your breath. (At this point, the therapist may want to count out loud 5-10 more breaths or silently count to allow participants time).

Finishing: When you are ready, take a deep breath in and make your final mark on your paper. As you breathe out, lift the marker from the paper and set it aside. When you feel ready, bring your awareness back to the room. Notice how you feel in your seat. If your eyes are closed, slowly open them. Look around the room. You all did an amazing job with drawing out your breath. You may look at the drawing now.

2. Debrief with participants. Encourage them to share their drawings if they feel comfortable. Ask them if they are able to tell where on the drawing they were breathing

in and where they were breathing out. Ask what parts were easy or hard and what urges came up.

This activity can also be modified and repeated with different media. The therapist can also substitute the two mindfulness activities with other mindfulness audios or scripts.

Week 1: Activity A

Each member will create their own skills book to help them remember the names of the nine skills.

Materials.

- Skills book handouts (see Appendix B)
- Small hole puncher
- Yarn (provide several different colors)
- Scissors
- Colored pencils
- Glue stick
- Masking tape.

Procedure.

1. Fold each paper along the dotted line.
2. While the paper is folded, use the hole puncher to punch holes on the grey dots.
3. Organize each paper of the book so that the nine skills come in order from 1 to 9, making sure each page is facing the right way and the punched holes align.
4. Cut a piece of yarn that is one arm's length long.
5. Wrap a piece of masking tape around one end of the yarn. This will make it easier to thread the yarn through the holes.
6. Tie a double knot in the first hole of the book.

7. Wrap the yarn around the spine of the book and through the next hole. Repeat this process until the yarn is threaded through the last hole in the book.
8. Tie a double knot with the leftover yarn, then cut the tail off. Participants may want to leave some of the tail still there to use as a bookmark if they'd like to.
9. With the newly-made book, participants and the therapist will go through each of the nine skills in the book. Each page will have a skill number, picture, and definition, but missing a skill name. The therapist will ask each participant to read aloud the definition and identify the name of the skill. When the therapist identifies the name of the skill, the participant will write it down on the book. By the end, each participant will have a brief reference guide to the skills system.

Guiding Questions.

- Now that you know what the skills are, you may find that you may have used at least one of these skills before without knowing it. What skills have you used before?
- What happened when you used the skills?
- What skills do you feel interested in learning more about?

Explanation.

This activity will lay out a plan for the next several weeks for participants to follow which provides structure to the group and informs others on what they can expect each week. It also acts as a useful reference guide they can use in their everyday lives as reminders for what each skill is.

Week 1: Activity B

Each participant will be creating a folder to hold various handouts and projects. They will be bringing this folder to each meeting.

Materials.

- Folders

- Small pieces of paper
- Glue
- Scissors
- Colored markers
- Ribbon
- Stickers

Procedure.

1. Explain that this folder will be where they can keep handouts, projects, and worksheets.
2. Have each participant think of the goal they want to achieve through the skills system. Have them write it on a small piece of paper and glue it wherever they'd like to on the folder as long as they can see it and still place items in the pockets.
3. Encourage participants to decorate the rest of the folder how they'd like. Encourage them to use materials, shapes, or colors they enjoy or are drawn towards.
4. When the folder is declared done, place any handouts and book from the day's activities in the folder.

Guiding Questions.

- What goal have you written for yourself? How did you come up with this goal?
- What drew you towards certain materials? What significance do they bear?
- How did you feel using the materials you chose?

Explanation.

The folder made during this activity will provide a common place for participants to store their various projects, handouts, files, etc. Having the goal in the paper will also allow them to be reminded of what they are striving towards throughout the group.

Week 2: Feelings Rating Scale

Participants will be creating emotion portraits to identify what their face may look and feel like when they feel a certain emotion.

Materials.

- Six sheets of paper per person
- Pencil
- Colored pencils
- Small table mirror

Procedure.

1. Have a discussion on the rating system and how people may experience different levels of intensity of an emotion. Encourage participants to pick an emotion and identify a time in their lives when they felt that level of intensity for that emotion (Ex: Last week, I felt a level 1 sadness when I went to the store and found that they were all out of my favorite cereal).
2. Have the participants use the mirror to act out what kind of facial expression they had during their lived experience or may have had if they do not have an example for that level of emotion. Ask them to look for a difference in the way their eyes look between different emotions, their mouth, or even their body posture.
3. On each sheet of paper, participants will draw the facial expression they see in the mirror. Each of the six papers will represent a different intensity level for that emotion (0-5). Some participants may choose to go in order while others may start with 0 or 1, then 5, then all the intensity levels in between.
4. When all six portraits are completed, encourage participants to share with each other or even compare with one another if two participants portrayed the same emotion, noting that two people may express the same emotion in different ways.

Guiding Questions.

- Describe the picture. What shapes does the mouth take on? Eyes? Nose? Cheeks? Eyebrows?
- Try acting out that expression you see on the paper. Where do you feel your muscles tensing up?
- How is your drawing unique to you? How do others express this same emotion? Is it the same or different?

Explanation.

There are many benefits to drawing out your own face instead of using a pre-established picture when creating an emotion scale. Neurodivergent people process facial expressions differently than their neurotypical counterparts. A study by Klin et al. (2001) suggested that people on the autism spectrum will interpret facial expressions and social situations by focusing on the mouth movements instead of the eyes. Using an emotion scale specific to the client and how they interpret facial expressions both provides a more effective emotion scale and encourages participants to use their personal strengths of unique facial expression interpretation. In addition, acting out a facial expression and drawing it will allow participants to familiarize themselves with how their facial muscles feel when they make that expression which, in turn, helps them recognize when they are using those same muscles next time they feel that emotion.

Homework.

Before the end of session, present each participant with the first homework assignment, “Feelings Rating Scale” (see Appendix C). If there is time left at the end, you may encourage participants to start the assignment in the group. Encourage participants to complete the feelings rating scale worksheet at home with an emotion different from the emotion focused on during session that day. If they have one emotion in mind already, encourage them to write it at the top.

Week 3: Clear Picture

Participants will create a picture of their surroundings to identify sensory information.

Materials.

- Sheet of paper
- Pencil and eraser
- Colored pencil
- Clip board

Procedure.

1. Encourage participants to identify their emotion and rate it using the rating system from last week.
2. Encourage participants to identify things they notice in the room. Have a discussion on what people can hear, see, touch, smell, and taste.
3. Ask participants to pick a spot in the room they'd like to draw. The scene they draw must have one of each of the five senses (objects can be placed in the room). Encourage them to draw what they observe.
4. Once the participants have completed the drawings, encourage them to outline what they can hear in blue, what they can touch in green, what they can taste in red, and what they can smell in yellow.

Guiding Questions.

- Before drawing, everyone was asked to use the rating scale to name their emotion and rate it. Name the emotion you feel now, after drawing what you see and using your five senses to identify what you hear, smell, taste, and touch. Is it different? How is it different?
- What did you notice about the process of drawing what you see? What shapes or colors did you find?
- How do our five senses help us become aware of where we are?
- How does using the Clear Picture skill help us in stressful situations?

Explanation.

Observational drawing encourages people to think about the lines, curves, and shapes that make up an object instead of identifying the object itself. This activity will allow participants to take the time to observe these lines and shapes as they draw them. It forces the participant to slow down and take their time in observing every detail of their surroundings. The process of outlining objects they can see that also emit sound, objects they can currently touch, taste, or smell allow them to see opportunities for the other senses in the world around them and in places they may not have considered.

Week 4: On-Track Thinking

Participants will create a portrait of their on-track self

Materials.

- Sheet of paper
- Markers/colored pencils
- Acrylic paint
- Paintbrushes
- Collage materials
- Scissors
- Glue

Procedure.

1. Encourage participants to think about their goals and what they want to accomplish. Then, encourage them to imagine themselves achieving that goal, what that person may look like, how they may feel.
2. Encourage participants to draw a portrait of themselves after they have achieved their goal. If a participant cannot imagine themselves making that goal, encourage them to

identify someone they look up to or another neurodivergent individual they admire and encourage them to draw that person.

3. Identify this person as their on-track mind, the mind that is within them that will help them stay on track, not just an imaginary being. This means that whatever the person did to stay on track in the picture, the participant can do, too.

Guiding Questions.

- What does the person in the picture look like? Do they look happy? Proud? What else might they feel?
- What happened to make them feel that way? How did they get there?
- If you had drawn an image of a person that is not you, describe them. What does this person mean to you?
- What is an example of an on-track thought? What thoughts have you written down?

Explanation.

The “on-track mind” in this activity is parallel to the concept of “wise mind” in the original DBT model. Those that have a specific goal in mind can use this activity to picture themselves achieving that goal which will boost motivation, especially as the participant considers how their “on-track” self may feel when they are actively working towards or achieving their goals. If an individual does not have a specific goal in mind, they can draw a portrait of someone they look up to or want to be like in the future. The therapist may help by giving examples of neurodivergent individuals who have achieved their goals or perhaps have a similar life story to the client. The person they look up to does not even have to be a real person. The person they look up to may be fictional as well. In either case, the portrait will provide the client with their on-track self, a picture of what to strive towards. When faced with a difficult decision, they may ask themselves “what would my on-track self do in this situation?”

Homework.

Before the end of session, present each participant with the second homework assignment, “Stay On Track!” (see Appendix D). If there is time, complete the homework assignment within the group. Follow the directions on the worksheets to set up the project so it can be set up at home. Encourage participants to think of examples of on-track thoughts they may want to create before the end of session.

Week 5: On-Track Action

Participants will use rocks and clay to understand that we cannot change the past, but we can change the way we see it and we have the power to shape the future.

Materials.

- Rock
- Package of polymer clay (e.g., sculpey)
- Acrylic paint
- Paintbrushes
- Markers

Procedure.

1. Explain to participants that the rock represents the past and the clay represents the future.
2. Encourage participants to write or draw something that happened in the past on the rock.
It may be an event that caused pain or something they may feel ashamed of.
3. Encourage participants to also think about the positive side of these events, a lesson they may have learned, an important experience they had, or with the event being inevitable.
4. Instruct participants to set that aside for now and focus on the clay. Encourage participants to think about something they would like to accomplish in the future. They may use a combination of sculpting, painting, and mark-making.

5. Once the sculpture is done, challenge participants to try and sculpt the rock like they did with the clay. Participants will find that they are unable to do so.
6. Have a discussion about how people are unable to shape their past, but they can look at it from different angles and change the way they think about the past by looking at the positive side. People can also shape their future by acting in the present. Link this back to on-track actions and how doing these on-track actions are how we shape the future in the way we want it to look.

Guiding Questions.

- If it's impossible to shape the rock (the past) like you did the clay (the future), and you can't break it, what can you do with it?
- How are these actions similar to our past?
- When you shape the future-clay right now, what does that do to the sculpture?
- What are some things you do in the present that help shape the future into something you want it to look like?

Explanation.

As Brown's (2016) model uses the on-track thinking skill to decide what is the on-track choice and the on-track action skill to carry out the on-track choice, so too does the art prompt focus on the self-determination and motivation required to make choices. We cannot shape the past, but we can change how we look at it, similar to how one cannot shape a rock, but they can color it, decorate it, and change the angle in which they look at it. However, we can shape our future with our actions in the present. The important part of this activity, as well as goal-forming in general, is the process of the client deciding on the goal they want to achieve. What the client deems as success may not align with what others deem as success. The therapist must encourage the client to shape the sculpture in a way they want. However, some participants may need help envisioning their ideal future that can be represented with the materials. The therapist can do this

by asking questions about where they'd like to be, what they'd like to be doing, and help the client identify objects they may find in that future.

Week 6: Safety Plan

Participants will create a safety plan by depicting different coping techniques, safe places, and people to contact on shield-shaped wooden pieces.

Materials.

- At least 3 wooden pieces shaped like shields with small holes in them
- Markers
- Acrylic paint
- Paintbrushes
- Collage materials
- Stickers
- Ribbon
- Cloth
- Clip Key Ring

Procedure.

1. Explain to participants what a safety plan is. Encourage them to think of a situation in which they felt stressed or was at risk of feeling stressed (low risk), a time when a risk to themselves was in the area (medium risk), or when they were in immediate danger (high risk). Ask about what they did to cope with the situation, the places they went to in order to feel safe, and the people they contacted to help them get to safety.
2. Identify each shield as the shields of defense that will help keep them safe or could help prevent high-stress situations: activities, places, and people. Encourage them to think about how they can be represented visually. Participants may choose to write the word or name of the activity or create a visual representation.

3. Participants will write, draw or decorate the first shield with one or more New-Me Activities (activities that can help them calm down, relax, or focus). Encourage them to think about different activities for different levels of risk.
4. Participants will write, draw, or decorate the second shield depicting safe places they can go to. Encourage them to identify more than one place in case one of these locations is not available.
5. Participants to write, draw, or decorate the third shield depicting people they can go to in order to help keep them safe. They may wish to include their contact information if they so choose.
6. When the three or more shields are done, encourage participants to either use a metal clip key ring or tie the shields together with a ribbon.
7. Practice using the shields of defense by proposing a pretend risky scenario and ask participants to state what they will do using their shields as references.

Guiding Questions.

- What do each of the three shields depict? What activities did you show on the first shield? What activities can you do for different levels of risk?
- Where can you go to be safe? What makes that a safe place?
- Who is the person you go to that you trust? How do you know you can trust them?
- When we role-played the scenario, how did you feel when you had a safety plan?

Explanation.

During crisis situations, it can be very difficult for anyone to remember details of a safety plan, much less follow the plan. However, having a physical object with them will provide the client with a portable “guidebook” for what to do in crisis situations. Having a plan in place will be especially helpful for neurodivergent individuals that thrive in having a pre-established plan close at hand. It may be helpful for the therapist to discuss who is a trusted individual the client

can go to. Depending on the individual, they may need someone who is always accessible and can also help them assess a situation for risk. The usage of shields frames the techniques as tools or defenses they can use to defend themselves against stressful or dangerous situations.

Homework.

While participants are at home, instruct them to gather several items that are or represent activities they enjoy doing such as a deck of cards, a fidget toy, a few favorite cooking recipes, a puzzle book, a favorite lotion, candy, favorite book, etc.

Week 7: New-Me Activity

Participants will create a box containing tools or reminders of several new-me activities.

Materials.

- Empty shoe boxes
- Acrylic paint
- Paintbrushes
- Colored and patterned paper
- Collage materials
- Scissors
- Glue
- Markers
- Ribbon
- Stickers
- Cutouts of inspirational quotes
- Cloth
- Essential Oils

Procedure.

1. Discuss the purpose of new-me activities. Identify the four types of New-Me Activities: Focus, Distract, Feel Good, and Have Fun. Ask people to name an activity and categorize it as focusing, distracting, feeling good, or having fun.
2. Participants will decorate the box with things that can inspire them to stay on-track. This could be a mix of images that help them remember their goals, imagery of the nine skills, inspirational quotes or figures, previous art they've done, objects they bring from home etc.
3. Participants will identify at least one of each category of New-Me Activity: focus, distract, feel good, and have fun. They will place or visually represent each item inside the box. For example, a box may contain a deck of cards(focus), a piece of soft cloth(feel good), a favorite book(distract), and a picture of a character from a favorite TV show(have fun).
4. Discuss how different occasions may call for different activities. Feeling confused or disorganized may require a focus activity, feeling stressed or uncomfortable may require a feel good activity, having to accept and/or wait during a stressful situation may require a distracting activity, and wanting to feel better or cheer up may require a fun activity.

Guiding Questions.

- Pick out one activity from the box. What kind of activity is it (focus, distract, feel good, or have fun)? When might you do this activity?
- When was there a time you did this activity in the past? What made you decide to do this specific activity? What happened after you did the activity?
- Think of a place in your home that's easily accessible to put the box.

Explanation.

Before the start of the activity, the process of participants going through their home and finding/identifying objects or activities that will help them cope in the future starts the process of

the participant getting used to knowing where to go and what to do when they decide to do a “new-me” activity. The making of the box will further facilitate this process of preparing a space to go to when they feel overwhelmed. In addition, neurodivergent individuals that have a heightened sensitivity to stimuli can benefit greatly from this activity as it allows them to explore positive sensory input and identify what sense helps soothe them best in stressful situations.

Week 8: Problem Solving

Participants will learn about problem solving through creating and “solving” a jigsaw puzzle.

Materials.

- 12 pc blank jigsaw puzzle
- Colored pencils
- Markers
- Acrylic Paint
- Glue
- Scissors
- Collage material
- Construction paper

Procedure.

1. Before handing out materials, the facilitator will remove one piece from each puzzle so that everyone has 11 total pieces.
2. Have a discussion with participants on how problems are solved. People can either fix a problem, change how they may think about the problem so it bothers them less, or they can accept the situation as it is.
3. Encourage participants to put together the puzzle. Once they are done, ask them what is weird about the puzzle. They may respond that there is a missing piece. Ask if the

missing piece is a problem. If they respond yes, encourage the participants to think about how they can address the problem using the three methods previously discussed. Open up the discussion so people may share ideas or how to address the problem. If people respond no, accept and embrace the answer by reaffirming that a puzzle with a missing piece does not have to be a problem.

4. Encourage participants to use the art materials to address the problem of the incomplete puzzle or to decorate the “complete” puzzle. They may use some materials to create the twelfth puzzle piece, use the missing piece as a focal point for the whole puzzle, or they may leave it as is.

Guiding Questions.

- What was your reaction when you realized there were eleven pieces instead of twelve?
How did it make you feel?
- I had asked you before if the missing piece was a problem. What would have happened if people said it wasn't a problem/why did some people see it as not a problem?
- If a puzzle without the twelfth piece is not a problem, why do some think it is?

Explanation.

This activity helps participants see a side to problem-solving skills that is oftentimes avoided: that, sometimes, the solution to a problem is to accept the situation. If participants accept the “incomplete” puzzle as a complete puzzle with a little space empty, it shows that problems only become problems if we perceive them to be so. It also enables participants to practice frustration tolerance and dealing with situations that may feel uncomfortable. During the activity, the therapist may use this frustration as a way to practice the previous skills by identifying the emotion, deciding what to do, and perhaps even using their “new-me” activity box.

Week 9: Expressing Myself

Participants will create a self-portrait that distinguishes what is on the mind and in the heart.

Materials.

- 18x12 paper
- Colored pencils
- Chalk pastels
- Watercolor paint
- Paintbrushes
- Collage materials
- Glue
- Scissors

Procedure.

1. Discuss the difference between what is on the mind(thoughts, concerns, organizational, needs) and in the heart(feelings, hopes, dreams, preferences). Ask the group to give examples of both on-my-mind and in-my-heart expressions. Ask the group to name different ways in which people communicate. Write down the different ways people communicate on a page poster or whiteboard.
2. Before beginning, explain the power of medium and how different mediums can help people get in touch with different ways of expressing themselves. Materials that are rigid and easy to control and manipulate help people express what is on their mind while fluid and difficult to control or manipulate mediums help people get in touch with what is in their heart.
3. Encourage participants to use the colored pencils or collage to write or represent something that is on their mind.

4. Encourage participants to use the chalk pastels or watercolor paint to represent what is in their heart.
5. Upon finishing, go around and let each person express what is on their mind and in their heart with their preferred form of communication, letting participants choose from the whiteboard or from a different method of their choosing.
6. Have a discussion about how people understood each other with different forms of communication.

Guiding Questions.

- If you feel comfortable, tell us about what is on your mind and in your heart?
- In this project, you used two different mediums to depict what is on your mind and in your heart? How did it feel using the colored pencils/collage? How did it feel using the chalk pastels/watercolors? How did they feel different?
- Why do people have different ways in which they communicate?
- If you chose a form of communication you don't usually do, what drove you to choose it?

Explanation.

Many neurodivergent individuals are skilled in communication methods unconventional to the common idea of what is considered effective communication. Some have become adept at non-verbal forms of communication in a world that strongly, sometimes forcibly, encourages verbal communication. This art prompt aims to be a celebration of the different ways people communicate and understand each other. It also utilizes different mediums to help participants differentiate cognitive expressions from affective expressions.

Week 10: Getting it Right

Participants will create a project using SEALS to obtain the right materials

Materials.

- Scissors

- Glue
- Markers
- Paper
- SEALS letters(do not cut them out)
- Collage materials
- Stickers
- Provide a poster with the explanation for SEALS. Limit the number of glue, scissors, and markers available, but provide enough paper and letter sheets for everyone.

Procedure.

1. Go over the SEALS acronym and what each letter stands for: Sugar (being polite), Explaining the situation, Asking for what you want, Listening, and Seal a deal (SEALS).
2. Introduce the project as completing a poster that will help them remember SEALS. They can only use the materials available on the tables. Point out that people will have to use the SEALS method to ask for materials they do not have but need. Model the process of using SEALS with another participant.
3. Participants will create a poster that will help them remember SEALS by using the provided materials. There are no specific content requirements and some participants may Problem Solve by not using materials that are currently in use (some may choose to use just a paper and a marker as opposed to a paper, scissors, glue, and a marker).

Guiding Questions.

- What was easy about using SEALS? What was hard about it?
- Were there times in which you had to compromise? If so, how did you do it? What was the compromise?

Explanation.

The prompt is partially an art activity and partially an extended, role-play-like experiential in which participants will be able to practice skills they had just learned and skills they had learned from weeks prior such as “expressing myself” and “problem-solving”. SEALS is the DBT parallel to the acronym DEAR MAN and provides a step-by-step process for how to advocate for oneself. It also builds group collaboration and communication in preparation for the next week’s activity (Clark, 2016).

Week 11: Relationship Care

Participants will work together to create a group portrait centered around a theme.

Materials.

- Sheets of white construction paper
- Markers
- Colored pencils
- Acrylic paint
- Paintbrushes
- Collage
- Glue
- Scissors
- Large piece of rolled paper

Procedure.

1. Briefly review “problem-solving”, “expressing myself”, and “getting it right” as participants will need to use all three of these skills in order to work together for the project. Explain that the goal of this project is to let everyone have an equal amount of say in the project.

2. Encourage the group to decide together on a theme for the project. If there is disagreement, encourage them to find a middle ground or for one side to accept the other with the promise that they will get to make the next decision.
3. Have each person complete a self-portrait using the available materials. These portraits can be depicting the actual individual or more symbolic of who they are.
4. After everyone is finished, go around the group and share their creation.
5. Ask the participants to consider the chosen theme, then decide on where to glue their self-portraits.
6. When all portraits have been glued, ask participants to decide on what background/environment might illustrate the theme. If necessary, remind participants of the give-and-take nature of relationships, offering people who have not had much of a say yet to make decisions.

Guiding Questions.

- Look at the picture. How is the space that each person took up divided? Is it equal? If not, where are areas in which a person has more or less space?
- Who emerged as leaders during this activity? If so, how did it feel to lead?
- Were there people who did not have as much input in this project? If so, how did it feel?
- Sometimes, people prefer to lead and some prefer to hang back a bit. What is your preference?

Explanation.

The activity is a modified version of Clark's prompt for completing a relationship portrait (Clark, 2016, page 200). During the activity, participants will be using many of the skills they had previously learned, especially ones that are focused more on interpersonal effectiveness skills such as problem-solving, expressing myself, and getting it right. This may also allow participants who have been quiet to participate more as everyone is encouraged to be mindful of

how much space each individual has. The process of completing a final group project will also contribute to the process of termination which will conclude at the end of next week.

Week 12: Review and Graduation

Participants will review the nine skills, then create their own graduation certificate.

Materials.

- Blank Certificate Printout (see Appendix E)
- Markers
- Colored pencils
- Acrylic paint
- Paintbrushes
- Stickers
- Collage materials
- Different papers/cloths
- Scissors
- Glue

Procedure.

1. Go over each skill by revisiting each art project completed throughout the twelve weeks.
Talk about what was learned and how people have used the skills in their everyday life.
2. Ask participants to decorate their certificate however they'd like, then sign/seal their certificate.
3. Have everyone share their creations and talk about what was the easiest part of group and what was the hardest part of group.
4. Congratulate everyone for their hard work throughout the weeks!

Guiding Questions.

- What were some of the easiest skills to learn? What were the hardest?

- Was there a time these past few weeks when you used the skills system? If so, when and how did it go?
- What skills do you feel most confident using? Least confident? What can you do to practice the skills you may not feel as confident in using?

Explanation.

The prompt focuses primarily on a review of all the previous skills learned and recognizing what areas are strengths and what areas may need more development in the future. Their badge is a symbol that they had completed the twelve-week curriculum and a send-off activity to facilitate termination.

Suggestions

A neurodiversity-acceptance approach focuses a lot on the strengths of the individual because, while neurodivergence can lead to some challenges, it also leads to strengths. By emphasizing and capitalizing on these strengths, the therapist can help the individual grow a stronger sense of self-efficacy and confidence. Many activities, such as the first activity, involve reading which may be difficult for some. In that case, the therapist can capitalize on their other strengths by asking them to describe the pictures instead.

Other activities involve using scissors to cut paper, string, or other materials. It may feel embarrassing or bring too much attention to the individual if the therapist stops to cut paper or strings for the participants. Therefore, if the therapist knows there are participants who may experience difficulties using scissors, they may provide some pre-cut pieces before the session, being sure to provide a variety so the participant may choose and fully participate. If the therapist must stop to help a participant, they are advised to only do so if the participant is clearly asking or looking for help and, even then, the therapist should involve the participant as much as possible. For example, the therapist can ask the participant to hold the string still while the therapist cuts it or vice versa.

It is also important to allow participants autonomy to choose. That means letting the participants choose their own goals, their own materials, and their own art style. Therapists can help the participant do this by asking them questions about what they want. If goals are difficult for the participant to picture, the therapist may ask them what they would like to do in the future. The therapist should be careful not to ask what others want the participant to do in the future, but what the participant themselves want.

Sometimes, a therapist may encounter emotional outbursts or resistance during group. However, the therapist can also interpret this as a strength. Someone that has these “emotional outbursts” may find it easier to express their emotions. This is a strength as it shows the participant has the desire to communicate to people what they are feeling. Participants who show “resistance” or “non-compliance” are showing an ability to say “no”, a knowledge about what they want, and the confidence to express that to others. This, too, is a strength. This modified skills system aims to bolster these strengths while also teaching that there is a time and place to express oneself and learning to calibrate how much to express oneself. Therefore, the therapist may be able to use “outbursts” as a teaching moment by utilizing the skills learned thus far. An individual who possesses a strength in expressing themselves can use the “clear picture” skill to name their emotion and the intensity of that emotion. An individual who is skilled in saying “no” and advocating for themselves may use the skill “getting it right” to advocate for what they want.

CHAPTER IV

CURRICULUM REVIEW AND EVALUATION

Curriculum Goals

According to Art Therapy Resources (2019), a crucial part in building the curriculum is establishing the goal of the group therapy. This includes what specific issues the group aims to tackle, what participants will learn, and the ending objective for the group to pursue. While the goals of this proposed group curriculum and Brown's curriculum are similar, they will deviate in some areas as the curriculum is rebuilt to adhere to a neurodivergent-acceptance perspective. In Brown's initial DBT-Informed approach, she had measured the effectiveness of the therapeutic intervention by asking the client and professionals working with the client to track a range of "challenge behaviors", anticipating a reduction in said behaviors. While some "challenge behaviors" are indicative of some emotional distress, it does not take into account all behaviors that may denote emotional distress but are not considered "challenge behaviors" such as crying, lethargy, or social isolation. In addition, many "challenge behaviors" that were tracked in the study such as yelling or swearing may be situationally or culturally acceptable to the client, but deemed unacceptable by others. In any case, the definition of "success" was not defined by the client, but rather by other professionals. Therefore, the primary goal of this group therapy curriculum will not be to reduce challenge behaviors, but rather to teach skills and how to adapt those skills into everyday life and improve the individual's ability to cope in stressful situations. Thus, it is up to the individual's own choice on when to use those skills and how helpful they are to them.

The following goals are intended to focus around empowering the individual to learn about and do what works for themselves. In order to discover what works for themselves, they need to build a self-awareness and understand their own identity, their own feelings, and their own patterns of communication. Once that is accomplished, participants are also identifying

skills they can use and feel comfortable with to navigate the world around them that synergizes with their own identity and patterns. When this occurs, it will result in an increase in the social and emotional well-being of the individual. Thus, the following objectives have been established to track progress towards these goals.

Goal 1: Awareness of the Self/Identity Exploration

1. Participants will have explored and recognized their patterns of emotional expression by identifying what they look and feel like when experiencing a certain emotion by the end of the 12-week program.
2. Participants will have explored, demonstrated, and practiced the form of communication they feel most comfortable with by the end of the 12-week program.
3. Participants will have named at least three personal strengths by the end of the 12-week program assessed through informal interview.

Goal 2: Skill Building

1. Participants will have identified the goal they wish to work towards by week 6.
2. Participants will have successfully identified four coping strategies to use in times of distress by week 8.
3. Participants will have demonstrated an increased mastery of DBT skills as measured by an average score increase of the DBT-WCCL Assessment at the end of the 12-week program.

Goal 3: Social and Emotional Well-Being

1. Participants will have demonstrated the ability to name and rate the intensity of their present emotion by the end of the 12-week program.
2. Participants will have practiced interpersonal effectiveness skills through weekly group discussion and group collaboration by the end of the 12-week program.

3. Participants will have shown an increase in their social-emotional well-being through an increase in their scores with the Outcome Rating Scale.

The goals here are the ideal goals in the most ideal timeline. Yet, the timeline set for these goals is unrealistic to generalize to every participant. Most of these goals can be accomplished to some degree by any potential group participant, regardless of ability with the right accommodations. However, a mastery and full adaptation of the skills learned during the curriculum may be unlikely to occur within the twelve-week timeline. Brown had articulated that many participants will need to undergo the group curriculum more than once in order to gain a mastery over the skills presented in the twelve-week program (2016). This adapted version may also require multiple cycles for the participant to achieve a mastery and adaptation of the skills depending on the individual.

Measurement of Effectiveness

There are three total assessments that will be used over the course of the group curriculum. The first assessments used at the start of the course of treatment is the Outcome Rating Scale (ORS) (Miller et al., 2003) and the Dialectal Behavioral Therapy-Ways of Coping Checklist (DBT-WCCL) (Neasciu et al. 2010). The third measure that will be used is the Session Rating Scale(SRS) (Duncan et al., 2003) administered in the middle of the 12-week group curriculum, along with the ORS, and at the end with the ORS and DBT-WCCL. Effectiveness will be measured through whether or not the client has learned the skills as opposed to the number of “challenge behaviors” exhibited by the client. In short, success will not be measured by a reduction in certain behaviors but rather an addition of skills to cope with feelings, thoughts, or behaviors the individual deems to be maladaptive.

The ORS is intended to measure the client’s overall well-being while the DBT-WCCL measures the client’s usage of DBT coping skills. Participants of the group will take both the ORS and the DBT-WCCL before the first group session in order to compare with post-treatment

outcomes. Participants will take the ORS a second time as well as the Session Rating Scale (SRS) in the middle of the treatment course after the group session during week 6 of treatment (Duncan et al. 2003). The SRS is intended to provide feedback to the therapist on the approach, agreement of goals, and the working relationship between the client and the therapist. Finally, after week 12 of the treatment course, each participant will take the DBT-WCCL, ORS, and SRS before concluding the treatment cycle. In the following sections, each assessment will be analyzed for their validity, reliability, strengths, and weaknesses.

Outcome Rating Scale

The Outcome Rating Scale works to provide a general “check-in” for clients. There are four measurements of well-being taken: individual, interpersonal, social, and overall. Individual well-being measures the personal sense of well-being which includes thoughts, feelings, or general mood. Interpersonal well-being measures the client’s quality of close relationships which includes family members and close friends. Social well-being measures the quality of the client’s social life which includes social interactions at school, work, or with friends and acquaintances. Finally, the overall sense of well-being asks the client to consider everything going on which includes all three previous measurements and even measurements not accounted for previously such as environmental factors. Each of the four factors are allotted their own visual analogue scale spanning 10cm. The place on the scale correlates with a score ranging from 0 to 10. All four scores are added together to provide a final score ranging from 0 to 40 (Miller et al. 2003).

In a study consisting of 336 individuals, the internal consistency of the ORS was found to range from 0.87 to 0.96. Out of the 336 individuals, 86 belonged to a non-clinical sample. This group was retested one to three weeks after the initial administration of the ORS and found a test-retest reliability ranging from 0.49 to 0.66 (Miller et al. 2003).

To assess the validity of the assessment, the ORS was compared with the OQ-45, a 45-item questionnaire that measures the individual, interpersonal, social, and overall wellbeing of

the client, and found a moderate correlation between the two total scores at 0.59 (Miller et al. 2003).

One of the biggest strengths of the ORS is how fast it is to complete to the point where it can take only 60 seconds to administer in full. This makes it optimal to use as a check-in at the beginning of a session. In this case, the ORS is ideal to integrate in the middle of the course of the curriculum as it provides a midway check-in to assess the social-emotional well-being of participants.

A weakness of the ORS assessment is that, by making the assessment so short, it sacrifices detail. One who takes the ORS may score a 3 out of 10 in the individual scale which alerts the facilitators that there may be a factor affecting their personal well-being. However, it gives no further information as to what that factor is or if the skills system would even be effective in resolving that factor. In the case of a low ORS score, the facilitator may want to discuss the drastically low score privately with the client, seek information from collateral individuals as necessary, or suggest additional services during week 13.

Dialectal Behavioral Therapy-Ways of Coping Checklist

The purpose of this assessment is to measure the use of DBT skills in everyday life. The assessment does this through a 59-item questionnaire. Initially adapted for DBT from Vitalino's revised Ways of Coping Checklist, items on the questionnaire were modified and tailored to concentrate on four core DBT skills: mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance. When assessing content validity, distress tolerance was divided into two categories: reality acceptance and crisis survival. The assessment also measured two categories of maladaptive coping techniques: general dysfunction and blaming others (Neasciu et al., 2010).

The questions would describe a skill and ask the test-taker how often they use that skill, having the option to select "never used", "rarely used", "sometimes used", and "regularly used".

Each response corresponds to a value of 0-3 with 0 representing “never used” and 3 representing “regularly used”. 38 questions focused on DBT skills, 15 questions focused on general dysfunctional coping, and 6 questions focused on blaming the self (Neasciu et al., 2010).

The DBT-focused questions maintained an excellent internal consistency ranging from 0.92 to 0.96. The questions focused on maladaptive coping methods displayed internal consistency scores that ranged from good to excellent, from 0.84 to 0.92. In an assessment of the content validity, DBT experts had rated the items on a scale of 0-100 on how well they matched DBT skill modules. Comprehensiveness was low for mindfulness-focused items(38.28%) and reality-acceptance focused items(37.24%, moderate for emotion-regulation focused items(43.10%) and interpersonal-effectiveness-focused items(43.45%) and high for crisis-survival-focused items(75.52%). In an assessment of criterion validity, before the treatment course, all groups were administered the assessment and a mean score of 1.57 was obtained. There were no significant differences between groups before treatment commenced. After a 4-month treatment course, individuals in groups that learned DBT skills demonstrated a higher mean increase in their coping skills score, 1.99, compared to their controls’ mean score which obtained a DBT treatment not focused on coping skills, 1.65 (Neasciu et al., 2010).

The strength of this assessment lies in the specialized nature of adapting a well-known measurement to assess the four core DBT skills, the same core skills the curriculum detailed in this study aims to develop. In addition, it does not measure the frequency of “challenge” behaviors like other measurements used in studies assessing the effectiveness of treatments for neurodivergent individuals, but rather focuses on how the individual responds to distress they may face and how they may use their own skills and strengths to approach the situation.

One of the prominent weaknesses that this measure has is its length. The time it will take to complete the assessment likely will require the therapist to meet with each client individually before the first group session to administer the DBT-WCCL or ask the client to fill out the form

before attending the first group. Another weakness relevant to this study is that the DBT-WCCL was not initially written for people with different abilities. As such, the therapist may need to arrange for appropriate accommodations for the client such as reading the assessment aloud, explanation of vocabulary, or providing a quiet space to administer the DBT-WCCL. Another weakness was that, while overall content validity was adequate, it may be more difficult to discern the effectiveness of specific skills which may make it more difficult for participants to understand what skills are strengths and which ones need to be worked on further.

Session Rating Scale

The Session Rating Scale, with a similar scoring structure as the ORS, measures the working alliance between the therapist and the client. The SRS measures four factors: the therapeutic relationship between the therapist and the client, the goals and topics addressed during the therapy session, the methodology the therapist used, and the overall quality of the session. Similarly to the ORS, each factor of the SRS is measured on a visual analog scale measuring 10 cm and scored between 0 and 10 based on where on the scale the client rates. Each of the four factors are then added up to a total final score of 0 to 40 (Duncan et al. 2003).

In a study done with 420 participants who took the SRS, they had found an internal consistency coefficient alpha of 0.88. In a study assessing the concurrent validity, the SRS was compared to the Helping Alliance Questionnaire II, a measurement that assesses the aforementioned three factors of a therapeutic relationship. The SRS and HAQ II had a moderate correlation ranging from 0.39 to 0.44 (Duncan et al. 2003).

A prominent strength of using this measure is that it provides direct feedback for the therapist to focus and improve on specific areas. This is especially important for neurodivergent individuals who have experienced an unfortunate history of not having input on their treatment type, methods, or goals (Miller et al., 2020). Thus, administering the SRS is another way in which future treatment methods can adhere to neurodiverse perspective.

A potential weakness, especially in applying the SRS to a group therapy that focuses on psychoeducation, is that the relationship between the therapist and the client is considered less important than the goals, topics, and approach of the treatment. Rather, in a group therapy, part of the “working relationship” is the relationship the participants have with other participants in the group as opposed to the therapist. Nevertheless, the SRS can still provide valuable information to a therapist regarding their style of facilitation.

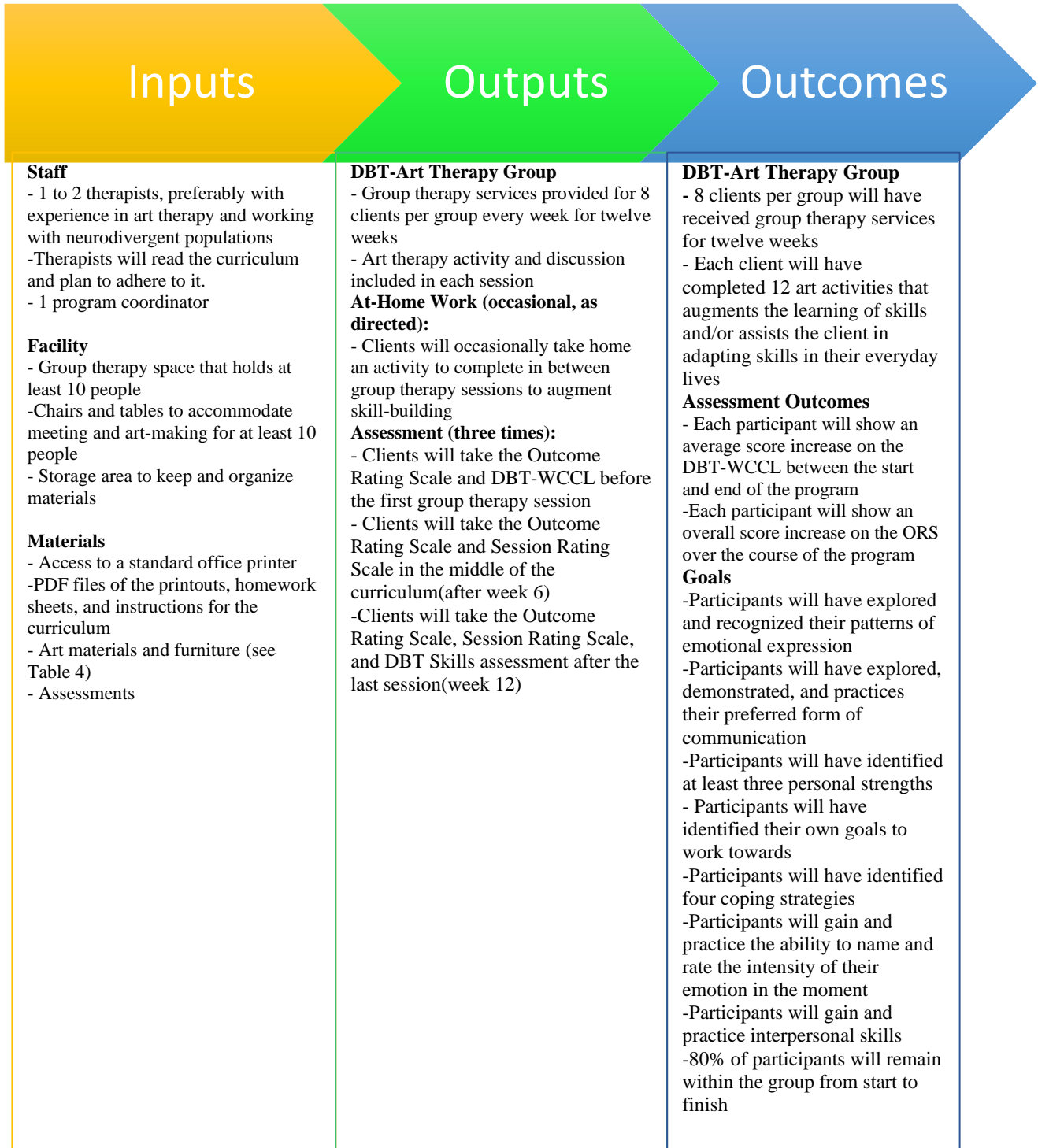
The usage of these assessment measures is critical to providing the therapist with feedback on how to adapt their own approach, the progress of each participant in the group, potential areas of improvement, and what next steps the client may take after the 12-week group curriculum is complete. In addition to the individual, brief interview the therapist has with the client, the scores obtained from these assessments can also help determine the future path for the implementation of the curriculum.

Logic Model

For this group therapy to operate and generate the desired outcomes, there are several resources and services the program must draw from. The logic model (see Figure 2) was used to illustrate these necessary resources and services and the outcome that participants will experience upon taking part in the group therapy. Inputs include three professionals, one of which will act as the program coordinator and two will act as co-facilitators in the group, a meeting space appropriate for group therapy, materials necessary for the art therapy activities, access to Brown’s *The Emotion Regulation System for Cognitively Challenged Clients: A DBT-Informed Approach* (2016), the curriculum elaborated in this study, and access to the three assessments: DBT-WCCL (Neasciu et al., 2010), the ORS (Miller et al., 2003), and the SRS (Duncan et al., 2003). Outcomes will include an increase in the participant’s usage of DBT skills as well as social-emotional well-being as indicated by increased scores after taking the DBT-

WCCL and the ORS. Participants will also have increased their understanding and acceptance of themselves as indicated through an informal interview at the end of the 12-week program.

Figure 2.
Logic Model



CHAPTER V

WORK PLAN AND BUDGET

In order to allow a group therapy to run effectively, there must be distinct roles and responsibilities that different professionals are dedicated to taking on. Ideally, a total of three people are needed to execute the group therapy curriculum effectively. Some roles or responsibilities may already be built into the community or organization choosing to execute the curriculum. As such, it will be up to the discretion of the therapists or professionals on how many people are needed and who must perform which tasks. In this work plan, two different roles are identified, the coordinator and the facilitator. The general task of the coordinator is to organize and provide adequate resources for the group. The program facilitators will be leading the group, preparing materials, and providing accommodations for clients as needed. The following section will highlight the responsibilities of each professional and provide a list of responsibilities (see Table 3).

Roles for Staff

The first role is the coordinator. During the preparation stage, they are in charge of purchases which includes securing an adequate group therapy space as well as purchasing the materials needed for the group activities which may include art materials or chairs and tables needed for the space. They are also in charge of recruiting participants. They may do this by reaching out to other therapists in their organization or area to ask if they have a client who may benefit from the group. Hours spent per week accomplishing all these tasks may vary, but it is estimated the coordinator will spend around 6-10 hours total accomplishing these tasks. In the week before the group, the coordinator will be in charge of obtaining consents from each individual who joins the group. They must obtain consent to provide care as is consistent with ethical standards. The coordinator may be spending around 6 hours during this week completing this task. As the group is ongoing, they will maintain contact, oversee the group, and purchase

additional materials that need to be replaced. The hours needed for this stage vary as it depends greatly on factors that cannot be predicted such as how much of a material participants will decide to use. During the final week, the coordinator will provide connections or resources as needed to individuals who would benefit from additional resources or programs. This, again, can vary greatly as it depends on the individual needs of each group participant as well as what connections or resources the coordinator is aware of beforehand.

The second role is the program facilitator in which there will be two facilitators total. Program facilitators are expected to be licensed to provide counseling services to clients as well as have a background in art therapy. The preparation stage involves each therapist learning about Brown's Skills System by reading chapters 2, 4, and 7 in *The Emotion Regulation Skills System for Cognitively Challenged Clients: A DBT-Informed Approach* by Julie F. Brown (2016). They will also review the art therapy curriculum in this paper. They will also establish contact with each participant of the group and schedule a time to meet during week 0. In total, each program facilitator can expect to complete these tasks in 12 hours. In the week before the group starts, the two program facilitators will organize the materials needed for the group, prepare the space in which the group will take place, and prepare materials for the first week. The program facilitators will meet with four participants each to administer the DBT-WCCL and the ORS individually. The program facilitators can expect to be working for about 10 hours during the week. During the 12-week group, facilitators will prepare the space and materials needed each week before the session. Then, they will co-facilitate a 90-minute session of group therapy each week, using the curriculum from pages 19-54. They will also complete documentation for the group session each week as deemed sufficient by ethical and community standards. After the group session on week 6, facilitators will have participants complete the ORS and SRS. Facilitators may choose to either ask participants to stay several minutes after the 90-minute mark or finish several minutes before to make time. Each facilitator can expect to be working

about 6 hours per week in order to complete all the tasks necessary. On week 13, after the group has finished, the program facilitators will meet with each participant individually. During the session, the facilitator will administer the DBT-WCCL, the ORS, and the SRS in order to assess progress made. The facilitator and the participant will also talk about the next steps for the participant, whether it be ending services, initiating an additional skills system cycle, or continuing with services elsewhere. If each facilitator meets with four individuals, they can expect to spend about 6 hours during the week completing these tasks.

In Brown's model and the IBT model, the role of the facilitator involves guiding the group through activities, calling on people as needed, leading the group through mindfulness exercises, etc (Brown, 2016; Tomasulo & Razza, 2006). Having an organized structure is critical to the progress of the group as it makes it easier for individuals with various disabilities to follow along and use their strengths to their fullest. Facilitation from the therapist is also important towards cheering participants on in completing activities in the group. Tomasulo & Razza (2006) emphasized the importance of the therapist's role in encouraging other participants to listen to each other. They noted that "many people with intellectual(cognitive) disabilities are unfortunately accustomed to people not listening to them and will continue to talk whether others are listening or not"(2006).

Table 3.
Work Plan

	Preparation Stage	Week 0	Week 1-12	Week 13
Coordinator	Secure a space, purchase materials, recruit participants(6-10)	Obtain consents from each individual(6)	Maintain contact, purchase materials that need to be replaced(varies)	Provide additional resources or programs as needed(varies)
Group Therapists(2)	Review Brown's Skills System book and art therapy curriculum, establish a connection with each group participant(12)	Organize materials, prepare space and materials, administer the DBT-WCCL and ORS(10)	Prepare space and materials each week, lead the group, complete documentation, administer the ORS and SRS on week 7(6)	Establish future plans with individuals as needed, administer the DBT-WCCL, ORS, and SRS(6)

The total time it would take to execute this curriculum may take twenty to sixteen weeks.

However, this may vary depending on the situation coordinators and facilitators that execute this plan. For example, if the organization has the space and materials already prepared and a group that would benefit from the service in mind, it may take less time to complete the preparation stage compared to an organization that needs to purchase many materials and find the space needed.

Budget Plan

Relevant costs for this group consist of the potential cost of renting a space to meet, wages the therapist would receive for services, and materials. The former two costs vary immensely and may even be dictated by the setting. The ideal setting for the group to take place would be an organization that already implements various group therapies. However, this does not bar other organizations from acquiring or renting the space necessary to execute the group curriculum. In either case, the cost of materials would need to be factored in for most circumstances and can be approximated. Materials were divided into three different categories:

reusable group materials, usable group materials, and individual materials. Reusable group materials are purchased objects that can be used again without running out such as scissors, paint brushes, hole punchers, etc. Usable group materials are art materials that will be used by the group and can run out such as paint, glue, fabric, yarn, etc. Individual materials are materials in which each individual will receive the material and take it home meaning that a new material(s) must be purchased for each group member. These costs include folders, wooden pieces, clip key rings, blank puzzles, etc. Prices for materials were found by looking for products on amazon that held an appropriate balance of price and quality and added to a total cost (see Table 4). Quantity of materials account for a group of eight participants which may change as the number of participants does. This cost can be further reduced by using materials that are already present in the counseling space, accepting donations of various art materials, or other means of acquiring materials.

Conclusion

This curriculum will run for a total of twelve weeks with 90 minutes devoted to each session in order to leave room for activities and discussion. Each session will use a combination of psychotherapeutic and psychoeducation techniques in a group setting to teach nine different coping skills and how to use them. Within the hour and a half, participants will complete a mindfulness exercise, review previous skills, be introduced to a new skill or concept, complete an activity that facilitates the learning of that skill, then hold a group discussion about the activity before closing the session for the day. This group uses various techniques, structure, and modifications so that it can welcome and accommodate neurodivergent individuals, including those with cognitive or development disabilities. The goal for this group is not to reduce “challenge behaviors” among neurodivergent individuals but rather teach new coping mechanisms to help deal with high emotional distress and achieve their own goals.

The ultimate dream that I hope this proposed curriculum helps achieve is facilitating a transformation of therapeutic techniques from its traditional, deficit-focused roots into a modern, strengths-based perspective that respects the individual and their neurodiversity. It is an unfortunate reality that many therapeutic practices initially acclaimed to be widely successful have inflicted harm on others or even caused trauma. I believe it is the worst nightmare for a therapist to be cited as the source of trauma for an individual they were trying to help and goes against our own code of “do no harm”. Yet, the very techniques that cause harm is what thousands of therapists have been told and trained to do and, quite possibly, all they know. Therapists who have hurt others through these techniques in the past might not be able to take back the harm they’ve caused, but they can help transform the future of the practice by learning how their techniques can change.

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APPENDIX A

MATERIALS BUDGET

Table 4.
Cost for Materials

Reusable Group Materials		Usable Group Materials		Individual Materials	
Table	\$39.96	Pencils(12ct)	\$2.69	Folders(8ct)	\$8.00
Mirrors(8ct)					
Clipboards(10ct)	\$24.99	Yarn Assortment	\$12.99	Smooth Rocks(12ct)	\$6.99
Scissors(5ct)	\$9.99	Colored Pencil Set(3ct)	\$13.35	Sculpey Clay(10ct)	\$29.98
Hole Puncher	\$4.49	Marker Set(3ct)	\$9.27	Wooden Shield Pieces(20ct)	\$8.95
Erasers(12ct)	\$5.99	Glue(3ct)	\$7.99	Loose Leaf Binder Rings(20ct)	\$4.99
Paint Brush Set	\$6.39	Masking Tape	\$5.63	Empty Cardboard Box(10ct)	\$9.95
6ft Folding Tables(2)	\$71.99	Ribbon Assortment	\$7.99	16pc Blank Puzzle(24ct)	\$9.99
Folding Chairs(10)	\$195.99	Sticker Assortment	\$9.99		
		Acrylic Paint	\$15.99		

		Collage Materials	\$9.99		
		Felt Squares	\$6.48		
		Patterned Paper Set	\$10.99		
		Essential Oils Kit	\$8.99		
		Construction Paper	\$4.70		
		18x12 Paper	\$4.69		
		Watercolor Paint Set(4ct)	\$9.98		
		Chalk Pastel Set(2ct)	\$15.98		
		Mural Paper	\$8.99		
		Printer Paper	\$6.40		
Individual Totals	\$349.83		\$173.08		\$78.85
Overall Total	\$601.76				

APPENDIX B

WEEK 1 ACTIVITY A BOOKLET

My Skills Handbook

Name:

Date:

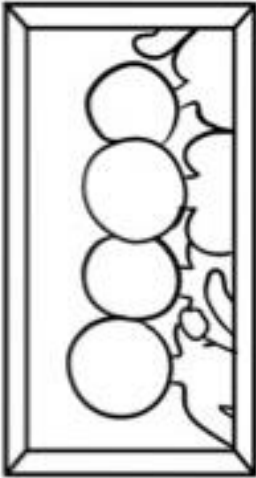


9



I name the emotion I am feeling right now and rate how intense the emotion is on a scale of 0 to 5. At an intensity of 0 to 3, I can use any of the 9 skills. At an intensity of 4 or 5, I only use the All-the-Time Skills(1-5).

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I build and maintain my relationships with people. I value our differences and trust in the other person just as I trust myself. I give as much as I take from the relationship and find middle ground with the person by finding something we can agree on or make compromises.

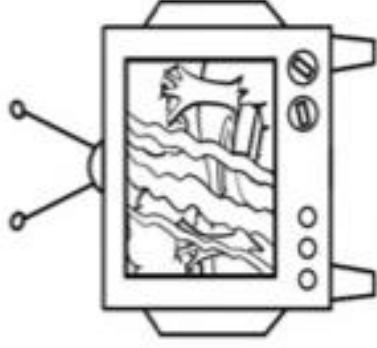
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8



I ask for something I want by using **SEALS**. I will be polite and use **Sugar**, **Explain** the situation, **Ask** for what I want, **Listen** to what the other person has to say, and **Seal** a deal by following through on what I promise to do or making a compromise.

1



I become aware of the present moment by using my five senses to observe what is around me, think about how my body feels, name and rate the emotion I'm feeling with the Feelings Rating Scale, and identify my thoughts and urges.

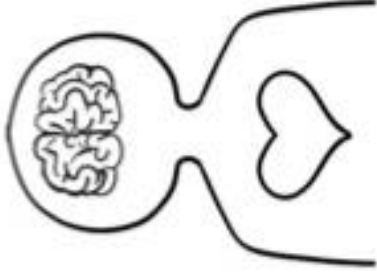
2



I think about what I want to do and decide if it will move me towards or away from my goal. If it moves me away from my goal, I think about what I can do instead that will move me towards it.

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7



I decide how I want to communicate with a person and share with them what is **on my mind**(thoughts, concerns) or **in my heart**(feelings, preferences, hopes, dreams) depending on the situation.

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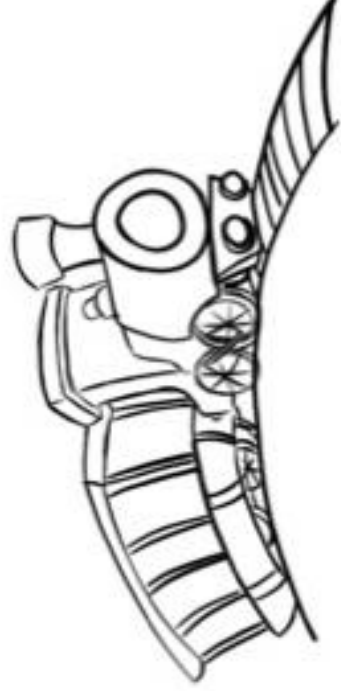
6



I will figure out whether or not there is a problem right now, decide on what I can do, make a plan of what to do, and find the pros and cons of doing that plan.

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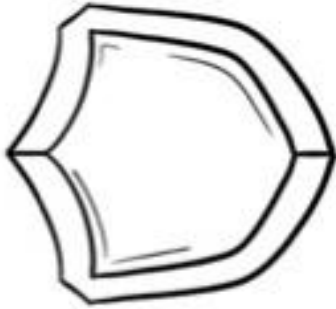
3



I decide on what I will do to move myself towards my goal and do it! I may be using another skill that will keep me moving towards my goal.

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4



I think about the level of risk the situation right now brings me. Depending on how dangerous or risky the situation is, I might talk to someone I trust, go somewhere safe, or do something that keeps me safe.



5



I do an activity that will help me focus, feel good, distract myself, or have fun. I decide which activity to do based on the situation and what I need at the time.



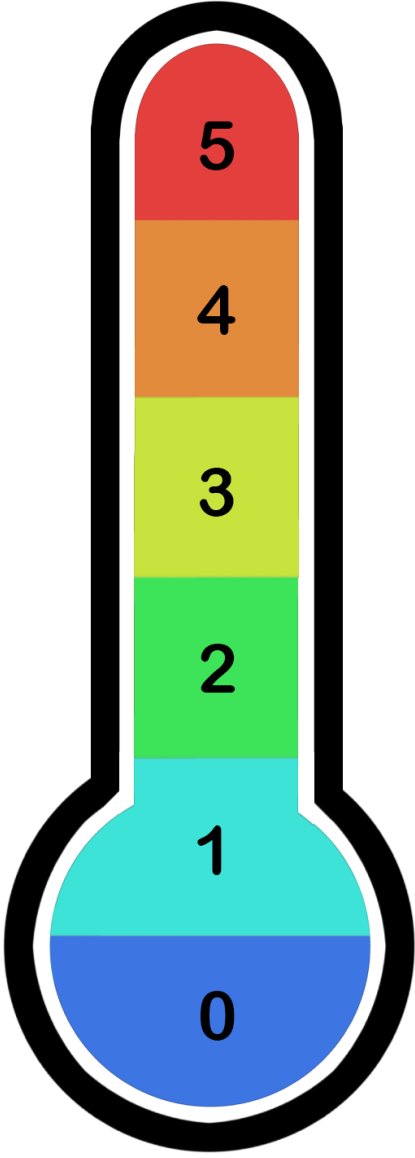
APPENDIX C

WEEK 2 FEELINGS RATING SCALE WORKSHEET

FEELINGS RATING SCALE

Name: _____ Date: _____

My Emotion Is: _____

Name a time you felt at a level...	Draw what your face looked like at a level...	
5	5	
4	4	
3	3	
2	2	
1	1	
0	0	

APPENDIX D

WEEK 4 ON-TRACK WORKSHEET

STAY ON TRACK!

Name: _____

Date: _____

You will be creating a track to help you stay on track towards your goals! Each time you do an on-track action, you add another piece to the track.

Materials you'll need:

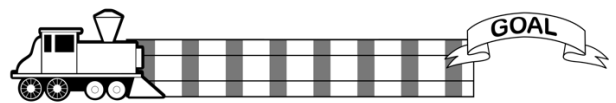
Stay On Track Cut-out worksheet

Pencil

Masking tape

Scissors

Colored pencils, markers, or
crayons(optional)



1. Write your goal on the banner.
2. Decorate the banner and train however you'd like.
3. Cut out the train, the banner, track 1, track 2, and the on-track pieces.
4. Cut the on-track pieces along the dotted line. You will have 17 small pieces by the end.
5. Think about a place you see often every day in your home like your bedroom or kitchen. Find a place on the wall to tape your track to.
6. Tape the empty track onto the wall.
7. On one end, tape the train at the beginning on the track. On the other end, tape the banner at the end of the track.

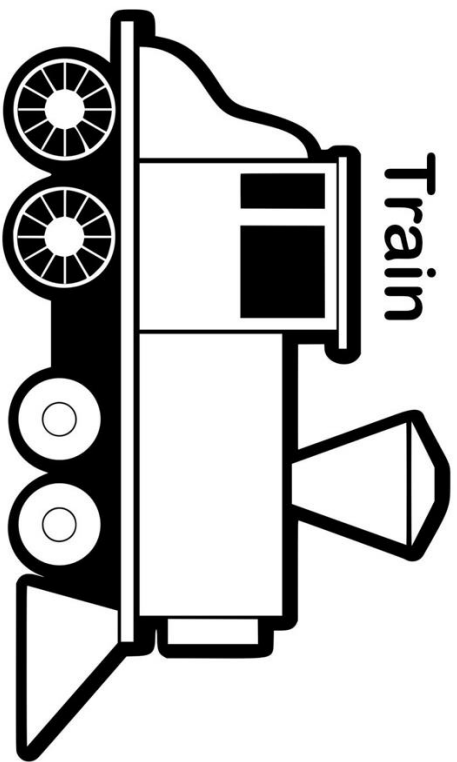
Staying On-Track:

Whenever you get an urge, write it down on an on-track piece. Then, decide whether this urge is on-track or off-track.

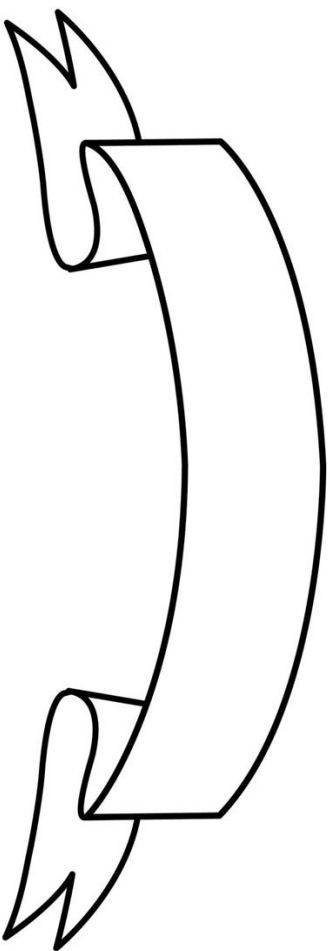
If it is OFF-TRACK, FLIP that piece over and write an opposite, on-track action on the other side. Then, tape the piece to one of the shaded areas of the empty track with the off-track urge facing down, and the on-track action facing up.

If it is ON-TRACK, tape the piece to one of the shaded areas on the empty rail

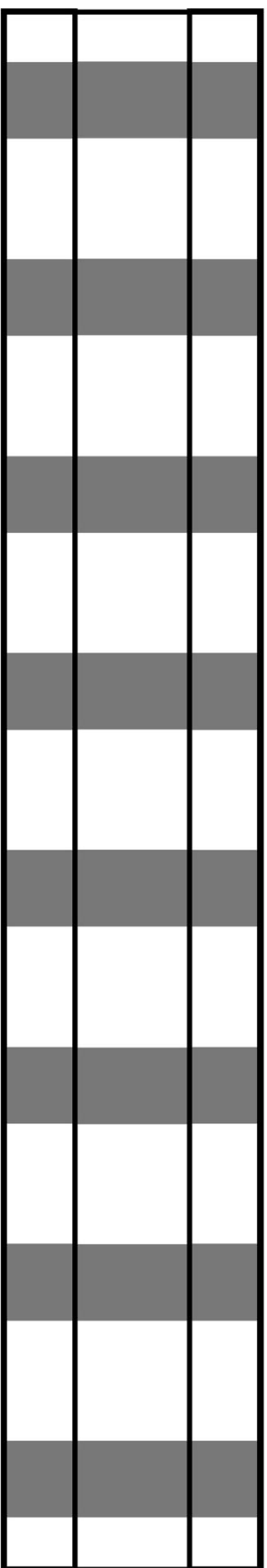
DO the ON-TRACK action



Train

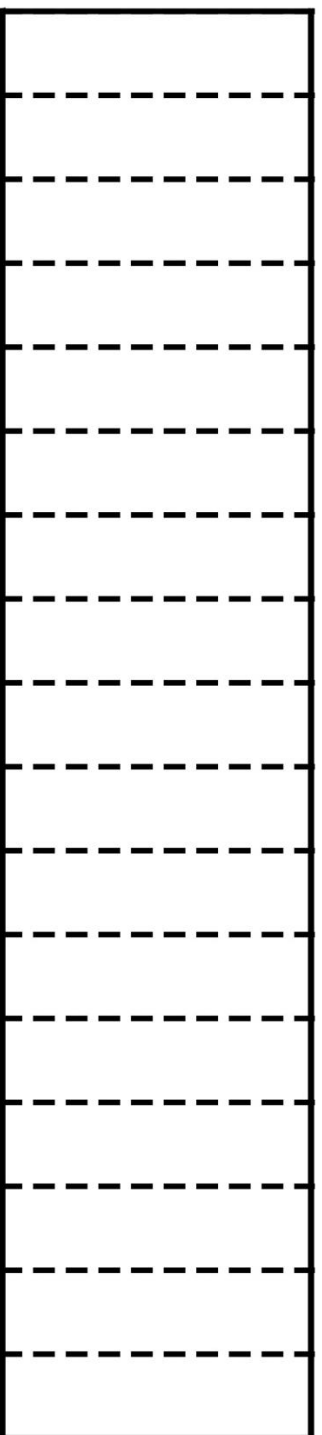


Goal Banner



Track

On-Track Pieces



APPENDIX E

WEEK 12 CERTIFICANT OF COMPLETION

Certificate of Completion

This certificate is awarded to

For showing perseverance, creativity, and determination in the completion of a 12-week DBT-Informed Art Therapy Group.

Date: _____

Facilitator Signature

APPENDIX F

DBT - WAYS OF COPING CHECKLIST

Data Entry Initials: _____
 Date: _____
 Second Entry: _____
 Date: _____

Client ID #: _____
 Date: _____
 Assessment: _____ Session: _____

DBT-Ways of Coping Checklist
 CITATION: Dialectical Behavior Therapy Ways of Coping Checklist (DBT-WCCL): Development and Psychometric Properties. Neacsiu, A.D., Rizvi, S.L., Vitaliano, P.P., Lynch, T.R., & Linehan, M.M. Journal of Clinical Psychology. In press.

The items below represent ways that you may have coped with stressful events in your life. We are interested in the degree to which you have used each of the following thoughts or behavior to deal with problems and stresses.

Think back on the **LAST ONE MONTH** in your life. Then check the appropriate number if the thought/behavior is: never used, rarely used, sometimes used, or regularly used (i.e., at least 4 to 5 times per week). Don't answer on the basis of whether it seems to work to reduce stress or solve problems—just whether or not you use the coping behavior. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

0 1 2 3
 Never Used Rarely Used Sometimes Used Regularly Used

I have:

- | | | 0 | 1 | 2 | 3 |
|----|--|---|---|---|---|
| 1 | Bargained or compromised to get something positive from the situation. | 0 | 1 | 2 | 3 |
| 2 | Counted my blessings. | 0 | 1 | 2 | 3 |
| 3 | Blamed myself. | 0 | 1 | 2 | 3 |
| 4 | Concentrated on something good that could come out of the whole thing. | 0 | 1 | 2 | 3 |
| 5 | Kept feelings to myself | 0 | 1 | 2 | 3 |
| 6 | Made sure I'm responding in a way that doesn't alienate others. | 0 | 1 | 2 | 3 |
| 7 | Figured out who to blame. | 0 | 1 | 2 | 3 |
| 8 | Hoped a miracle would happen. | 0 | 1 | 2 | 3 |
| 9 | Tried to get centered before taking any action. | 0 | 1 | 2 | 3 |
| 10 | Talked to someone about how I've been feeling. | 0 | 1 | 2 | 3 |
| 11 | Stood my ground and fought for what I wanted. | 0 | 1 | 2 | 3 |
| 12 | Refused to believe that it had happened. | 0 | 1 | 2 | 3 |
| 13 | Treated myself to something really tasty. | 0 | 1 | 2 | 3 |
| 14 | Criticized or lectured myself. | 0 | 1 | 2 | 3 |
| 15 | Took it out on others. | 0 | 1 | 2 | 3 |
| 16 | Came up with a couple of different solutions to my problem. | 0 | 1 | 2 | 3 |
| 17 | Wished I were a stronger person — more optimistic and forceful | 0 | 1 | 2 | 3 |
| 18 | Accepted my strong feelings, but not let them interfere with other things too much. | 0 | 1 | 2 | 3 |
| 19 | Focused on the good things in my life. | 0 | 1 | 2 | 3 |
| 20 | Wished that I could change the way that I feel. | 0 | 1 | 2 | 3 |
| 21 | Found something beautiful to look at to make me feel better. | 0 | 1 | 2 | 3 |
| 22 | Changed something about myself so that I could deal with the situation better. | 0 | 1 | 2 | 3 |
| 23 | Focused on the good aspects of my life and gave less attention to negative thoughts or feelings. | 0 | 1 | 2 | 3 |

24	Got mad at the people or things that caused the problem	0	1	2	3
25	Felt bad that I couldn't avoid the problem.	0	1	2	3
26	Tried to distract myself by getting active.	0	1	2	3
27	Been aware of what has to be done, so I've been doubling my efforts and trying harder to make things work.	0	1	2	3
28	Thought that others were unfair to me.	0	1	2	3
29	Soothed myself by surrounding myself with a nice fragrance of some kind.	0	1	2	3
30	Blamed others.	0	1	2	3
31	Listened to or played music that I found relaxing.	0	1	2	3
32	Gone on as if nothing had happened	0	1	2	3
33	Accepted the next best thing to what I wanted.	0	1	2	3
34	Told myself things could be worse.	0	1	2	3
35	Occupied my mind with something else.	0	1	2	3
36	Talked to someone who could do something concrete about the problem	0	1	2	3
37	Tried to make myself feel better by eating, drinking, smoking, taking medications, etc.	0	1	2	3
38	Tried not to act too hastily or follow my own hunch.	0	1	2	3
39	Changed something so things would turn out right.	0	1	2	3
40	Pampered myself with something that felt good to the touch (e.g., a bubble bath or a hug)	0	1	2	3
41	Avoided people	0	1	2	3
42	Thought how much better off I was than others.	0	1	2	3
43	Just took things one step at a time.	0	1	2	3
44	Did something to feel a totally different emotion (like gone to a funny movie).	0	1	2	3
45	Wished the situation would go away or somehow be finished.	0	1	2	3
46	Kept others from knowing how bad things were.	0	1	2	3
47	Focused my energy on helping others.	0	1	2	3
48	Found out what other person was responsible.	0	1	2	3
49	Made sure to take care of my body and stay healthy so that I was less emotionally sensitive.	0	1	2	3
50	Told myself how much I had already accomplished.	0	1	2	3
51	Made sure I respond in a way so that I could still respect myself afterwards.	0	1	2	3
52	Wished that I could change what had happened.	0	1	2	3
53	Made a plan of action and followed it.	0	1	2	3
54	Talked to someone to find out about the situation	0	1	2	3
55	Avoided my problem	0	1	2	3
56	Stepped back and tried to see things as they really are	0	1	2	3
57	Compared myself to others who are less fortunate.	0	1	2	3
58	Increased the number of pleasant things in my life so that I had a more positive outlook.	0	1	2	3
59	Tried not to burn my bridges behind me, but leave things open somewhat.	0	1	2	3

APPENDIX G

OUTCOME RATING SCALE

OUTCOME RATING SCALE (ORS)

Name: _____ Age (Yrs): _____ Sex: M/F

Session #: _____ Date: _____

Who is filling out this form? Please check one: Self _____ Other _____

If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually

(Personal well-being)

-----|

Interpersonally

(Family, close relationships)

-----|

Socially

(Work, school, friendships)

-----|

Overall

(General sense of well-being)

-----|

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Source: www.centerforclinicalexcellence.com

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APPENDIX H

SESSION RATING SCALE

SESSION RATING SCALE (SRS V.3.0)

Name: _____ Age (Yrs): _____ Sex: M/F

Session #: _____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

I did not feel heard, understood, and respected.	Relationship -----	I felt heard, understood, and respected.
We did <i>not</i> work on or talk about what I wanted to work on and talk about.	Goals and Topics -----	We worked on and talked about what I wanted to work on and talk about.
The therapist's approach is not a good fit for me.	Approach or Method -----	The therapist's approach is a good fit for me.
There was something missing in the session today.	Overall -----	Overall, today's session was right for me.

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