ART THERAPY FOR MAJOR DEPRESSION: POSITIVE PSYCHOLOGY AND THE THERAPEUTIC ALLIANCE

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ABSTRACT

POSITIVE PSYCHOLOGY FOR MAJOR DEPRESSION: BUILDING AND MAINTAINING THE THERAPEUTIC ALLIANCE

MEGAN BOYLE

This research set out to answer the following research question: How is the therapeutic alliance built and maintained using a positive psychology model applied to art therapy with a client diagnosed with major depression? Research in positive psychology shows hope for the treatment of individuals diagnosed with major depressive disorder. Some critiques, however, suggest that individuals with major depressive disorder may feel invalidated by therapists using a positive psychology approach. A bibliographical qualitative research design was used to collect data, synthesize, and answer the research question. The research suggested that the therapeutic alliance can be built and maintained between a positive psychology informed art therapist and a client with major depression. A list of recommendations for positive art therapists working with this population is provided. The findings of this paper can be used to further research the application of positive psychology model in art therapy for clients diagnosed with major depressive disorder.

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Chapter 1: Introduction

In April 2013, I was hospitalized for major depression. A few days into my stay, a nurse walked into my room and asked me which positive affirmations I was saying to myself each day. I had no idea what she was talking about, but I asked her to come back with some examples for me. She did. That day, my therapist gave me *The Artist's Way* by Julia Cameron in hopes that it would help me begin creating during my difficult time. Looking through the book while I lay in my bed, I exclaimed to a student nurse that I actually felt inspired – a feeling I did not take for granted at that time. I slowly worked through the process described in *The Artist's Way*, neglecting it some days but feeling inspired on others. I went to yoga classes and practiced Vipassana meditation. I made a large painting to represent my strength, which was revealed to me during that difficult time, and slowly moved forward.

Focusing on the positive aspects of my life, while learning to listen to and care for my body, mind, and soul, changed my experience of living. I believe that these shifts in my mind and perception, and tools that I have come to know that increase my well-being, have helped me not to relapse thus far.

Since adapting a more positive frame of mind had helped me with my own mental health struggles, I found myself wanting to share this experience with people close to me who were also dealing with major depressions. However, prior to beginning my master's in art therapy, two of my friends confided in me that during their heaviest days over the previous few years, my positivity was not helpful nor appreciated at certain moments. As someone who wanted to study art therapy in order to work in mental health, I felt ashamed that I had not attuned with my friends appropriately all of the time. I thought that maybe I would not be able to work with those who are depressed because of the way I have learned to navigate the world. Through research and further experience, I have learned that it is possible to bring positivity into practice. It is just important to consider how it is brought in.

Once I began this master's program and began to learn counselling skills, I started to understand some of the most fundamental therapeutic tools: helper congruency, unconditional positive regard, and empathy (Rogers, 1951, as cited in Hill, 2014). This learning drew my curiosity, leading me to the following question: How can positive art therapy be conducted with clients diagnosed with major depression? I am an art therapy intern who finds herself naturally inclined to hold a positive frame of mind, and I have a deep desire to work with clientele who

have major depression. Since positive psychology research neither denies the importance of nor excludes negative affect, but rather informs us of the importance of bringing balance to the range of emotions explored and experienced in our clients' lives, I know there is a way it can be applied to art therapy (Wood & Johnson, 2016). Through this research I will begin informing my journey as an art therapist working with clients with major depression.

This paper begins with a literature review on positive art therapy and is followed by the methodology, findings, and discussion chapters.

Chapter 2. Literature Review

This literature review begins by introducing the positive psychology model of practice. This chapter gives a basic overview of the history of this model and defines key concepts. After introducing the model, the review covers the evolution of positive psychology, from studying what makes a happy and fulfilled human, to the implementation of knowledge through clinical practice. Once this foundation of positive psychology is provided, positive art therapy is introduced. This section explores how art therapists are currently working with a positive psychology informed model. The final section of the chapter builds the case for successful treatment of major depression using a positive psychology informed approach to art therapy.

Positive Psychology

Positive psychology is a relatively new model developed by Martin Seligman in the 1990s. Seligman's (1999) mission was to start a field of study and profession whose goal is to understand what makes for a fulfilling life, for both those in good mental health and those who are suffering from mental illness. The term positive psychology was coined in 1998 while he was president of the American Psychological Association, in response to the more medically informed model of psychology (Seligman, 1999). A key construct to understanding the paradigm shift in positive psychology is *negativity bias* (Maddux, 2002, as cited in Wilkinson & Chilton, 2018, p. 19). Like animals, humans are biologically hard-wired to detect potential threats to our survival (Seligman, Rashid, & Parks, 2006). This creates a bias towards noticing negative cues in our environments (Wilkinson & Chilton, 2018). Researchers argue that it is because of this bias that psychological research has focused primarily on understanding disease and mitigating distress (Seligman & Csikszentmihalyi, 2000; Wood & Johnson, 2016). In other words, since disease and distress are threats to our survival, research has focused on understanding these problems, and consequently has spent an insignificant amount of time on understanding well-

being. Thus, as a consequence of negativity bias, "we have a clear idea of what is wrong but much less of what is right" (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001, as cited in Wilkinson & Chilton, 2017, p. 19) when it comes to human psychological experience. In an attempt to remedy this unbalanced focus in mental health research on pathology and suffering and the lack of research on human well-being and illness prevention, Seligman developed the model of positive psychology (1999, p. 559).

Seligman and Csikszentmihalyi (2000) outline the various topics covered in positive psychology:

> The field of positive psychology at the subjective level is about valued subjective experiences: well-being, contentment, and satisfaction (in the past); hope and optimism (for the future); and flow and happiness (in the present). At the individual level, it is about positive individual traits: the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future mindedness, spirituality, high talent, and wisdom. At the group level, it is about the civic virtues and the institutions that move individuals toward better citizenship: responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic. (p. 5)

Defining well-being. Scholars of positive psychology have set out to measure and define well-being. Diener, Lucas, and Oishi (2009) researched and named subjective well-being (SWB), and Ryff (1989) identified psychological well-being (PWB). Both concepts are necessary to understand well-being as it applies to positive psychology.

Subjective well-being. Diener, et al. (2009) assumed that an individual must in fact perceive their life as enjoyable in order to be living a good life. Subjective well-being (SWB) is thus defined as an individual's evaluations of his or her life. SWB explains that as positive experience increases and negative experiences decrease, life satisfaction will increase (Diener, et al. 2009, p. 63).

Psychological well-being. Carol Ryff (1989) coined the term psychological well-being (PWB), which identifies qualities that make for long lasting life satisfaction. PWB involves perseverance and self-actualization (Ryff, 1989). Instead of measuring fleeting moments of satisfaction, Ryff (1989) was interested in the qualities that result in lasting happiness. Wilkinson and Chilton (2017) explain that Ryff operationalized PWB, which involves the following six elements:

> 1) Finding meaning, purpose, and direction in our lives; 2) having a sense of autonomy and personal standards to guide us; 3) experiencing personal growth and employing our strengths and talents; 4) connecting meaningfully with others; 5) mastering the complexities of life; and 6) knowing and accepting ourselves. (p. 29)

Defining flourishing. Keyes (2007) defines flourishing as an optimal state of being that combines subjective well-being (SWB) and psychological well-being (PWB), as well as "positive social functioning" (p. 98). In order to say one is flourishing, the person in question must report a high level of one of the components of SWB and score at least six out of eleven on PWB (Keyes, 2007). Keyes (2007) states that those who are absent of mental illness, and who are also flourishing, display ultimate levels of well-being. Keyes's (2007) research reminds us that the absence of mental illness does not automatically result in well-being, supporting the movement towards a positive psychology approach. Furthermore, Keyes' (2007) research shows us that individuals experiencing physical or mental challenges could be coping effectively and experience well-being, whereas those who are free from mental illness may still be unhappy and dysfunctional.

PERMA. Seligman (2010) created the acronym PERMA to promote an awareness of what he believes to be the five most important elements of well-being. PERMA stands for: positive emotions, engagement, relationships, meaning, and achievement (Seligman, 2010, p. 236). Seligman (2010) offered that PERMA provides a guide to well-being that includes elements of subjective well-being and psychological well-being. Seligman (2010) developed PERMA based on his beliefs of well-being, and the holes that existed in the prior theories, but has since supported each element of his model with science.

Positive psychology applied in the education system and workplace. Diener (2008) states that positive psychology is now commonly referred to as "the scientific study of optimal functioning" (p. 11). The author explains that high levels of well-being result in greater physical health and longevity, improved work performance, good citizenship, and stronger social networks and societies (Diener, 2008). Diener (2008) notes that educators are beginning to understand that students' natural strengths can be identified and enhanced in school, resulting in optimal learning, while boosting self-esteem. The author highlights a study in which students were taught a "speed reading method" (Diener, 2008, p. 13). The "traditional weakness-focus approach" (p. 13) suggested that the poor readers in the program would have the most to gain.

However, the results showed that the top readers benefitted most from the program. The top readers began with 300 words per minute, and increased to 2,900 words per minute (Diener, 2008). This study shows how effective fostering a student's strength can be; because the top readers were offered the program as well, they were able to significantly multiply their words per minute count, building on their skills. Diener (2008) notes that many North American and Australian schools are hiring their colleague, Jenny Fox Eades, to collaborate with them in enhancing their students' individual strengths while in school. Furthermore, youth programs promoting character building, leadership, resilience, and gratitude are becoming more prevalent.

The Gallup Organization, a research-based consultant company that focuses on helping leaders and organizations implement strategies to ensure long-term success, found that billions of dollars are wasted every year due to disengaged employees. One study of disengaged workers in Germany, found that the economy lost between 139.1 billion to 178.9 billion euros due to disengaged workers (Nink, 2016). Nink (2016) explains that absenteeism is 67% "higher among actively disengaged employees compared with engaged workers" (para. 9), and notes that German companies lose an estimated 254.40 euros each day a worker calls in sick. Annually, German companies may lose more than 18.9 billion euros due to absenteeism. Furthermore, Nink (2016) notes that the costs of replacing a disengaged worker may be 1.5 times "the employee's annual salary" (para. 13). The Gallup Organization found that 70% of disengaged employees report that they do not plan to be with their current company in three years, speaking to a high turnover rate (Nink, 2016).

In contrast to employee disengagement, workers who feel happy are more often positively reviewed by employers and customers: They are more punctual, helpful to their co-workers, bring in more money, call in sick less, and are more creative in their problem solving (Lyubomirsky, King, & Diener, 2005, as cited in Diener, 2008). It is also noted that top managers take the time to get to know their employees and end up assigning projects based on their individual strengths (Clifton & Harter, 2003, as cited in Diener, 2008). The authors found that these workers are more productive when placed based on their strengths and have the opportunity to apply to their work what they feel they do best in life (Clifton & Harter, 2003, as cited in Diener, 2008). Diener's (2008) review demonstrates how increasing individual well-being can in turn benefit the wider community, supporting the importance of positive psychology research.

Sin and Lyubomirsky (2009) make an important cultural note that many of the interventions used in positive psychology align with individualist cultural beliefs. Given this, therapists must be mindful to adapt this model in consideration of their clients' cultural beliefs. The cultural background of our clients may affect which interventions will be most relevant and effective. For example, an individual from a collectivist culture may benefit more from prosocial interventions than from activities that focus on individualism (Sin & Lyubomirsky, 2009).

Positive psychology's ancestors. Although Seligman is responsible for naming and conceptualizing the model of positive psychology, it is important to note that it is based on the philosophy of Socrates, Plato, and Aristotle on what makes "the good life" (Duckworth, Steen, & Seligman, 2005, p. 632). Additionally, religious and spiritual leaders have repeatedly highlighted the significance of living a good life and having a positive character (Diener, 2008). Although many psychological theorists have explored positive aspects of human experience, humanistic psychology is most connected to positive psychology (Duckworth, Steen, & Seligman, 2005). Maslow's (1971) belief that humans are innately good and motivated to become the best version of themselves is an underlying assumption of positive psychology. Practitioners of positive psychology have built on Maslow's (1971) concept of self-actualization (Chilton & Wilkinson, 2016; Wood & Johnson, 2016).

Positive Clinical Psychology

As shown in the section above, positive psychology research has been applied to and is being integrated into various systems in society. In addition to educational systems and the work force, psychologists, counsellors, art therapists, and other mental health professionals have also informed themselves with research in positive psychology. The difference between positive clinical psychology and the way positive psychology may be broadly applied to professionals' therapeutic approaches is that the former seeks to use research grounded in positive psychology to develop a comprehensive treatment approach to a variety of mental health disorders (Dunn, 2012, p. 334). Although this has not yet been accomplished, researchers in positive clinical psychology are working towards this so that the field can stand on its own rather than being "part of a predominately negatively focused approach" (Dunn, 2012, p. 334).

Originally, positive psychology was interested in the prevention of mental illness and in helping human beings thrive (Chilton & Wilkinson, 2016; Seligman & Csikszentmihalyi, 2000). Now, with the field expanding, research is developing to help those who are clinically ill as well

(Wood & Johnson, 2016). Practitioners of positive psychology recognize a shortfall in the medical model: "the relief of suffering does not always lead to wellbeing" (Wilkinson & Chilton, 2017, p. 16). Clinical psychologists practicing positive psychology believe that the positive should be focused on in sessions as well as the negative (Diener, 2008; Wood & Johnson, 2016). Duckworth, Steen, and Seligman (2005) argue that:

> …persons who carry even the weightiest psychological burdens care about much more in their lives than just the relief of their suffering. Troubled persons want more satisfaction, contentment, and joy, not just less sadness and worry. They want to build their strengths, not just correct their weaknesses. And, they want lives imbued with meaning and purpose. These states do not come about automatically simply when suffering is removed. (p. 630)

Positive clinical psychology is interested in the relationship between well-being and the symptoms of mental health disorders (Bohlmeijer, Bolier, Lamers, & Westerhof, 2017). Wood and Joseph (2010) conducted a 10-year study that found that individuals who scored lower on levels of well-being were at a significantly higher risk of developing depression than those who scored higher on PWB. Similarly, Fredrickson et al. (2003) found that resiliency, which positively correlates with well-being, can predict one's ability to overcome challenges and may also effectively offset stress. Duckworth et al., (2005) also state that positive affect, meaning making, and engagement may offset the symptoms of mental illness. Frankl (1985), an early humanist and existential therapist, connected depression with a lack of meaning in life. Since increasing well-being, resiliency, positive affect, and meaning making are all areas of study in positive psychology, positive clinical psychology researchers may use these elements to build on their treatment approach.

Another interesting phenomenon that is highlighted and explored in positive clinical psychology research is that many individuals end up experiencing positive change as a transformation of their hardship (Wilkinson & Chilton, 2017). This phenomenon was named "posttraumatic growth" by Calhoun and Tedeschi (1999, 2001, as cited in Tedeschi & Calhoun, 2004, p. 1). The authors note that posttraumatic growth may be manifested in several ways, such as "an increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life" (Tedeschi & Calhoun, 2004, p. 1). Tedeschi and Calhoun (2004) developed a model to

understand the process of this phenomenon (p. 1). The authors define a traumatic experience as something that brings "major challenges to the person's understanding of the world… including assumptions about the benevolence, predictability, and controllability of the world; one's safety is challenged, and one's identity and future are challenged" (Janoff-Bulman, 1992, as cited in Tedeschi and Calhoun, 2003, p. 5). They further note that posttraumatic growth does not necessarily happen as a result of a traumatic event. How an individual struggles with and integrates their new reality determines the aftermath (Tedeschi & Calhoun, 2004). The authors note that emotional elements connected to traumatic events play a key role in developing post traumatic growth, since lessons are learned on an emotional level as well as an intellectual level (Tedeschi & Calhoun, 2004). It is important to note that posttraumatic growth does not simply replace the experience of a traumatic event, but rather lives alongside the recognition of the memory or "residual distress of the trauma" (Tedeschi & Calhoun, 2004, p. 5). In this way, it is likely a process that occurs for "psychological survival," and results in valuable meaning making (p. 5). In addition to emotional learning, cognitive processing is also necessary for posttraumatic growth to occur. Cognitive restructuring occurs after the trauma takes place, and included in this rebuilding is the possibility of such events happening again in the future. This rebuilding makes individuals better prepared and more able to cope should the event reoccur (Tedeschi & Calhoun, 2004). Tedeschi and Calhoun (2004) break down the key components that they have found contribute to posttraumatic growth after a traumatic experience:

1. "Personality characteristics" (p. 8): Research shows that the personality traits of extraversion and openness to experience are modestly related to posttraumatic growth, whereas other personality traits were not related at all. The authors also found that optimism also positively correlates with posttraumatic growth.
2. "Managing distressing emotions" (p. 8): The individual must find ways to manage the stress immediately after the trauma. Although this period can incredibly destabilizing, this is necessary for cognitive processing to take place. Eventually the individual will come to know that their past way of navigating the world no longer works and that new goals and assumptions need to be formed. This may result in a grieving process, since part of who they were before the traumatic event took place is lost. It is important to grieve this loss.

3. "Support and disclosure" (p. 8): The individual must be supported and be able to disclose in order to formulate their story and describe any changes that have followed the traumatic event. The perspective of others may also be integrated into new cognitive schemas. Talking to others who have experienced the same trauma can be crucial, as it can foster co-construction of meaning. This also creates deep and meaningful relationships. Secure and ongoing support may be important in the progression of posttraumatic growth. Lepore and Helgeson (1998, as cited in Tedeschi & Calhoun, 2004) found a strong relationship between individuals who did not disclose about their experience and/or intrusive thoughts and depression.
4. "Cognitive processing and growth" (p. 9): Self-confidence may contribute to engagement in coping mechanisms and prevent trauma survivors from giving up. The authors note that individuals must disengage with past goals and assumptions that no longer serve them, all while developing meanings and new cognitive schemas, and setting new goals for the future. This process requires confidence and persistence, but can help the individual feel that they are moving forward, which increases perceived well-being.
5. "Rumination or cognitive processing" (p. 9): The individual must identify and work through any feelings of regret or invasive thoughts of how the traumatic situation may have been prevented, as this type of rumination has been found to increase distress.

Tedeschi and Calhoun (2004) state their assumption that posttraumatic growth is positively correlated with "general wisdom about life and further development of the general framework, the narrative people have for thinking about their lives" (p. 12). Individuals who have experienced traumatic life events often conceptualize their life narratives as having a before and after: before the accident, and after the accident, for example. Finally, Tedeschi and Calhoun speak about posttraumatic growth as an ongoing process and an end goal or outcome, and they note that how each person experiences it may differ. Tedeschi and Calhoun (2004) developed a 21-item questionnaire with five factors in order to quantifiably test for posttraumatic growth in clients.

Positive Art Therapy

Lomas (2016) suggests that the arts are related to flourishing. Tarnas (1991) states that art may contribute to flourishing in individuals' lives by supporting meaning making, or by helping individuals make sense of their deep spiritual or existential needs. Tarnas (1991) highlights that

individuals throughout history have used art as an outlet to express and represent their religious and spiritual beliefs and practices. Lomas (2016) argues for an avenue in the arts called "positive art" which would focus on the connection between the arts and flourishing. Lomas (2016) offers that art can help an individual with "sense-making, enriching experience, aesthetic appreciation, entertainment, and bonding" (p. 171).

Positive psychology has added vital contributions to the knowledge and practices applied in the art therapy field. Wilkinson & Chilton (2017) coined the term "positive art therapy" in 2009. They describe this movement as a union of art therapy and positive psychology's vision: Positive art therapy fosters individual and collective well-being by supporting what is positive and functioning in our lives. Since 2009, Wilkinson and Chilton (2016) have extensively studied some of the ways that the mode of art therapy and the model of positive psychology are complimentary, specifically by incorporating Seligman's acronym PERMA into their art therapy practice. Chilton and Wilkinson (2016) state that art therapy can help increase well-being by eliciting positive affect, providing experiences that allow for meaning making and full engagement, and through enriching relationships. Wilkinson and Chilton (2017) state that:

> Positive emotions (P) foster creative thinking, which leads to engagement and flow (E), and when this results in the generation of ideas and actual artifacts, promotes feelings of accomplishment and pride (A), which contributes to sense of meaning and purpose (M), motivation and achievement (A), and when shared with and witnessed by others (R) lead to even more positive emotions (P). (p. 85)

Kaplan (2000) speaks of the "sensual pleasure" (p. 76) that one feels when they appreciate and create art that can invite an opportunity to feel satisfaction and delight, supporting Wilkinson and Chilton's (2017) explanation of how art making can provide a feeling of accomplishment and pride.

Defining flow. The concept of flow, which was coined by Csikszentmihalyi (2009), refers to the "harmonious, effortless state" (p. 40) of optimal functioning. Csikszentmihalyi (2009) found that states of flow are entered when one is fully focused on one's goals, with no problems or concerns blocking this process. He further notes that when a person is able to enter this state of flow, life automatically improves and even mundane tasks can be enjoyable. Csikszentmihalyi (2009) explains how flow can help "to integrate the self because in that state of deep concentration consciousness is unusually well ordered. Thoughts, intentions, feelings, and

all the senses are focused on the same goal" (p. 41). When one comes out of a state of flow, they will commonly feel more "together" (p. 41) internally and in their relations with other people (Csikszentmihalyi, 2009). Kaplan (2000) lists the nine characteristics necessary for one to enter a state of flow:

1. Clear goals
2. Feedback regarding progress
3. Exercise of skill
4. Intense concentration
5. Diminished awareness of mundane concerns
6. A sense of control
7. Loss of self-consciousness
8. An altered sense of time
9. Enjoyment of the experience for its own sake (p. 72)

Kaplan (2000) notes that when one reaches a state of flow in their art making, "it provides the kind of optimal experience that produces feelings of psychological growth and makes life in general more worth living" (p. 76). Kaplan (2000) shares an example from neurologist Bruce L. Miller (1998, p. 19, as cited in Kaplan, 2000) of how art can increase quality of life:

> John, who in middle age left his job at a brokerage firm and took up painting – although he had shown no previous interest in art. John explained to family and friends that he had a new ability to see vibrant colors that filled his head 'like notes of music' (p.16). At first, no one was particularly impressed with John's artwork. Oddly, as his paintings became more striking and esthetically pleasing, his ability to comprehend language began to diminish, along with his ability to control his social behavior. Brain imaging revealed that he suffered from frontotemporal dementia, a degenerative disease that generally affects both the frontal lobes and the anterior portion of the temporal lobes of the brain. In John's case, however, only the temporal lobes were involved. Miller speculates that this unusual degenerative pattern left John's ability to plan and execute activities intact; at the same time, his visual imagery was heightened by loss of inhibitory circuits that turn off visual stimulation, 'perhaps allowing the artist in John to wake from dormancy' (p.19). (p. 68)

Kaplan (2000) notes that although art making does not cure or reverse cognitive decline, it

certainly may increase quality of life, like it did for John.

Chilton and Wilkinson (2017) provide a list of ways that art therapy can enhance positive psychology. For one, art encourages positive emotions such as "enjoyment, interest, amusement" (p. 61). Through an engagement with art materials, it may activate focused attention and flow, which can induce relaxation, help an individual retrieve and process information from the subconscious, and allow distancing from thoughts and feelings while offering a unique opportunity for emotion regulation.

Strengths-based art therapy interventions. In practice, positive art therapists may draw on clients' strengths (Wilkinson & Chilton, 2017). As an intervention, Wilkinson and Chilton (2017) will ask their clients: "What is your 'super power' – a quality for which you are known, that you feel is core to who you are as a person?" (p. 108) The authors state that if their client is having trouble thinking of a strength and can only name weaknesses, they may ask them to think about something that their friends, family, or community members appreciate about them (Wilkinson & Chilton, 2017). Sometimes the authors give out lists of strengths and clients may go through the list and find some that they identify with (Wilkinson & Chilton, 2017).

Booth and Sleeman (2007, as cited in Wilkinson & Chilton, 2017) developed 150 cards called "Strengths in a Box" (p. 124) to be used as an interactive resource to encourage strength-based conversations. Wilkinson and Chilton explain that each card has a different strength, which they sometimes use to warm up and engage their clients in dialogue for strengths-based art making. The cards fall into one of four strength categories – heart, head, hands, and spirit – making them similar to a deck of playing cards (Wilkinson & Chilton, 2017). Wilkinson and Chilton give examples of the strengths listed, such as "determined," "punctual," and "team player" (p. 124). Booth (Creative Wellbeing Workshops, n.d.) offers training in using Strengths in a Box to many different mental health professionals and educators. Wilkinson and Chilton (2017) add that some clients may be able to identify their own strengths and work at making their own personalized deck of cards.

Wilkinson and Chilton (2017) introduce an intervention they call "Spirit Dolls to Honor Strengths and Resilience" (p. 124) in which clients are prompted to attach a message to one of their strengths and put it inside a doll that they make with wire and cloth. They also offer a spirit doll creation workshop for individuals who have been diagnosed with a life-threatening illness (p. 124). They warm up their clients, as mentioned above, by having them look through the deck

of Strengths in a Box and asking them to identify some of their strengths. Once the individuals identify the strength that resonates with them at that time, they write a message to themselves incorporating the strength. This message goes into the doll that they make during the workshop (Wilkinson & Chilton, 2017).

In another noteworthy intervention that the authors call "strengths stretching," (p. 228) clients are asked to make art using their strengths in a new and challenging way (Wilkinson & Chilton, 2017). This can be a way for clients to try on a new behaviour in a safe environment. The authors (2017) have found that these positive art therapy interventions can be just as effective with populations who are struggling with mental illness as it is with healthier populations.

Asking clients to depict an image of a positive emotion that they would like to feel more often can be a very effective intervention (Wilkinson & Chilton, 2017). Wilkinson & Chilton (2017) show images that some of their clients made of "serenity" and "love" (p. 126), two emotions that their clients with substance abuse wished to feel more often.

In an arts-based assessment, Kaplan (2000) highlights noticing how clients engage with art materials. Kaplan's arts-based assessment is based on a more general approach to art therapy. Although many modalities draw on the strengths-based approach in clinical practice, it is important to note how central this is in positive psychology. Kaplan (2012, as cited in Wilkinson & Chilton, 2017) highlights elements we may notice during an art-based assessment such as: "level of investment, effort, energy, physical vitality, ingenuity, imagination, ability to focus, and tolerance for frustration" (p. 120). In noticing our client's engagement during the assessment process, we may identify our client's creative strengths and begin there in our treatment (Kaplan, 2000).

Treating Major Depression with Positive Psychology

Depression is a common mental health disorder, affecting more than 300 million people worldwide (WHO, 2017). The World Health Organization (2017) states that "depression is the leading cause of disability worldwide" (para 1).

Positive clinical psychologists have been urging for research to be done to find ways of integrating treatments for depression that focus on reducing symptoms and increasing the ability to experience pleasure and positive emotion (Dunn & Roberts, 2016). Anhedonia, a common symptom of major depression, is the inability to experience pleasure and is experienced by

approximately one third of individuals with a MDD diagnosis (Dunn, 2012). Since current treatments do not directly work on remedying this symptom, positive psychologists are researching how to help individuals suffering with depression reconnect with pleasure (Dunn, 2012). Dunn and Roberts (2016, p. 184) build the case for the development of a treatment intervention plan that both works to reduce negative symptoms and foster positive affect. Anhedonia can predict response to medication and cognitive behavioural therapy at intake (Geschwind, Nicolson, Peeters, van Os, Barge-Schaapveld, & Wichers, 2011) and has been found to positively correlate with the risk of ongoing depression one-year after treatment (Spijker, Bijl, de Graaf, & Nolen, 2001, as cited in Dunn & Roberts, 2016). Mindfulness based cognitive therapy has been found to effectively decrease rates of relapse (Piet & Hougaard, 2011), and scholars hypothesize that this is partially due to the fact that the therapy supports positive affect (Geschwind Peeters, Drukker, van Os, & Wichers, 2011; Batink, Peeters, Geschwind, van Os, Wichers, 2013).

Founded by Giovanni Fava (2016, as cited in Dunn & Roberts, 2016), well-being therapy (WBT) "aims to bolster well-being in depressed or other clinical populations" (p. 187). Fava (2016, as cited in Dunn & Roberts, 2016) used Ryff and Singer's (1996, as cited in Dunn & Roberts, 2016) "six areas of eudaimonic well-being (autonomy, environmental mastery, personal growth, purpose in life, self-acceptance, and positive interpersonal relationships)" (p. 187) to develop the intervention. Combining WBT with cognitive behavioural therapy for depression has been found to prevent relapse in individuals, even those with a history of multiple relapses (Fava, Rafanelli, Frandi, Conti, & Belluardo, 1998b, as cited in Dunn & Roberts, 2016). The research for WBT is promising.

Goal-setting and planning (GAP) by MacLeod, Coates, and Hetherton (2008) is an intervention rooted in positive psychology that helps individuals make positive goals that align with their self-identify, and then work towards actualizing them. GAP has been found to both decrease symptoms of depression and increase well-being (MacLeod et al., 2008; Coote & MacLeod, 2012; Farquharson & MacLeod, 2014).

Seligman, Steen, Park, and Peterson (2005) found that interventions focusing on gratitude, strength identification, and using strengths in a new way have been correlated with decreased depression and increased well-being. The authors conducted a study and used pre- and post- study measures of depression and happiness, comparing the experimental group to a control

group (Seligman et al., 2005). They used the Center for Epidemiological Studies Depression Scale (CES-D) symptom survey by Radloff (1977, as cited in Seligman et al., 2005) to measure for depression, and the Steen Happiness Index (SHI) to measure for happiness. The experimental group maintained their happiness and depression scores at follow up, three and six months after the study took place (Seligman et al, 2005). They found that although participants were only asked to engage in each intervention for a week, those who continued it after the study remained the happiest at follow-up. Dunn and Roberts (2016) hypothesize that positive psychology interventions may help prevent relapse and maintain well-being as the tools the clients learn remain relevant to them even when they are not experiencing depressive symptoms. In other words, individuals can always practise gratitude and exercise their strengths in new ways, enhancing and/or maintaining their well-being, whether they are feeling depressed or not.

In Sin and Lyubomirsky's (2009) meta-analysis, they found that individuals who were motivated to seek out the positive interventions themselves seemed to reap more benefits from the studies than did peers of theirs who had been sought out by researchers. This makes sense, since across therapeutic models and interventions, it can be expected that clients who believe in and are engaged in the process will benefit most from their therapy.

Sin and Lyubomirsky (2009) also found in the literature a positive correlation between the positive impact of positive psychology interventions and older clients. The authors hypothesize that this is due to "greater wisdom and more effective emotional regulation and self-regulation associated with older age" or to elder participants taking their treatment and the individual interventions more seriously (Sin & Lyubomirsky, 2009).

Set point theory. Lyubomirsky, Sheldon, and Schkade (2005) suggest that 50% of a person's chronic happiness level may be determined by their happiness "set point" (p. 116). This is the baseline happiness level that we are "naturally inclined" to return to (Wikinson & Chilton, 2017, p. 34). The authors state that a person's set point is biologically determined and remains fixed overtime (Lyubomirsky et al., 2005). Studies comparing monozygotic twins with dizygotic twins showed that monozygotic twins "exhibit considerably more similar patterns of happiness change than do dizygotic twins, providing converging support that the variance in adult happiness is in large part determined genetically" (Lyubomirsky et al., 2005, p. 117).

Dunn and Roberts (2016) state that individuals vulnerable to depression are "likely to have a dispositionally low happiness set point, setting a ceiling on the potential for growth in

positivity" (p. 190). The authors urge that encouraging our clients to strive for a happiness level above their set point could result in a feeling of alienation. We must be careful not to alienate our clients, as this would negatively affect the strength of the therapeutic working alliance. Diener, Lucas, and Scollon (2006, as cited in Wilkinson & Chilton, 2017) found that our set point may change or fluctuate over time and suggest that we call it our set range of happiness. With negative events, however, we return to this baseline more slowly (Wilkinson & Chilton, 2017). Parks and Titova (2016) highlight however, that with hard work, behaviour may counter any biological susceptibilities. The authors suggest that even if a person has a low happiness set point, that they may practise improving their mood, which may lead to increased happiness. Sin and Lyubomirsky (2009) conducted a meta-analysis to see if positive psychology interventions could increase well-being and treat symptoms of depression in participants. They reviewed "51 interventions with 4,266 individuals" (p. 467) and found that individuals with depression improved more significantly in increased well-being and decreased depressive symptoms than those who were not diagnosed with depression. The authors attributed this to the floor effect, which suggests that individuals with depression have more latitude to increase their well-being (Sin & Lyubomirsky, 2009). Their findings challenge "the notion that depressed people might benefit less from positive psychology interventions, because their characteristic cognitive, affective, and behavioral deficits prevent them from taking full advantage of the relevant positive activities" (Sin & Lyubomirsky, 2009, p. 482). This research shows that positive psychology interventions can be effective for individuals diagnosed with depression, despite the presence of anhedonia and set point theory, and that these clients may actually have more to gain from the exercises compared to non-depressed individuals.

Critiques

Pollyanna problem. Alongside the promises that positive psychology offers in the treatment of depression, there are also potential challenges. A main challenge of using positive interventions with this population that is specifically relevant for this paper is called the "Pollyanna problem" (Dunn, 2012, as cited in Dunn & Roberts, 2016, p. 188). The Pollyanna problem explains that "a focus on positivity can seem naively optimistic about the world and this can invalidate individuals' suffering and distress" (Dunn & Roberts, 2016, p. 188). When an individual is in a dark place, it can be hard to imagine brighter days, and we may risk invalidating clients if we chose to offer positivity rather than mirror their experience. Dunn and

Roberts (2016) warn that individuals experiencing a depression may feel that positivity is not important, nor achievable, or is just completely offensive (Dunn & Roberts, 2016). An example that they provide is a hypothetical client who has suicidal ideation and a therapist who suggests that they try to access their inner gratitude (Dunn & Roberts, 2016, 188). The insensitivity of the therapist's suggestion and the likelihood that the client may feel their experience is being discounted and invalidated is evident in this example.

Emotional Courage. The psychologist Susan David (2017) presented a TED talk on emotional courage and its importance in the world we live in today. She highlights the tendency of our culture to reward positivity over "emotional truth," and how dangerous this is to our personal lives and our global society. She shared a personal story of how this pattern in our culture is harmful. She lost her father when she was 15 years old. As she continued to get top grades in school and wear a smile, she was socially rewarded for this behaviour, and individuals told her she was so strong (David, 2017). She notes that she became "the master of being OK" (David, 2017, 13:45). Even though she maintained her image in the world, her family struggled deeply at home. She spiraled into mental illness and an eating disorder, and she felt that she was part of a culture that was not interested in her suffering (David, 2017). She tried to deny her true emotional experience, to suppress it. Then, a teacher of hers asked her to write her true feelings down in a journal and reminded her that no one had to read them (David, 2017). This was a moving suggestion that has shaped her work as a psychologist; she moved from "emotional rigidity" to "emotional agility." She stresses the importance of looking at all of our emotions as valuable and as information (David, 2017). She conducted a study of 70, 000 people and found that one third of the population "either judge themselves for having so-called 'bad emotions,' like sadness, anger or even grief. Or actively try to push aside these feelings" (David, 2017, 6:04). She makes a connection to depression, and how depression has become the leading cause of disability worldwide. This makes sense given the research done on emotional suppression, which shows that the more you push away an emotion, the stronger it gets, and the tighter its grip on you becomes. You feel you should have control over your unwanted emotions, but you don't: You feel helpless, and you become depressed (David, 2017). David (2017) urges us to stop embracing "false positivity" and to accept all of our emotions, "even the messy, difficult ones" (11:09), so that we may build resilience, witness what our true emotions are telling us, and experience "authentic happiness" (11:09).

Conventional Depression Treatment. Johann Hari (2018), author of *Lost Connections: Uncovering the Real Causes of Depression – and the Unexpected Solutions*, has connected with leading scholars studying depression and reveals new information about antidepressants and the state of the current epidemic. Hari (2018) talks about Irving Kirsch's findings on the science behind the popularity of anti-depressant based depression treatments. Kirsch found that pharmaceutical companies were only publishing the trials that backed up their effectiveness and failed to share that "between 65 and 80% of people on antidepressants are depressed again within a year" (para. 14) despite maintaining the dose of the drug (Hari, 2018). Hari (2018) found that some individuals may be depressed due to low serotonin levels, but increasing serotonin levels is not a silver bullet, and more options for treatments need to be developed. Hari (2018) states that every human has "psychological needs. We need to feel like we belong. We need to feel valued. We need to feel we're good at something. We need to feel we have a secure future" (para. 17). The article states that there is new evidence that shows that many of these psychological needs may not be being met in our current society, and that humans are disconnected from what these needs are (Hari, 2018). Hari mentions the Gallup study that was mentioned earlier in this literature review, stating that 87% of people are not engaged in their work (Hari, 2018). He looked into this to see if there was a connection between disengagement at work and depression. Michael Marmot, an Australian researcher, found that indeed there is a positive correlation between feeling a lack of control in the workplace and feeling stressed (Hari, 2018). This, the author argues, is one example of a societal issue that we may begin unpacking with individuals who are experiencing depression in their lives. Hari quotes the United Nations statement for World Health Day in 2017 that urged that we stop looking to "chemical imbalances" and instead acknowledge "power imbalances" (para. 29). Hari (2018) closes the article with a noteworthy message:

"If you are depressed and anxious, you are not a machine with malfunctioning parts. You are a human being with unmet needs. The only real way out of our epidemic of despair is for all of us, together, to begin to meet those human needs – for deep connection, to the things that really matter in life." (para. 31)

Between the need for a more diverse range of treatments for depression, the potential of positive art therapy to treat this population and our culture's tendency to reward false positivity and the potential for clients with depression to feel invalidated by positive interventions, I am left

wondering how this model might be considered in terms of the therapeutic alliance. This leads me to ask how an art therapist using a positive psychology informed model might build and maintain the therapeutic alliance with a clientele experiencing depression.

Chapter 3. Methodology

The literature review helped me formulate my research question: How is the therapeutic alliance built and maintained using a positive psychology model applied to art therapy with a client diagnosed with major depression? This chapter covers the rationale for, methodology, and analysis procedure used to answer my research question. This section also mentions relevant ethical considerations including my assumptions and biases regarding the topic of research.

Rationale

My literature review highlighted the benefits and promise of positive art therapy for treatments across populations, but also highlighted the potential challenges of applying it in practice and critiques of the approach. There are currently no examples in the literature dedicated specifically to the topic of positive art therapy for depression, and thus no articles exploring the therapeutic relationship a therapist using this approach would have with such a client. The findings chapter of this paper covers what is currently being stated about the therapeutic relationship within the positive art therapy model in clinical settings and best practice psychotherapy for clients diagnosed with major depression. These findings are then synthesized into recommendations for positive art therapists working with clients experiencing a major depression.

Method

A bibliographical approach was applied for the theoretical research used to answer my research question. This method was appropriate because it allowed me to read a variety of texts in positive clinical psychology, positive art therapy, and major depressive disorder and synthesize information to answer my research question. Theoretical research allows one to unpack a phenomenon and "build a depth of understanding" of it (Leavy, 2017). It is important to synthesize the information gathered from an exhaustive literature review on a topic before further research can be conducted. This project was based on a literature review and concludes with recommendations based on the synthesized data. My data was extracted from relevant texts and put onto cue cards so that I could spread the data out and review it as needed. I retrieved texts through the Concordia University's online library database, St. Francis Xavier's online

library database, and books from Concordia's Webster library. The keywords I used to begin searching the databases were: "positive art therapy", "positive psychology" AND "major depressive disorder" OR "major depression", "therapeutic alliance" AND "major depression" OR "major depressive disorder", "positive art therapy" AND "therapeutic alliance", "art therapy" AND "therapeutic alliance".

Procedure.

Data collection steps were as follows. I: (a) read literature that describes how clients dealing with depression present to therapy; (b) did an exhaustive search on positive art therapy literature; (c) gathered information from relevant texts listed in their references, to answer my research question; (d) looked at how alliance is built and maintained between clinical positive psychologists and clients diagnosed with major depression; (e) read best practice psychotherapy research on alliance building with clients diagnosed with depression. All the texts I read were excellent vehicles for further reading found in the Bibliography of each book.

Data Analysis

My data analysis was structured as recommended by Leavy (2017). I collected "chunks" of data relevant to answering my research question. The data was written down on cue cards with the author, date, and page number, so that I could spread them out during analysis. The reference was also downloaded to my desktop and added to a folder titled, "research literature". Leavy (2017) recommends having an immersion period, during which you "read, look at, and think about the data" (p. 150). This was the period between data collection and the formulation of my ideas. During the data organization and immersion, I sorted my chunks of data into themes, which ended up being my headings in my findings section. Once my data was coded and categorized, I looked at how the different themes fit together. From there, I synthesized my interpretations into recommendations for alliance building between a positive art therapist and clients with major depression.

Validity and Reliability

Leavy's (2017) data analysis and interpretation strategies structured my research project, and ensured the credibility and trustworthiness of my project.

Assumptions and Biases

I hold a humanistic perspective. A fundamental assumption that I make in this research is that humans are inherently good, and are "motivated to reach their full potential" (Linley &

Joseph, 2004, as cited in Wilkinson & Chilton, 2013, p. 4). I believe that since humans are happier and more productive in a state of wellness (Diener, 2008), this is our innate state.

I chose to live my life with a positive perspective as it helps me stay well. I have personal experience with depression and anxiety disorders and I believe that staying in touch with what makes me happy, and what gives me a sense of wellbeing, helps prevent relapse. Thus, I am biased because this approach works for me, and I am assuming that it can be applied to the wider population.

Chapter 4. Findings

This chapter focuses in on literature that is specific to building or maintaining the therapeutic alliance between a positive art therapist and a client diagnosed with depression. Topics explored are: elements of depression that are covered by positive psychology, prevention of the Pollyanna problem, factors of the therapeutic alliance that are model independent, factors of the therapeutic alliance specific to positive art therapy, and factors of the therapeutic alliance to keep in mind when working with individuals diagnosed with depression.

Positive Art Therapy as a Complimentary Model

Dunn and Roberts (2016) urge for research to be done to integrate "existing depression-focused clinical interventions with elements drawn from positive psychology" in order to reduce symptoms of depression while building on well-being to reduce the likelihood of relapse. Wilkinson and Chilton (2017) also state that positive art therapy is currently used as an adjunctive theoretical model to be integrated into a foundational model, and argue that this may make for the most effective use of positive psychology in general. The authors suggest that positive art therapy be used as a compliment to therapists' existing theoretical foundations. Gelenberg, Freeman, Markowitz, Rosenbaum, Thase, Trivedi, and Rhoads (2010) note evidence that supports the use of each of these models for the treatment of major depression: cognitive behavioural therapy, interpersonal psychotherapy, psychodynamic psychotherapy, and problem-solving therapy. Thus, I hypothesize that integrating positive psychology with one of these models may make for the most effective treatment of major depression.

Elements of Depression addressed by Positive Psychology

Negativity Bias in Depression. In order to establish a working alliance with our clients, it is important to be sensitive to their concerns (Gelenberg et al., 2010). Individuals diagnosed with depression may have a strong negativity bias. Clients who are experiencing an acute phase

of major depression may be "poorly motivated, unduly pessimistic about their chances of recovery with treatment, suffering from deficits in memory, or poorly caring for themselves" (Gelenberg et al., 2010, p. 29). Mid treatment, clients may fixate on the burdens of treatment and devalue its benefits (Gelenberg et al., 2010). Furthermore, Gelenberg et al. (2010) state that clients diagnosed with depression often have negative views of themselves and may feel undeserving of therapy, or feel shame and embarrassment about having mental health difficulties. Swann, Tafarodi, and Wenzlaff (1992) looked at the self-verification theory that states that individuals will strive to verify their self-views even when they are negative. Their study confirmed this, but they noted something interesting: Although depressed individuals feel as badly as non-depressed individuals when they are given negative appraisals, they continue to look for validation of their self-beliefs by seeking out negative feedback. Swann et al. (2010) thus concluded that individuals with depression are caught between the yearning for approval and the feeling that they are not worthy of it.

Furthermore, some clients with depression may actually fear having the experience of positive affect and may actively avoid pleasure (Werner-Seidler, Banks, Dunn, & Moulds, 2013; Gilbert, McEwan, Catarino, Baiao, & Palmeira, 2014). Many clients talk about the painful contrast between feeling good and bad, and the "fall back to earth" (Dunn & Roberts, 2016, p. 189) that follows positive feelings, stating that they would rather feel no pleasure at all.

Appropriate negativity. Wilkinson and Chilton (2017) stress the importance of negative emotions, that they are essential to our survival, and that experiencing and expressing appropriate negativity can indeed help us to flourish (p. 68). The authors note that it is critical to express negative emotions, and that suppressing them is in fact detrimental to our health (Gross & Levenson, 1993, as cited in Wilkinson & Chilton, 2017). It is when negative emotions become persistent that they become harmful to our health (Wilkinson & Chilton, 2017).

David (2017) critiques this labeling of emotions of positive or negative, good or bad. She highlights that this unhealthy system of categorizing shames individuals out of acknowledging emotions that they do not label as positive, resulting in denial and suppression: This is neither sustainable nor healthy. The happiness that individuals express when they refuse to face their challenging emotions may be called false happiness. David (2017) argues that the only way to feel authentic happiness is to welcome the full range of our emotions, and to feel that they are all

important and valuable. We must be careful not to use an over-simplified categorical system of our natural, healthy, human emotions.

Pollyanna Problem: Prevention

Taylor, Lyubomirsky, and Stein (2017) conducted a study to see if activities deemed positive could simultaneously reduce negative-affect and increase positive-affect in clients with depression and anxiety. They found that beginning the intervention period with psychoeducation on positive psychology clarified that "the aim of the intervention was not to feel positive emotions all of the time, nor to deny the existence of negative emotions or life experiences" (p. 17). The authors hypothesize that the psychoeducation session may have prevented the Pollyanna problem (Taylor et al., 2017). Similarly, Dunn (2012) states that it is very important to inform clients that the goal of treatment is not to feel 100% positive 100% of the time, but rather to make life even the slightest bit more enjoyable.

Dunn (2012) suggests that positive therapists should not assume that their client wants to feel more positive, but rather to identify and work towards removing motivational blocks with each client. Sin and Lyubomirsky (2009) also emphasize how important it is to build motivation and encourage our clients. Wilkinson and Chilton (2017) state that the therapist must strategically use positive emotions to motivate and engage our clients, while encouraging them to go outside their comfort zones, but not to deny negative experience or emotion. Betts (2011, as cited in Wilkinson & Chilton, 2017) recommends highlighting strengths in our clients during the assessment period as this can help build the therapeutic alliance. Wilkinson and Chilton (2017) further state that using positive emotions at the onset of therapy can be an effective tool for enhancing the relationship, as they can provide hope for the new client. Seligman et al. (2006) report that when working with major depressive disorder, ideally positive and negative talk are balanced in sessions – the positive does not outweigh the negative focus.

The Therapeutic Alliance

This section focuses on the development and maintenance of the therapeutic alliance. It begins by exploring common factors known to influence the development of the therapeutic alliance that are not model dependent. Next, the section goes into considerations for the development of a therapeutic alliance with individuals diagnosed with depression, specifically within the context of positive art therapy.

Common factors for building the therapeutic alliance. Wilkinson and Chilton (2017) state that the way a therapist approaches the relationship with their client may change depending on their theoretical orientation and "the role they believe that the relationship plays" (p. 129). Despite variations in how this relationship is used in therapy, many researchers state that the therapeutic alliance may be the most important element for successful treatment (Gelenberg, et al., 2010; Malin & Pos, 2015). Heynen, Roest, Willemars and van Horren (2017) found that the therapeutic alliance was positively correlated with symptom reduction in clients diagnosed with anxiety and depression in creative arts therapy. Ackerman and Hilsenroth (2003) conducted a literature review of research on the personal attributes and techniques of therapists that have been found to positively influence the therapeutic alliance regardless of therapeutic approach.

Personal attributes of the therapist. Price and Jones (1998) conducted a study to reveal the relation between the process used by the therapist and the development of the therapeutic alliance. To do this, they used two measures: the California Psychotherapy Alliance Scale and the Psychotherapy Process Q-Sort. They found that the therapist's ability to demonstrate an understanding of the client and to take a supportive stance was positively correlated with higher ratings of positive alliance (Price & Jones, 1998). Other researchers have also found that therapists who hold supportive attitudes and have the ability to "facilitate a greater sense of understanding" in their clients had higher alliance ratings (Mohl, Martinez, Tichnor, Huang, & Cordell, 1991, as cited in Ackerman & Hilsenroth, 2003, p. 6). Price and Jones also found that the therapist's confidence in their ability to help the client and be "perceived as proficient" may also lead to higher ratings of the therapeutic alliance. Other researchers also found that the therapist's confidence in the therapeutic alliance and expectation of positive results was found to positively influence the therapeutic alliance (Al-Darmaki & Kivlinghan, 1993; Saunders, 1999, as cited in Ackerman & Hilsenroth, 2003).

Kivlighan, Clements, Blake, Arnzen, and Brady (1993, as cited in Ackerman & Hilsenroth, 2003) studied the relationship between therapist flexibility and the development of the therapeutic alliance. They recruited student participants to share issues from their current lives and then rate the working relationship after each meeting. The researchers found a positive correlation between therapist flexibility and higher ratings of the therapeutic alliance (Kivlighan, Clements, Black, Arnzen, & Brady, 1993, as cited in Ackerman & Hilsenroth, 2003).

Therapist's use of intervention. Luborsky, Crits-Christoph, Alexander, Margolis, and Cohen (1983, as cited in Ackerman & Hilsenroth, 2003) conducted a study in which they had judges report on a therapist's actions and assess whether they promoted or discouraged the therapeutic alliance. Luborsky et al. (1983, as cited in Ackerman & Hilsenroth, 2003) found that the following behaviours aided the development of the therapeutic alliance:

> communicating a sense of hope for patients to achieve their goals, noting patient progress toward goals, understanding, accepting, and respecting patients, being open-minded and enthusiastic, referring to common experiences between the patient and therapist, conveying a feeling of working together in a shared effort against the patient's anguish, communicating a trust in the patient's growing ability to use what has been learned in treatment, as well as facilitating the use of healthy defenses and supportive activities. (p. 13)

Sexton, Hembra, and Kvarme (1996, as cited in Ackerman & Hilsenroth, 2003), studying which processes help develop and maintain the therapeutic alliance, found that "reflection, listening, interpreting, questioning, and advising" (p. 16) all had a positive impact.

In sum, the personal attributes that were found to positively influence the therapeutic alliance are: flexibility, experience, honesty, being respectful, trustworthy, confident, interested, alert, friendly, warm, and open (Ackerman & Hilsenroth, 2003, table 3). The therapy techniques that positivity influence the therapeutic alliance are: facilitation of exploration, depth, reflection, being supportive, noting past therapy success, accurately interpreting, facilitating expression of affect, active collaboration and verbal exchanges, affirming, understanding, attending to patient's experience (Acerman & Hilsenroth, 2003, table 3).

Goodness of fit. Dr. Patrick Keelan (2017) explores the importance of goodness of fit between therapist and client in terms of personal fit and approach and methods. Personal fit refers to whether the therapist and client "like, respect, and get along with each other" (Keelan, para. 3). Keelan (2017) notes that the majority of therapists make strong efforts to develop a liking for their clients and a respectful relationship. However, there are times where it just won't feel right. For example, a client may just not feel comfortable working with a therapist because of their age, or they may not like the tone or sound of the therapist's voice (Keelan, 2017). Conversely, a client may respect their therapist right away because of the way they dress, have their office set up, or the way they are greeted when they arrive. If mutual liking and respect are

lacking in the relationship, despite all efforts to work together, it may be best for the client to switch to another therapist.

The second aspect to consider of goodness of fit refers to the approach and methods utilized by the therapist. Some therapists may work primarily with a cognitive behavioural therapy model, some a psychodynamic model, and others may have an integrative approach. It is important that the model that the therapist is working with makes sense to and works for the client (Keelan, 2017). The client must be informed of the therapist's approach and decide whether they believe it can work for them. It is important to acknowledge that the need to switch to another therapist is not a negative reflection on the client or the therapist (Keelan, 2017).

Building the therapeutic alliance. Wilkinson and Chilton (2017) state that the clinical positive art therapist needs skill in order to affectively validate a client's struggles and hardships while gently bringing the clients' strength and resilience to the forefront. Seligman et al. (2006) note that the goal of the positively informed therapist is to notice a client's strengths and protective factors, and to remind them of these strengths while exploring behaviours that induce positive responses from people around them. Furthermore, the positive therapist should work to build on the client's existing strengths, rather than trying to teach "the reinterpretation of negative aspects" (p. 780). Seligman et al. (2006) note that this way, you empathetically attend to the client's seemingly unpleasant emotions and experiences, while also building on the strengths that the clients have already identified in themselves. This is how balance can be restored. It is important for positive art therapists, as well as other positive health practitioners, to validate, convey compassion and empathy, and be sensitive towards the wide range of their clients' emotions and experiences (Wilkinson & Chilton, 2017; Gelenberg et al., 2010). This will help enable their clients to foster the feeling of safety that is necessary in order to build the therapeutic alliance (Wilkinson & Chilton, 2017). Seligman, Rashid, and Parks (2006) support this comment by stating that the therapeutic alliance can be ruptured if the client does not feel that their problems are validated and appreciated. Malin and Pos (2015) found that those clients who rated their therapists high in empathy also rated their therapeutic alliance higher. "Vocal matching, therapist warmth and interpersonal safety, and responsive attunement" (Malin & Pos, 2015, p. 453), were most positively correlated with alliance formation.

Wilkinson and Chilton (2017) describe how the positive art therapist must look for the times in their clients' lives when things weren't as bad as usual, for example: When has the client

felt some symptom relief? Can they remember a time when they were feeling okay, or can they identify a time when they were managing their stress well?

Huffman, DuBois, Healy, Boehm, Kashdan, Celano, Denninger, and Lyubomirsky (2014) conducted a study to see how effective positive psychology exercises would be for suicidal inpatients. They found these patients in crisis were most successful with basic interventions that did not require significant self-analysis (Huffman et al., 2014). Among the successful exercises were: writing a "gratitude letter and counting blessings," and focusing on a personal strength (Huffman et al., 2014, p. 93). More demanding exercises such as "the forgiveness letter" and the life purpose exercise proved to be too difficult for this clientele at this stage of their treatment (Huffman et al., 2014, p. 93). The authors report that a significant number of patients experienced anger and/or sadness while recalling past experiences that may require forgiveness and that they had difficulty to move past this trigger. They surmised that, "asking patients to take on 'big' issues such as life purpose or imagining an optimal future might have been more difficult for some patients at this stage. Alterations in delivery or timing (e.g., after some symptom recovery) might render these exercises more useful in this population" (p. 93).

The therapeutic art alliance. Heynen et al. (2017) state that there are three important aspects of the therapeutic alliance: "the bond between the therapist and the client, the agreement on goals and the collaboration on tasks" (p. 112). The authors found that the therapist and client's interactions with the materials and artistic methods used to create artworks provided increased opportunities to collaborate on a task, and in turn, encouraged the development of the therapeutic alliance (Heynen et al., 2017). It is due to this hypothesis that Heynen et al. (2017) claim that the art in art therapies may help develop the working alliance. Wilkinson and Chilton (2017) also note that the artwork can deepen the ability to relate to and connect with the other, which can encourage the development of the therapeutic alliance.

In order to build the therapeutic alliance, the therapist must be present with and listen to the client. When the client feels heard and validated, they feel safe: this allows the therapeutic work to unfold. Kossak (2009) refers to this type of being with another person as "tuning in" (p. 13) to them and their experience. Kossak (2009) suggests that the art of tuning in, which is required to attune with our clients, may be a skill that comes naturally to artists. The author states that artists tend to be skilled in tuning into oneself and the human condition, and builds an argument that this may allow them to tune into their clients with a relative sense of ease (Kossak,

2009). This tuning in, which is necessary in building alliance with our clients, may also be required for authentic artistic self-expression (Kossak, 2009). Kossak (2009) refers to a term called "therapeutic attunement," (p. 13) and explains that this type of connecting occurs when both the client and therapist are fully experiencing the present moment together. Kossak (2009) continues to explain this connection as a, "kind of mutual resonance experienced as connectivity, unity, understanding, support, empathy, and acceptance that can contribute greatly to creating a sense of psychological healing" (p. 13).

Maintaining therapeutic alliance. Once the therapeutic alliance is built and the therapeutic work begins, there is the possibility for ruptures in the relationship. If a rupture occurs in the relationship, there is opportunity for repair. That said, the literature offers some tips on how to maintain the therapeutic alliance during the course of treatment. Gelenberg et al. (2010) state that family beliefs and attitudes about mental illness and treatment of depression can influence a client's engagement in therapy. Furthermore, if the client has major depression, it is possible that their family or closest friends are playing a role in getting the individual to treatment, thus it is important that they believe that therapy is effective and important in their loved one's recovery. The authors note that family involvement in the treatment of our clients with major depression disorder can make a big difference in terms of promoting optimism, encouraging patient involvement, and supporting the therapeutic alliance (Gelenberg et al., 2010). If the family and friends of your client are optimistic about the treatment, they can share that with your client and encourage them to engage in therapy. Finally, the establishment of the working alliance and the move towards changes depend on the client's active engagement in their therapy.

Wilkinson and Chilton (2017) describe a type of love that develops in the therapeutic relationship and solidifies the bond. Wilkinson and Chilton (2017) are careful to state that this is not a romantic love, but rather what therapists know as:

> attachment, attunement, resonance, interactive reciprocity, intimacy, empathy, compassion, etc… moments of shared compassion, humor, and physical alignment fuel connection and willingness to engage… Both clients and therapist experience love that neither exploits nor violates professional boundaries. Instead it is evidence of healthy attachment. (p. 138)

Alliance considerations for those diagnosed with Depression. Kushner, Quilty, Uliaszek, McBride, and Bagby (2016) studied how personality mediates the development of the therapeutic alliance between a therapist and a patient with major depressive disorder. The authors found client personalities scoring higher in agreeableness may develop the working alliance quicker than others. The authors also found that extraversion and openness may help in maintaining the therapeutic alliance throughout treatment (Kushner et al., 2016).

Gelenberg et al. (2010) found that when there is extreme difficulty in developing a working alliance this may be due to the actual symptoms of depression. Early in the treatment of depression, for example, the client may be "poorly motivated, unduly pessimistic about their chances of recovery with treatment, suffering from deficits in memory, or poorly caring for themselves. During the maintenance phase, euthymic patients may undervalue the benefits of and focus on the burdens of treatment" (p. 29). The therapist may psycho-educate the client on the possibility that some of these symptoms may be preventing adherence to treatment and the development of the therapeutic alliance and explore these issues in their therapy sessions.

Chapter 4. Discussion

When setting out to explore my research topic, I wondered: Is positive art therapy *too positive* a theoretical approach to work with clients diagnosed with major depressive disorder? Reflecting on the Pollyanna problem and my experiences with my friends, I imagined the client being in a dark emotional place, receiving and feeling the positive talk of the therapist as invalidating and offensive. This led me to conceptualize the mindset of the art therapist working from a positive psychology informed model as "positive" – the polar opposite of the mind of an individual diagnosed with depression. I wondered if a "positive" mind and "negative" mind could work together. I wondered if a working alliance could be developed between two individuals at opposite ends of this polarized concept. This research project, however, has reminded me that the mind is far more complex than the generalized dichotomy that I created in order to articulate my research question. Through this research I have developed the hypothesis that an art therapist working with a positive psychology informed model and a client diagnosed with major depressive disorder may indeed develop and maintain a working alliance. Although some people may assume that positive psychology is a branch of psychology that focuses solely on the positive and wants nothing to do with anything negative, this is a misconception. Positive psychologists and mental health practitioners believe that the positive aspects of our clients' lives

should be focused on as much as the negative aspects. I believe that many therapists work in this way already without identifying that they are in fact incorporating a positive psychology approach, as other models also incorporate strengths-based approaches. I have been taught by professors who emphasize the identification of strengths in order to support recovery, and have witnessed my own therapists work with this very approach. Positive art therapists may be trained in psychodynamic theory, cognitive behavioural therapy, interpersonal therapy, or any other theoretical framework in psychotherapy. Positive art therapy is currently not being practiced as a stand-alone theoretical foundation, but rather is used integratively with other approaches.

Finding the concept of appropriate negativity helped me to realize that feeling and acknowledging "negative" emotions is absolutely essential in order to live a life of well-being. Positive art therapists should not avoid "negativity," but rather welcome the expression of negative emotions as this allows one to let go and move forward. Working through negativity enables flourishing. This echoes what psychologist Susan David (2018) spoke about in her TED talk: Avoiding and suppressing negative emotions creates a culture that fosters and rewards false happiness. As a society, I believe that we need to become aware of this, welcome genuine experience, and look at all emotions as valid and important information. This is how we can begin to build authentic happiness.

Sometimes our clients may feel stuck in an unhealthy cycle that maintains their depression. Aiding our clients in identifying what is keeping them stuck and preventing the motivation that would help them move forward is where the positive art therapist can be helpful. This needs to be approached gently by the therapist, while validating and attuning with the client. If the motivation blocks are revealed in session, the art therapist may help build motivation and encourage the client to set goals and work towards change. The research that discussed the fear that some clients with depression have of feeling positive emotions and the low that they experience after feeling pleasure conveys the importance of moving slow in therapy and creating small goals, so that alliance may be built and maintained.

It became obvious to me while carrying out this research that positive art therapists must practice identifying strengths and protective factors in all of their clients. Research by Seligman et al. (2006) shows that it is much more effective to work on growing strengths that already exist in the client with depression, rather than trying to teach new ones, as this learning curve may discourage clients and in turn threaten alliance. Working on characteristics that our clients

already possess can increase well-being while simultaneously decreasing depressive symptoms (Huffman et al., 2014; Sin & Lyubomirsky, 2009). Building on our clients' strengths and positive aspects may help them remove these blocks on their own, raising self-esteem and enhancing the therapeutic relationship.

Sin and Lyubomirsky (2009) found that clients with depression experienced "enhanced well-being and reduced depressive symptoms relative to non-depressed ones" (p. 482) in their study on positive psychology interventions. The authors speculate that this is because individuals with depression may simply have more to gain in terms of well-being (Sin & Lyubomirsky, 2009). Set point theory, however, also speaks to how much individuals with depression may gain, and Dunn and Roberts (2016) state that individuals vulnerable to depression are "likely to have a dispositionally low happiness set point, setting a ceiling on the potential for growth in positivity" (p. 190). When I look at these two pieces of research together, I am reminded that well-being and happiness will look different for each of our clients. Our experience with one client diagnosed with major depression may look vastly different than the next, and that the interventions and relationship building with this clientele will likely require much flexibility on the part of the therapist.

A central part our work as art therapists is, of course, art. I discovered the benefits that witnessing our clients' art making process, and listening to their experience of it, can have on building the therapeutic alliance (Wilkinson & Chilton, 2017). Heynen et al. (2017) present three aspects of the therapeutic alliance: "the bond between the therapist and the client, the agreement on goals, and the collaboration on tasks" (p. 112). Heynen et al. (2017) argues that the art-making portion of art therapy provides an opportunity for collaborating and shared experience that can serve as a foundation for the development of the therapeutic alliance. Collaboration can take place between art therapist and client during the selection of the materials used, whenever the client needs an extra hand, and, in select circumstances, when the two make an art piece together. For example, in Wilkinson & Chilton's "Sprit Dolls to Honor Strengths and Resilience" (p. 124) intervention, the therapist would offer the instructions to the client and provide support throughout the project. This project allows for the third aspect of the therapeutic alliance to be developed, the collaboration on the creation of a spirit doll.

Kossak (2009) argues that the therapeutic alliance may be positively influenced by some skills that are often developed in the artist therapist. Kossak theorizes that artists are skilled in

the type of "tuning in" (p. 13) that is required to attune with our clients. The author is referring to the ability to tune into oneself and the human condition, which allows an artist to produce works of art that speak to the many levels of human experience and emotion. This ability, the author argues, may be helpful in regard to tuning into clients (Kossak, 2009). As the alliance is found to be a key factor in a successful psychotherapeutic treatment, it is important for advocates of art therapy to highlight how the benefits of art-making and being an artist – benefits that are exclusive to our practice – may aid the building of the therapeutic alliance (Gelenberg, et al., 2010; Heynen, Roest, Willemars and van Horren, 2017; Malin & Pos, 2015).

Reflections on My Personal Experience

Positive and negative emotions. I experienced a major paradigm shift while carrying out this research. I began this research labeling emotions either positive or negative, and I no longer believe that this simplistic system is helpful. David's (2018) research on emotional agility, as explored in the findings section, helped me to re-conceptualize how I understand emotions and the consequences of labeling them in this dichotic way. David (2018) talked about her own experience with mental illness and how being part of a culture that rewards positivity made her feel that she could not speak out about her experience; she felt that no one cared. Her experience resonated with me, and resulted in my reflection on my own experience with mental illness in a novel way:

When I was 18-years-old, I travelled abroad to volunteer for six months with children who were abandoned and living with the human immunodeficiency virus (HIV). I went to a Spanish speaking country only knowing how to say "hola" and "gracias." I had never experienced anxiety like I did when I arrived in this country. When I arrived I immediately felt the need to start counting down the days until I could go home. Six months felt like an impossible amount of time. What is noteworthy is the fact that I did not tell anyone that I was feeling homesick and scared that I would not be able to stick it out for six months. I prided myself on being a bright and sun-shiny young woman, who was always happy and fun to be around. I looked up to the girls a few years older than me who travelled abroad together, and I thought if they could do it, so should I. When I posted my photos on Facebook, people would message me, "You are so lucky, I wish I was you," I told everyone that I was having the greatest experience. Day after day I counted the time until I would go home, worked on my Spanish, and tried to enjoy it. Then, three months into my stay, my general anxiety turned into an anxiety

attack. I was working at my placement, and a teenager living there picked her scabs off of her arm, squeezed her blood out, and laughed at me as she wiped it down my arm. Knowing there was no risk of contraction, I went to the washroom, washed my arm, and continued with the day. However, as I closed the door behind me at the end of the day, I cried. I cried more than I ever had before. I cried for fear. I cried for loneliness. I cried for injustice. Why was I so lucky? Why had I been born healthy? Why had I been born into a family and country that wanted me? My rational mind knew I was physically safe, but my irrational mind took over. I felt so unsafe. I felt like my core being was ripped out from underneath me and that I did not know how to function anymore. I messaged my family and told them I needed to come home. Some wondered about the regret I would feel if I did, but one of my aunts understood that my situation was too stressful and talked my family into flying me back. I hoped that everything would automatically go back to normal, but it didn't. Things did not go back to normal: I was sick. But I worked hard to portray the Megan that I was before I left, the Megan that people wanted to be around. I portrayed a false happiness. I lived like that for three years before being hospitalized for depression and suicidal thoughts. I began to recover. The people who wanted to help me were there for me, and the ones who could not handle it, left. Once I stopped suppressing and refusing the thoughts and feelings that I had labeled as bad and negative, I was able to start building a life towards authentic happiness.

Critique. With these reflections, I started identifying false positivity in my life and contrasting it with authentic happiness. I think it's very important not to encourage false positivity and to be sure that individuals feel safe and able to talk about their not-so-pleasant life experiences. With this, I started thinking about the name positive psychology, and how I wish it were called well-being psychology, or something of that sort. Calling one thing positive automatically makes another thing negative, and I believe labeling our emotions in this way is very dangerous. All of our emotions need to be welcomed, acknowledged, and processed. All of our emotions are information. For example, an emotion like anger, which some may experience and label as negative, can be looked at as telling us that there is something happening around us that we do not accept. Learning what in life makes us angry, the behaviours and situations in life that do not sit well with us, or that we do not accept, can be very valuable information and help us to make adjustments in our life for the better. There are models in psychology, such as CBT, psychodynamic, emotionally focused therapy and mindfulness-based art therapy, that look at all

emotions as information, I have developed an interest in mindfulness based art therapy after taking the course on Mindfulness Based Stress Reduction (MBSR) developed by Jon Kabat-Zinn and his associates in 1979 at the University of Massachusetts Medical School. Mindfulness invites us to welcome all emotions and experiences as they are, without judgment (The Mindfulness Institute, 2015). With this comes great insight into our experiences and our responses to them. My teacher, Emily Moody (2018), invited the class to notice that no emotion that we are experiencing is inherently good or bad, but rather that our mind forces a label onto them. I am convinced that this approach to emotional processing is important and necessary for us all to thrive and achieve authentic well-being.

In the findings section, I wrote about Dunn & Roberts' (2016) research on the experience individuals with depression may have if feeling very low after periods of pleasure. I remember feeling hope for the first time after a long depression, and, believing that I was instantly better, contacting all my friends to reconnect, only to feel more depressed the next day. It was important for me to recognize this phenomenon and to try and balance out the highs and lows when coming out of my depression. I find myself talking to my clients about this phenomenon as they experience it. Often this conversation will evolve into a discussion about impermanence, and bringing into awareness the common desire to hold onto good feelings or to push away feelings that we perceive as negative or uncomfortable. I believe that my meditation practice, and the teaching of impermanence, helped me to bring awareness and balance to my life. When I was feeling low I would remind myself that it would pass, and when I was feeling high, I would enjoy it, but would be aware that it, too, would pass. This tool helped me build my resilience and continue with my journey to wellness rather than becoming discouraged. As I learn more about the MBSR program, I am increasingly interested in the mindfulness based art therapy model, and wonder if it might integrate well with positive art therapy to broaden the toolbox for working with the full range of human emotions.

Gelenberg et al. (2010) discuss the importance of family involvement in the treatment of an individual's depression. While working on this project, I did reflect on the fact that my recovery started when I reached out to my family and got their support. I do believe that family involvement is an important piece to recovery, if the client does have family that can be supportive and safe for them. I also reflected on the fact that I had multiple mentors in my life when I was coming out of my depression. As I mentioned in my introduction, I had a yoga

teacher, meditation teacher, my art teachers, my therapist, and many family members and friends who supported my journey. I believe that building multiple outlets, supports, and connections may be a valuable goal of treatment. Professor Paul Raymond Gilbert (2007) developed a biopsychosocial approach to treating depression with a model that includes the exploration of the multi-level systems involved in depression, the need for social connectedness, and the development of social goals with each of his clients. Isolation and social relationships may be an important piece of depression treatment and should be incorporated into the plan. Building and maintaining therapeutic alliance with our clients is very important, and this relationship may help prepare the client to work on building other positive relationships and connections outside therapy sessions.

Posttraumatic growth. "Posttraumatic growth" may be a very important concept for our clients experiencing major depression, and it may help them conceptualize their recovery. Tedeschi and Calhoun (2004) state that, "the frightening and confusing aftermath of trauma, where fundamental assumptions are severely challenged, can be fertile ground for unexpected outcomes that can be observed in survivors: posttraumatic growth" (p. 1). Some of our clients may have experienced a trauma that led to or contributed to the development of their depression. Others may not be able to identify a trauma, but I feel it is important to suggest that experiencing major depression is a mental trauma in itself. Experiencing intense self-loathing, numbness, isolation, suicide ideation, and/or anhedonia, etc. is traumatic. It changes you fundamentally. I certainly feel that my fundamental assumptions about life were challenged during my experience abroad and during my years struggling with anxiety and depression. However, after recovering, I am grateful for the changes that I have made in my life and for the perspective I now have. I believe that I went from experiencing false happiness to knowing what authentic happiness feels like. I developed my spirituality and learned about yoga, meditation, and quieting my mind. One change that I am particularly grateful for is my deepened understanding of suffering and mental illness, as this allows me to relate to and have a deeper understanding of others. I also notice this in some of my clients who acknowledge the growth and strength that has come from their trauma. Before learning about posttraumatic growth, I talked about this growth as resilience. Resilience and posttraumatic growth may prove to be related, and this is an area that could be further researched.

The Alliance

Building therapeutic alliance. This research discovered some important tips that can assist the positive psychology informed art therapist in building the therapeutic alliance with a population diagnosed with major depression. The first is to provide psycho-education on positive psychology and share an understanding that its goal is to restore a balance in the clients' well-being, not to push the client to feel great 100% of the time (Dunn, 2012; Taylor, Lyubomirsky, and Stein 2017). It is also important in the first or second session to determine whether there is a goodness-of-fit. Research shows that treatment is most affective for those clients with depression who believe in the treatment approach, so client agreement of treatment plan is especially important (Sin and Lyubomirsky, 2009). With that being said, Wilkinson and Chilton (2017) state that using positive affect during assessment can help build therapeutic alliance as it can instil hope in our clients. In order to build a safe environment in which the therapeutic alliance can grow, our clients must feel safe (Malin & Pos, 2015; Wilkinson & Chilton, 2017). In order to create a safe environment, we must respond to and address our clients with empathy and compassion (Wilkinson & Chilton, 2017). We must also validate and attend to all our clients' emotions and experiences, both positive and negative (Gelenberg et al., 2010; Wilkinson & Chilton, 2017). Seligman (2006) notes that it is most effective to notice strengths already present within our clients and build on those, rather than trying to teach new interpretations of their negative perceptions. Thus Seligman (2006) offers that the therapist should validate negative perceptions, experiences, and affect, but bring to the forefront strengths and positive behaviours when appropriate. Attuning to clients can help the therapist learn when the client needs validation of whatever they are feeling, or when gently bringing a positive aspect to the forefront will be important (Malin & Pos, 2015).

Maintaining therapeutic alliance. To maintain the therapeutic alliance, empathic response, compassion, validation of experience and emotion, and attunement must all be maintained with our clients. Furthermore, Huffman et al. (2014) show that choosing interventions that are appropriate for where our clients are at in their depressive episode is important to prevent rupture in the working relationship. For example, early in treatment, clients were successful in completing straightforward exercises involving simple strengths or gratitude with positive results. Interventions requiring more complex introspection were too difficult and provoked negative responses; these should not be introduced until the client has more strength (Huffman et al, 2014). Dunn (2012) and Sin and Lyubomirsky (2009) state that a successful

positive treatment should be focused on identifying motivational blocks for each client and working toward removing them. It is important for the positive art therapist to provide encouragement and "promote engagement and willingness to take risks" (Wilkinson & Chilton, p. 74) within the therapeutic relationship.

Practice Considerations for Positive Art Therapists: Building and Maintaining Therapeutic Alliance

As I worked through my findings and discussion sections of this research paper, I extracted the key considerations for positive art therapists who build and maintain the therapeutic alliance with those struggling with major depression. The list of these considerations is as follows:

1. Take time to psycho-educate on PAT: The goal is not to feel perfect 100% of the time, but rather to create a healthy balance.
2. Discuss with the client your approach to therapy, and assess goodness of fit.
3. Practice noticing the strengths of your clients – work these into therapy session.
4. If your client needs to express and experience emotions that they label as negative, stay there, both verbally and artistically, and practice validation and empathy.
5. Educate on labeling emotions as "negative" and "positive" and the consequences of this; offer the possibility that all emotions are valuable information.
6. If the client feels stuck, work together to identify motivation blocks. The therapeutic work may be to remove these blocks.
7. Set small achievable goals.
8. Begin with straightforward positive art therapy exercises (ex: focus on strengths and gratitude).
9. Psycho-educate on how the highs can feel really high, and the lows really low, when coming out of a depression – and find appropriate emotion regulation tools.
10. Involve the family when possible.
11. Keep in mind each client may have their own set point of happiness, which may be lower in clients with chronic depression.
12. Stay attuned with yourself as an art therapist in order to maintain well-being and to be fully present with clients; resonating with your client in the positive moments in therapy may be very important.

13. If the client developed depression after a traumatic experience, support and foster posttraumatic growth (see page 7-9).

Chapter 5. Conclusion

Summary/Future Research/Limitations

This paper reviewed positive psychology and positive art therapy. Within the literature review, the potential of positive interventions for the treatment of depression were explored, as well as the potential challenges and critiques of this treatment approach. With my research question in mind, I set out to find answers on how the therapeutic alliance may be built and maintained between a positive art therapist and a client diagnosed with depression. After analyzing my findings, the research conveyed that the positive art therapy model may work well for building the therapeutic alliance with clients diagnosed with major depression.

The future of positive art therapy for major depression is promising. From this work, and a literature review on interventions used for a major depression, a formal intervention may be constructed: a positive art therapy intervention for major depressive disorder. This intervention could then be tested via a pilot study and further larger applications to determine its effectiveness.

Additionally, case studies focused on a positive art therapy treatment for a client with major depressive disorder would be an important area for research to highlight the therapeutic "dance" between a therapist and client. It would be important to see the work of validating, attuning, and gently motivating our clients simultaneously.

Furthermore, given that this is a model that is best integrated with other models, I would recommend research on motivational interviewing and solution focused therapy to see how they can be integrated and applied to this population. If a treatment for this clientele will focus on the removal of motivation blocks, these may be helpful models to compliment a positive art therapy approach. I also recommend research on mindfulness based art therapy as a complimentary model, as it may help clients access, accept, and process the range of human emotions.

In closing, positive art therapy may prove to be an effective model to use in the treatment of major depression as it can help to restore balance to one's experienced emotions. It may also play an important part in restoring one's relationship with the full array of human emotions, offering the understanding of all emotions as valuable information. This understanding helps prevent the suppression of difficult emotions that can lead to depression. Helping our clients to

access and gain understanding of the emotions that feel uncomfortable or overwhelming, or that our society may label as "negative" plays an important role in guiding them to accessing their authentic happiness. Given this, some positive art therapy sessions with clients diagnosed with depression may not be filled with joy and rays of sunshine, but rather with deep sorrow and storm clouds. Research suggests that walking with our clients through the storm can help them learn from their experiences and emotions, create meaning, and move forward stronger than before. Moving forward with new meanings, strengths, and tools to cope with life's difficult emotions and experiences may allow an individual to feel ready for life and ready to open up to its many pleasures. Even if the path is rocky and difficult to walk, guiding our clients to the point where they are able to access their authentic happiness is the goal of a positive art therapist.

References

Ackerman, S. J. & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1-33. doi: S0272-7358(02)00146-0

Batink, T., Peeters, F., Geschwind, N., van Os, J., & Wichers, M. (2013). How does MBCT for depression work? Studying cognitive and affective mediation pathways. *PLoS ONE 8*(8): e72778. doi: 10.1371/journal.pone.0072778

Bohlmeijer, E. T., Bolier, L., Lamers, S. M. A., & Westerhof, G. J. (2017). Positive clinical interventions: Why are they important and how do they work? *Psychologist Papers, (38)*1, 34-41. http://doi.org/10.23923/pap.psicol2017.2819

Chilton, G. & Wilkinson, R. A. (2016). Positive art therapy. In J. A. Rubin (Ed.), *Approaches to art therapy* (249-267). New York, NY: Routledge.

Coote, H. M. J. & MacLeod, A. K. (2012). Self-help, positive goal-focused intervention to increase well-being in people with depression. *Psychology and Psychotherapy, 19,* 305-315. doi: 10.1002/cpp.1797

Creative Wellbeing Workshops. (n.d). Retrieved from http://creativewellbeingworkshops.com

Csikszentmihalyi, M. (2009). *Flow: The psychology of optimal experience.* Harper Collins e-books.

David, S. (2017). The gift and power of emotional courage [Video file]. Retrieved from https://www.ted.com/talks/susan_david_the_gift_and_power_of_emotional_courage/details?utm_source=tedcomshare&utm_medium=email&utm_campaign=tedspread--b

Diener, R. B. (2008). *Invitation to positive psychology: Research and tools for the professional.* London, England: British Library Cataloguing-in-Publication Data.

Diener, E., Lucas, R. E. & Oishi, S. (2009). Subjective well-being: The science of happiness and life satisfaction. In E. Diener (Ed.), *The Science of Well-Being: The Collected Works of Ed Diener.* Social Indicators Research Series: Springer.

Duckworth, A., Steen, T. A., & Seligman, M. E. P. (2005). Positive psychology in clinical practice. *Annual Review of Clinical Psychology, 1*(1), 629-651. doi: 10.1146/annurev.clinpsy.1.102803.144154

Dunn, B. D. (2012). Helping depressed clients reconnect to positive emotion experience: Current insights and future directions. *Clinical psychology and psychotherapy, 19*, 326-340. doi: 10.1002/cpp.1799

Dunn, B. D. & Roberts, H. (2016). Improving the capacity to treat depression using talking therapies: Setting a positive clinical psychology agenda. In A. M. Wood & J. Johnson (Eds.), *The Wiley Handbook of Positive Clinical Psychology, (1)*, 183-204. Sussex, England: John Wiley & Sons, Ltd.

Farquharson, L. & MacLeod, A. K. (2014). A brief goal-setting and planning intervention to improve well-being for people with psychiatric disorders. *Psychotherapy and Psychosomatics, 83,* 122-124. doi: https://0-doi-org.mercury.concordia.ca/10.1159/000356332

Gelenberg, A. J., Freeman, M. P., Markowitz, J. C., Rosenbaum, J. F., Thase, M. E., Trivedi, M. H., Van Rhoads, R. S. (2010). Formulation and implementation of a treatment plan. In *Practical guideline for the treatment of patients with major depressive disorder (3rd ed.).* Washington, DC: American Psychiatric Association.

Geschwind, N., Nicolson, N. A., Peeters, F., van Os, J., Barge-Schaapveld, D., & Wichers, M. (2011). Early improvement in positive rather than negative emotion predicts remission from depression after pharmacotherapy. *European Neuropsychopharmacology, 21*(2), 241-247. doi: 10.1016/j.euroneuro.2010.11.004

Gilbert, P. (2007). *Psychotherapy and counselling for depression* (3rd ed.). Los Angeles, California: Sage Publications.

Gilbert, P., McEwan, K., Catarino, F., Baiao, R., & Palmeira, L. (2014). Fears of happiness and compassion in relationship with depression, alexithymia, and attachment security in a depressed sample. *British Journal of Clinical Psychology, 53,* 228-244. doi: 10.1111/bjc.12037

Hari, J. (2018). Is everything you think you know about depression wrong? *The guardian.* Retrieved from https://www.theguardian.com/society/2018/jan/07/is-everything-you-think-you-know-about-depression-wrong-johann-hari-lost-connections?CMP=share_btn_fb

Heynen, E., Roest, J., Willemars, G., & van Hooren, S. (2017). Therapeutic alliance is a factor of change in arts therapies and psychomotor therapy with adults who have mental health

problems. *The arts in psychotherapy, 55,* 111-115. doi: http://dx.doi.org/10.1016/j.aip.2017.05.006

Hill, C. (2017). *Helping skills: Facilitating exploration, insight, and action.* Washington, DC: American Psychological Association.

Holmqvist, G., Roxberg, A., Larsson, I., & Lundqvist-Persson, C. (2017). What art therapists consider to be patient's inner change and how it may appear during art therapy. *The arts in psychotherapy, 56,* 45-52. doi: http://dx.doi.org/10.1016/j.aip.2017.07.005

Huffman, J. C., DuBois, C. M., Healy, B. C., Boehm, J. K., Kashdan, T. B., Celano, C. M., Denninger, J. W., & Lyubomirsky, S. (2014). Feasibility and utility of positive psychology exercises for suicidal inpatients. *General hospital psychiatry, 36,* 88-94. doi: http://dx.doi.org/10.1016/j.genhosppsych.2013.10.006

Isis, P. A. (2016). In D. E. Gussak & M. L. Rosal (Eds.), *The Wiley Handbook of Art Therapy,* 90 – 97. West Sussex, UK: John Wiley & Sons, Ltd.

Leavy, P. (2017). Research design: Quantitative, qualitative, mixed methods, arts-based, and community-based participatory research approaches. New York, NY: The Guilford Press.

Kaplan, F. F. (2000). *Art, science, and art therapy: Repainting the picture.* Philadelphia, PA: Jessica Kingsley Publishers.

Keyes, C. L. M. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist, (62)*2, 95-108. doi: 10.1037/0003-066X.62.2.95

Kossak, M. S. (2009) Therapeutic attunement: A transpersonal view of expressive arts therapy. *The arts in psychotherapy, 36,* 13-18. doi: 10.1016/j.aip.2008.09.003

Kushner, S. C., Quilty, L. C., Uliaszek, A. A., McBride, C., & Bagby, R. M. (2016). Therapeutic alliance mediates the association between personality and treatment outcome in patients with major depressive disorder. *Journal of affective disorders,* 201, 137-144. doi: http://dx.doi.org/10.1016/j.jad.2016.05.016

Lomas, T. (2016). Positive art: Artistic expression and appreciation as an exemplary vehicle for flourishing. *American Psychological Association, 20*(2), 171-182. doi: http://dx.doi.org/10.1037/gpr0000073

MacLeod, A. K., Coates, E., & Hetherton, J. (2007). Increasing well-being through teaching goal-setting and planning skills: results of a brief intervention. *Journal of Happiness Studies, 9*(2), 185-196. Doi: *10.1007/s10902-007-9057-2*

Malin, A. J., & Pos, A. E. (2015). The impact of early empathy on alliance building, emotional processing, and outcome during experiential treatment of depression. *Psychotherapy research, 25*(4), 445-459. doi: http://dx.doi.org/10.1080/10503307.2014.901572

Maslow, A. H. (1971). *The farther reaches of human nature.* New York, NY: Penguin Books.

Moody, E. (2018). *Personal communication.*

Nink, M. (2016). *The negative impact of disengaged employees on Germany.* Retrieved from http://news.gallup.com/businessjournal/190445/negative-impact-disengaged-employees-germany.aspx

Parks, A. C. & Titova, L. (2016). Positive psychological interventions: An overview. In A. M. Wood & J. Johnson (Eds.), *The Wiley Handbook of Positive Clinical Psychology, (1),* 3-18. Sussex, England: John Wiley & Sons, Ltd.

Piet, J. & Hougaard, E. (2011). The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis. *Clinical Psychology Review, 31*(6), 1032-1040. doi: https://0-doi-org.mercury.concordia.ca/10.1016/j.cpr.2011.05.002

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, (57)*6, 1069-1081. doi: 0022-3514/89/$00.75

Seligman, M. E. P. (1999). The president's address. *American Psychologist, 54*, 559-562.

Seligman, M. E. P. & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychological Association, (55)*1, 5-14. doi:10.1007/978-94-017-9088-8_18

Seligman, M. (2010). Flourish: Positive psychology and positive interventions. *The Tanner Lectures on Human Values.* The University of Michigan.

Seligman, M. E. P., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist,* 774-778.

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist, (60)*5, 410-421. doi: 1 0.1037/0003-066X.60.5.410

Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of clinical psychology, 65*(5), 467-487. doi: 10.1002/jclp.20593

Swann, W. B., Tafarodi, R. W., & Wenzlaff, R. M. (1992). Depression and the search for negative evauations: more evidence of the role of self-verification strivings. *Journal of abnormal psychology, 10*(2), 314-317. doi: 0021-843X/92/S3.00

Taylor, C. T., Lyubomirsky, S., & Stein, M. B. (2017). Upregulating the positive affect system in anxiety and depression: Outcomes of a positive activity intervention. Retrieved from UC Riverside Previously Published Works. doi: 10.1002/da.22593

Tarnas, R. (1991). *The passion of the western world: Understanding the ideas that have shaped our world view.* London, UK: Pimlico.

Tedeschi, R. G. & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15(*1), 1-18. doi: 10.1207/s15327965pli1501_01

The Mindfulness Institute. (2015). *Mindfulness based stress reduction (MBSR).* Retrieved from http://www.mindfulnessinstitute.ca/mbsr/

Werner-Seidler, A., Banks, R., Dunn, B. D., & Moulds, M. L. (2013). An investigation of the relationship between positive affect regulation and depression. *Behavior Research and Therapy, 51,* 46-56. http://dx.doi.org/10.1016/j.brat.2012.11.001

Wilkinson, R. A. & Chilton, G. (2013). Positive art therapy: Linking positive psychology to art therapy theory, practice, and research. *Journal of the American Art Therapy Association, 30*(1), 4-11. doi: 10.1080/07421656.2013.757513

Wilkinson, R. A. & Chilton, G. (2017). *Positive art therapy: Theory and practice: Integrating positive psychology with art therapy.* New York, NY: Routledge.

Wood, A. & Johnson, J. (Eds.). (2016). In A. M. Wood & J. Johnson (Eds.), *The Wiley Handbook of Positive Clinical Psychology, (1),* 3-18. Sussex, England: John Wiley & Sons, Ltd.

Wood, A. M. & Joseph, S. (2010). The absence of positive psychological (eudemonic) well-being as a risk factor for depression: A ten year cohort study. *Journal of Affective Disorders,* 122, 213-217.

World Health Organization. (2017, February). *Depression.* Retrieved from http://www.who.int/mediacentre/factsheets/fs369/en/

Zilcha-Mano, S., Roose, S. P., Barber, K. P. & Rutherford, B. R. (2015). Therapeutic alliance in antidepressant treatment: Cause or effect of symptomatic levels. *Psychotherapy and Psychosomatics, 84,* 177-182. doi: https://0-doi-org.mercury.concordia.ca/10.1159/000379756