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THE EFFICACY OF ART AND MOVEMENT TREATMENT MODALITIES ON AN INDIVIDUAL WITH AUTISM SPECTRUM DISORDER

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Abstract

Current statistics report 1 in 54 children have been identified with Autism Spectrum Disorder (ASD), many of whom have co-occurring mental health disorders. However, minimal research has been conducted on adults with autism with co-occurring mental health disorders and the efficacy of art and movement therapy techniques. This is the case study by Tristen Valentino, clinical therapist, of a client, David Smith (who was given the pseudonym to maintain confidentiality), a 35-year-old, obese, single, cisgender, heterosexual, Caucasian, male. The implications of this case study are discussed relative to the diagnosis and treatment of adults with ASD who possess comorbid clinical depression and clinical anxiety to assess the efficacy of utilizing the experiential nature of art and movement treatment modalities to effect positive change. David initially sought treatment for unspecified mental health disorders citing depression, anxiety, sensory sensitivity, and potential difficulty differentiating reality from fantasy. His ending diagnoses were Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), and Major Depressive Disorder (MDD). He received psychotherapy treatment from Tristen Valentino 66 times over a 12-month timespan with art and movement treatment modalities being instrumental in creating an experiential therapeutic environment. David responded well to treatment, with inventories in depression and anxiety demonstrating a reduction in both depression and anxiety. He also demonstrated higher levels of functioning and an increased desire to function independently.

Keywords: Autism Spectrum Disorder, comorbidities, art and movement modalities
Introduction

Tristen Valentino is a clinical therapist who works with a wide array of populations ranging from children to adults. He specializes in working with individuals with special needs and their families. He started his education in the Creative Pulse program from the University of Montana in 2017 where he was exposed to creative arts practices and theories, experiencing firsthand the benefits of these practices, which inspired him to further pursue the arts and their cathartic qualities.

Tristen’s curiosity in the benefits of art and movement practices when combined with mental health therapeutic techniques inspired him to incorporate art and movement techniques into his therapy to develop a more holistic approach to mental health and healing. This initial curiosity led him to pursue research into art and movement therapy and their benefits on individuals with Autism Spectrum Disorder. Over the course of his research from Summer 2020 through Spring 2021, Tristen found a significant lack of information regarding the benefits of psychotherapy combined with the creative arts for individuals with Autism Spectrum Disorder, which led him down the path of investigating his own experiential research with a client in order to see what the benefits of incorporating art and movement therapy practices (introduced from his experience in the Creative Pulse) would have for an individual with Autism Spectrum Disorder. Tristen was seeking to observe an increase in holistic healing for his client, as well as increases in motivation toward improving the client’s quality of life, happiness, and overall success, while decreasing symptoms of distress which presented in anxiety, depression, and other disorders from which this client was suffering.

The particular elements set in motion from this journey included incorporating techniques that emphasized healing the mind, body, and spirit; utilizing creative approaches that
incorporated several art forms (such as music, movement, and visual arts); and incorporating the art of writing and martial arts, which Tristen categorized as art and movement practices, respectively. Structural elements included writing in a journal, utilizing preferred music to reduce social anxiety and agoraphobia, utilizing qi gong to decrease stress and increase exercise and physical activity, incorporating finger painting to ignite creativity in a calm and non-intimidating method, and to encourage synergizing mental, physical, and spiritual health within the client.

Traditional mental health therapy typically consists of talk therapy that has a client explore thoughts, feelings, emotions, behaviors, and past experiences through discussion with his or her therapist. However, by incorporating experiential techniques demonstrated in the Creative Pulse, and becoming inspired to further find and create more techniques of a similar fashion as what the Creative Pulse utilizes, Tristen was able to engage in more than talk therapy — he attempted to create a holistic approach to health and healing incorporating the mind, body, and spirit. This paper documents the outcomes his approach to therapy has had with an individual with Autism Spectrum Disorder due to the techniques and methods he incorporated from the Creative Pulse program.
The Therapeutic Potential of Art and Movement Therapy

What is Autism Spectrum Disorder?

Autism Spectrum Disorder (ASD) is a developmental disability which has been identified in 1 in 54 children (CDC, 2020). It is a disorder that affects language, social interaction, and can impair fine and gross motor skills. The DSM-5 (American, 2013) states that ASD is a “…persistent impairment in reciprocal social communication and social interaction (Criterion A), and restricted, repetitive patterns of behavior, interests, or activities (Criterion B). These symptoms are present from early childhood and limit or impair everyday functioning (Criterion C and D).” (p. 53).

What is art therapy?

Art therapy is a fairly recent addition to therapeutic techniques. According to David Edwards (2004), the term art therapy only came into use around the mid-1940s. However, as time has elapsed, it has become more widely utilized and accepted in professional realms of therapy. As support and research for art therapy have continued to grow, a new focus for art therapy to be utilized and studied is with individuals with ASD and comorbid disorders. Research suggests that this particular type of therapy can have a therapeutic benefit for its participants and is efficacious on people diagnosed with various disabilities.

Art therapy has become a term that encapsulates two distinct approaches: art in therapy and art as therapy. Diane Waller discussed the differences in art therapy when writing (as cited in Edwards, 2004), “Subtle though this distinction may at first appear, it is of crucial importance in understanding art therapy as it is practiced today. This is because art therapy has developed along ‘two parallel strands: art as therapy and art psychotherapy’ (Waller, 1993: 8)” (p. 1). Waller further explains (as cited in Edwards, 2004), “The first of these approaches emphasizes
the healing potential of art, whereas the second stresses the importance of the therapeutic relationship established between the art therapist, the client and the artwork” (pp. 1-2).

Within art therapy, there are several mediums that can be selected for utilization with clients. Often, art therapy conjures images of clients participating in the visual two-dimensional arts, such as drawing and painting. However, it can also be used with three-dimensional mediums, such as clay and papier-mâché. While two- and three-dimensional mediums are the more popular themes associated with one’s understanding of art therapy, it has also moved into writing and movement, with forms such as dance and expressive or creative movement.

While the concept of art therapy may have slightly different interpretations from practitioner to practitioner and organization to organization, the boundaries of what it is are more similar among those associated with its practice than they are different.

The American Art Therapy Association (2017) defines art therapy as:

an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship. Art Therapy, facilitated by a professional art therapist, effectively supports personal and relational treatment goals as well as community concerns. Art Therapy is used to improve cognitive and sensory-motor functions, foster self-esteem and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce and resolve conflicts and distress, and advance societal and ecological change. (The Profession section, para. 2-3)

**What are some general benefits of art therapy?**

Art therapy has numerous benefits. It allows individuals to express their thoughts, feelings, and emotions even when they are unable to communicate them clearly in a verbal manner. Often, individuals who suffer from developmental disabilities may lack the words to describe how they are feeling (Valentino, 2016). Art therapy allows them to express themselves in a nonverbal way. This happens with individuals who do not yet have the mastery of
vocabulary and the acquisition of language skills to accurately represent what they wish to convey. As stated by Karen Kaufman (2006), “The social benefits of dance are particularly relevant for individuals with disabilities, who often experience social isolation and loneliness.” (p. 30). Additionally, art therapy can be fun, cathartic, and can help people release their inhibitions to enable them to explore topics and situations in ways they would not be able to explore otherwise with different methods of therapy. Art therapy is also beneficial for those who suffer from intellectual disabilities as it affords them an alternative medium of expression, making it fully inclusive.

Art therapy has been shown to reduce stress in children who have suffered trauma (Pizzaro, 2004), and dance movement therapy has provided evidence to support its efficacy with elderly people suffering from dementia (Karkou & Meekums, 2017). Dance movement therapy has also been shown to increase empathy and psychological healing with children in Sierra Leone who were forced to become child combatants (Harris, 2007). Furthermore, a study on the outcomes of art therapy by Sarah Slayton, Jeanne D’Archer, and Frances Kaplan (2010) found evidence to support that art therapy is efficacious with patients (including children and adults, males and females) suffering from chronic and terminal diseases (Ho, 2005), medical professionals working with oncology patients, children and young adults who were sexually abused, and people diagnosed with mood and personality disorders.

Art therapy has been shown to be effective with a wide array of people, from children to the elderly, persons along the male-female gender spectrum, individuals of various socioeconomic statuses, and people of various races, ethnicities, and cultures. While the preferred mediums may differ from population to population, the basic premise behind art therapy has proven effective across a wide population of clients (Edwards, 2004).
Challenges to art therapy

One of the major challenges to implementing art and movement therapy is the field of psychology’s focus on evidence-based practices and the lack of research surrounding the efficacy of art and movement therapy as an independent orientation. As Slayton, D’Archer, and Kaplan (2010) write:

Within this small body of outcomes studies, several of the complications that historically have been found in art therapy research continue to exist. There is a lack of standardized reporting and utilization of control groups, and a tendency to use anecdotal case material to demonstrate treatment outcomes rather than measured results. Often, poor or only vague descriptions of the treatment interventions are provided, which makes it difficult or impossible to determine the study procedures. Finally, studies that mix interventions prevent an examination of which intervention led to the changes reported. (p. 116)

Additionally, gathering the materials and supplies for art therapy, getting approval for its use, and obtaining the extra funds to utilize it in various settings are all challenges that are faced when employing art therapy as a therapeutic medium. These are some of the issues that may need to be overcome, however it will depend on the level of support and personal stance of the mental health provider wanting to utilize art therapy in different professional environments (such as schools, prisons, and other community mental health agencies).

Approach

In a study regarding outcomes of art therapy by Slayton, D’Archer, and Kaplan (2010), found that there is evidence to support that art therapy is useful with adults with learning and developmental disorders. Additionally, David Gussak (2009) conducted studies on inmates suffering from various mental and cognitive disorders, including depression, loss, mood disorders, personality disorders, and learning and developmental disorders. Gussak (2009) wrote, “These studies demonstrated a marked improvement in mood, behavior, and problem solving” (p. 5). Additionally, he shared that, “Many inmates have an inherent mistrust for verbal
disclosure. Rigid defenses exist for basic survival. Despite these defenses, there has been support for art therapy as a valuable tool” (Gussak, 2007, p. 444). Gussak’s (2009) explanation as to how art therapy helped these populations was that it had been shown to be effective in both male and female inmate populations by increasing positive behaviors and reducing depressive symptoms. As is evidenced by the research indicating the benefits of art and movement therapy for populations who may struggle with learning and developmental disorders, the implications for how art and movement therapy may benefit populations with ASD are promising. The research surrounding the benefits of art and movement therapy with individuals of varying diagnoses, needs, and conditions has inspired a year-long case study to help determine the efficacy of art and movement treatment modalities on an individual with ASD.
Case Study

Background Information

This is the case study of David Smith, (who was given the pseudonym to maintain confidentiality), a 35-year-old, obese, single, cisgender, heterosexual, Caucasian, male who received psychotherapy treatment over a 12-month timespan. He reported being married twice and divorced twice, with five children among his two ex-wives and one ex-girlfriend. He earned a high school diploma and after high school has held numerous unskilled labor positions. However, at the time of initial treatment, David had been unemployed for several years. He reported that he and his youngest child live with his grandmother, with him sharing custody of another child, and receiving visitation on weekends of his other three children. He reported using tobacco daily and alcohol infrequently. He denied using illicit substances since late adolescence, however he did report that he was addicted to benzodiazepine prescription medication in his twenties but has been in recovery for seven years.

David reported mental health issues in his family with his mother, father, and brother being diagnosed with depression. He reported his family of origin as being his father, mother, and three brothers all present during his childhood. He reported that the quality of his relationship with his family is fair. He has five children who he reported the quality of his relationship as being fair. David reported having no friends or close associates. He shared that throughout his life he had always had difficulty relating to others and that it had caused him to not have many social relationships. He initially reported that the distress in his life revolved around his difficulties controlling his mood and his inability to communicate effectively. His goals for therapy were to identify the root cause of his distress and learn coping skills to help him navigate his life’s challenges successfully. David initially did not possess many healthy coping
mechanisms, preferring to avoid uncomfortable situations. David was unable to identify any strengths within himself.

**Case Conceptualization**

David initially reported having depression, anxiety, and anger issues. David reported that his anxiety had escalated to the point where he began refusing to leave his home, which spurred his desire to engage in therapy. He stated that his depression made him isolate and become irritable, placing strain on his few relationships, and causing them to decay. David also reported difficulty in controlling his emotions, expressing that he could not identify them or communicate them appropriately. He shared this caused him great shame and guilt to the extent that he preferred to avoid contact with friends and family.

David originally arrived having reported as being diagnosed with Bipolar Disorder I (BPI), Bipolar Disorder II (BPII), MDD, and an Unspecified Anxiety Disorder with Schizophrenia and Schizoaffective Disorder being possible diagnoses for ruling out. These diagnoses came from previous providers he had seen prior to his services starting with Tristen Valentino. David reported experiencing headaches from stress and expressed that he could feel sounds, and that loud, sharp noises, such as his child crying, caused him to feel pain in his jaw.

David reported that he became overwhelmed by sound easily and found it difficult to navigate his responsibilities or accomplish simple tasks. He reported that when he became overwhelmed, he could not regulate his emotions, and oftentimes became very angry, venting his anger at whoever, or whatever, was present. David was very concerned that he was experiencing psychosis and had a psychotic disorder.

Over the first three sessions, David was given several assessments to help screen for potential diagnoses. David’s screenings indicated that he likely had ASD, depression, and
anxiety. Posttraumatic Stress Disorder (PTSD), psychotic disorders, and intellectual impairments were ruled out.

**Diagnosis**

The primary focus of initial treatment was to build rapport with David and to gather enough clinical data to rule out his reported former diagnoses from his psychiatric history and to create provisional diagnoses. Psychotic disorders, such as schizophrenia and schizoaffective disorder, were ruled out very early on. While David reported experiencing certain sensory events, such as feeling sounds, he was able to differentiate between reality and fantasy. David denied ever experiencing hallucinations, and any distortions of perception were better explained by other conditions.

BPI and BPII were eventually ruled out as David did not experience any manic or hypo-manic episodes during treatment. He also did not report experiencing any manic or hypo-manic episodes throughout his life. His mood and behavioral issues were better explained by other conditions.

David’s provisional diagnoses were ASD and MDD. However, there were many challenges to developing his diagnoses due to his presentation, his reported symptoms, and the comorbidity of his disorders. David was initially very disheveled and unhygienic. He had lost most of his teeth due to poor dental hygiene, would wear clothing soiled with food stains, and would enter into treatment unbathed and carrying an odor. He also wore clothing at first which masked certain symptoms that he did not initially report, such as lesions from his picking behaviors.

His eventual working diagnoses were ASD, MDD, Agoraphobia, Obsessive-Compulsive Disorder (OCD), Excoriation, Social Anxiety Disorder (SAD), and ADHD.
David was screened for ASD with the Autism Spectrum Quotient (AQ). He scored a 41 out of 50, indicating the presence of clinically significant autistic traits. David reported and presented with deficits in social-emotional reciprocity, difficulty identifying and interpreting nonverbal communication, and a history of skill deficits in developing, maintaining, and understanding interpersonal relationship. He also reported and presented with hyperreactivity to auditory sensory input, rigid, black-and-white thinking, and difficulty with transitions.

Differential diagnoses that were explored included Schizophrenia, Schizoaffective Disorder, Neurocognitive Disorder due to a Traumatic Brain Injury, and other Unspecified Intellectual Disorders. Neurocognitive Disorder due to a Traumatic Brain Injury was ruled out due to no history of a traumatic brain injury; and an Unspecified Intellectual Disorder was ruled out due to David scoring within normal ranges on both the Mini Mental Status Exam and the Montreal Cognitive Assessment. David met criteria for ASD according to the DSM-5 and was diagnosed.

David was screened for MDD with the Becks Depression Inventory (BDI). He scored a 35 out of 63, indicating the presence of severe depression. David reported and presented with depressed mood most of the day, nearly every day, diminished interest or pleasure in all activities, significant weight gain, an extended period of insomnia, general fatigue, difficulty thinking and concentrating, and suicidal ideation. He also reported and presented with the desire to isolate himself from friends and family. Differential diagnoses that were explored were BPI and BPII and were eventually ruled out due to no history of hyper-manic or hypo-manic episodes. David met criteria for MDD according to the DSM-5 and was diagnosed.

David was screened for Unspecified Anxiety Disorders with the Burns Anxiety Inventory (BAI). He scored a 46 out of 99, indicating the presence of severe anxiety. David reported and presented with extreme distress when outside of his home in open spaces, being outside of his
home in enclosed spaces, being in a crowd of people, irritability, difficulty concentrating, fear surrounding social situations, excessive worry surrounding being judged by others, recurrent and persistent thoughts and urges, repetitive behaviors, and recurrent skin picking which resulted in skin lesions. He also reported and presented with insomnia and difficulty remembering or recalling information. The differential diagnosis that was explored was General Anxiety Disorder (GAD), which was ruled out due to symptomology being better explained by the comorbidity of other diagnoses. David met criteria for Agoraphobia, SAD, Excoriation, and OCD according to the DSM-5 and was diagnosed.

David was screened for ADHD with the Adult ADHD Self-Report Scale (ASRS-v1.1). Scoring for this assessment was not quantitative, however the qualitative answers were indicative of ADHD traits. David reported and presented with having difficulty giving close attention to detail, making careless mistakes, difficulty sustaining attention, difficulty with following through with activities and projects, difficulty organizing information, frequently lost or misplaced items of importance, psychomotor agitation, and impulsivity. He also reported and presented with difficulty remembering or recalling information. Differential diagnoses that were explored were mainly diagnoses with overlapping symptoms and presentations to determine if they were isolated disorders or if they were comorbid (such as ASD independent of ADHD or if ASD and ADHD were co-occurring). David met criteria for ADHD according to the DSM-5 and was diagnosed.

The Intervention

**Sessions 1-4.** David was experiencing significant distress from his disorders and was becoming increasingly isolated from the world, which was exacerbating his symptoms. The primary focus of therapy for the first four weeks was to stabilize David’s emotional crisis, then
establish rapport, helping David feel safe and secure in the therapeutic environment, and to provide psychoeducation to David on what therapy was and what to expect from the therapeutic process. Concurrent to educating David and developing rapport was assessing, screening, and developing provisional diagnoses to establish a treatment plan. Once stabilization, education, rapport, and evaluation were established, a treatment plan was created which focused on the most debilitating disorder first, his agoraphobia.

**Sessions 5-10.** David’s interventions for his agoraphobia began on the fifth session and were implemented until the tenth session. These involved skill introduction and development to help him explore, identify, and express his thoughts, feelings, and behaviors appropriately. He was introduced to and participated in reducing his breathing rate by utilizing 3x3 breathing exercises (inhale for three seconds, hold for three seconds, exhale for three seconds, pause for three seconds, then repeat three times or more as needed). He was also encouraged to bring his senses into the present by utilizing the 54321 Technique (five things that can be seen, four things that can be felt, three things that can be heard, two things that can be smelled, and one thing that can be tasted). Additionally, he was taught to employ a body scan exercise to help him develop awareness of physiological responses and deliberately reduce or remove tension or stress in the body by utilizing coping skills such as the 3x3 breathing exercise and the 54321 Technique.

The purpose of these exercises was to help David become more focused on what his mind, body, and spirit were experiencing in the moment, and to become more mindful of his present. David would frequently catastrophize events that could occur outside of his home and would become focused on a potential negative future outcome that prevented him from experiencing the present. Once David developed proficiency with those three exercises as independent exercises, he was then encouraged to combine all three to achieve a meditative
process that included positive visualization (David visualized himself achieving a desired goal with a desirable outcome). Meditation was introduced to help David learn and practice how to accept his thoughts without letting those thoughts distract from his purpose. After David became proficient in meditation, he was then introduced to Qi Gong as a therapeutic movement technique where he added physical movement to his breathing exercise, grounding exercise, and body scanning. This added another layer of complexity to help him harmonize his mind, body, and spirit connection while also introducing the arts into his therapy. He was directed to initiate these interventions, individually or collectively, whenever he felt anxious or stressed, and for when he did not feel anxious or stressed but anticipated an event or experience that may cause anxiety or stress.

He also began to engage in a blending of exposure therapy and movement therapy techniques. These techniques began with David leaving his house and concluded with him driving to Walmart, selecting a bandanna, and purchasing the bandanna from a human cashier before driving home. The intervention utilized progressively challenging exposure to the feared stimuli (outside) for increased durations, frequencies, and intensities. David kept a journal recording his anxiety before, during, and after the intervention to determine efficacy of the intervention.

David’s first stage of the intervention was to exit his home, walk to and around his grandmother’s car, and then walk back inside. He was instructed to do this three times per day for the first week of his intervention. The second stage of intervention was for him to exit his home, walk to his grandmother’s car, drive to Walmart, park in the parking lot for five minutes, then return home. Due to the intense distress David suffered during this stage, music was added while he was in the vehicle (car radio) to help relax him while he practiced his meditation. The
third stage of the intervention was for David to exit his home, walk to his grandmother’s car, drive to Walmart, park in the parking lot for five minutes, get out of the car, and walk five laps around the vehicle, then return home. David again reported increased distress during this stage, so music was added while he was in the vehicle, during his walk (ear buds) to help him relax while he practiced his meditation, and while walking his five laps around his vehicle. The fourth stage of the intervention was for David to exit his home, walk to his grandmother’s car, drive to Walmart, park in the parking lot for five minutes, get out of the car, walk five laps around the vehicle, walk into the southern entrance of Walmart, walk out the northern entrance, then return home. The fifth stage of the intervention was for David to exit his home, walk to his grandmother’s car, drive to Walmart, park in the parking lot for five minutes, get out of the car, walk five laps around the vehicle, walk into the southern entrance of Walmart, walk five laps around Walmart, walk out the northern entrance, then return home. From the fifth stage on, David wore one ear bud playing music while inside Walmart.

The sixth stage of the intervention was for David to exit his home, walk to his grandmother’s car, drive to Walmart, park in the parking lot for five minutes, get out of the car, walk five laps around the vehicle, walk into the southern entrance of Walmart, walk five laps around Walmart, select an item to purchase, check the item out at the self-checkout area, walk out the northern entrance, then return home. The seventh, and final, stage of the intervention was for David to exit his home, walk to his grandmother’s car, drive to Walmart, park in the parking lot for five minutes, get out of the car, walk five laps around the vehicle, walk into the southern entrance of Walmart, walk five laps around Walmart, select an item to purchase, check the item out at a register with a human cashier, walk out the northern entrance, then return home. His graduation from this intervention was measured by his purchase of a red bandana and skin lotion.
(which he had to ask for help finding) to assist him in the next set of interventions to address his excoriation. David worked on these interventions for six weeks (sessions five through ten) and recorded his levels of anxiety throughout. At the end of the intervention, Agoraphobia was discharged from David’s diagnosis list.

**Sessions 11-13.** Beginning on session eleven, the focus of David’s treatment revolved around addressing his excoriation. David had a habit of picking his scalp when he became nervous and would not stop, even after he was bleeding. As a byproduct of his earlier intervention work for his Agoraphobia, his excoriation had reduced in frequency and intensity over the six weeks of intervention. However, his symptoms were still present. The first step was for David to cut his fingernails, shave his head with hair clippers, then shave the remaining stubble with a razor blade to reveal the lesions on his scalp. David had long, unkempt, and matted hair prior to therapy and had stated he had never seen his scalp nor the lesions he had inflicted upon himself. This served as a visual deterrent to his picking behaviors. The second step was for David to apply the skin lotion to his scalp and then wear the bandana. This would allow David to continue to feel his scalp as needed without damaging it any further and allowing for his damaged skin to heal. The third step was to introduce a replacement behavior; instead of picking at his scalp when he was anxious, he was to run his fingers across his head over the bandana and massage the lotion into his scalp while doing so. He was also expected to continue practicing his meditative routines and Qi Gong to help prevent and reduce stress. Throughout this process, he was expected to keep a journal to record his progress. David worked on these interventions for three weeks (sessions eleven through thirteen). Due to the likely residual effects of the interventions for agoraphobia being beneficial to his treatment of excoriation,
David’s picking behaviors extinguished. At the end of the intervention, excoriation was discharged from David’s diagnosis list.

**Sessions 14-21.** Beginning from session fourteen, the focus of David’s treatment was to address, diagnose, and treat his depression. After David’s agoraphobia and excoriation were discharged, he expressed that his depression caused him the most distress. Due to the interventions utilized for agoraphobia and excoriation, David reported his depression had reduced in intensity, indicating that the prior interventions had some effect on his depression.

Since the prior interventions had appeared to reduce the levels of intensity in David’s depression, and because he reported enjoying and feeling comforted by those interventions, the decision was made to continue to scaffold interventions that developed skills to overcome David’s deficits in order to address his depression. He was encouraged to add onto his journaling by including another facet of keeping a feelings journal where he wrote down how he was feeling, without censorship. He would then use his writings as a tool to help develop awareness and insight into his thoughts, feelings, and needs by returning to his writings and reading them at a later time. In addition, he participated in the creation of a new life routine which revolved around diet, exercise, sleep, and sun (DESS).

Diet was defined as anything David consumed (such as food and drink, media, and relationships). Exercise was defined in three categories of two parts each: mental, physical, and spiritual (mind, body, and spirit). The mental category included mental activity (such as engaging in conversation and communication with others) and mental exercises (such as practicing meditation). The physical category included physical activity (such as walking or exerting oneself during activities) and physical exercise (such as resistance training, Qi Gong, and walking with the intention of exercising). The spiritual category included spiritual activity
(such as sitting in nature and listening to music) and spiritual exercise (such as meditation and creative writing). Sleep was defined as sleep hygiene and included other hygiene areas (such as making sure that he created an environment conducive to restful sleep, that he practiced proper dental and physical hygiene by brushing his teeth, showering, dressing in clean clothing, etc.). Sun was defined as exposing himself to direct sunlight.

The diet portion of the DESS intervention was composed of adjusting his meals, drinks, tobacco, technology, and relationships. For his meals, David was encouraged to adjust his food intake to six times per day, spread out every two to three hours. For example, he would have breakfast (7am), snack (10am), lunch (12pm), snack (2pm), dinner (5pm), and a snack (7pm). He was also encouraged to drink a minimum of eight 8 oz glasses of water each day and remove soda and energy drinks from his consumption. The only non-water beverage he was permitted to drink was coffee (caffeinated and decaffeinated), which he could drink caffeinated coffee until 11 am and then was permitted to drink decaffeinated coffee until 4 pm. David began the intervention smoking six cigarillos a day and chewing tobacco five times per day. He began to reduce his tobacco intake by switching from cigarillos to cigarettes, then by reducing his chewing of tobacco, and ultimately quitting his chewing tobacco use. During this phase of treatment, he was also encouraged to switch his leisure habits from aimlessly surfing social media to researching items that stimulated his imagination, creativity, and interest (such as reading about autism, playing crossword puzzles, and learning how to play the piano). He was also encouraged to seek out healthy interactions and relationships, such as reaching out and reconnecting with his brothers and accepting invitations from his friends to join them during fun activities.
The exercise portion of the DESS intervention addressed the three categories of mental, physical, and spiritual exercise with a purpose of adjusting his current isolated and sedentary lifestyle into one that incorporated more engagement and movement. He progressively increased his time pursuing active events through replacement behaviors that were designed to be more engaging to him and stimulate his mental, physical, and spiritual range.

David was very closed off from social interactions with his mental stimulation coming in the form of television and social media. For the mental exercise section, David was encouraged to reduce his time spent on passive mental stimulation (such as television and social media) and to pursue more engaging activities that would evoke thought and emotion (such as initiating conversations with friends and family, reading books or magazine articles of interest, starting a blog about living with autism as an adult, and learning how to play the piano). These activities helped with transitioning David’s passive mental state into one which actively pursued more engaging activities evoking thought, creativity, and emotion exploration.

For the physical exercise section, David developed a physical exercise routine. On Mondays, Wednesdays, and Fridays he would engage in resistance training for 30 minutes per day, which included compound and isolated muscle group movements. On Tuesdays and Thursdays, he was expected to practice his Qi Gong movements for 30 minutes. This brought his physical exercise up to 30 minutes per day, five days per week. He was also tasked with increasing his physical activity by walking to the park with his children rather than driving them, playing basketball with them rather than watching them, and helping clean in and out of the house.

For the spiritual exercise section, David developed a routine where he would engage in activities that moved him on a spiritual and emotional level. This included continuing to engage
in meditation each day and keeping a feelings journal where he could explore and express his spiritual and emotional awakenings to help develop insight and awareness. For the spiritual activities, he was encouraged to seek out opportunities to immerse himself in nature, listen to music, and practice playing the piano.

For the sleep and hygiene portion of the intervention, David was encouraged to attempt gaining eight hours of restful sleep per night, showering or bathing each day, brushing his tongue twice per day, maintaining his dentures, grooming himself each day, and wearing clean clothes each day. David initially reported sleeping for less than four hours each night, showering or bathing once per week, rarely brushing his teeth (resulting in the loss of his teeth and the need for dentures), and grooming himself and changing clothes only when his grandmother would force him. To address his sleep hygiene, he was encouraged to create an environment conducive to restful sleep, which included the reduction of caffeine from his diet portion, the increase in mental, physical, and spiritual activity from his exercise portion, the removal of himself from technology 30 minutes before he planned to go to sleep, and the utilization of a sound machine or music to help him relax. To address his other areas of hygiene, they were paired together and developed into a routine where he would wake, shower, brush, groom himself, then change into a fresh set of clothing for the day. He was encouraged to take quick showers after each time he exercised and change into a fresh set of clothing. At night he would brush and clean his dentures before he fell asleep.

For the sun portion of the intervention, David was tasked with spending 30 minutes outside, in the sun, at least three times per week. David had initially spent the last several months mostly confined to his home due to his agoraphobia and rarely had experienced direct sunlight. This had served to exacerbate his agoraphobia, and also worsen his depression as he
had removed himself from the outside world and all the positive experiences and social
interactions that can occur.

During the eight weeks of this intervention phase, David recorded his progress through
his journal and his progress was debriefed during sessions. His beginning weight was 293
pounds and after eight weeks of his routine he had dropped to 278 pounds. His initial tobacco
use was six cigarillos, and five chewing tobacco uses per day, and his ending tobacco use was
five cigarettes per day. His initial reported average depression-happiness score was a 3 (with a 0
indicating suicidal ideation and 10 indicating bliss) and his ending depression-happiness score
was a 6. He became open to accepting invitations to socialize with his family at gatherings and
accepted two social invitations from friends, one to play darts at a bar, and another to attend a
bonfire. David worked on these interventions for eight weeks (sessions fourteen through twenty-
one). Due to the scaffolding of the interventions for agoraphobia and excoriation in combination
with the DESS interventions, David’s depression went into full remission. At the end of the
intervention, MDD was discharged from David’s diagnosis list.

An unintended effect from this stage of intervention is that David’s social anxiety was
greatly reduced. His initial reported average anxiety score was a 7 (with a 0 indicating no
anxiety and 10 indicating extreme anxiety) and his ending anxiety score was a 4. He developed
greater confidence and comfort interacting and socializing in different settings to the point where
he began to initiate interactions with others. At the end of the intervention, SAD was also
discharged from David’s diagnosis list.

**Sessions 22-48.** Beginning from session twenty-two, the focus of David’s treatment was
to treat his OCD. Over the years, David’s maladaptive behaviors had manifested in him
becoming more rigid and ritualistic in his thought patterns and behaviors. He reported that when
he was distressed, he would send continuous text messages to a recipient for hours, even when he wanted to stop. He also expressed having intrusive thoughts that prevented him from engaging in preferred activities, such as conversation and sleep. David reported that stress exacerbated his OCD behaviors and that the skills and tools he had learned to date had helped alleviate some of the stress and reduce the intensity, frequency, and duration of the OCD events. However, he expressed that they were still present and caused him great distress, impairing him from living the life he wished to live.

Due to the severity of his presentation of OCD, it was agreed that David would attend therapy twice per week during this intervention stage. David’s experience with the previous interventions had given him skills and tools he had developed, which had created confidence in him that he could effect change upon his life. However, his obsessive thoughts and compulsive behaviors continued to frustrate his progress.

David had an intellectual awareness of his behaviors and he was also aware that they were maladaptive. He had developed his emotional awareness to the point where he understood that his behaviors were oftentimes manifestations of unexpressed emotions. Yet, even with insight into his thoughts and feelings, David still demonstrated difficulty in adjusting his behaviors.

All previous interventions were maintained during this intervention phase and journaling was further emphasized for this stage of David’s intervention. In addition to the existing intervention, the therapeutic technique known as the paradoxical technique was applied to David’s interventions as a direct attachment to his journaling interventions. The paradoxical technique is a technique where the individual is directed to not only continue to express maladaptive behaviors, but to increase them. The purpose is to represent to the individual that
they have power and control over the behavior and can effect change. However, this technique and its purpose was not explicitly expressed to David during the initial application.

David’s paradoxical technique intervention began with encouraging him to journal all his thoughts and feelings each day. He was encouraged to focus his attention on the moment and create a narrative of his life written in the present tense, “I am feeling frustrated because I am not able to drive a car.” Much of his intrusive and obsessive thoughts were future based “what ifs” and a difficulty in addressing them was that he could neither prove nor disprove a future positive thought or negative thought.

David was also encouraged to apply a replacement behavior toward his compulsion to text. Instead of writing his clarifications via text, he was invited to write them in his journal. Additionally, he was urged to use I statements such as, “I feel sad when I am not understood” rather than continue to text to make himself understood.

David was directed to sort his journaling activities into separate journals so that he could keep relevant information together. During this stage of his interventions, he became overwhelmed with keeping all the information in one journal, so he decided to organize the information he wished to record into five journals; a thoughts and feelings journal, activity/exercise journal, food/drink/tobacco journal, text-to-journal journal, and a daily planner where he tracked his chores, responsibilities, and his daily levels of depression and anxiety.

David was required to bring all his journals each session and debrief on each of his entries in each journal. He was continually encouraged to increase his writings in each journal with feedback focused in areas where he could apply interventions into his journal writings. During the course of this phase of intervention, David’s writings increased until he began to experience distress from attempting to maintain all of the information required to input in each
journal. He expressed his desire to reduce his writing and it was agreed that he would reduce his writings, eventually culminating with David reducing to two journals: a feelings journal and a diet/exercise journal.

The key focus for this intervention was to develop in David his awareness of his ability to change these behaviors. Initially, his intrusive and obsessive thoughts at night distressed him to the point where he could not sleep. However, after he was encouraged to write about those intrusive and obsessive thoughts until they ceased disrupting his sleep, he discovered that the writing became more distressful. With the alleviation of the writing, he then found that he was able to stay more focused in the present by identifying his thoughts and feelings, and then letting them pass as his threshold for stress had been expanded to the point where those thoughts and feelings were no longer as distressing as they had been previously.

He also developed an understanding of writing in a journal instead of texting and how time consuming it was. He found that during certain times he would spend hours writing in his journal attempting to clarify a perceived miscommunication, only to discover that after hours of writing he had missed out on what he preferred to do, such as spend time with his friends, family, and children. In comparison, his desire to seek clarification became less important to spending time doing what he wanted to do.

Due to the scaffolding of the interventions from previous phases and the increased journaling paired with the paradoxical technique, David no longer met criteria for OCD. At the end of the intervention, OCD was discharged from David’s diagnosis list.

**Sessions 49-66.** During this stage in David’s treatment, the focus was to continue to provide support and guidance into David’s new life routine to help it become established into his reflexive life. He had been continuously evolving throughout his treatment and this was the first
time he had been able to achieve a maintenance mindset, where he is working toward consolidating what he has learned, versus continuing to consume new information.

David was encouraged to continue practicing the skills and tools he had learned in treatment up to this point to further cement his progress. His adherence and application to his activities for self-care, exercise, and coping skills increased. He also reported an increase in his overall confidence in his ability to identify his emotional state and administer appropriate coping skills. Furthermore, he reported an overall reduction in obsessive and compulsive thoughts and behaviors.

At session fifty, David experienced a temporary regression in treatment. He had experienced a major interpersonal conflict that reactivated his symptoms of SAD and excoriation. He also demonstrated a partial reemergence of his MDD. His coping skills became the focus of his treatment and reviewing and practicing what he had already learned. Art and movement interventions were utilized in session to help David remain grounded in his routine. He practiced Qi Gong, meditation, value sorts, finger painting, journaling, and expressive movement to help him develop awareness into his emotional state, regulate that emotional state, then communicate appropriately the emotional state. This regression lasted until session fifty-eight when his symptoms abated once more.

The regression served as a tempering of David’s mind, body, and spirit, and he emerged more confident and capable of exploring, identifying, and expressing his thoughts, feelings, and needs. He was able to integrate the coping skills and interventions of his life routine into his daily life quickly and smoothly. The progress he made from his treatment plan goals exemplified the successes he had achieved throughout his treatment, culminating in David living a healthier and happier lifestyle. David exited session sixty-six carrying the diagnoses of ASD
and ADHD, with his MDD in full remission. As a result, David’s treatment was stepped down to one session per week.

**Conclusion**

Integrating art, in any setting, can have a positive impact on those engaging in it. Integrating art and movement into therapeutic practices can work particularly well with individuals who struggle to conceptualize and verbalize their distress and experiences. This presents clinicians and their clients an additional tool to help explore the process of therapy together, and helps the clinicians build a shared reality with their clients as art and movement therapy may allow for a free exchange of information in a medium more comfortable for the client than the spoken word.

In this way, the Creative Pulse has driven not only the pursuit of this research, but the application of art and movement in practice. Many of the interventions utilized in David’s case study were activities demonstrated during courses from the Creative Pulse, such as Personal Performance, Body as Teacher, Art and Insanity, Journaling, Yoga, and connecting the mind and body together for overall intrapersonal improvement and success. The impact of the arts can be seen in David’s progress through treatment with the combination of therapeutic interventions in combination with the arts. As David’s proficiency in his interventions increased, so too did his confidence in his ability to express power and control over his mind, body, and spirit. Through his efforts, David was increasing his experiences outside of his home until he no longer felt anxiety when doing mundane activities (such as getting gas or buying groceries). He became more confident in his ability to communicate after learning tools and skills to help him explore, identify, and express his thoughts, feelings, and needs in various ways.
This also demonstrates that not only are the activities the Creative Pulse teaches beneficial for the client, but also demonstrates how these teachings can be beneficial to the clinician. This journey has evolved Tristen Valentino’s therapeutic approach where the arts are integrated into his practice. He utilizes art and movement therapy treatment modalities to help create more comprehensive, holistic, and engaging interventions for client and clinician. Through the learning and use of the interventions, and through the shift in perception of what qualifies as communication, this allowed him to not only be an outside observer to his client’s treatment, but an active participant sharing in the evolution of a new perception of a shared reality. It is in this way that the efficacy of art and movement treatment modalities have been shown to benefit an individual with ASD, and helped to support alternate forms of communication, increased participation and commitment levels in treatment, and instill life changing practices that will continue to benefit this client throughout his future.
Bibliography


Annotated Bibliography


The American Art Therapy Association is a non-profit organization dedicated to the education and growth of the professionals and profession of art therapy. This section of the AATA website details their vision for the definition of art therapy.


This is a diagnostic manual cataloging psychiatric disorders, their description, criteria to achieve the diagnosis, and differential diagnoses.


This is a diagnostic tool utilized to screen for Autism Spectrum Disorder.


This is a diagnostic tool utilized to screen for clinical depression.


This is a book written by David D. Burns regarding his treatment for depression. In the book is a diagnostic tool utilized to screen for pathological anxiety, which is used by clinicians to aid in identifying signs for anxiety within patients.


The Center for Disease Control and Prevention is a government-run, national health agency. This section of the CDC website details the rates of Autism Spectrum Disorder in children.

In this article, Edwards discusses the burgeoning identity of art therapy as a clinical approach. He further discusses the evolution of art therapy and its philosophical approaches.


Gussak details the results of his work creating an art therapy pilot study in a corrections environment and the influence on participant depression scores. He discusses the challenges to art therapy in general and with the inmate population specifically. He concludes that his art therapy pilot program had measurable improvement on participant levels of reported depression.


This article is a detail of a follow up study Gussak does to develop more research for his 2006 pilot study of the effects of art therapy on depression in prison populations. In this study, Gussak seeks to expand his measurement of influence of art therapy to include depression, locus of control, and behaviors in both male and female inmates.


In this article, Harris details his work to restore empathy through dance movement therapy to adolescent males who were formerly child combatants in the war in Sierra Leone. His work centers around healing the participants who experienced being both the victim and perpetrator of violence during the war. He demonstrates that the participants experienced a reduction in aggression, depression, anxiety, and intrusive recollections as a result of treatment.


This article details a pilot study by Ho and demonstrates how dance movement therapy influenced the cancer treatment and recovery of Chinese cancer patients. In this study, Ho discusses the importance of a holistic approach to health and how treating the mind, body, and spirit produced reported results of increased ability to take pleasure in their bodies, increased ability to express their feelings and emotions, increased self-esteem, and decreased stress in the patients.

This is a protocol developed by Karkou and Meekums to evaluate what effects dance movement therapy has on patients with dementia. They researched numerous studies to create a protocol to measure the influence dance movement therapy would have on patients diagnosed with dementia in the realms of behavioral, cognitive, emotional, and social health in comparison with patients who did not receive treatment.


This book details inclusive practices for teachers to use in the classroom by incorporating creative movement and dance. The purpose is to promote inclusivity among students of all ability levels all enable them to express their thoughts, feelings, and needs through creative movement and dance techniques.


This is a diagnostic tool utilized to screen for attention-deficit hyperactivity disorder.


In this article, Pizzaro discusses the benefits of art and writing therapy with patients who have experienced trauma. She asserts that writing therapy helps relieve social dysfunction and that art therapy can help retain client involvement, thereby allowing for the reduction of traumatic stress.


This article discusses the efficacy of art therapy as an isolated therapeutic modality. In it, Slayton, D’Archer, and Kaplan detail the results of their meta-analysis where art therapy was the focused intervention and explain the challenges of research into art therapy.

This paper details the benefits of art therapy in a school environment with children with special needs. In it, Valentino discusses utilizing interventions of visual art, music, dance, and creative movement to help improve the children’s behaviors, social-emotional skills, and cognitive abilities through the creation of a mural to teach a history lesson.