St. Stephen's College

Single-Session Art Therapy as Mind-Body Medicine: A Systematic Review of Treating Emotional Crisis in Time-Limited Psychotherapy

by

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Abstract

This research study presented and elaborated on the published materials, in recognized search aggregators, OVID and EBSCO, regarding the topic of emotional crisis in brief and short-term psychotherapy, single-session therapy, and art therapy literature. An emotional crisis is an unexpected and sudden moment when someone experiences a temporary loss of mind-body connectivity as a measure to ensure immediate survival, which is threatened by an unresolved and repressed psychological conflict reactivating in their psychosocial environment. A research synthesis was conducted to systematically generate a list of the published content. The researcher evaluated, deconstructed, and analyzed the findings to present a general overview; then composed single-session art therapy, a mind-body treatment modality with a spiritual perspective, that places individuals as the focus of the clinical encounter. Although most of the published content was outdated and primarily focused on describing and detailing the clinical event of an emotional crisis, the researcher consequently provided a contemporary, in-depth account with influential psychotherapeutic, theological, and medical concepts. The result is a single-session art therapy modality that can restore a person's embodied connection, which leads to an adaptive and authentic resolution of a repressed psychological conflict. Future research will further study how art therapy encourages and facilitates an individual's creative abilities and potential to resolve psychological conflicts, and prevent future, similar emotional crises from occurring.

Key words: art therapy, brief psychotherapy, creative process, emotional crisis, imagination, mind-body therapy, poiesis, Self, short-term psychotherapy, single-session therapy, spiritual development, stress, time-limited psychotherapy

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Glossary of Terms

Active Imagination: A psychodynamic method that directly focuses on the individual (Jung).

Addictive Process, The: The individual's repression of their painful moments and feelings into the unconscious that developed into compensatory cognitions and behaviour (Keating).

Allostasis: The physiological process that restores homeostasis when the individual's body responds to internal and external stressors (Fricchione).

Allostatic Load: The acute or chronic accumulation of stress that affects the individual's metabolism at the cellular level (Frichionne).

Anxiety: A state that is produced when an individual expects or prepares for a danger or a threat (Freud).

Anxiety-Provoking Psychotherapy: A psychotherapeutic approach that focuses on the individual's anxiety (Sifneos).

Anxiety-Suppressive Psychotherapy: A psychotherapeutic approach that focuses on the individual's symptom relief from anxiety (Sifneos).

Archetypal Imagery: An unconscious sign or message within an individual (Corbett and Stein).

Archetypal Separation Anxiety: The individual's anticipation of the pain about a personal loss (Fricchione).

Archetypes: Universal patterns and images that convey an individual's inherited potentials that become actualized through images or behaviour (Jung).

Art as Therapy: A methodological approach that focuses on the individual's creative process (Kramer).

Art Psychotherapy: A methodological approach that explores and focuses on the individual's thoughts and feelings regarding a particular issue (Naumburg).

Art Therapy: The use of imagery where color and shapes are utilized to promote the individual's thoughts and feelings within the psychotherapeutic context and the creative process (Canadian Art Therapy Association).

Art: The application or expression of an individual's creativity and imagination.

Art-making: The behavioural act of creating art.

Authenticity: The individual's commitment to remain true to their being and becoming (Helminiak).

Awareness: An individual's relationship to an object (Helminiak).

Brief Psychotherapy: A mutually agreed upon number of sessions, commonly six to twenty sessions, or a pre-determined termination date between the therapist and client. Short-term and single-session therapies fall under this umbrella term.

Central Nervous System: Part of the nervous system that comprises of the brain and spinal cord that controls most physiological functions in the body**.**

Cognitive Reflexivity: The ability to subjectively reflect on an experience (Helminiak).

Complexes: Repressed emotional themes that cause a psychological conflict (Jung).

Conscious: An individual's subjective self-presence that does not objectify them (Helminiak).

Consciousness: An individual's reality that is not bound by linear space and chronological time (Helminiak).

Defense Mechanisms: The individual's automatic reaction to their psychosocial environment or relationships (Freud).

Decisive Encounter: An individual's stage of development when they autonomously exert their psychical energy towards growth and personality development (Erickson).

Disequilibrium: A loss of stability or equilibrium; also referred to as instability.

Distinctions: An individual's insight and qualitative judgement about an experience that is true to them (Helminiak).

Ego: The individual's management, decision-making, and unique personality attributes (Freud).

Emotional Crisis: An acute psychological upset that disrupts an individual's state of external and internal equilibrium, and triggers a painful state of being for the person (Caplan, Sifneos).

Enduring Attachment: An individual's lived experience and personal understanding towards objects or figures; otherwise known as object-relations (Bowlby).

False Self: An individual's entrenched way of being that maintains relationships by anticipating the demands of others, and following the external rules of the environment (Winnicott).

Feelings: An individual's embodied wisdom about themselves that involve a bodily sensation (O'Connell Killen and de Beer).

Focal Conflict: A psychological issue that is an individual's pre-conscious derivative of a nuclear conflict (Bloom).

Focused Single-Session Therapy: A specialization of single-session therapy that is influenced by psychodynamic theory. It was developed by the American psychologist, Bernard Bloom.

Four-Stage Creative Process in Brief Psychotherapy, The: A psychotherapeutic model developed by psychologists Ernest Rossi, Jane Mortimer, and Kathryn Rossi.

Healthy False Self: When the individual complies with their psychosocial environment to attain their needs and wants, but does not feel forced to comply (Winnicott).

Homeostasis: The physiological function to sustain life by maintaining overall stability and functioning.

Homeostatic Balance: An individual's frame of reference of how to restore their psychological homeostasis when a change in their psychosocial environment causes instability.

Homeostatic Mechanisms: An individual's internal adjustments to address a change in their psychosocial environment (Baldwin).

Id: The individual's childhood needs and wishes (Freud).

Imagery: The individual's figurative and descriptive language that represents their lived experience, and enduring attachments.

Imagination: The individual's ability to be adaptive, creative, and resourceful towards understanding and manifesting their meaningful reality.

Insight: An individual's spiritual act towards understanding an experience (Helminiak).

Mentalization: The belief that **s**ocial proximity and interaction is the most powerful approach for the individual's affect regulation that involves the brain's neurological processes (Springham).

Mind-Body Intervention: A clinical practice that supports the individual's connection between their mind and body to restore overall mental and bodily functioning.

Motivation: The individual's reason to act or behave in a circumstance or situation.

Movement towards insight: When an individual enters their experience to encounter feelings, and then acknowledges those feelings (O'Connell Killen and de Beer).

Nervous System, The: Integral for the individual's overall functioning, because it regulates cognition, homeostasis, the endocrine and immune systems, and the muscle fibers/cells surrounded by connective tissue.

Nuclear Conflict: An individual's repressed psychological issue that originates from an earlier developmental period in their life (Bloom).

Oxidative Stress: The cellular level of metabolic activation that produces free radicals, heart shock, and protein gene expression in an individual's body (Frichionne).

Peripheral Nervous System: Part of the nervous system that produces the individual's involuntary and voluntary responses to the environment.

Pleasure Principle: Involves an individual's unconscious psychic processes that either directs them towards pleasure or withdrawal from an experience that might cause pain (Freud).

Poiesis: A creative act that serves as an affirmation of the power of art to transform life, and gives speech to the Self (Levine).

Precipitating Factor: An internal or external change in the individual's psychosocial environment. It is also referred to as the emotionally hazardous situation or stress event.

Pre-conscious: The transition stage between the conscious and unconscious, information in which is capable of becoming conscious if the person does not censor or avoid their unconscious content (Freud).

Psyche: The substrate of the individual's spirit that can support or constrain movement towards their Self.

Psychological Conflict: The individual's internal and external tension between themselves and their psychosocial environment that reflects what is fantasy and what is real (Freud).

Reality Principle: An individual's psychic process where they decided to act upon their pleasure principle in a socially-accepted manner even if they did not agree to the circumstances (Freud).

Relaxation Response: An individual's physiological state when there is a decrease in their bodily and mental stress.

Repression: The conscious act of avoiding or keeping something away (Freud).

Resiliency: The ability to thrive from an adverse life event or psychosocial stressor.

Schema: A person's belief system about themselves (Solomon).

Self: The archetype of unity that is an individualization process towards re-birth and wholeness (Chodorow).

Self-confidence: The individual's positive evaluation about their capabilities and potential to resolve problems (Beck).

Separation: A physical act that causes an individual to experience a loss of sensation, perception, and awareness (Helminiak).

Single-Session Art Therapy (SSAT): It is a mutually-agreed upon decisive encounter that the individual initiates with a focused goal and outcome with the therapist. The therapist uses a mentalization approach that encourages the individual's mind-body connectivity with art therapy tasks that facilitate and promote their embodied connection for adaptive, authentic, and healthy resolution of a psychological conflict.

Single-Session Therapy (SST): A sub-specialty of brief psychotherapy that is mutually considered as an intentional single session by the client and therapist (Hoyt & Talmon).

Spirit: The individual's dynamic and conscious movement towards being (Helminiak).

Spiritual Development: The individual's spirit that moves in an authentic self-transcendence of being in a normative and constitutive process that is parallel to their psychological development (Helminiak).

State of Adaptedness: When the individual's bodily and mental processes adjust to their altered environment (Bowlby).

Stress: A separation challenge that involves allostatic threats (environmental and/or psychosocial) that may increase an individual's allostatic loading (Frichionne).

Superego: The person's internalized view of their self and their hopes, dreams, and goals that are influenced by their moral and cultural influences (Freud).

Symbolic Play: An individual's innate psychological process that can heal their emotional pain (Chodorow).

Sympathetic-Parasympathetic Balance: A daily occurrence where one shifts between excitation and relaxation states to maintain homeostasis and regulatory functioning (Carr & Hass-Cohen).

Symbol: The individual's language of their unconscious that conveys a meaning beyond its conventional understanding (Jung).

System: Refers to the individual.

Third Hand, The: A metaphorical term where the art therapist supports the client by enhancing their creative capabilities and potential without being intrusive (Kramer).

Three Primary (Biological) Needs, The: Security and survival, power and control, and affection and esteem (Keating).

Time-limited Art Psychotherapy: A developing clinical crisis intervention practice that requires more theoretical linkages and applied research (Springham).

Transcendent Function/Transcendent, The: An intrinsic dynamic process that facilitates an individual's psychical movement towards uniting the psyche's energies to create a new symbolic position from a state of psychic suspension in a non-self-destructive process that expands upon their inherent capabilities, potentials, and understanding (Chodorow, Helminiak).

Transitional Space: The individual's metaphorical container when they shape their experience into imagery by deconstructing themselves non-destructively towards symbolic formation (E. Levine).

True Self: When someone asserts themselves in the environment with a sense of integrity and wholeness (Winnicott).

Trusting the Process: When an individual is willing to be uncertain about their circumstance, and opens themselves to explore the unknown where insights and discoveries can emerge (Allen, McNiff, Rubin).

Unconscious: A condition of latency where information is censored by the individual for specific reasons (Freud).

Unhealthy False Self: When an individual adapts to the environment, but feels forced to be compliant and is unable to adapt in a healthy manner (Winnicott).

Vulnerability: An individual's perception about their sense of safety when an internal or external change in the psychosocial environment threatens them (Beck).

Introduction

Throughout an individual's life, a *precipitating factor*, such as a relationship, memory, or event, can trigger a repressed *psychological conflict* that causes intense and acute pain in their body, mind, and *spirit*. This moment is an individual's emotional crisis - a severe psychological upset that is influenced by an unresolved psychological conflict. The person's psychological conflict has its origins in childhood, and if the conflict remains unresolved as they transition throughout life, poor coping strategies and skills can contribute to a systematic and chronic disintegration of their overall functioning. Their nervous, immune, and endocrine systems become compromised as a result of repressing the psychological conflict. If they continue their repression of the psychological conflict, it inevitably affects their physiological, cognitive, affective, and spiritual well-being. In the circumstance that an individual finds themselves in a painful state of being, uncertainties and anxieties emerge, developing in regard to their past, present or future. Their repressed psychological conflicts do not follow the traditional notions of time because it is cyclical and timeless, and can remain dormant in the person's body, mind, and spirit if they choose to avoid an adaptive and healthy resolution. However, repressing a psychological conflict requires a significant cost from the body and mind that can lead to overall deterioration of functioning and lower quality of life.

According to Dr. Gerald Caplan (1963), an emotional crisis is an acute psychological upset that disrupts an individual's state of external and internal equilibrium (Caplan, 1963); whereas Dr. Peter Emmanuel Sifneos defined it as an "intensification or aggravation of a painful state of being" (Sifneos, 1972, p. 29). There is a precipitating factor that triggers an individual's emotional crisis, and is often determined by an

external event. The rise of an emotional crisis activates repressed, dormant feelings, and the precipitating factor may be a precursor of an individual experiencing a psychotic break, or suicide attempt (Sifneos, 1972).

Therefore, a precipitating factor already triggered the repressed psychological conflict which resulted in an emotional crisis. The individual already reacted to the event, responded in their systematic manner, and eventually decided to seek alternative options such as using acute therapeutic services. Therefore, the person initiates a clinical encounter with the intention to end an emotional crisis either by alleviating or resolving their painful feelings and *anxiety* symptoms regarding an unresolved psychological conflict.

The person's anxiety is a physiological reactionary signal for them to halt forward movement or exercise caution when a precipitating factor triggers a psychological conflict that threatens their survival, safety, needs, and wants. When anxiety is felt, the person must then respond to the perceived immediate threat in their psychosocial environment. Their response is usually automatic due to learned behaviours and actions that are habitually maintained; however, their response can also be voluntary and idiosyncratic in that different actions can be created in response to the sudden change in their psychosocial environment. It is common that a fleeting image or memory is produced in the individual's body and mind when anxiety occurs, and this image influences their response to the emotional crisis.

In consideration that an emotional crisis causes instability between the body, mind, and spirit yet produces a sensed response, such as imagery, it was crucial to explore a mind-body approach that placed the individual at the core of their emotional

crisis, and their consequent psychological work during and after the clinical encounter. Although there are various psychotherapies and mind-body interventions that can be used to address an individual's emotional crisis in an acute clinical setting, single-session therapy and art therapy were selected as the clinical specialization for this study.

When an individual suddenly and unexpectedly experiences an emotional crisis, they may seek immediate assistance. Traditional clinics are unable to administer immediate care to clients whose emotional crisis is a time-sensitive issue that cannot be placed on hold. *Single-session therapy* (SST) is a sub-specialty of *brief psychotherapy* (Bloom in Hoyt & Talmon, 2014, xvi), and it is a clinical framework that is focused on providing immediate care. It is mutually considered as "a deliberate single session" (Hoyt & Talmon, 2014, p. 5) by the therapist and client. The expectation is usually of a "complete, one-time experience [... and clients] may return again in the future if desired" (Hoyt & Talmon, 2014, p. 13). It is integral that communities provide clinics that offer acute treatment, because unsuccessful resolution can lead to maladaptive coping strategies and the development of chronic issues.

Art therapy (AT) "combines the creative process and psychotherapy, facilitating self-exploration and understanding. Using imagery, colour and shape as part of this creative therapeutic process, thoughts and feelings can be expressed that would otherwise be difficult to articulate" (Canadian Art Therapy Association, 2017). Art therapy is a clinical modality that treats an emotional crisis in a supportive and secure environment that leads to the adaptive and healthy resolution of a psychological conflict by promoting and facilitating unconscious-conscious dialogue with the individual's imagery in response to their emotional crisis. By understanding the origins of their emotional crisis,

an individual can become conscious of their unconscious content that covertly influences their *motivation* to attain specific needs and wants in their environment.

Although the community may perceive brief psychotherapy services as having a defined time construct, such as six to twenty sessions based on one-hour visits to a clinic, it does not diminish the value of a single-session. SST is not operated with the goal to replace the long-term assistance of ongoing therapeutic treatments. SST is about creating pivotal moments and motivating individuals towards the realization of what can be accomplished as part of a larger process. Individuals will see improvement depending on their willingness and motivation to change during the session and the post-therapy period. Additionally, art therapy during single-sessions encourages an individual's understanding of their psychological conflict and promotes momentum, an inner movement, which further motivates them to continue their post-therapeutic work to heal their pain.

The researcher's interest in this topic was influenced by their practicum placement at an acute treatment clinic as a graduate student. At the clinic, they provided single-session art therapy (commonly as walk-in appointments) and brief/short-term art therapy for six-eight sessions. It was uncommon for art therapy to be offered as a treatment modality to immediately address an individual's psychological concerns in a single session, and it brought conceptual challenges to the then student counsellor, now the researcher, when discussing art therapy in the interdisciplinary clinical setting. Although the researcher was able to discuss art therapy in its own language, there remained a conceptual gap when conversing with other colleagues who were not familiar with the discipline.

The researcher's goal for this thesis was to systematically explore the published literature on emotional crisis in time-limited settings with art therapy as the clinical discipline; then connect influential psychotherapeutic, theological, and medical concepts to synthesize a clinical treatment modality, *single-session art therapy*, as a spiritually-oriented mind-body approach that treats an emotional crisis by placing the individual at the focus of the clinical encounter that symbolically transforms the repressed psychological conflict that was suddenly re-activated. The researcher purports that single-session art therapy is a clinical treatment modality that uses an art therapy interventional task, which aligns with the individual's present state of functioning and motivation for emotional crisis resolution, to promote an adaptive and authentic unconscious-conscious relationship with their repressed psychological conflict.

The purpose of this study was to explore the published literature on emotional crisis in an acute clinical setting. Due to the acute and unexpected nature of an emotional crisis, selecting an acute clinical framework was integral because immediate therapeutic assistance is necessary when a dormant psychological conflict is triggered by a precipitating factor that places the person in immediate danger. However, most of the published literature focused on the precipitating factor, or the specific methodological steps that the therapist needed to perform during the clinical encounter. The precipitating factor does not cause the psychological conflict; it re-activates a person's dormant and repressed feelings that were previously avoided. As a result, most of the literature focused on the details of a precipitating factor and how it caused instability for the individual.

The primary research questions of this thesis were: 1) what is emotional crisis, and 2) was it addressed in brief and short-term psychotherapy, single-session therapy, and art therapy literature? After the presentation of the initial research results, additional foci were added because there needed to be more information about the theoretical and methodological application of addressing an emotional crisis from a creative and spiritual perspective: 3) exploration of influential psychotherapeutic, theological, medical, and creative expressive arts therapies, and 4) emphasize how the clinical encounter can address the experience of a loss of the Self, and how to best restore the client's stability to their body, mind, and spirit that leads to a healing experience.

A significant gap in the literature was that the unique experience and psychological origins of an emotional crisis were not thoroughly discussed. Therefore, the literature did not emphasize the individual as the subject of their pain, or elaborate why and how an emotional crisis caused instability and re-activated underlying psychological conflicts. As a result, it was necessary to present influential psychotherapy, theological, and medical theories and concepts that further explained the clinical phenomena of an emotional crisis.

Although the clinical phenomena of an emotional crisis were systematically researched and analyzed throughout the study, it was just as important to offer therapists, who provide acute therapy services, another perspective. Therefore, brief/short-term psychotherapy and single-session therapy literature were selected to further refine the study's parameters. This selection provided a more concrete aspect about how psychotherapy has developed as an acute practice to address emotional crises in the community. Furthermore, an acute psychotherapeutic practice has general principles and

recommendations to follow, which are beneficial in crisis work, even though there are numerous types of psychotherapy that can be offered to an individual in emotional crisis.

Within this thesis, pertinent data was not included that imposed on the rights and informed consent of the mentioned clinic, their psychotherapeutic approach or other information that stemmed from the researcher's biographical history as the findings were derived from a systematic search within specific scholarly databases. As a result, the researcher did not make an explicit or implicit indication of their naturalistic observations from the clinical practicum placement. No human rights violations or harm incurred to the clinic, others, or the researcher as the disclosure of the content aligned with the Master's Thesis Guidelines (St. Stephen's College, 2015). In conclusion, the thesis was comprised of published literature that was systematically procured by the researcher's search algorithms within internationally recognized aggregators that did not involve heuristic, personal inquiry, or living human subjects that would have required human rights and informed consent before conducting the research.

There are five chapters to this study: Methodology, Systematic Review, Creative Synthesis, and Single-Session Art Therapy. In the Methodology chapter, the researcher provides the reasoning for the pre-determined limitations and set definitions that establish the scope and focus of the systematic review. Then, the researcher describes and categorizes the research synthesis in five stages. The first stage, preparation, was an overview of the researcher's resources that were used for the research synthesis. The second step was implementing a brief search to answer the first research question, "what is emotional crisis?" The third stage narrows the basic search results with Boolean operators to generate a set of relevant literature which was more manageable and

comprehensive to the scope of this thesis. The fourth stage, advanced search, was the researcher's application of Boolean expressions to produce a specific, in-depth data collection of material about emotional crisis (clinical concept) and art therapy (clinical modality) within time-limited settings. The last stage, experimental interventions search, was the researcher's unstructured search process that expands and augments the data collection. Furthermore, the researcher discusses the validation process that leads to the Systematic Review chapter.

The Systematic Review chapter contains the information derived from the data collection where the researcher discusses the results from the basic to advanced search stages. The researcher explicitly states which sources were derived from the experimental interventions search stage of the research synthesis to maintain the validity and reliability of the thesis. This chapter has three subsections: emotional crisis conceptualization, emotional crisis in a time-limited context, and emotional crisis resolution and art therapy. It is designed to provide an overview of the published literature that was derived from the research synthesis.

In consideration that the published literature did not thoroughly present a general theoretical account of the origins of an emotional crisis, the researcher offers additional content to augment the initial findings in the Creative Synthesis chapter. Various psychotherapy, theological, creative expressive arts therapy, and mind-body literature are linked to the initial findings that establish the researcher's experimental approach to address an emotional crisis in an acute setting that places the individual as the focus of the encounter. Within this chapter, the researcher presents three subsections: the implicit foundation of emotional crisis theory, the definitional construct of emotional crisis, and

theoretical assertions. The focus of this chapter is to analyze the data collection and synthesize the findings in a way that can be applied in general psychotherapy practice.

The fourth chapter is where the researcher provides a preparatory theoretical and methodological account for SSAT. The theoretical and methodological practice of SSAT is based on the individual's image formation as a response to a repressed psychological conflict by using their words and art-making to resolve their emotional crisis. The researcher then presents how and why art therapy is an effective clinical modality that addresses and resolves emotional crises in a time-limited setting. Then, the researcher draws upon the data collection and connects it to art therapy practice and its potential for interdisciplinary and integrated applications. Although the psychotherapeutic, theological, and medical concepts may be considered as separate from one another, distinctions are made that connect the various disciplinary concepts.

Finally, the Conclusion chapter contains the researcher's overall interpretation of emotional crisis and how SSAT can optimize an individual's healing experience. General statements from the Systematic Review and Creative Synthesis chapters summarize the researcher's findings and discussion. Lastly, the researcher offers recommendations for the development and application of SSAT as a spiritually-oriented practice that places the individual at the core of their healing experience.

The theme of this study is to highlight the individual as the *subject* of the clinical encounter, rather than an object that is subjected to pain, and link various interdisciplinary theories as an integrated framework designed to place the individual as the core focus during the therapeutic encounter. If the individual continues to place themselves as an *object* to their pain rather than the subject, there may be a further

suppression of overall functioning that inadvertently constrains inner movement towards healing and resolution, because a repressed psychological conflict is maintained. The major gap in the literature generated from the research synthesis was that the individual was presented as *an object that experienced pain and anxiety symptoms* due to the precipitating factor (subject of the clinical encounter), rather than offering an explanation or theoretical understanding of how the individual is the subject of their pain, and why a precipitating factor triggered a particular psychological conflict that led to an emotional crisis.

The researcher presents a general account of emotional crisis and how SSAT is a means to address this phenomenon as a community service. Due to the preparatory nature of this thesis, the researcher considers it integral to explore and discover the theoretical and methodological underpinnings of emotional crisis. As such, a tentative conceptual foundation is established that will eventually test the hypothesis of whether SSAT optimizes an individual's healing experience from an emotional crisis, because future contributions regarding this topic will study the clinical measures and outcomes of SSAT.

Chapter One: Methodology

The researcher designed the study to address specific research questions: (a) what is an emotional crisis; (b) was emotional crisis discussed in the time-limited contexts of brief/short-term psychotherapy and single-session therapy with art therapy as the clinical modality, and (c) was art therapy exclusively presented in the time-limited settings. The literature was systematically aggregated using specific search algorithms in EBSCO and OVID, and the results are presented in the Systematic Review chapter. The researcher analyzed, deconstructed and elaborated on the clinical phenomena of emotional crisis and synthesized a tentative clinical treatment modality – single-session art therapy. The overall thesis is summarized as describing emotional crisis, and how to address it in an acute clinical setting with art therapy as the treatment modality.

The researcher utilized research synthesis as the methodology, and detailed the steps in three sections: the systematic procedure, data collection characteristics, and limitations of the study, A research synthesis is commonly known as a research review or a systematic review (Cooper & Hedges, 2009), and is a systematic, comprehensive, explicit, and reproducible method wherein the researcher identifies, evaluates, and synthesizes an existing body of current knowledge contributed by researchers, scholars, and practitioners.

In contrast to a research synthesis, a literature review is a qualitative summary of selected content that pertains to a particular subject. In the Creative Synthesis chapter, the researcher analyzed the data collection and presented additional content to enhance the initial findings. The supplementary material in that section involves critical medical, psychotherapeutic, and theological concepts which the researcher connected to the

research findings. Overall, the researcher's goal was to offer a preliminary account of relevant interdisciplinary ideas that enhance the initial data collection as a majority of it was outdated.

A similarity between a research synthesis and a literature review is that the researcher is required to uphold reliability and validity. As such, the researcher used four evaluative components, outlined by Fink (2014, p. 141), to maintain reliability and validity of the data collection: (a) all key variables and specifics were defined and described by the researcher; (b) evidence of internal consistency, test-retest reliability, and inter- or intra-rater reliability; (c) proof of the variables being measured accurately and appropriately for what it intends to measure; and (d) the clinical phenomenon was presented in a reliable and valid approach.

The research synthesis process was comprehensive, and the researcher reduced bias by practicing openness and flexibility towards developing concepts, and adapting specific criteria when required. As the researcher analytically screened the literature, they continually modified, documented, and confirmed the research process to uphold validity and reliability to ensure that it can be reproduced by another researcher. Also, the researcher referred to original primary sources as much as possible when local access was available, and examined, described, and justified the use of all sources derived from the data collection. These practices ensured that another researcher may reproduce the methods and laid the foundation for others "to accept the results of the review" (Fink, 2014, p. 14). For a visual representation of the research synthesis procedure, refer to Appendix A, and Appendix B for the search stages.

Research Synthesis Procedure

Preparation search stage. The researcher used two search aggregator databases: OVID and EBSCO Discovery Services (EBSCO). OVID and EBSCO performed cross-searches amongst The University of Alberta (U of A) bibliographic content and resources. The U of A Library Catalogue, commonly known as the NEOS catalogue, references the NEOS Library Consortium which is made of the materials and holdings of the U of A Library along with other Alberta provincial libraries. The U of A Book Depository and Record Collection building stored archived print journals that were not in the main campus libraries. In addition, the U of A has access to a variety of electronic resources such as e-books, e-journals, and databases. For instance, U of A has access to 2,297 Humanities and Social Sciences e-journals.

OVID aggregates the U of A's electronic resource subscriptions. It is one of the modern health sciences service providers for scholarly research. OVID is a unique and integrated provider due to its natural language processing for everything from basic searches to advanced searching techniques such as "explode" and "focus" (expand and narrow). In regard to the thesis, the researcher directed OVID to search within the psychology database, PsycINFO®.

The American Psychological Association (APA) established PsycINFO® as a comprehensive and international bibliographic database. PsycINFO® provides systematic coverage of psychological literature from 1806 to present. This abstract database provided brief synopses and citations from book chapters, books, thesis, peer-reviewed journal articles, and technical reports. The publications were relevant in the field of psychology and related disciplines that contained psychological concepts. "Medicine,

psychiatry, nursing, sociology, education, pharmacology, physiology, linguistics, anthropology, business, and law" (OVID, 2017) were some of the disciplines. Due to PsycINFO® being indexed by controlled vocabulary terms, it made "searching easier and more successful" (APA, 2017) for relevant content. The APA publications and material provided the researcher with a systematic coverage of literature referencing “emotional crisis” that spanned across multiple disciplines. Furthermore, OVID's user interface provided the researcher with a procedure that assisted the structure of the study in a manner "that is consistent among users” (APA, 2017).

Similar to OVID, EBSCO cross-searched the NEOS catalogue, aggregated the U of A's electronic resource subscriptions, and its scholarly database, Academic Search Complete. EBSCO is one of the leading social sciences and humanities databases for research. EBSCO provides users with full-text and peer-reviewed journals, "periodicals, reports, books and more" (EBSCOHost, 2017) from a range of multidisciplinary subjects. EBSCO provided indexing and abstracts from scholarly journals across multiple disciplines and offered full-text documents from several of these journals.

The researcher implemented RefWorks, a software citation management service, that collects, imports, organizes, and shares user content when bibliographic content is uploaded. The researcher used this resource to import and organize the search result lists compiled during the research synthesis. In order to view the uploaded bibliographic content, a RefWorks account is required to share and access content.

Sample, size, and power. Since the researcher used two service aggregators, there was journal subscription (content) overlap between the Academic Search Complete and the PsycINFO® databases. Therefore, the researcher implemented a search in Gold

Rush® Decision Support (formerly Gold Rush® Reports). It is an electronic resource management system that performed a content overlap inquiry between Academic Search Complete and PsycINFO®.

The researcher performed their systematic search on August 5, 2016. The following day, they conducted an inquiry to compare EBSCO and OVID content. EBSCO – Academic Search Complete had 13,178 journals whereas OVID – PsycINFO® had 2,561 journals. The Academic Search Complete and PsycINFO® databases shared 1,399 common journals. In addition to comparing the databases, they performed a search of art therapy journals in these databases. Academic Search Complete had access to the American Journal of Art Therapy (AJAT), and PsycINFO® contained no art therapy journals. As a result, the researcher determined that there was not enough art therapy material to conduct a thorough research synthesis.

Thus, they accessed the *Taylor & Francis e-journal* to increase the art therapy sample, size, and power of the thesis. Throughout the researcher's graduate studies, they obtained art therapy literature from the AJAT, the Canadian Art Therapy Association (CATA) journal, and the International Association of Art Psychotherapy journal (IAAP; formerly Inscape). The Taylor & Francis e-journal contained the CATA (2005 – present) and IAAP (1990 – present) journals. Taylor & Francis Online content platform hosted the journals; however, the platform did not have similar searching functionality and user interface as EBSCO and OVID. Therefore, they were unable to conduct a systematic search, and thus considered the Taylor & Francis e-journal as a supplementary search process and classified it in the experimental intervention stage.

Search algorithms. The researcher implemented search algorithms for the systematic search and outlined an organizational flowchart. Their reasoning for each algorithm is described in its appropriate search stage. For a visual representation of the applied search algorithms, refer to Appendix C.

Basic Search Stage

OVID – "what is emotional crisis?" The researcher established two foci for the research synthesis. The first research focus was the exploration of the brief clinical question: "what is emotional crisis?" The second research focus was the investigation of whether emotional crisis (the clinical concept) was discussed in the clinical setting (framework) of brief psychotherapy, short-term psychotherapy and single-session therapy (SST) with art therapy as the core psychotherapeutic modality.

First, they conducted a basic search that was limited to the widely recognized international database for psychological literature, PsycINFO®. The researcher selected the database publication date as 1806 to present (2016) because they were interested in the conceptual development of emotional crisis. This implementation assisted them in reducing bias, and promoted flexibility and adaptability to their search development strategy.

OVID's primary search function used a natural language processor. Therefore, they framed their main search as a question instead of using an advanced searching technique that involved Boolean operators. The researcher's primary search algorithm was "What is emotional crisis?" in which the words became automatically truncated. Due to OVID's automatic truncation of the algorithm, they were not required to use wildcards. OVID's code for a wild card is the % symbol. Therefore, adding wild cards, such as the

search phrase "emotion% cris%s," was not necessary. OVID automatically truncated the word "emotional" to emotion, emotions, and emotionally; and "crisis" as crises. The search algorithm, "What is emotional crisis?" aggregated 109 results. Afterwards, they applied the English Language limiter that narrowed it down to 87 results.

The researcher considered all the relevant results and did not employ exclusion or inclusion criteria at this stage. Even though there were several dated qualitative and quantitative studies that are not applicable to the socioeconomic and historical contexts of the 21st Century, it remained relevant towards the evolution of the concept of emotional crisis. In addition to the dated studies, there were results that at first glance, did not appear relevant. However, the researcher's intention was providing a thorough exploration of the clinical concept of emotional crisis from philosophical, theoretical, and methodological perspectives.

EBSCO – "emotional crisis". The second phase of the basic search stage was locating the local resources at the U of A Libraries regarding emotional crisis. The researcher placed the term in quotations because it is a nested concept which meant that results were generated with the exact phrase. The absence of the quotation marks would have produced too many results. EBSCO would have aggregated all accessed materials and databases for the occurrences of the two words (emotional and crisis) rather than the one particular phrase ("emotional crisis").

The primary search function produced results within four general publication formats: Books, media & more, Articles & more, e-journals, and Databases. Books, media & more yielded six results with four books and two videos/projections. E-journals and Databases produced zero results. However, Articles & more produced more than 600

results without the application of limiters. Therefore, the researcher applied limiters to narrow down the results to a more manageable amount that more closely reflected the goals of the study.

Intermediate Search Stage

EBSCO – "emotional crisis". The researcher continued to apply the nested concept with the following limiters in the Articles & more search list: Full Text, Scholarly/Peer-Reviewed Journals, and Language: English. They excluded other formats such as books and media because the core search in PsycINFO® and EBSCO produced relevant results. After the application of limiters, there were 112 English results; however, the automatic removal of duplicates totaled 91 English results.

In consideration that OVID and EBSCO had overlapping journal content, the researcher manually cross-referenced the EBSCO and OVID result lists, and removed the duplicates from the EBSCO search list because OVID provided a more systematic coverage of emotional crisis. Due to APA standardizing their indexing functionality to be consistent in PsycINFO®; OVID was selected as the primary aggregator. After cross-referencing the lists, the researcher found 13 duplicates between EBSCO and OVID, which narrowed the EBSCO list to 78 English results. With the knowledge that EBSCO does not have an indexing procedure like OVID, the researcher located 12 duplicates in the EBSCO list itself, and determined that there were 66 unique results from EBSCO's aggregation across interdisciplinary databases.

Advanced Search Stage

The researcher's purpose in conducting several advanced searches in EBSCO and OVID was to locate additional material that matched the thesis topic using pre-

determined subject headings. Their formulations used the pre-determined clinical concept and the clinical discipline (psychotherapeutic modality) and setting, and the search algorithm was established as such: emotional crisis, and brief psychotherapy or short-term psychotherapy or single-session therapy or art therapy. Both EBSCO and OVID removed the hyphen from hyphenated words; therefore, it was not necessary to include the hyphen in short-term psychotherapy and single-session therapy in the final formulations.

OVID. Within the PsycINFO® database, the researcher used the search algorithm for emotional crisis and the pre-determined subject headings: *emotional crisis/ and (*brief psychotherapy/ or *short term psychotherapy/ or *single session therapy/ or *art therapy/). They initially formatted the Boolean operators in upper-case (AND/OR); however, OVID automatically re-formatted the Boolean operators after the search. Additionally, OVID automatically applied the right-forward slashes after each search term. The asterisk in front of each search term functioned as a nested concept which is similar to the quotation marks in EBSCO. The researcher implemented the nested concepts because they required specific and relevant results that did not include other variations. There were zero results.

The purpose of the next search was to focus on relevant art therapy literature that explicitly used brief psychotherapy, short-term psychotherapy, and single-session therapy clinical settings. The researcher entered this search algorithm in the PsycINFO® database: (art therapy and (brief psychotherapy or short term psychotherapy or single session therapy)).mp.

The primary limiter in this search was "mp.” which narrowed the results to the search terms that appeared in the title, abstract, heading word, table of content, key concepts, original title, and tests and measures. Since the researcher did not implement nested concepts in this search, the terms became single word constructs. Therefore, the search terms were: art, brief, psychotherapy, session, short, single, term, and therapy. There were 35 English results.

EBSCO. The search algorithm that the researcher implemented in EBSCO was: "emotional crisis" AND ("brief psychotherapy" OR "short term psychotherapy" OR "single session therapy" OR "art therapy"). Once again, they implemented nested concepts for the same reason as previously discussed, and did not include limiters in this search. There were five results (all English Language) after automatic de-duplication. Even though automatic de-duplication removed results that had the same indexing components, there remained three repetitive results that were manually removed.

Since EBSCO had access to significantly more journals across various disciplines, the researcher decided to maintain the search terms as nested concepts for art therapy and the pre-determined subject headings. The search algorithm was: (“art therapy”) AND (“brief psychotherapy” OR “short term psychotherapy” OR “single session therapy”). They did not include limiters since all the results were in the English language with 20 results. Similarly to the earlier search, the researcher manually cross-referenced the advanced search lists to remove duplicates from the results.

As part of a comprehensive search strategy to appropriately research art therapy in the specified clinical settings, the researcher expanded the search inquiry and accessed two additional art therapy journals: the Canadian Art Therapy Association (CATA) and

the International Association of Art Therapy (UK) formerly known as Inscape. These art therapy journals were selected by the researcher due to their familiarity with many authors and their contributions being published and connected with the AJAT, CATA, and International Association of Art Therapy (UK) journals.

Experimental Interventions Search Stage

Examining the data collection, the researcher came across more relevant sources in the reference lists and accessed them when possible. This research method is known as "citation growing," and the researcher considered this stage as ongoing as they deconstructed the literature findings to compile the Systematic Review chapter. The researcher classified the content from the experimental intervention as supplemental findings, and presented those results in the Creative Synthesis chapter to present a contemporary account in contrast to the outdated material from the Systematic Review chapter. Due to the lack of systematic indexing functionality, the resources collected from the Taylor & Francis e-journal, and the American Art Therapy Journal were also classified as supplemental content.

Taylor & Francis e-journal. The researcher performed a search inquiry within the Taylor & Francis e-journal under the respective art therapy journals with the specific words/phrase: ("single session" OR "brief" OR "short" OR "time limited"). They included "time limited" because the primary art therapy text from the systematic search included that term in its title. The searches within the Canadian Art Therapy Association Journal and the International Association of Art Therapy each produced more than 200 results. The experimental interventions search stage was subject to bias because of the user

accessibility, the limited search functions in The Taylor & Francis e-journal, and the informal selection of the content to be applied in this study.

The Taylor & Francis e-journal did not have search functions and capabilities similar to EBSCO and OVID. Many of the articles did not have abstracts or subject headings, and often had vague or no additional information other than the title, author, and publication details. Therefore, the researcher implemented exclusion criteria to narrow down the search results. The first exclusion principle was the relevancy of the article. If there was no abstract or other identifying information as to what the article may be about, they disregarded it. If the article was about ethical and research issues, they did not exclude them. The researcher considered the content necessary for the theoretical and methodological issues of art therapy as a clinical psychotherapeutic modality. The second criterion was if they had full, free access to the article. There were many articles that the researcher considered relevant, but did not have free access. They found 72 related articles from the International Association of Art Therapy Journal but were only able to access 58 articles. In regard to the Canadian Art Therapy Journal, they considered 37 articles relevant but were able to access 25 articles. The total results from this search produced 83 articles.

American Journal of Art Therapy. One last search was implemented in EBSCO to ensure that the researcher did not miss relevant articles. The search formula was: JN "American Journal of Art Therapy" AND ("single session" OR "brief" OR "short" OR "time limited"). There were four results.

Data Collection Characteristics

The emotional crisis content focused on the individual's psychological reaction to a traumatic or adverse life event. The emotional crisis research spanned across these main disciplines: nursing, psychiatry, and psychology. Other subjects included: communications technology, fine arts, law, and sociology. The data collection emphasized two characteristics. The first characteristic was that emotional crisis was primarily analyzed as an external event/stimulus that manifested psychological and physiological changes in an individual. The second research component focused on how an individual can address an emotional crisis with healthy or unhealthy coping strategies to attain either a desirable or undesirable outcome in a particular social context/environment.

The primary research emphasis of an individual's healthy adjustment coping strategies was presented in a communal context. These contexts involved schools, post-secondary campuses, psychiatric wards, hospitals, and clinics. Several of the researchers developed suicide prevention, counselling programs, and/or treatment guidelines that were directed towards specific emotional crises. Examples were rape, chronic illness, death, infertility, and life transition events such as parenthood. There were numerous types of research studies that were either qualitative, quantitative, or mixed research design. The common types of research studies were:

- Case reports, and case series. The primary aspect of these studies focused on an individual's or a group's response to an actual or potential issue. The contributor described, explored, and explained the clinical phenomena. As a

result, the researcher provided an anecdotal account of the clinical phenomena.

- Case control studies. This type of study was characterized by an individual or a group who had a specific condition, the clinical phenomena of which the researcher was analyzing. As a result, the researcher identified potential factors. Often, the individual's medical record and recollection of events were the primary source of information for the researcher.
- Cohort studies. These studies were observational and were characterized by a group of individuals who experienced an emotional crisis or a specific treatment to resolve the psychological issue clinically. The researcher determined a time frame to conduct the study, and afterward compared the results to another group who were not subjected to the same treatment conditions as the initial group.
- Randomized controlled clinical trials. The researcher designed an intentional treatment model/intervention for a group of individuals who did not have prior exposure to the experiment. The people presented with an emotional crisis, and were offered intervention in a clinical research setting. These studies included methodological criteria that reduced bias, such as blinding and randomization, between the controlled group (no treatment) and test group (with treatment). The researcher observed and analyzed the treatment effects on the research participants.

There were several characteristics of the data collected that the researcher noticed during their explication. The first distinction was that most of the literature was dated, on

average, 30-50 years ago. In addition, the content was typically comprised of case reports, case control studies, and cohort studies. Those types of studies were not as valid or reliable as randomized, controlled, clinical trials; however, this thesis is a research synthesis that is oriented towards the theoretical and methodological presentation and integration of emotional crisis. For the researcher to comprehend the potential reason as to why the emotional crisis literature was quite dated, they performed a search of continuous subject headings and thesauri terms in OVID.

A unique function of OVID was that it indexed the keyword, emotional crisis, throughout all accessed databases and provided a "map" of other subject headings and thesauri terms. The function "Map to Subject Headings" in OVID provided the researcher a list of indexed subject headings: crises; mental disorders; brief psychotherapy; emotional disturbances; crisis intervention; emotional trauma; suicide; emotional states; neoplasms; psychotherapeutic processes; psychiatry; psychotherapy; spirituality; caregivers; and family.

The term emotional crisis was not found in OVID's thesaurus. The alternative term that was alphabetically sequential to emotional crisis was emotional control. In the following list, the researcher presents several equivalent terms with their alternative keywords that were relevant to emotional crisis:

- Emotional adjustment and its related terms: adjustment; emotional control; identity crisis; adjustment disorders; codependency; coping behavior; emotional disturbances; emotions; mental disorders; mental health; personality psychopathology; and resilience (psychological).

- Emotional control and its related terms: emotional adjustment; anger control; coping behavior; emotion focused therapy; emotional regulation; internal external locus of control; self-control; social control; stoicism; stoicism (philosophy), and tantrums.
- Emotional content and its related terms: communication; and emotions.
- Emotional development and its related terms: psychological development; attachment behavior; attachment theory, childhood play development; developmental age groups; emotional intelligence; emotions, object relations; personality development; physical development; psychosexual development; and psychosocial development.
- Emotional stability and its related terms: personality traits; emotional instability; emotional security; neuroticism; and resilience.
- Emotional trauma and its related terms: emotional states; trauma; acute stress disorder; adjustment disorders; complex PTSD; debriefing (psychological); disinhibited social engagement disorder; false memory; post-traumatic stress disorder; repressed memory; separation reactions; and stress and coping measures.

Overall, the above subject headings, keywords, and terms were related and are characteristics of the data collection. The realization that the researcher made in regard to the emotional crisis literature being dated was that it evolved into specialized topics such as post-traumatic stress disorder (PTSD), resiliency, and emotional intelligence.

The researcher considered resiliency and PTSD research as the modern evolution of the concept emotional crisis, due to the chapter *The Creative Psychosocial Genomics*

of Human Resilience and Resourcefulness (Rossi, Mortimer, & Rossi, 2011a) in the e-book *Continuity Versus Creative Response to Challenge: The Primacy of Resilience and Resourcefulness in Life and Therapy* (Eds. Celinksi & Gow, 2011) appearing in the OVID basic search stage list. It was the sole reference from the e-book that connected the researcher with an alternative to updated research regarding the topic of emotional crisis within five years.

The second distinction that they generated from the data collection was the distinction between Borderline Personality Disorder (BPD) and emotional crisis. It appeared that BPD was the prominent psychopathological manifestation of an individual's continuous and unsuccessful chronic attempts at resolving an emotional crisis in a healthy, adaptive manner. It was interesting to note that most of the cohort studies and randomized controlled clinical trials indicated BPD as an ineligibility criterion. Furthermore, several of the researchers did not show clear reasoning for excluding the individuals who presented with a BPD diagnosis or symptoms.

The researcher believes that the main reason for the lack of explanation was due to the literature being directed to a specific audience – psychiatrists and psychologists who are experienced in providing specialized acute treatment models. In contrast, in several case reports and studies, clinicians observed individuals who presented with BPD symptoms. The clinicians provided insight into a person's psychopathological origins of BPD and provided treatment.

Aside from BPD, suicide attempts and suicide were the other psychopathological manifestations of a person's unsuccessful attempt at resolving an emotional crisis. In the Creative Synthesis chapter, the researcher suggests that BPD and suicide are severe

maladaptive coping strategies that people employ in response to acute trauma and chronic stress after several attempts at emotional crisis resolution. Due to the composition of the thesis, they address BPD and suicide intermittently throughout the remaining chapters to ensure that the data was attributed to the correct sources and search stages.

The published content focused on three underlying aspects of their research studies: clinical experience, current evidence, and individual (client) perspectives. These points emphasized evidence-based practice. Despite that most of the literature was approximately 30 to 50 years old, the researcher engaged with the content. Furthermore, they established an experimental intervention search stage to ensure that they presented a thorough, valid, and reliable study that connected to evidence-based practice.

In summary, the research findings were primarily oriented towards answering these questions: how does an emotional crisis affect an individual, and how can an emotional crisis be resolved in a time-limited environment? The Systematic Review chapter contains the data extraction of what is emotional crisis, how does emotional crisis affect an individual, and art therapy as relevant to resolution in an acute clinical setting.

Limitations of the Study

As the researcher processed the data, they employed methodological criteria and excluded the following content:

- studies that were based on fine art content as the primary topic;
- book reviews provided that the original text did not appear on the search lists;
- sources that only had the term “emotional crisis” in the abstract, as the term did not reappear elsewhere throughout the content;

- sources that did not define-or describe the term emotional crisis as it was not mentioned validly and reliably for what the researcher intended to study;
- sources that the researcher was unable to access as full-text through U of A Libraries, or local institutions;
- material that included creative arts therapies such as music therapy, dance therapy, sand therapy, and play therapy;
- content that primarily focused on other clinical disciplines such as Solution-Focused Brief Therapy, and Cognitive-Behavioural Therapy whether or not it was discussed in a time-limited clinical setting; and
- gray literature and theses because the content was too specific in its research foci.

The researcher set these limitations because the excluded material surpassed the scope of their exposition. Future research that explores and discovers the clinical measures and outcomes will discuss sub-specializations of psychotherapeutic modalities following the affected client population and context. In summary, the researcher excluded sources that were too specialized and strayed from the focus of the topic.

It was decided that this study ought to be a research synthesis first due to the intentions and goals to explore how art therapy can be offered as a treatment modality in acute settings. As such, the researcher became immersed in the published literature and research, focused upon art therapy as an acute treatment modality to address emotional crises, and assessed the results. Future research, such as randomized controlled clinical trials, will further assess art therapy as an acute clinical modality for emotional crises.

Summary

The researcher organized the research synthesis in five stages: preparation, basic search, intermediate search, advanced search, and experimental interventions search. The preparation stage involved the pre-determination of the search terms, and exploring the resources that were available at the time to this researcher. The preliminary step included the navigation of each service platform that was employed in the study: EBSCO, OVID, Taylor & Francis e-journal, Gold Rush® Reports, U of A Libraries, and the U of A Record Depository. The primary search stage was researching the fundamental clinical question "what is emotional crisis?" with defined limiters. The intermediate search stage involved advanced searching techniques to reduce more than 600 articles to 66 articles in EBSCO with defined limiters. The advanced search stage encompassed the research of emotional crisis and the pre-determined subject headings. Afterwards, the researcher searched whether art therapy was applied in brief psychotherapy, short-term psychotherapy, and single-session therapy contexts. The last stage, experimental interventions search, was the expansion of the data collection to other pre-determined resources.

Chapter Two: Systematic Review

The researcher's first step was to define the concept of emotional crisis as the clinical phenomena under investigation. Their first research question, "what is an emotional crisis?" was intended to develop the theoretical construct. They explored and identified the influential contributors from the research synthesis results, who were the psychiatrists Erich Lindemann, Ralph Hirshchowitz, Gerald Caplan, and Peter Emanuel Sifneos; the psychologists Yves Rouleau, Robert Landry, and Bruce Baldwin, and the registered nurse Mary Brownell. Then, the researcher listed, clarified, and summarized their contributions. Throughout the explication, they included additional content from other contributors who were also included in the research synthesis. After the researcher presented the content, they elaborated on the material and offered the analysis which further augments and clarifies the clinical phenomena of emotional crisis.

The second research question was to explore and identify whether the clinical phenomena of emotional crisis was discussed in the time-limited psychotherapy literature. The main contributor to this topic was psychiatrist Dr. Peter Emanuel Sifneos, who defined *anxiety-provoking psychotherapy* as a clinical approach to resolving an emotional crisis in a time-limited context. The researcher augmented Dr. Sifneos' contributions with other influential authors in the literature on time-limited therapy: the psychologists Michael Hoyt, Moshe Talmon, and Bernard Bloom. They used Bloom's time-limited model, *focused single-session therapy*, to further identify and clarify the topic's focus. Afterwards, the researcher introduced Ernest Rossi, Jane Mortimer, and Kathryn Rossi's model, the *four-stage creative process in brief psychotherapy*, to expand upon Sifneos' notion of an individual's creative process during their emotional crisis

resolution. After the researcher's review of the content, they presented an interpretation of the literature to clarify the scope of the topic further.

The final research question was to explore and identify whether the clinical discipline, art therapy, was discussed in the time-limited psychotherapy literature. The researcher pre-determined art therapy as the clinical treatment modality, and expanded and augmented upon Sifneos' and Rossi et al.'s contributions to the creative process that occurs in psychotherapy. The main contribution was compiled in Rose Hughes' edited book, *Time-Limited Art Psychotherapy: Developments in Theory and Practice* (2016). The edited book included various art psychotherapists who are based in the UK. Their contributions are introduced and presented throughout the explication. The researcher added additional content from other contributors derived from the research synthesis and offered their perspective regarding art therapy as an acute treatment to address an emotional crisis in a time-limited psychotherapy context.

In summary, the researcher provides a general overview of emotional crisis art therapy as a clinical discipline implemented for potential resolution in a time-limited psychotherapy context. First, they introduced the clinical phenomena that they were interested in learning more about – emotional crisis. Second, they explored emotional crisis within the brief and short-term psychotherapy literature, as well as single-session therapy literature. Also, the researcher emphasized the notion of a creative process that occurs in relation to emotional crisis. Finally, art therapy was selected as a clinical modality and discipline, in which emotional crisis can be addressed in a time-limited psychotherapy context. The researcher's interpretation of the theoretical constructs divulged from the literature findings is further analyzed, expanded, and refined in the

Creative Synthesis chapter. To conclude, they identified connections and perceived gaps in the literature, and suggested the next step of further expanding and refining the initial research data collection.

Emotional Crisis Conceptualization

Crisis theory. An emotional crisis occurs when an individual experiences a change or shift in their psychosocial environment that causes alterations in a relationship with others and themselves that the person perceives as negative (Caplan, 1963; Baldwin, 1979). The fundamental aspect of conceptualizing emotional crisis begins with *crisis theory*. Lindemann (Cobb and Lindemann, 1943; Lindemann, 1944) is attributed for establishing the work that Caplan and his colleagues would further pioneer as crisis theory (Argles and Mackenzie, 1970; Baldwin, 1959; Brownwell, 1984; Caplan, 1963; Dressler, Donovan, and Geller, 1976; McGee, 1958).

At a hospital disaster ward, Cobb & Lindemann (1943) conducted a series of psychiatric interviews with 101 bereavement patients to study their grief reactions. These patients included: “psychoneurotic patients who lost a relative during treatment, relatives of patients who died in hospital, bereaved disaster victims [from The Cocoanut Grove fire] and their close relatives, and relatives of members in the armed forces” (Cobb & Lindemann, 1943, p. 141). In the data collection, several of the authors cited the Cocoanut Grove Fire as the primary detail of Cobb & Lindemann's (1943) study, but that is incorrect as per the source.

Working from that study, Lindemann hypothesized that an individual will experience threatening situations throughout life, and will either adapt to the situation or experience impaired functioning if adaptation is unsuccessful. Due to Lindemann’s early

contributions from his studies of the acute grief reactions of bereaved individuals, crisis theory developed.

Crisis theory key terms include: *system; homeostasis; disequilibrium* also referred to as *instability; homeostatic balance; homeostatic mechanisms;* and *the emotionally hazardous situation* also referred to as the *precipitating event* or *stress event*. These terms have remained the same throughout the published content on this topic, and the researcher elaborates on them throughout the study.

Caplan (1963). Caplan's contribution to emotional crisis was commonly cited throughout the data collection. Caplan (1963) defined an emotional crisis as an acute psychological upset that disrupts an individual's state of internal and external equilibrium. Furthermore, an individual's ability to address life issues are affected because their overall functioning is compromised (Caplan, 1963; Argles & Mackenzie, 1970; Baldwin, 1979; Brownell, 1984; Dressler, Donovan, & Geller, 1976; Forman, 1983; Solway, 1985; Okamoto & Matsouka, 2009).

As an expansion to Caplan's definition, similar definitions included: a narrow moment "in time when a person is not able to cope effectively" (Berman, Davis-Berman, & Gillen, 1998, p. 96), a disruption in an individual's habitual ways of adjustment (Hirschowitz, 1973; Solway, 1985), "a severe emotional upset" (Carey & Rogers, 1985, p. 27), "emotional and psychological discomfort" (DePasquale et al., 2012, p. 1876), a state of "continuous chaos" (Sommerseth & Sundby, 2010, p. 114), and "a period of emotional turbulence" (Castelnuovo-Tedesco, 1962, p. 398). In addition, several authors emphasized the notion of stress and contributed the following: a state of stress (Dressler, Donovan, & Geller, 1976), a degree of emotional stress (Ferdinande & Colligan, 1980;

Norris, 1967), and “a stressful, emotional event” (van der Meer & Verhoeven, 2014, p. 534).

Caplan (1963) provided an example to explain an emotional crisis. An individual in their environment adjusted internally and externally to the air temperature. However, when the environment's air temperature increases, this external event influences the individual's homeostatic balance. The person experiences "a rise of tension and signs of strain" (Caplan, 1963, p. 521), and is temporarily incapacitated. Despite an increase of tension in the altered environment, the individual gradually creates internal adjustments to the environment to restore homeostatic balance.

For the individual to adapt to the sudden rise in air temperature and restore homeostatic balance, that person is required to increase their perspiration and breathing. This phenomenon is considered as the individual's behavioral reactions to the temperature change. The individual's increase in sweating and breathing promote further evaporation and cooling of their body in response to the altered environment. The person's perspiration and breathing are signs of strain in response to adapting to the rise of tension. Due to the sudden change in the environment, the individual temporarily experienced instability. During the moment of instability, the person implemented internal adjustments to restore their homeostatic balance (Caplan, 1963).

In a psychological context, an emotional crisis occurs when a person experiences a sudden and unanticipated shift in their psychosocial environment and perceives it as negative. The individual’s internal rise of tension and signs of strain alters their relationship with self, others, and the environment. Initially, that person is in a state of instability because of the sudden change in their relationship with the external

environment. For the individual to adjust to the altered environment and restore homeostatic balance, that person is required to create internal adjustments. The individual's internal adjustments can be observed as signs of strain that are the behavioral responses to the emotional crisis. The individual's behavioral response influences their capacity to adapt to the situation.

During an emotional crisis, the individual displays unique behavioral characteristics and manifestations as that person internally creates adjustments. These features include but are not limited to:

- signs of tension-release such as motor restlessness, fidgeting, and muscle tension (Caplan, 1963);
- an increased susceptibility to fantasies and irrational stereotypes (Caplan, 1963);
- a preoccupation with the issues that precipitated the crisis (Caplan, 1963);
- mental rehearsal or attempts to solve the issues (Caplan, 1963);
- the recollection of past crises and influential memories that have a particular relevance to the current crisis (Bailey, 2010; Caplan, 1963);
- a resurgence of the person's old anxieties and feelings (Bailey, 2010; Caplan, 1963);
- the presentation of dysphoric symptoms such as anxiousness, irritability, guilt, shame, hostility, or depression (Caplan, 1963; Hirschowitz, 1973; Stepney, Kane, & Bruzzese, 2011; Okamoto & Matsouka, 2009);
- cognitive confusion and personal understanding attributed towards the experience (Berman et al., 1998; Dressler, Donovan, & Geller, 1975);

- loss of hope, lack of coping mechanisms, and the perception that there is no way forward (Baldwin, 1979; Caplan, 1963; Marini et al., 2005; Sifneos, 1972);
- a repetitive or habitual response towards their needs or wants (Granich, 1935; Russell, 2006; Sifneos, 1972);
- disorganization in daily life routine and functioning (Baldwin, 1979; Caplan, 1963; Dressler, Donovan, & Geller, 1975; Meissner, 1966; Rouleau & Landry, 1971; Sifneos, 1972);
- a defective appetite, difficulty sleeping, and signs of unusual fatigue (Caplan, 1963,
  p. 524);
- professional and personal dissatisfaction, affected self-esteem and efficacy (Dressler, Donovan, & Geller, 1975; Gouva et al., 2009);
- conscious or unconscious damage to self-esteem (Castelnuovo-Tedesco, 1962);
- grief reactions (Aminzadeh et al., 2007; Cobb & Lindemann, 1943; Lindemann, 1944); and
- the "mobilization of new modes of problem-solving" (Wiseman, 1975, p. 205).

For the individual to re-establish a stable psychological homeostatic balance between their affective, cognitive, and physiological functioning, that person needs to implement coping mechanisms or problem-solving processes (homeostatic mechanisms). Homeostatic mechanisms are behavioral maneuvers that a person implements to reduce,

control, or avoid unpleasant emotional experiences. In addition, these behavioral maneuvers facilitate an individual's stability, and may be used simultaneously during an emotional crisis. An individual's homeostatic mechanisms occur at three different levels of awareness (Perlman in Baldwin, 1979): (a) the unconscious level that includes the individual's ego *defense mechanisms*; (b) the pre-conscious level that is similar to an individual's automatic response to stress that can be brought to conscious awareness; and (c) the conscious level in which the individual is fully aware of their coping behaviors that are used selectively as the result of their active decision process (p. 44).

It is important to note that an individual's internal adjustment involves a qualitative aspect. Even though an individual may implement a coping mechanism with the intent to restore stability in their relationships in the psychosocial environment, the adjustment can either be maladaptive or adaptive. There are healthy and unhealthy adjustment patterns and coping mechanisms that an individual may implement towards restoring homeostatic balance (Caplan, 1963).

According to Caplan (1963) and the data collection, an individual's effective and healthy patterns of coping are characterized by:

- an active and explorative approach characterized by seeking assistance to develop a realistic perspective towards understanding the crisis and its potential hazards;
- the creation of adaptive internal adjustments that align with their cultural context;
- the expression of negative feelings caused by the emotional crisis;
- a willingness to address their frustrations until a solution is attained;

- organizing the issue into manageable pieces to be addressed one at a time;
- an awareness of their physical state, and self-care practices especially during moments of tension;
- actively attempts to master certain issues and feelings;
- displays flexibility and willingness to alter their perception of the emotional crisis;
- the acceptance of inevitable circumstances that were beyond their control;
- a basic trust in themselves and their relationships; and
- an attitude that one will be relatively intact after the crisis despite the frustrations and pain involved (Caplan, 1963, p. 551).

In contrast, an individual's unhealthy maladaptive adjustments were characterized as the individual's:

- passive approach, and the denial or avoidance of the potential hazards of the emotional crisis;
- skewed perception of the situation that was influenced by wish-fulfilling or fear-arousing fantasies;
- projection of feelings onto others to avoid or deny acknowledging their own emotional state;
- overall disorganization in daily functioning;
- inability to physically pace oneself;
- refusal to seek or accept assistance and support;
- the portrayal of stereotyped reactions towards the situation; and
- experience of being quickly overwhelmed (Caplan, 1963, p. 551).

An emotional crisis is a "catalyst that disturbs an individual's old habits, evokes new responses, and becomes a major factor in charting new developments" (Rapaport in Brownell, 1984). If the individual resolved the crisis with a realistic perspective, that person psychologically developed and matured in the altered environment. Their stable psychological functioning is characterized by a lessened presence of dysphoric affect, the maintenance of a reasonable cognitive perspective towards the emotionally hazardous situation, and the utilization of problem-solving skills (Baldwin, 1979, p. 44). However, if the individual's external circumstances were extreme and the person was incapable of creating adaptive internal adjustments, psychological disintegration occurred (Caplan, 1963, p. 521; Sifneos; 1972).

In summary, an individual's homeostatic balance becomes temporarily unstable as that person addresses the emotional crisis. To restore homeostatic balance, that person creates internal adjustments to adapt to the altered environment. Initially, there is a rise in the individual's tension and signs of strain as that person implements a new steady pattern of psychological functioning. Therefore, the individual's altered behavioral pattern leads to "a new homeostatic balance between the altered system and its altered environment" (Caplan, 1963, p. 521).

Sifneos (1972). Sifneos defined an emotional crisis as an “intensification or aggravation of a painful state of being” (Sifneos, 1972, p. 29) in which an individual’s repressed, dormant feelings become activated. Even though Sifneos’ definition was not extensively cited throughout the data collection, his contributions toward this topic are significant. His influential text *Short-term Psychotherapy and Emotional Crisis* (1972) appeared in both search result lists.

The researcher expanded upon Sifneos' definition with authors who contributed similar content:

- "the existence of an intensified emotional state" (Waldfogel, 1959, p. 52);
- "repressed emotions of distressing nature" (Trautman, 1962, p. 151);
- "psychogenic disturbances" (Burke, 1926) such as emotional strain;
- an intolerable situation (Rouleau & Landry, 1971); and
- an individual's uninhibited expression of fantasy (Granich, 1935, p. 395).

Sifneos' conceptualization of an emotional crisis begins with the individual in an unpainful state of being. Throughout the individual's lifespan, that person is subjected to internal and external stressors. The individual's perception of particular stressors involves "a threat to basic needs or integrity" (Wiseman, 1975, p. 205) that elicits a painful state of being. Although the individual may experience temporary psychological instability, that person is motivated to restore and return to a relatively unpainful state of being.

For the individual to go back to an unpainful state of being, that person needs to respond to the precipitating event. The individual uses previously learned coping mechanisms and problem-solving techniques. However, if the person's current behavioral repertoire does not re-establish an unpainful state, the painful state is further intensified. Although an individual may temporarily experience stability in this state, that person remains vulnerable because the responses are inadequate for the situation or there is a lack of external resources to acquire new capabilities. The precipitating event further creates instability and intensifies the individual's painful state of being. If the individual resolves the presenting issue, then that person returns to an unpainful state.

If the issue is not resolved, the individual progressively disintegrates, and the potential of developing acute psychiatric symptoms and neurosis are increased. This result is due to the individual's vulnerable and painful state of being. Even though the individual may resolve that emotional crisis, they achieved it by developing pathological and maladaptive coping mechanisms to avoid a painful state of being. An individual's maladaptive adjustment is a defense mechanism that includes "specific denial and somatization" (DePasquale et al., 2012, p. 1878) that may lead "to psychiatric or psychosomatic illnesses" (Argles & Mackenzie, 1970, p. 187). If the individual remains in a maladaptive painful state of being, that person may experience reduced impulse control. This reduced impulse control occurs when the individual wants "to put an end" (Schnyder et al., 1999, p. 67) to their painful state of being. This resolution may lead to psychiatric emergencies, hospitalization, and suicide.

An individual's maladaptive adjustments, otherwise known as maladaptive coping strategies or defense mechanisms, include but are not limited to:

- substance use, thought disturbance, suicidal gestures, anxiety and withdrawal (Ferdinande & Colligan, 1980);
- an increase of harmful behaviour, anxiety, and apprehension (Berman et al., 1998);
- continued emotional deprivation (Roman & Blackburn, 1979; Rose & Sonis, 1959);
- physical consequences (Burke, 1926);
- continued incongruence between their "values system and knowledge framework" (Gouva et al., 2009, p. 158);

- a high level of uncertainty related to their perception of ability to address, and prevent future crises (Brummette & Fussell Sisco, 2015); and
- "the seeming loss of identity" (Wald, 1973, p. 366).

In summary, an emotional crisis is a personal and dynamic experience. It is a dangerous moment for the individual, because that person is in a painful state of being. The person is required to learn and implement internal adaptive adjustments in response to their feelings. The individual is capable of adopting maladaptive processes to prevent psychological deterioration. The remaining contributors in this section further clarified the research question, "what is emotional crisis?"

Brownell (1984). The emotional crisis continuum developed by Brownell was her response to the perceived shortcomings of the crisis concept. Brownell (1984) listed three issues with the theoretical construct of a crisis: (a) the precipitating event was the primary focus of the conceptualization; (b) the individual's crisis was the pre-cursor for crisis intervention; and (c) the precipitant was defined as the crisis instead of the individual's emotional state (Brownell, 1984, p. 17). Adapted from Brownell (1984):

- Potential crisis state: "The potential for a crisis state exists within every human by virtue of living and experiencing life" (Brownell, 1984, p. 17).
- Precrisis state: The individual has a high probability of exposure to a known stressful event (situational or developmental), may be unaware of the potentially stressful event, and at risk for the development of a crisis state. The individual may present with a poor history of handling stress, inadequate social supports, and/or lack of coping abilities. The individual may or may not display external manifestations of stress.

- Immediate crisis state: The individual is immediately exposed to the stressful event. The individual's behavioral manifestations depend on the nature of the event, and their habitual responses to stress.
- Intermediate crisis state: The stressful event occurred and the person perceives the event as highly stressful. The individual attempts to resolve the issue with available resources, but does not attain resolution. Unsuccessful resolution is influenced by a lack of supports and/or the individual's initial solution was inadequate. The individual's behavioral manifestations are then characterized by increased anxiety, and exaggeration of symptoms.
- Advanced crisis state: The individual initially failed at resolving the stressful event, and continues to draw upon inner resources for new solutions, and reviews past problem-solving attempts. Despite continued attempts, the individual fails to resolve the situation, and may seek crisis intervention due to an increased desire for assistance to ease the stress symptoms.
- Full crisis state: The individual failed to resolve the issue from previous attempts, and crisis intervention did not occur. The individual lacks symptom relief, and may believe that they have used all available resources. Severe anxiety responses, feelings of helplessness, and a disruption in daily functioning are behavioral manifestations that the individual may experience in the full crisis state.

Brownell's continuum represented an initial effort at defining the concept of emotional crisis as an individual's actual or potential state of mind in response to significant life events (Brownell, 1984, p. 18). Although Brownell (1984) mentioned the

shortcomings of crisis models, Sifneos explicitly addressed the individual's emotional state as one that is in pain. Also, Caplan and other contributors before her publication discussed the individual's cognitive state of anticipated loss and threat in response to an emotional crisis.

Rouleau and Landry (1971). The authors presented a methodology for resolving a severe and acute emotional crisis. The authors showed how an emotional crisis threatens an individual's biological, psychological, and social integration. In this circumstance, a crisis was explained through a maturational developmental lens with a psychodynamic explanation at the moment of crisis intervention. Therefore, their suggestion of establishing a therapeutic plan was analyzed from the precipitating event. Adapted from Rouleau & Landry (1971):

1. Human organism: The model starts with the individual in a pre-crisis state.
2. State of stability: The individual is psychologically functioning in daily life.
3. Precipitating event/Incident of stress: A precipitating event imposes on the individual’s state of stability, and the individual then experiences a state of instability.
4. State of instability: The individual is temporarily incapable of implementing coping strategies in response to the event.
5. The felt need to restore stability: The person is motivated to return to a relatively normal state of stability and psychological functioning. The individual will either display stability factors (step six), or instability factors (step seven).

6. Present factors of stability: The individual conveys a realistic perception of the event, has an adequate social support and resources in the current situation, and presents sufficient adapting coping mechanisms. As a result, the individual resolves the problem, restores stability, and does not experience an emotional crisis.
7. Instability factors: The individual conveys a skewed perception of the event, has inadequate social supports and resources in the current situation, and presents inadequate adaptive coping mechanisms. As a result, the individual is unable to resolve the problem. The person's state of instability continues, and an emotional crisis occurs. Crisis intervention is prescribed in this circumstance.

Sifneos' conceptualization is similar to Rouleau and Landry's model (Rouleau & Landry, 1971), but a significant difference is that the individual experiences an emotional crisis after their initial resolution attempts, and it is not the final phase of unsuccessful crisis resolution. Thus, Rouleau and Landry's model emphasizes the individual's rise of tension and signs of strain.

Baldwin (1979). The lifecycle of an emotional crisis has four distinct phases as outlined by Baldwin (1979): the emotionally hazardous situation, the emotional crisis, crisis resolution, and post-crisis adaptation.

1. Emotionally Hazardous Situation: The individual experiences unpleasant feelings that cause a homeostatic imbalance due to the altered environment. To reduce the unpleasant affect, the person becomes motivated to restore stable psychological functioning by using previously learned coping

behaviors. "In most instances, learned coping behaviors are successful in returning the individual to homeostatic balance in a short amount of time" (Baldwin, 1979, p. 44).

2. The Emotional Crisis: If the individual attempts to reduce the unpleasant affect without initial success, the effect intensifies and the individual experiences gradual cognitive disorganization. The individual attempts to restore psychological functioning with “new and/or novel coping behaviors or problem-solving techniques” (Baldwin, 1979, p. 44), and may seek support and assistance for crisis resolution.
3. Crisis Resolution
    - Adaptive Resolution: The individual can identify issues, address their feelings, make decisions, and learns new problem-solving techniques or coping behaviors with external assistance. As a result, the individual's underlying conflicts that were reactivated or initiated by the emotional crisis may be identified and partially resolved. However, the person needs to focus on crisis resolution to reduce the unpleasant affect and return to a pre-crisis state of functioning.
    - Maladaptive Resolution: The individual is unable to identify the issues influenced by their underlying conflicts that were reactivated or initiated by the crisis. Also, the individual does not attempt to seek assistance or adequate support due to a lack of internal and external resources. Several reasons include but are not limited to the avoidance or denial of feelings, decision-making, or acquisition of new techniques. However, the individual can reduce

the unpleasant effect by addressing the immediate crisis but “returns to a less adaptive level of functioning than in the pre-crisis period” (Baldwin, 1979, p. 45).

4. Post-Crisis Adaptation

- Adaptive Resolution: Due to the individual focusing on their capabilities and acquiring new techniques and skills for addressing the situation, that person will become less vulnerable in future, similar crises. The individual’s underlying conflicts were resolved and are less likely to be reactivated when a similar circumstance occurs. Furthermore, the individual experiences improved psychological functioning due to personal growth and maturation from the situation.
- Maladaptive Resolution: The person remains in a vulnerable state when similar emotionally hazardous conditions occur because the underlying conflicts were not resolved. Furthermore, these dormant conflicts will reactivate in similar, future circumstances. Thus, the individual may acquire "maladaptive, self-defeating, or neurotic mechanisms" (Baldwin, 1979, p. 45) to cope with the unpleasant affect and altered environment. In addition, the individual experiences deterioration in psychological functioning and presents a high risk of developing a similar emotional crisis in the future.

In addition to the lifecycle, Baldwin (1979) provided an emotional crisis classification list. This list provides a framework for clinicians to administer appropriate intervention strategies. Baldwin (1979) discussed the six types of emotional crisis, and stated that “with movement from Class 1 to Class 6, crises become more serious and the

locus of stress that produces the crisis shifts from external stressors to internal conflicts of the individual that reflect psychopathology" (Baldwin, 1979, p. 47). Adapted from Baldwin (1979, p. 47-49):

1. Dispositional Crises: The individual experiences distress from a problematic situation, and requires clarification and appropriate supports to address the issue. Therapists may use intervention strategies such as offering referrals and providing appropriate psychological or medical information relative to the individual's issue. An emotional resolution is not necessarily required, and if it is, then the therapist is required to respond to the person's crisis at the appropriate level of intervention.
2. Crises of Anticipated Life Transitions: These crises are characterized by anticipated, normative life transitions in which the individual "may or may not have substantial control" (Baldwin, 1979, p. 47). Examples include parenthood, starting or ending a career, and pursuing post-secondary education. The therapist focuses on developing an in-depth understanding of the changes that occur in the individual's life before, during, and after the transition. In addition, the therapist explores with the individual the adaptive coping strategies, support/resources, and the psychological implications of the situation.
3. Crises Resulting from Sudden Traumatic Stress: The individual experiences a sudden, unexpected, or uncontrolled emotionally hazardous situation such as "rape, sudden death of spouse or family member, [or] accidents with physical dismemberment" (Baldwin, 1979, p. 48). Due to the sudden onset of the

precipitating event, the individual's usual coping strategies are ineffective and inadequate as that person's psychological functioning is temporarily affected. In addition, "there may be a refractory period which the client experiences emotional paralysis and coping behaviors cannot be mobilized" (Baldwin, 1979, p. 48).

The primary focus for the therapist is implementing supports and resources for the individual during the refractory period. After the refractory period, the therapist may motivate the individual to acknowledge and express the unpleasant emotions of the situation, and provide anticipatory guidance to further motivate the individual "in planning for and coping with changes that result from the traumatic situation" (Baldwin, 1979, p. 48).

4. Maturational/Developmental Crises: The individual attempts to address "interpersonal situations that reflect a struggle with a deeper, but usually circumscribed developmental issue" (Baldwin, 1979, p. 48) due to unsuccessful attempts at adaptive resolution towards restoring psychological balance.

   Caplan (1963) and Sifneos (1972) focused on these crises due to the idiosyncratic psychodynamics of the individual, and their "repeated pattern of specific relationship difficulties that occurs over time" (Baldwin, 1979, p. 48). The individual shifts from an external locus of stress to an internal locus when these situations arise.

5. Crises Resulting from Psychopathology: These crises are characterized by the individual's pre-existing psychopathology that manifested from the

emotionally hazardous situation. It is commonly a relationship context that triggered the individual's maladaptive habitual patterns and responses, or the significant incapacitation towards achieving adaptive resolution. They experience various difficulties that impair more than one aspect of functioning (affective, cognitive, and physiological).

6. Psychiatric Emergencies: This crisis is the most severe, because the individual is significantly impaired and "incapable of assuming personal responsibility" (Baldwin, 1979, p. 48). The characterizations and potential social outcomes of this crisis include: hospitalization (medical and psychological intervention, psychiatric emergency), substance abuse such as alcohol and drugs, homicidal and/or suicidal impulses, or an impaired relationship with reality (acute psychoses).

In summary, Baldwin (1979) conceptualized and classified six types of emotional crisis that delineated the various crisis states for clinical research and practice. In addition, his lifecycle of emotional crisis provided an outline of the general conceptualization of what happens when an emotional crisis is experienced.

As an overview of crisis intervention work regardless of what type of emotional crisis that a person presents, Baldwin (1979) listed ten general principles from crisis theory:

1. A person is unique with idiosyncratic reactions and responses to stress and emotional crises.
2. An emotional crisis is a self-limiting event and may last between four to six weeks. The individual may resolve the emotional crisis with either adaptive or

maladaptive behaviors. If adaptive resolution does not occur, the individual may develop maladaptive, neurotic coping behaviors that relatively reduces their stress but does not lead to the mastery of psychological conflicts.

3. The individual's psychological defenses are weakened or absent, and they may experience a heightened affective and cognitive awareness. As part of the crisis resolution process, the individual is more capable of addressing important past experiences that may be highlighted in an emotional crisis. This is due to the person's motivation for psychological change to strive towards a deeper and lasting resolution. However, their motivation may be directed towards symptom relief and returning to a pre-crisis state that maintains the *repression* of past experiences.
4. In a state of instability, the individual becomes vulnerable to internal and external forces, yet their motivation to re-establish stability increases their capacity for affect regulation and cognitive learning.
5. Crisis work is implemented to motivate the individual towards a resolution of their underlying psychological conflicts. These conflicts influence the emotional crisis, and interfere with the individual’s resolution.
6. Crisis work allows for small influences to create large changes that extend beyond the session.
7. An individual's resolution is shaped in the "here-and-now" of the session with the unique psychological influences and cultural relativity present in the meeting.

8. The inherent aspect of an emotional crisis is an actual or anticipated loss for the individual.
9. An emotional crisis is always an interpersonal event that involves a significant person who is represented directly, indirectly, or symbolically in the individual's situation.
10. Crisis work includes the prevention of similar incidences from occurring in the individual's present and future, and empowering the person's inherent potential and capacities for adaptive psychological change (Baldwin, 1979, p. 46).

In summary, an individual's emotional crisis is caused by an underlying psychological conflict that influences their ability to create internal adjustments in the altered environment. An individual's lifecycle of emotional crisis has a cyclic, and fluctuating nature as that person navigates the altered environment with an internal and external locus of control. Clinical intervention is an option for the individual where that person actively engages in crisis work towards resolution of an underlying psychological conflict.

Emotional Crisis in a Time-Limited Context

If a person is incapable of implementing adaptive internal adjustments to re-establish a stable state of functioning and an unpainful state of being, an emotional crisis becomes a turning point in their life. One of the potential behavioral maneuvers that an individual may implement as a response to an emotional crisis is to seek external assistance. Thus, the individual's decision to seek psychotherapeutic intervention is an adaptive internal adjustment. The person finds and places oneself in a supportive

environment while in a painful state of being. The therapist motivates that person towards an adaptive resolution of the emotional crisis (Caplan, 1963, p. 529; Sifneos, 1972). Therefore, psychotherapeutic intervention is an adaptive adjustment where the individual consciously decides to pursue an alternative resolution rather than continue their perpetuation of maladaptive coping strategies. The individual's motivation for psychotherapeutic intervention is to address and resolve the emotional crisis in a way that is in congruence with their needs and desires.

The emotional crisis concept influenced the development of treatment and rehabilitation programs from a community perspective. The community responded to this acute phenomenon, and agencies adjusted their administrative arrangements and services. They aimed to address emotional crises, provide remedial efforts for individuals who sought assistance and prevent people from developing a homeostatic resistance to change. In addition, the agencies that promoted this immediate service engaged in interdisciplinary consultation, training, and special education. These organizations developed service delivery models where individuals and families had direct access to psychotherapy services. If people were unable to receive immediate assistance, they were more likely to adapt a homeostatic state resistant to change (Caplan, 1963; Hoyt, 1995; Hoyt & Talmon, 2014; Sifneos, 1972; Talmon, 1990). Thus, brief and short-term psychotherapy, single-session therapy, and time-limited psychotherapy emerged to counteract the inefficiency of long-term psychotherapy administration (Caplan, 1963; Hoyt, 1995; Hoyt & Talmon, 2014; Hughes, 2016; Mann, 1973; Sifneos, 1972; Talmon, 1990).

Time-limited psychotherapy "refers to a course of therapy whereby the number of sessions and therefore the anticipated ending date is agreed with the client early in the treatment" (Hughes, 2016, p. 8). This characteristic is shared with the brief and short-term psychotherapy, and single-session therapy literature. Time-limited therapies are not based on the replacement of long-term therapy and ongoing treatments, but rather a professional adjustment in providing available treatment to individuals and families who experienced crises.

The uniqueness of acute treatment is that change is at the core of treatment, and the individual's "tears of dysphoria" (Hoyt, 1995, p. 218) are explored. Brief therapy is "intended to be quick and helpful, nothing extraneous, no beating around the bush" (Hoyt, 1995, p. 281) as the therapist and individual endeavor to "get from Point A (…) to Point B" (Hoyt, 1995, p. 281) – from the problem to resolution. A core aspect of these acute therapies is that they emphasize the individual's reality-fantasy, conscious-unconscious, and time-timelessness boundaries of the treatment (Hoyt, 1995; Mann, 1973; Hughes, 2016). The ultimate therapeutic goal for the individual is to master underlying psychological conflicts (Hoyt, 1995). The underlying psychological conflicts affect that person's sense of self and ability to prevent current and chronically endured pain.

Single-session therapy extends the basic criteria of brief psychotherapy and is considered as a specialization. A common criticism of single-session therapy is that the first session is also the last. Although the first meeting may be the last, the therapist and the individual mutually determine whether the session was successful, or additional services and/or follow up is requested or required. Furthermore, single-session therapy

does not imply that one session is absolute, that one session is appropriate for all individuals, or that one session is all that is required (Sifneos, 1972; Hoyt, 1995; Hoyt & Talmon, 2014; Talmon, 1990).

The researcher arranged this section to expand upon the contributions that were initiated by Caplan, Sifneos, Brownell, Rouleau and Landry, and Baldwin from the previous section. They further explicated Sifneos' contributions as he was the main contributor on the topic of emotional crisis in a time-limited context, and highlighted his methodological approach of anxiety-provoking psychotherapy as it emphasized the individual's motivation and movement towards emotional crisis resolution. In addition, the researcher presented Sifneos' eligibility criterion that assists a therapist to determine the applicability of time-limited services for the individual. These standards developed by Sifneos were implemented and adapted for acute therapies. As an extension to anxiety-provoking psychotherapy, the researcher summarized Bernard Bloom's focused single-session therapy model to augment Sifneos' contribution. Then, they discussed Rossi et al.'s 4-stage creative process in brief psychotherapy to highlight the individual's crisis work.

Anxiety-provoking psychotherapy. Sifneos (1972) defined two types of crisis work: *anxiety-suppressive psychotherapy*, and anxiety-provoking psychotherapy. The terms anxiety-provoking and anxiety-suppressive were used for communication purposes. The terms described the therapist's tasks and the structure of the session (Sifneos, 1972). Anxiety-suppressive psychotherapy is focused on the individual's symptom relief, and the therapist does not increase that person's anxiety. The crisis work is focused on supporting the individual's stability and overall functioning. Anxiety-suppressive psychotherapy

establishes the foundation of a person's future psychological work when they will be capable of addressing underlying psychological conflicts in a relatively stable state with a sense of self.

In contrast, anxiety-provoking psychotherapy is focused on an individual's emotional crisis resolution that emphasizes the therapist's clinical brevity, emotional re-education, problem-solving, and focused goals (Sifneos, 1972). The therapist who provides anxiety-provoking psychotherapy displays the following methodological characteristics:

- the pursuit of unconscious material such as instinctual drive, and ego defenses (Mann, 1973; Sifneos, 1972);
- an active and anxiety confronting intervention (Rouleau & Landry, 1971; Sifneos, 1972);
- the attention to a central focus that limits the degree of the individual's psychological regression or deterioration (Sifneos, 1972);
- challenges the individual's psychological defenses;
- highlights the dynamic interrelationship of the individual's impulses;
- clarifies the person's anxiety;
- interprets the individual's defense mechanisms that are used to contain repressed feelings, and the lifelong pattern of object relations that characterize the person's past and present functioning; and
- implements supportive techniques when tension threatens the treatment.

Anxiety-provoking techniques, such as clarification, confrontation, and interpretation, are directed towards motivating the individual to face the repressed

feelings that arise from enduring past experiences. These techniques are intended to stimulate the individual to examine the areas of emotional difficulty that one tends to avoid. Clarification, confrontation, and interpretation techniques motivate the individual to become aware of the repressed feelings, experience the underlying conflicts, and learn new ways of solving their issues (Sifneos, 1972) in a developmental and supportive environment. Clarification is when the therapist restates the individual's responses to motivate them to define the psychological issue more concisely. Interpretation involves the therapist providing insight regarding the individual's unconscious forces that drive a behavior, and offering alternatives to cease repetitive, maladaptive patterns. Confrontation is the therapist's attempt to bring awareness to the individual's unrecognized thoughts and emotions. It is a technique used to make a person conscious of their habitual response to a psychic event, along with their underlying conflict, source, and history.

The therapist's utilization of these techniques requires the therapist to use the individual's own words to respect that person's unique worldview. In addition, the individual determines what is beneficial or not from the session. If the individual considers the therapeutic intervention successful, they may use the therapeutic encounter and experience towards the prevention and reduction of future crises. Furthermore, the individual returns "to a mentally healthy level of functioning" (Sifneos, 1972, p. 29) once an adaptive resolution is attained.

Sifneos (1972) developed selection criteria to determine if an individual was appropriate for short-term psychotherapy services. First, the person must comprehend and perceive the emotional crisis as a psychological event. If the individual did not consider

their emotional crisis as psychological, that person was not deemed appropriate for psychotherapeutic services. As such, the individual was then referred to a more appropriate resource and support. If the individual considered their emotional crisis as psychological in nature, the following criteria were implemented: (a) does the individual have a meaningful relationship with another person in their life; (b) does the individual appropriately express affect and interact well with the therapist; and (c) display motivations towards the therapeutic service and process.

Sifneos then elaborated on the therapist's assessment of the individual's motivation for psychotherapeutic assistance. The person's motivation was assessed with these criteria: a willingness to understand, explore, change, and become an active participant in the therapeutic encounter and process; the cognitive ability to demonstrate introspection and provide an honest account of the emotional crisis; and realistic and reasonable expectations for the service which include time and fee requirements.

Overall, Sifneos' contribution formed the foundation for emotional crisis resolution. Baldwin's ten principles of crisis work elucidate the therapeutic alliance between the therapist and individual. Working from this base, the researcher would next like to consider focused single-session therapy and the 4-stage creative process in brief psychotherapy, in order to refine the theoretical and methodological focus of the study.

Focused single-session therapy. Bernard Bloom is an American psychologist who developed focused single-session therapy. Bloom (1997) stated that focused single-session therapy is about assisting individuals “understand more about themselves – how their past experiences have influenced their motivations, their affect, and their conflicts, and how these experiences, if they are unassimilated, continue to influence their daily

lives" (p. 69). Thus, focused single-session is influenced by psychodynamic theory and the concept of repression, and Bloom's contribution augments Sifneos' conceptualization of emotional crisis and is a sub-specialization of brief and short-term psychotherapy with an emphasis on anxiety-provoking characteristics.

According to Bloom (1997),

> Focused single-session therapy matches the general ways in which primary medical care is delivered. The therapist provides some form of remediation that is judged to be pertinent to the presenting problem, with the understanding that the patient should feel free to return if the remedy does not appear to be sufficiently effective. Thus, focused single-session therapy can be thought of as primary health care. As such, it can be appropriately followed by additional contact between the patient and the therapist, if and when that additional contact is needed (p. 83).

Bloom (1997) noted that single-session therapy as a service and its therapeutic impact on individuals are underestimated (p. 66). The therapeutic principles of single-session therapy are no different than time-unlimited psychotherapy, and can be categorized as *awareness* and *insight*. Individuals "discover something significant about themselves" (Bloom, 1997, p. 86) that they may find useful if it is communicated to them by the therapist to promote awareness. Insight motivates individuals "to identify a course of action that they have the capacity and the willingness to carry out" (Bloom, 1997, p. 69) after the initial therapeutic encounter. Bloom (1997) stated that these principles "may only take a "teaspoonful" for clients to get unstuck and get on with their lives" (Bloom, 1997, p. 69). Overall, the therapeutic principles of awareness and insight motivate

individuals towards “changing the viewing, and changing the doing” (O’Hanlon in Bloom, 1997, p. 69).

Bloom (1997) outlined four phases of focused single-session therapy: "introductory material, middle identification and development of important themes, the planning period, and the gradual closing" (Bloom, 1997, p. 71). Throughout these phases, the therapist ought to be prudently active towards uncovering new material in a process that does not disable the person with anxiety and enhances the individual's outlook to continue addressing the issues after the session (Bloom, 1997). The therapist's role in focused single-session therapy is "to develop a sense of how the patient is in the world and what processes can be started that can make a difference" (Bloom, 1997, p. 70) that the individual can carry forth after the therapeutic encounter.

The four-stage creative process in brief psychotherapy. According to Sifneos (1972), there is a creative process that is associated with an individual’s motivation. Inspiration, discovery, and invention are three aspects of the creative process (Sifneos, 1972). He considered motivation and creativity to go “hand in hand” (Sifneos, 1972, p. 91). As an individual becomes engaged in creative work, the person’s fragments are synthesized into a meaningful whole (Sifneos, 1972). Within this synthetic process, there is “the discovery of hidden similarities and the tolerance of paradoxical situations” (Sifneos, 1972, p. 91). An individual’s willingness and openness to change, explore, experience, and transform is comprised of a passive and active dimension. The passive dimension is the individual’s willingness to discover new insights while the active dimension is characterized by the individual's responsibility to express their ideas. Sifneos (1972) recommended that therapists ought to keep an open mind in providing

brief services, because once the therapeutic encounter is initiated, individuals may have discoveries and insights.

Rossi et al. (2011a, b) developed the 4-stage creative process model in brief psychotherapy. Their contributions expanded and clarified Sifneos' notion of an individual's creative process in emotional crisis resolution. Rossi et al.'s model was designed to promote and facilitate the individual's "creative psychosocial genomic healing experience" (Rossi et al., p. 416). The person engages in psychological work that is focused "on the implicit (unconscious) levels or the therapeutic replay, reconstruction, and reframing of negative (stressful) human experiences into positive "inner resources" that many cultures have called "healing," "therapeutic," or "wisdom." (Rossi et al., 2011a, p. 65-66). A summary of their 4-stage creative process is outlined below.

Stage One: Preparation. This stage involves history-taking and data collection. The therapist asks open-ended questions to "initiate an inner search" (Rossi et al., 2011b, p. 416) that optimizes the psychotherapeutic process and healing experience. The therapist and the individual then identify the psychological issues and the potential life transitions "that are at the source of the patient's conflicts" (Rossi et al., 2011a, p. 64). Throughout this stage, both parties can determine the individual's "readiness for embarking on a potentially healing experience" (Rossi et al., 2011a, p. 64).

Stage Two: Incubation. The individual expresses the conflict, emotions, and symptoms of the adverse life event that affects their psychological functioning. The therapist supports the individual "through this typically difficult stage of [their] natural cycle of creativity, problem-solving, and healing" (Rossi et al., 2011b, p. 416) with active, respectful listening and open-ended questions. "Less is often more at this stage"

(Rossi et al., 2011b, p. 416); therefore, the therapist is recommended to adopt a supportive role to promote and facilitate the individual's expression of a psychological conflict in a safe environment.

Stage Three: Illumination. At this stage, the therapist adopts a more active role in the therapeutic process. The therapist validates and affirms the individual's conscious act of creativity towards problem-solving, resolution, and healing of a psychological conflict that occurred "after a period of inner struggle in Stage 2" (Rossi et al., 2011b, p. 417). "Many people automatically dismiss their own originality as worthless when it was never reinforced in their early life" (Rossi et al., 2011b, p. 417); therefore, it is important for the therapist to facilitate a developmental learning experience in a psychosocial context that synthesizes an individual's inherent creativity to transform, resolve, and heal in a healthy, adaptive manner.

Stage Four: Verification. This stage is characterized by the parties' "conscious co-creation and ratifying the reality of the new" (Rossi et al., 2011b, p. 417) in and after the therapeutic session. The therapist's task is to validate and affirm the individual's insights and initial resolutions that manifested in Stage Three (Rossi et al., 2011b, p. 417), and reframe the person's "symptoms into signals and psychological problems into inner resources" (Rossi, et al., 2011b, p. 417). As such, the therapist validates and affirms the individual's resilience and resourcefulness. A follow-up experience (appointment) and additional supports are arranged by the therapist and individual if future psychological work is required.

The individual gains insight from Stage Three, and is motivated to reality test the solutions that were created from their resilience and resourcefulness during the inner

struggle experienced in Stage Two. After the session, they reality test the solution(s) that were synthesized in Stage Three to address the psychological conflict in a new, adaptive manner. The individual makes the conscious decision to proceed and develop adaptive adjustments that unite their unconscious and conscious forces.

The following subsection expands upon art therapy as the clinical psychotherapeutic modality of the creative process. The individual's creative healing experience via art-making re-establishes and re-stabilizes their mind-body connectivity and communication. Furthermore, the individual's resiliency and resourcefulness are facilitated, explored, affirmed, and validated with the therapist in a psychosocial context.

Emotional Crisis Resolution and Art Therapy

Time-Limited Art Psychotherapy: Developments in Theory and Practice (2016) was the prominent text from the data collection. This edited volume exclusively discussed art therapy as a clinical psychotherapeutic modality in a time-limited context. The contributors are based throughout England, and are experienced in providing individual and group art psychotherapy services in an interdisciplinary context. The text was an exploration and a response to the changing social and economic environment that affected art psychotherapy practice. As a result, art psychotherapists responded "creatively to the needs of art psychotherapy clients" (Hughes, 2016, p. 7-8).

The aims of this text included: (a) the integration of time-limited and art therapy literature; (b) the clinical application of art therapy as a psychotherapeutic intervention to resolve psychological distress via art-making with various concepts from "traditional art psychotherapy understandings integrated into new effective methods and understanding

of self" (Hughes, 2016, p. 8); and (c) the evaluation and the recovery model of art psychotherapy in various service delivery settings such as hospitals.

Time-limited art psychotherapy as a clinical crisis intervention "has not been definitively theorized (...) [and] all theory is provisional and subject to change" (Springham, 2016, p. 24). Several authors throughout the text used the term brief therapy or time sensitive instead of time-limited. As mentioned in the previous sections, acute clinical frameworks are characterized by the therapist's need for brevity and time sensitivity towards addressing an individual's emotional issue. Thus, the interchange of terms between contributors did not affect the results of the study. In addition, the terms *art psychotherapy* and art therapy are considered by the researcher as synonymous in this study, because it is the clinical modality of interest even though published contributors have their preference of which term they use.

The theoretical underpinnings of time-limited art psychotherapy. The contributors' perspectives on time-limited art psychotherapy are influenced by attachment, cognitive, neurobiological, and psychoanalytic theory. One of the results from combining the theories was the discussion of a *mentalization* approach to address an individual's psychological distress. A mentalization approach "works with the concrete state of mind that accompanies that distress" (Springham, 2016, p. 22). Mentalization purports that social proximity and interaction is the most powerful approach for the individual's affect regulation that involves the brain's neurological processes. Thus, time-limited art psychotherapy is an experiential psychotherapeutic approach that addresses an individual's psychological distress in a supportive and developmentally healthy psychosocial environment. The individual's psychological work and recovery are based

on a psychotherapeutic treatment that is suited to that person's present functioning and capabilities. The therapeutic focus is on the individual's behavior and their making of an image (art-making) that “can be observed and measured” (Solomon, 2016, p. 154) as psychological change.

A mentalization approach is heavily influenced by art psychotherapy and cognitive therapy concepts. Cognitive therapy research presented "how ‘mental' imagery is indeed both positive and necessary" (Solomon, 2016, p. 158) and how it may be implemented as a problem-solving tool for bringing about an individual's affective and cognitive change. An individual's mental (internal) imagery can influence maladaptive coping strategies, increase anxiety, and lead to inadequate resolutions. An individual's art-making is an act of re-drawing and re-scripting of a singular experience. Thus, art-making is a behavioral action that facilitates and promotes an individual's synthesis of a coherent self. An individual's psychological distress separates their thoughts and images (cognitions), emotions, and memories.

With art-making, the individual’s presentation of their cognitions, emotions, and memories as imagery encourage the “exploration of unconscious implicit representation” (Solomon, 2016, p. 157). An individual’s art-making allows the “implicit unprocessed, perhaps negative images to become expressed, and this allows us to see in what way they are causing distress” (Solomon, 2016, p. 157). Thus, the individual's imagery is a representation of the underlying psychological conflicts that were previously repressed. The person's release (catharsis) of their unconscious via art-making contains that person’s implicit knowledge of how to resolve the psychological conflict that causes psychological distress.

The individual's implicit knowledge of an underlying conflict sometimes emerges from the imagery. The imagery sometimes allows the individual to perceive how their repression influences an emotional crisis. In addition, the person's expression of memory and affect via art-making may lead to an explicit knowledge of how to create a preferred reality. Furthermore, the individual's unconscious is rendered visible via art-making. The person's art-making externalizes that person's cognitions, emotions, and memories. It liberates that person from the internalized cognitions that perpetuate psychological distress and maladaptive adjustments.

An individual's *schema*, that person's belief system about the self, can be represented in the past, present, and future because of the ability of art-making. The individual's art-making and resulting imagery elucidate that person's frequent repetition and maintenance "of the unhelpful thoughts, feelings, and behaviour" (Solomon, 2016, p. 155) that prevents emotional crisis resolution. In addition, an individual's imagery represents the past, present, and future due to art-making bridging the split between reality-fantasy, and the unconscious-conscious.

An individual's psychological distress such as "trauma and other states brought to art psychotherapy are most often repetitious and this is very distressing for the client. However, within this lays the potential to review and rework past time impact thereby allowing new potential and generativity to follow into future time" (Hughes, 2016, p. 4). The individual's psychological distress is exposed and externalized during art-making, and it is a behavioral act that enables that person to create a preferred reality in a therapeutic environment. In this supportive environment, the therapist facilitates a safe

container for the individual to release tension and strain, explore, and discover their creative process towards cognitive restructuring and psychological change.

Art is a vehicle of emotional language that "facilitates time travel as an internal journey into the self" (Hughes, 2016, p. 4). The individual's creation of a safe container provides that person with an altered environment to address trauma, grieve, and facilitate an embodied connection (of body and mind). The person's feelings from a psychological conflict are released, thus ending the individual's habitual pattern of maladaptive adjustments. An individual's psychological conflicts are witnessed and encountered in the therapeutic environment with art-making and imagery. This is an alternative response to an emotional crisis that bypasses the individual's automatic and repetitive maladaptive adjustments. This safe container via art-making is created to support effective clinical work to offer the individual a new perceptive and emotional process towards an improved sense of self and being. Thus, art-making is an altered environment that provides a novel experience for the individual to explore and discover latent (alternative) creative responses and resolutions.

In art psychotherapy, the individual is asked to use “the art materials and [their] managing in the object that was previously unmanageable psychologically” (Hughes, 2016, p. 3). The individual’s art-making process where imagery is made by hand is a unique and alternative presentation of their suffering and the feelings of the past self. The art-making process and the imagery are the individual's psychological re-working and re-scripting "of the deprived child as an adult" (Hughes, 2016, p. 3).

The individual’s defense mechanisms are a behavioral act to preserve the child self from historical or current life experiences (Hughes, 2016, p. 5). The defense

mechanisms protect their child self. The purpose of an individual's defense mechanism is to contain and repress the painful feelings related to a psychological conflict. Thus, the individual maintains a habitual way of being and establishes a repertoire of maladaptive internal adjustments to avoid compromising the survival and safety of their child self.

The individual's defense mechanisms serve the purpose of maintaining repression and are unhealthy internal adjustments. Even though that person may be able to contain and adapt to life circumstances with defense mechanisms, the emotional accumulation or a precipitating event will eventually cause psychological disintegration. An individual who accepts the defense mechanisms as an adaptive solution is not likely to seek therapy. However, when an individual's defense mechanisms are unable to maintain their purpose by containing a particular state of being, that person is more likely to seek support and assistance from others.

The principles of time-limited art psychotherapy practice. The therapist assumes that the individual wants to resolve the emotional crisis, and motivates them towards skill mastery and self-confidence in a resolution. The individual's verbal and pictorial imagery defines areas for therapeutic exploration, frames their intense affect, and can provide a sense of control and mastery of the situation. Furthermore, art-making provides a visual record of the individual's imagery that occurs before, during, and after maladaptive behavior (Lane, 1982).

If an individual is hyper-aroused, displaying fear, confusion, or anger – a "highly interpretive complex process" (Springham, 2016, p. 22) may prematurely make matters worse. Thus, the therapist ought to re-establish the individual's affect regulation and conduct an initial assessment to determine if time-limited services are appropriate for that

person. If the individual considers their issue as psychological, and is deemed suitable for time-limited services, then the therapeutic task is mutually conceptualized.

The therapist establishes a focal point of the therapeutic encounter, practices flexibility, and exudes a high-level of participation with the individual. The therapist and the individual mutually agree on an art psychotherapy task. The therapeutic work is conceptualized by a shared understanding of the individual's difficulties with a focus on a core issue. The therapist ought to be transparent with the therapeutic goals and minimize "unhelpful interpersonal ambiguity" (Springham, 2016, p. 15) to reduce the individual's anxiety. The mutual focus on a core issue is intended to support that person in managing their feelings and the “balance between despair and denial” (Springham, 2016, p. 15) of an underlying psychological conflict. Thus, the individual can focus on a central issue, perceive the challenges, and synthesize new internal adjustments that will inevitably prevent defense mechanisms and unhealthy internal adjustments (Liebmann, 2016).

The individual can integrate their psychological conflict and nurture their inner world with art-making and imagery. The therapeutic task is to give shape and form to the painful memories that maintain and influence their emotional crisis. Art-making promotes the individual’s self-expression, and the creative process itself is therapeutic (Atlas, Smith, & Sessoms, 1992). They can reduce anxiety, control disruptive imagery, identify precipitating stressors, and explore resources and supports with the therapist. Furthermore, the individual can access internal *archetypes* and object relations that are embedded in their cognitions (thoughts and images) as a deprived child with art-making and imagery. The individual is then able to develop a narrative and cognitively reframe the negative experience (Steele & Kuban, 2012). The individual’s psychic deficits can

influence internal imagery, but also use the natural creative force within that person (Shore, 2000). Furthermore, the person gains self-confidence even with a small change in self-expression (Liebmann & Francis, 2016).

The therapist facilitates the individual's personality development by focusing on their strengths, and by addressing potential psychic deficits from parent/child bonds. The therapist emphasizes the individual's here-and-now moments of the therapeutic process (Halbreich, 1978). Furthermore, the therapist motivates the individual to reduce their psychological distress towards a reappraisal of the situation, difficulties, and alternative options. Thus, the therapist encourages the individual to rediscover their capacity for change with "the seeds of resilience and generativity" (Hughes, 2016, p. 5). The therapist's focus is not on psychopathology, but rather on the individual's inherent potential to provide for their deprived inner child as an adult. Furthermore, the therapist connects the individual with additional resources and supports to ensure that the person can carry forth the psychological change after time-limited work.

It is important that the therapist implements a therapeutic task that the individual can accomplish. If the individual completes the task with the therapist, that person experiences: (a) a sense of empowerment that they have the capacity and potential to address adverse life events resiliently; (b) spontaneity and new imaginative possibilities that circumvent their entrenched ways of being (Selekman, 2010); and (c) a relationship where their needs and wishes for personality development are nurtured and actualized.

The art psychotherapy task is structured in a collaborative manner where the individual can actively master a core psychological conflict that causes an emotional crisis. Art-making is a behavioral act that is a representation of a person's lived situation

that can be used to re-script psychological conflicts towards an improved sense of being. The individual's conscious act of giving shape and form to internal imagery can document their entrenched way of being, and can "be used to provide evidence of psychological change and cognitive restructuring" (Solomon, 2016, p. 153). Thus, the ultimate goal for the art psychotherapy task is for the individual to create a reality as a whole being, cease the *separation* of their child and adult self, and move towards mastery of life difficulties and circumstances. The goal-focused and action-oriented therapeutic approach provides the individual with insight and resolution (Selekman, 2005) that is congruent with their inherent capacities and potential. Overall, the therapist and individual need to mutually implement a structured intervention to ensure that the person's core issue is addressed in a manner that is best suited for the individual.

The methodological concerns of time-limited art psychotherapy. Solomon (2016) stated that there is pressure for art psychotherapists "to conform and provide evidence of information about the efficacy of what we do" (p. 153). The role of imagery in psychotherapy has advantages over words, because words "are unable to express affective truth (… and) can only tell us about that which is logical and one dimensional" (Solomon, 2016, p. 158). Furthermore, words may reinforce an individual's depression or anxiety, because there is "access to one side of the self at a time" (Solomon, 2016, p. 158). Only one side of the self is revealed through words, and as a result, it may cause an individual "to compare and contrast one with the other causing rumination and suffering" (Solomon, 2016, p. 158). Despite this pressure to show how imagery has advantages over words, Solomon (2016) believed that this is an opportunity for art psychotherapists to

integrate their “work in the formal theorized field of current clinical psychotherapy practice” (p. 153).

It is essential for art psychotherapists "to show how and why what we do works" (Solomon, 2016, p. 154). Art psychotherapists have been addressing this pressure, and research studies of individuals with anxiety and depression within a time-limited model, are becoming more prevalent in art therapy literature. As such, models of assessment may be developed to “document psychological change in a systematic way” (Solomon, 2016, p. 153) that will further assist art psychotherapists to understand and explain how art-making influences affective change, and the qualitative difference between images from an individual’s *imagination* and that individual’s indirect images described with words (Solomon, 2016, p. 154).

Therapists operating in a time-limited manner ought to have structured aims that motivate them in using time efficiently and in being accountable for the therapeutic work that they deliver, especially in interdisciplinary settings (Doyle, 2016). This outcome can be addressed by the therapist actively integrating various theoretical approaches that lead to a continuum of brief art therapy tasks that benefit individuals who seek time-limited services (Wood, 2016). Another suggestion is ending the session with a case formulation that includes the therapist, interdisciplinary team, and the individual.

A case formulation summarizes what occurred in the session and how that person's unresolved emotional crisis has detrimental and recurring effects (Springham, 2016). Also, the therapist reviews the individual's art-making and imagery. The resulting conversation provides that person with "a coherent narrative of [their] progress" (Springham, 2016, p. 15), and consolidates the psychological change that the individual

gained from the session. The person's completion of a therapeutic task carries emotionally salient information that can prevent future psychological conflict from reoccurring, and prevent maladaptive internal adjustments. Furthermore, a mutual case formulation that emphasizes the individual's inherent capacity for change can encourage that person to continue their psychological work after the session.

Overall, time-limited art psychotherapy is effective in multidisciplinary settings. Whether or not the individual is transitioning from another service delivery care model, such as hospitals or long-term therapy services, time-limited art psychotherapy may be offered from multiple care network pathways to ensure continuity for the individual's journey towards recovery. The therapists and/or interdisciplinary team ought to provide a consistent, comprehensible, adaptable, and repeatable therapeutic approach that benefits people who experience a borderline/ emotionally unstable state of being (Thorne, 2016).

Summary

In conclusion, the therapeutic session aims to prevent the individual's psychological disintegration by addressing, resolving, and establishing an individual's affect regulation and re-establishing a stable balance of external and internal changes. The therapist motivates the individual with a therapeutic alliance, mutual goals/aims for intervention, acknowledging the person's positive feelings, and the creation of pivotal moments in session. A central moment in session is directed towards the individual's understanding of what can be accomplished as part of a larger process. The psychological tasks in the session require mental "work" which is called "crisis work" in the crisis intervention literature.

Overall, the acute nature of an emotional crisis requires the individual and therapist to focus on the present moment to actively re-establish homeostatic balance. Time-limited therapies and crisis work are based on the premise that an emotional crisis is a turning point for an individual. Their habitual pattern of coping strategies and defense mechanisms can be diminished with a clinical intervention that is offered as a mutually agreed-upon therapeutic task. The individual is more likely to engage in adaptive psychological change during an emotional crisis, because that person is more open and willing to remain in a painful state of being in hope for a change for the better. Thus, the individual can attain awareness and insight towards an underlying psychological conflict that causes pain and instability. The therapist motivates the individual in this endeavor by providing a structured, focused, and supportive environment for psychological change to occur. Thus, the therapist facilitates, nurtures, and empowers the individual's latent capacity for adaptive internal adjustments that do not perpetuate further repression, or avoidance of their painful feelings.

Chapter Three: Creative Synthesis

As the researcher deconstructed and analyzed the published literature on the study's topic, the emotional crisis literature appeared to emphasize a reductionist approach in its conceptualization in the acute setting. An individual's emotional crisis was commonly described as a reaction-formation event that caused physiological and psychological changes. Therefore, the emotional crisis was the *subject* of clinical investigation, and not the individual per se. In other words, the individual was not the subject of clinical investigation, but rather an object subjected to bodily and mental processes. As a result, the individual's emotional predicament during a crisis was not sufficiently explored. Although this lack in the analysis may be perceived as a gap in the literature, the researcher considers an opportunity to augment the findings in a contemporary manner that places an individual at the focus of emotional crisis treatment and resolution.

The researcher considers a creative synthesis as the analysis and expansion of the influential concepts that were discussed in the Systematic Review chapter. Even though the contributors focused on the theoretical and methodological perspective of emotional crisis with a clinical lens that emphasized physiological concepts, the researcher expands, clarifies, and refines the literature findings in a manner that places the individual as the *subject* of an emotional crisis. In this section, they analyze and connect the results with additional content. Although the data collection provided an adequate account of information about emotional crisis, the researcher decided that a direct connection of distinct theoretical perspectives provides more insight and information on this subject which emphasizes the individual's subjective experience of an emotional crisis.

The researcher presents their analysis with: 1) an introduction to biologist Ludwig von Bertalanffy's general system theory that influenced crisis theory; 2) an analysis of the emotional crisis definition; 3) an overview of theoretical, theological, and art therapy perspectives that are relevant to emotional crisis conceptualization and resolution; 4) an overview of the mind-body approach with influential concepts that forms the researcher's perspective of the clinical crisis work in time-limited contexts; 5) a discussion of art therapy as a mind-body therapy; and 6) their synthesis of a tentative clinical model, SSAT, that details the art psychotherapeutic task as per the parameters of the study. The composition of this section is of a fragmentary nature because of the distinctions that were required to connect concepts amongst the various disciplines. The separation of concepts needs to be presented as is, with original sources cited when possible, and then integrated into a general discussion to maintain the validity and reliability of the study.

Due to the focus of the study, the researcher emphasizes certain information and explains their reasoning for the inclusion. They continue to address the limitations of the study throughout the remainder of this text, and present a general, tentative, and subject-to-change conceptual framework of emotional crisis. The researcher's contribution is intended to be the foundation of future clinical work in the interdisciplinary health field. In conclusion, the researcher presents content that aligns with the data collection, and includes content that highlights an individual's subjective experience of an emotional crisis.

The Implicit Foundation of Emotional Crisis Theory

Crisis theory appears to be influenced by general system theory that was pioneered by the biologist Ludwig von Bertalanffy in 1928. General system theory is

comprised of universal principles that define systems. A system is defined as "sets of elements standing in interaction" (Bertalanffy, 1969, p. 38) in which the living organism maintains itself in a continuous in- and outflow as an open system but is "not in a stable equilibrium but show[s] cyclic fluctuations which result from the interaction of subsystems" (Bertalanffy, 1969, p. 48). Thus, an individual is an open system that is privy to changes that are influenced by their interactions with themselves, others, and the environment.

Bertalanffy (1969) stated that:

> In all irreversible processes, entropy must increase. Therefore, the change of entropy in closed systems is always positive; order is continually destroyed. In open systems, however, we have not only production of entropy due to irreversible processes, but also import of entropy which may well be negative. This is the case in the living organisms which imports complex molecules high in free energy. Thus, living systems, maintain themselves in a steady state, can avoid the increase of entropy, and may even develop towards states of increased order and organization" (p. 41).

Therefore, an individual is capable of maintaining a steady state, but there cannot be a stable state of psychological balance because they are continuously subjected to internal and external stressors. Their capacity to maintain homeostatic balance without destroying themselves in the process is a complicated endeavor. They can avoid psychological and physiological entropy (deterioration), restore homeostatic balance, and strive for a higher functioning in a different state of being. They are dynamic systems – not static, closed systems with predictable, controlled experiences. Psychological and

physiological deterioration may be considered as the entropy of their being (system) because they are unable to sustain and maintain a steady state of functioning. Thus, emotional crisis resolution requires an individual to address the underlying psychological conflict, contain and transform the psychical energy, and organize their body and mind to establish a higher state of functioning that leads to *spiritual development*.

The term general system theory was not prevalent throughout the data collection, because contributors "had been led to similar conclusion and ways of approach" (Bertalanffy, 1969, p. 38). Crisis theory may be considered as a derivative of general system theory, which is directed towards the conceptualization of emotional crisis that occurs within an individual's physical, biological, and social subsystems.

The Definitional Construct of Emotional Crisis

As the researcher conducted the review, there were inconsistencies throughout the data collection. The first inconsistency was the term emotional crisis. Although the explicit definitions for emotional crisis were located within Caplan's (1963) and Sifneos' (1972) contributions, it appeared that most authors defined crisis with the phrase "emotional crisis" embedded within their content. *The American Heritage® Dictionary of the English Language* (2011) defined crisis as

> 1. A crucial or decisive point or situation, especially a difficult or unstable situation involving an impending change.
> 2. A sudden change in the course of a disease or fever, towards either improvement or deterioration.
> 3. An emotionally stressful event or traumatic change in a person's life.

4. A point in a story or drama when a conflict reaches its highest tension and must be resolved. (crisis, 2011).

The English word crisis originates from the Greek word krisis. The Indo-European root of crisis is “krei-”. Its etymological origin stems from “skeri-” to cut, to separate (Brownell, 1984, p. 10; Krei-, 2011), which means “to sieve, discriminate, distinguish” (Krei-, 2011). The root krei- has Latin and Greek derivatives. Several of those words include but are not limited to: ascertain; critic; criterion; decree; decide; discern; discrete; epicritic; excrement; excrete; exocrine; garble; hematocrit; hypocrisy; incertitude; judgement; paracrine; recrement; secern; secret; and separate (Krei-, 2011).

As a complement to the English definition of crisis, the Chinese character for crisis *(*wēijī/危机) conveys a similar meaning. Victor Mair (2009), a Sinologist, stated that

> the jī of wēijī, in fact, means something like incipient moment; crucial point (when something begins or changes). Thus, a wēijī is indeed a genuine crisis, a dangerous moment, a time when things start to go awry. A wēijī indicates a perilous situation when one should be especially wary. It is not a juncture when one goes looking for advantages and benefits (2009).

Wēijī is composed of two characters: wēi (danger) and jī (opportunity). The character 机 by itself is neutral, and qualitative aspects are attributed by other graphs. Several connotations “of jī include: mechanism, inner workings (and by extension secrecy), germinal principle, pivotal juncture, crux, or a witty turn of thought” (Mair, 2009). As such, jī possesses secondary meanings, and its understanding varies with context.

External to the data collection, there were authors who defined crisis as an opportunity due to them semantically separating the Chinese characters of wēijī. However, the definitions and root influences of crisis do not have connotations of opportunity or a qualitative aspect. An emotional crisis places an individual in a state of instability where that person's psychological and physiological functioning becomes compromised. It is not a moment of opportunity because the person temporarily experiences a separation from their bodily and mental processes. It is a turning point in which they have to make internal adjustments to adapt to the altered environment. There are physical and mental consequences for the individual if they are unable to create adaptive internal adjustments in response to the crisis.

For a situation to be an opportunity for the individual, they have to intentionally create a set of circumstances to attain a particular outcome. When a person is subjected to an emotional crisis, that person suddenly experiences a painful state of being. The person did not anticipate the sudden change in relationships and environment, and most importantly, was not seeking to be in a painful state of being. In an emotional crisis, the individual is subjected to dangerous outcomes. As supported by the data collection, the individual consciously decides whether to:

- remain in a painful state of being due to ineffective internal adjustments and inadequate external supports and resources;
- avoid being in a painful state of being with maladaptive coping strategies and defense mechanisms;
- cease the pain by ending their life;
- seek assistance to alleviate their painful state of being; or

- request the assistance to explore and discover alternative adaptive internal adjustments while in a painful state of being.

It is more appropriate to state that the individual has a decision to make in the face of adversity, rather than saying that there is an opportunity in a crisis. There is no inherent opportunity in an emotional crisis because the outcomes are potentially dangerous. The individual has to discern which course of action to pursue to re-establish stability and return to an unpainful state of being. Even though an individual may decide to seek assistance, the adaptive change occurs while one is in a painful state of being. Therefore, an emotional crisis is not an opportunity, because the individual did not intentionally create a set of circumstances to be placed in a painful state of being to achieve a better outcome in life.

Throughout the data collection, all the crisis definitions and connotations were implemented in the contributions. For example, there were several anecdotal sources that discussed art, stories, and movies with the emphasis on definitions one, three, and four (crisis, 2011). The authors of oncological and psychosomatic medicine literature primarily focused on definitions two and three (crisis, 2011). In the psychological literature, there was an emphasis on definition three (crisis, 2011) because the focus of the research emphasized the reactive process of crisis. As such, the contributors discussed the concept of crisis when individuals experienced an emotionally stressful event or traumatic change.

Due to the English definitions of crisis, authors may have removed the word "emotional" from the term emotional crisis to avoid redundancy. In this circumstance, it was appropriate for the clinical content to be labeled as "crisis literature" because the

authors noted the emotional predicament between the individual, the emotional hazard(s), and the crisis situation within their contributions. The next inconsistency of the definitional construct of emotional crisis was that the words crisis and stress were used interchangeably throughout the data collection, especially in the medical literature.

Hans Selye, a medical doctor, stated that "*stress is essentially reflected by the rate of all the wear and tear caused by life"* (Selye, 1976, p. xv) and that "no one can live without experiencing some degree of stress all the time" (Selye, 1976, p. xv). Selye (1976) noted that stress is not necessarily negative for an individual, because stress for one person may be an entirely different experience than another's. Thus, von Bertalanffy's general system theory of open systems and the ability to avoid deterioration is applicable content, because of interrelationships between subsystems.

As an expansion of Selye's definition in this study, Rapaport (in Brownell, 1984) stated that stress carries a negative connotation. It also gives a pathogenic potential where an individual may perceive stress as "a burden or load" (Rapaport in Brownwell, 1984) in which that person either survives or suffers. In contrast, crisis may be regarded as "a special case of stress" (Rapaport in Brownwell, 1984, p. 13).

Concerning the authors who discussed emotional crisis with the interchange of crisis to stress (Dressler, Donovan, & Geller, 1976; Ferdinande & Colligan, 1980; Norris, 1967; van der Meer & Verhoeven, 2014), they indicated the intensity and acute nature of the precipitating event. Furthermore, stress was not described in their content as a low or moderate degree of emotional and physical discomfort with a persistent or chronic nature.

Thus, an individual's emotional crisis is indeed a special case of stress. It is characterized by an acute rise or a series of peaks in their tension and signs of physical

and mental strain, and the individual's challenge to re-establish stability with adaptive internal adjustments in response to the altered environment. Due to the conceptual consistency between stress and crisis throughout the data collection, it was logical to use these terms interchangeably. The conceptual overlap of crisis and stress transitioned into the theoretical and methodological constructs of addressing an individual's emotional crisis in a time-limited context.

Theoretical Assertions

The researcher structured the analysis as preparatory because of the introduction of general concepts from psychotherapy and medical literature, and contributed to the general theory of emotional crisis as derived from the research synthesis. This analysis and interpretation of emotional crisis are tentative and subject to change after this study, and an understanding of this clinical phenomenon will evolve as more research and experiences provide expository accounts on this subject.

There are psychotherapeutic and medical concepts that influence an individual's emotional crisis. The researcher first presents Freud's psychoanalytic contributions: the psyche's structure (*consciousness*, *pre-conscious*, *unconscious*); the psyche's regulatory principles (*pleasure principle*, *reality principle*); the psyche's agents (*id*, *ego*, *superego*); psychological conflict; repression; and anxiety. Then, they highlight aspects from object-relations theorist, John Bowlby, and his contribution about the *state of adaptedness* to attachment and loss, and Donald Winnicott's notion of the *False Self*, *healthy False Self, unhealthy False Self,* and *True Self*. Third, Erick Erickson's concept of a *decisive encounter* to address a psychosocial conflict or a series of psychosocial challenges is discussed because it incorporates a lifespan perspective of personality development.

Fourth, cognitive theorist Aaron Beck's concepts, *vulnerability* and *self-confidence*, provide an account of how certain characteristics of individuals are necessary to make cognitive changes to their perception of danger or threats. In addition, the researcher highlights Beck's findings of how imagery is produced in individuals who experience anxiety. Then, they discuss several of Carl Jung's psychodynamic concepts, *complexes, transcendent function, Self, symbolic play,* and *active imagination,* which transitions into the researcher's composition of SSAT. Overall, the researcher links and connects influential key concepts from the above theorists and their contributions to emphasize a subjective and creative account of emotional crisis that complements the Systematic Review chapter.

Psychoanalytic principles and concepts. An individual's *psyche* has three levels of awareness: the conscious, pre-conscious, and unconscious. An individual's present awareness of their fantasy, feelings, perceptions, and/or memories of a moment or event is deemed as the conscious (Freud, 1991d). The pre-conscious is "capable of becoming conscious" (Freud, 1991d, p. 175) and is the transition stage between the unconscious and conscious. Lastly, the unconscious is a condition of latency where the individual censors information for particular reasons that are unique to that person. An individual's unconscious content is capable of becoming conscious similar to the pre-conscious. However, an individual becoming aware of unconscious and pre-conscious material is dependent on whether or not the person psychically acts upon it.

An individual's psychological conflict causes internal and external tension within themselves, their relationships, and the environment. There is instability between the pleasure and reality principles. These psychic principles regulate the individual's id, ego,

and superego, and ultimately their awareness of the psychological conflict. The functioning of the individual's id, ego, and superego become compromised as that person experiences a temporary imbalance of their regulatory principles. Due to this moment of psychical instability, they experience a state of anxiety.

In a state of anxiety, the person's pleasure principle becomes heightened. They experience a psychical cyclic fluctuation between the psychic agents, especially the id and ego. In this circumstance, their superego—their ego ideal and value system—is unable to mediate between the individual's id and ego. Due to the separation between the pleasure and reality principles, their unconscious content is no longer in a condition of latency. The formerly repressed content becomes pre-conscious or conscious, and regardless of what level of awareness the content is perceived on – the individual is in a painful state of being. As a result, their pleasure principle may direct that person towards pleasure or withdraw from the psychological conflict. Therefore, the person's reality principle and ego-functioning are compromised. The person temporarily experiences a loss of sensation and perception of the psychological conflict. It is a challenge for them to function in the present moment, because of a temporary lapse in ego-functioning. Thus, they primarily work based on their id—the unmediated yet fundamental needs and wishes for pleasure or avoidance of a psychological conflict.

Freud (1991a) stated that when an individual turns away from reality, it is because that person considers "it unbearable – either the whole or parts of it" (p. 35). As a result, the individual represses specific moments and feelings from becoming conscious. The individual's act of repression affects their psychological functioning and adaptation to a psychological conflict. The repression affects their pleasure and reality principles, and

influences psychological tension. The psychological tension is the result of their repression of a psychological conflict. Consequently, the individual does not address or reality-test the underlying psychological conflict. The consequence of the repression of a psychological conflict lingers in their psyche in which the unconscious will continue to exert psychical energy towards their conscious. Thus, the individual will use bodily and mental energy to pursue the repression of a psychological conflict from becoming conscious. The individual avoids the perceived danger or threat of addressing a repressed psychological conflict.

Due to the individual's repression as regulated by the pleasure principle, that person experiences psychical signs of strain. In addition, that person experiences a rise of tension as the unconscious exerts pressure to the conscious to become known. The individual's signs of strain involve the psychical agents. As their rise of psychical tension increases, the id, ego, and superego will be unstable. There is a lack of communication and functioning between these agents because of the decreased regulation from the pleasure and reality principles. Thus, when an individual experiences a psychological conflict, their id, ego, and superego functioning is affected, because they cannot perform in a congruent manner.

The individual's repression of a psychological conflict is a symbolic representation of that person's unfulfilled innate needs and wishes in their external reality. Repression is the person's unconscious or subconscious avoidance of a psychological conflict where bodily and mental functioning can be suppressed in order to ensure immediate survival in their environment. For the individual to attain a reality that is in harmony with their pleasure and reality principles as carried out by the id, ego, and

superego, they are required to address the suppression and repression of a psychological conflict, and reality-test their internal adjustments. This shift enables the individual to make physiological and psychological adjustments in their external reality that is in accordance with their internal reality.

The psychological rise of tension and signs of strain require psychical energy to maintain their repression of a psychological conflict. This defense mechanism can lead to chronic stress and the development and maintenance of maladaptive coping strategies. It perpetuates a psychological system where an individual chronically experiences instability. Even though the person avoids a psychological conflict, the repression lingers in pre-consciously and unconsciously (Freud, 1991b, 1991c, 1991d; Jung, 1964, 1997). The repression of a psychological conflict is released and brought into awareness when that person experiences an intense and unanticipated emotional pain. At any moment, the individual's repression of a psychological conflict can be released, and this psychical release of the unconscious creates a painful state of being. As a result, the individual then produces anxiety as an initial reaction to the event. Therefore, an individual's repression is always capable of becoming conscious due to the rise of tension and signs of strain that are exerted by the unconscious. This process places psychological pressure on their conscious to establish a balance between their pleasure and reality principles that are to be carried forth by the id, ego, and superego.

If an individual processes the psychological pressure that originates from the unconscious, they may be capable of resolving the psychological conflict that was formerly repressed. As a result, that person has the potential to re-establish psychological stability and internally adapt to the environment in a congruent manner between the id,

ego, and superego as regulated by the pleasure and reality principles. This phenomenon is an adaptive response that requires the individual to temporarily remain in a painful state of being and experience bodily and mental manifestations of anxiety.

It is necessary for the individual to stay in this state of ambiguity because the unconscious is being addressed in a novel manner that transcends their habitual psychological act of repression. The individual's conscious act of discussing glimpses of the unconscious may lead to a resolution of the psychological conflict. This transcendent moment halts the individual's habitual act of repression and may prevent future psychological conflicts from occurring similarly. In addition, their unconscious is addressed in an adaptive manner that re-establishes an individual's psychological functioning. Furthermore, the individual releases the psychical energy related to the repression, and can strive towards a life that is congruent internally and externally. However, if the individual is incapable of resolving a psychological conflict and further perpetuates repression, there are maladaptive consequences.

An emotional crisis is "the personal experience of psychosis" (Romme & Escher, 2012, p. 1) because that person suffers a loss with their external reality. The individual is borderline between their internal and external reality. This phenomenon is influenced by their inability to reality-test their needs and wishes, and making internal adjustments within the environment (perceived external reality) to attain them. The individual’s emotional crisis originates from the repression of a psychological conflict, in which the unconscious continually exerts psychical tension towards the conscious until the individual can no longer avoid it.

An individual's underlying psychological conflict is commonly repressed in the environment as that person adapted to the set and known circumstances. However, when the situation suddenly becomes altered, known as a precipitating event, the individual's rise of tension and signs of strain intensify. In addition, the individual's repression of their unconscious content may become conscious which can place that person in a state of anxiety to avoid a further painful state of being. Thus, that person perceives and anticipates danger and threat to their well-being. The body and mind react to this moment and manifest further signs of strain. These signs of stress are the result of the individual's repression of a psychological conflict and the consequent physiological and psychological suppression to compensate for this endeavor.

If a person continually and chronically represses a psychological conflict, that person may develop a psychosis. In order to avoid a psychological conflict, their body is required to suppress physiological functioning which affects their overall ability to adaptively resolve an emotional crisis. The individual's body and mind are constrained, and incapable of carrying out the pleasure and reality principles with integrated ego-functioning. The individual's integrated ego-functioning assists in their reality-testing and fulfillment of needs and desires, because the psychical agents become stabilized in order to establish an adaptive internal and external reality that is congruent with them. Thus, for the individual to maintain a constant repression of a psychological conflict, body and mind processes are compensated to maintain an avoidance of unconscious material becoming conscious.

In the data collection, an individual who does not successfully resolve a psychological conflict creates maladaptive internal adjustments to maintain functioning

in the altered environment. However, the individual's underlying psychological conflict causes tension between the unconscious and conscious. Thus, the person's repression of an underlying psychological conflict is triggered at any moment when they anticipate or perceive a separation or a loss of Self, or external relationships. Therefore, the individual experiences instability because of the intense feelings of separation and loss.

The individual is consistently producing anxiety as a reaction to separation and loss. Therefore, the person is unable to be present with themselves and restore homeostatic balance in a relatively stable state of functioning that integrates the body and mind processes. It is a challenge for that person to develop adaptive internal adjustments as they are constantly fluctuating between an unpainful and painful state of being. Their effort to focus on personal development is impeded by the chaos and disorganization in their life.

As supported by the data collection, an individual who was unable to cope or adapt to an emotional crisis successfully was prone to impulsive and risk-taking behavior as a response to end their painful state of being. In this instance, the individual experienced a distinct loss of reality functioning because their pleasure principle was intensified to avoid or withdraw from the pain with compensatory processes such as substance abuse and self-harming behaviors. Thus, an individual’s emotional crisis can be a personal experience of psychosis (Romme & Escher, 2012), because they are borderline between the unconscious-conscious, fantasy-reality, and time-timelessness realms with a distinct separation from their body and mind.

The individual is in a painful state of being and is unable to discern if they will survive and remain safe from the emotional crisis. Their feelings of separation and loss

are intensified to the point where they only perceive the pain of their self, relationships, and psychological development. Also, an individual's perception of their self and personality development may be traced back to childhood and adolescence (American Psychiatric Association, 2013) where that person's needs and wishes were not fulfilled. Thus, their psychological development and movement towards a self-identity are stunted because that person perceives themselves as impoverished in life. Due to this perception, the person feels chronically empty and relies on interpersonal relationships and the environment to fulfill their needs and wishes.

"Borderline personality disorders, severe neuroses, characterological problems, and psychoses that are non-organic or not drug induced" (Baldwin, 1979, p. 48) are emotional crises that result from psychopathology as per Baldwin's six types of emotional crisis classification. These crises are similar to maturational/developmental crises, but the emotional crisis becomes repeatedly re-activated by the individual's unresolved issues "rather than by external stressors per se" (Baldwin, 1979, p. 48). The therapist's task in this circumstance is to provide a supportive clinical intervention to establish the individual's sense of self, and refer that person to additional services to ensure that the emotional crisis does not repeatedly trigger a state of instability. Furthermore, psychiatric care such as hospitalization is required if the individual engages in impulsive and high-risk behaviors that are destructive to themselves and others.

First and foremost, an individual’s body and state of being ought to take precedence in an emotional crisis, because the body is the *direct connection* between that person’s internal and external world. The individual’s body is the *vessel* that carries out their dreams, goals, and aspirations, because their body is the *projection* of the ego,

which can be referred to as the *body-ego* (Freud, 1991f, p. 364). Although the objective account of emotional crisis was well-documented from a physiological perspective with psychological consequences, the researcher determined that the subjective account, the *meaning* of an emotional crisis, was latent in the data collection. Even though several case studies discussed an individual's possible understanding of an emotional crisis, that person's interpretation and contribution to the topic as a subject (rather than an object of study), was missing.

Object-relations theory. Several authors emphasized the theme of separation and loss during an emotional crisis (Caplan, 1963; Cobb & Lindemann, 1943; Baldwin, 1979; Rouleau & Landry, 1971; Sifneos, 1972), and the researcher determined that object-relations theory was necessary to expand on this theme for emotional crisis conceptualization. Continuing from the psychoanalytic perspective, an individual is unable to sense and perceive the reality of the situation with their bodily and mental processes in an emotional crisis. The person may decide to cease their pain by enacting automatic, compensatory processes. However, the repetitive and maladaptive pattern of ego-functioning inhibits that person's fulfillment of their inherent needs and wishes for life. If the pleasure principle dominates the reality principle, there will be a state of instability and a loss of ego-functioning. In addition, an individual's personality development may be impaired which then affects their identity and interpersonal relationships. In this regard, Freud (1991a) stated that "the dominance of the pleasure principle can really come to an end only when a child has achieved complete psychical detachment from its parents" (p. 37).

In consideration that an individual anticipates and perceives separation and loss from an object-relation (figure), the theory of psychic attachment plays a key role. John Bowlby developed attachment theory and addressed “the enduring attachments that children and older individuals make to particular figures” (Bowlby, 1982, p. 372) throughout their life. If a person is attached to or has an attachment to someone, that person" is strongly disposed to seek proximity to and contact with a specific figure and to do so in certain situations” (Bowlby, 1982, p. 371). However, the individual’s attachment to a specific figure may not be reciprocated by the other person. Furthermore, Bowlby (1982) discussed that “rejections, separations and losses are some of the most important” (p. 378) moments in an individual’s life.

Therefore, an individual’s enduring attachment is not bound by time or space, and can influence a psychological conflict. These object-relations are enduring attachments that convey lived experience and personal meaning. As a result, the researcher replaced the term “object-relations” with “enduring attachments” throughout the remainder of this thesis to emphasize the individual’s personal experience of an emotional crisis.

In addition, Bowlby discussed that a person is required to be organized to achieve a specific goal in an environment (Bowlby, 1982, p. 14). If the individual decides to achieve a desired outcome in the situation, that person is required to create internal adjustments. This is similar to Caplan's example of a person adjusting to the rise in air temperature. The individual's bodily and mental processes adapt to the altered environment which is considered as a state of adaptedness. However, it is a challenge for an individual to place themselves in a state of adaptedness when an enduring attachment to a figure continues to influence their psychological functioning to adverse life events.

Prior to expanding on those concepts, the researcher presents Donald Winnicott's concepts of the False Self and True Self as it influences someone's state of adaptedness. The True Self is a when a person asserts themselves in the environment with a sense of integrity and wholeness. The False Self is when the individual attempts to maintain relationships by anticipating the demands of others, and following the external rules of the environment.

Winnicott (1960) made a distinction of the False Self: the *healthy False Self*, and the *unhealthy False Self*. The healthy False Self is when the individual feels that one is still upholding their True Self, and is compliant with the environment. During difficult moments, the individual's True Self may override the healthy False Self, and act as a conscience (the superego) when adaptation is necessary. However, the unhealthy False Self is the instance when an individual adapts to the environment, but feels forced to be compliant and is unable to change in a healthy manner that is congruent with their integrity.

As a discussion point, when there is a psychological conflict between an individual's False Self and True Self, a person can find it difficult to assert themselves in the altered environment. In this circumstance, they may choose to affirm the False Self and adapt to the environment rather than uphold their True Self. If the individual adapts to the environment with unhealthy coping mechanisms, that person's True Self is not involved in the process as their superego is inhibited. It is important to note that there is a certain amount of False Self functioning in every individual because it is necessary for survival. However, when an individual operates from the False Self (especially the unhealthy False Self), that person may experience more difficulty connecting with others

and developing meaningful relationships. In addition, the individual's adaptedness is strongly influenced by enduring attachments.

In the data collection, situational and maturational emotional crises were commonly discussed by the contributors. Situational and maturational events are integral to personality development, and childhood is a critical developmental period. It serves as a foundation for our transition from adolescence to adult life. As children, we are privy to the nuances of the social environment and do not have much control over the situation as survival is important. As we navigate our childhood and learn how to achieve our goals in particular environments, we develop attachments and skills through diverse experiences. We carry those attachments and experiences throughout our lives, and it endures in our bodies and minds.

Adverse life events are construed as a psychological conflict between an individual's True Self and False Self. The person is required to make a conscious decision via ego to assert themselves, or comply with the rules of the environment towards attaining their needs or wants despite their id. If the individual decides to adapt to the environment in a healthy manner that does not compromise their overall ego-functioning, then the healthy False Self prevails. This is due to the individual asserting their True Self via superego in a state of adaptedness. Furthermore, the individual separates from enduring attachments and asserts themselves in the altered environment. Thus, that person can fulfill their needs and wishes dependent from enduring attachments.

However, if the individual *feels forced to comply* with the environment to achieve their goals, then they do not assert their True Self. This idea is related to the individual's pleasure principle, and to avoid the pain of separating from their enduring attachments.

However, the person does experience a state of adaptedness as their ego-functioning is compromised to restrain the id and superego. As a result, the individual may experience continual impaired functioning and maintain their repertoire of unhealthy coping strategies. Furthermore, the internal and external psychical tension remains in the individual, and causes strain on that person's mind and body. Time and space do not bind the psychical tension; therefore, the individual continues to hold onto enduring attachments that were developed in childhood and maintained into adulthood.

Psychosocial crisis theory. Every adult was a child once, and the content of childhood life and experiences are latent within an individual's personality. In consideration that time and space do not bind a person's attachments, Erickson provided a lifespan perspective of psychological conflicts that occur in a cultural context. Erickson (1959) discussed that an individual's growth (personality development) involves a series of psychosocial challenges. These challenges are moments "of special ascendency" (Sugarman, 2004, p. 22) where that person chooses to become an autonomous or dependent being.

The individual’s motivation to resolve a psychosocial challenge, or emotional crisis, depends on whether or not the individual chooses to initiate a decisive encounter (Erickson, 1959, p. 53). The decisive encounter is a stage of development when the individual's psychical energy produces a shift towards growth and personality development in an autonomous manner. The psychosocial stages entail crises that a person can succeed or fail depending on their decisive encounter with themselves and the psychosocial context. The individual may choose to increase their inherent potential and capacities for growth and awareness. The individual’s incipient growth and awareness

produced from the decisive encounter contributes to a sense of self, success, and health. Each successive stage requires a shift in the individual's perspective of the crisis to configure a new internal adaptive adjustment towards personality development (growth and awareness). Thus, their psychological development "is a potential crisis because of a radical *change in perspective*" (Erickson, 1959, p. 55) that challenges the person's "*particular ideas and concepts of autonomy and coercion*" (Erickson, 1959, p. 53).

During infancy, individuals form attachments to objects in a psychosocial context. The resulting situational and maturational moments are carried forward throughout an individual's lifespan development. An individual's decisive encounter between autonomy and dependency contributes to their personality development, and whether one is successful in achieving specific outcomes in a social context.

Childhood is a lengthy personality development period, and an individual may be exposed to anxieties and insecurity that were formed during this time. If those fears and insecurities are intensified and unresolved, they may persist "in the adult in the form of vague anxiety" (Erickson, 1959, p. 100). Also, the production and maintenance of anxiety will inevitably contribute to an internal and external tension that affects an individual's cognitive, affective, and physiological functioning.

Throughout the data collection, there was a proliferation of psychosomatic content concerning an individual's cognitive and affective functioning. In consideration that a person's ego-functioning is temporarily impaired in an emotional crisis, that person's cognitive state—their mental processes of information acquired through experience, thought, and senses— is important to understand the individual's initial reaction.

Cognitive theory concepts. An individual produces anxiety when the altered environment is perceived as threatening or dangerous. The person's vulnerability and diminished self-confidence may lead to inhibitions and further instability of that person's functioning. Beck (1985) stated that an individual's confidence plays a key role in maintaining stability. An individual who experiences a lack of self-confidence begins to experience inhibitions and anxiety towards attaining a goal. The presence of anxiety in a person is a signal for them to stop progressing and discourage further movement. In addition, their perception of internal and external dangers is also an inhibitory signal. If the person chooses to withdraw from the pressure, anxiety decreases. However, if they advance towards the pressure, tension rises. In this instance, the individual is required to make a conscious decision to proceed because that person needs to "override the primal inhibitory reaction" (Beck, 1985, p. 72) that ensures survival and safety.

The individual's anxiety is functional and serves a purpose. Anxiety "is not the cause of psychological disturbance" (Beck, 1985, p. 15). It is an internal signal for the individual to cease forward progress and protect oneself from pain and vulnerability. An individual withdrawing from pain does not indicate disease (Beck, 1985, p. 15), it is a sign that the person's cognitive process is maintaining a repetitive inhibitory pattern that continues to structure "external and/or internal experiences as a sign of danger" (Beck, 1985, p. 15).

The individual may feel threatened in a state of vulnerability due to the perception of internal and external dangers that influence ego-functioning. Also, there is a connection "between cognitive and somatic manifestations of vulnerability" (Beck, 1985, p. 68) where an individual "may experience tension or muscle spasm" (Beck, 1985, p. 68)

as a reaction to the threat. In this state, an individual usually has difficulty recognizing their previous successes, abilities, and capabilities to address the immediate danger. Therefore, this may lead the individual to “interpret environmental events as danger” (Beck, 1985. p. 86). The individual’s cognitive appraisals of the situation influence their self-confidence, affect, and behavior. Furthermore, their cognitive appraisal of themselves and the situation changes that person's adaptive capacities.

Therefore, an emotional crisis is an acute psychological upset because the individual perceives the situation as a danger. The person becomes vulnerable and questions their self-confidence in success. The individual's reaction to the threat is producing anxiety. The person's reaction-formation of an emotional crisis is well documented throughout the data collection. However, the individual has a response to the reaction (anxiety) itself. The clinical issue is not the production of anxiety, but rather the individual's cognitive process that "may take the form of an automatic thought or image that appears rapidly, as if by reflex, after the initial stimulus" (Beck, 1985, p. 5-6). Thus, it is integral to explore how an individual's response to anxiety either constrains or encourages further movement to growth and awareness.

Individuals who are in a state of anxiety usually "have visual images of danger before and during their anxiety" (Beck, 1985, p. 210) that correlates with their verbal cognitions. An individual's anticipation of danger or threat tends to be associated with psychosocial or physical trauma (Beck, 1985, p. 210), and is represented as verbal cognitions and/or images. These cognitions and images are part of the individual's fantasy, and often "represent a distortion of reality" (Beck, 1985, p. 210) that is more congruent with the person's feelings. A distinction between fantasy and reality needs to

be made here – fantasies vary from moment to moment in an individual but are not reality-tested in the external world; whereas the reality is an individual's conscious decision to reality-test a fantasy and discern whether it is true or not in the external world.

The individual is borderline between their fantasy and reality which may result in a psychotic episode. This occurrence is due to the continuous pressure that the unconscious exerts on the conscious. The notion arises that BPD and impulsive acts, such as suicide, are results of unsuccessful adaptation and coping strategies. Furthermore, these maladaptive internal adjustments may be construed as the individual's fantasies that were not addressed and reality-tested in a supportive environment where anxiety was not produced.

An individual who believes in a fantasy may temporarily confuse it with reality. It is necessary for the individual to reality-test that fantasy to return to a relatively stable state of functioning. It is important that the individual perceives the reality of the situation, comprehends the results that coincide with each decision, and assume responsibility towards taking care of themselves and developing healthy internal adjustments that uphold their True Self. In the circumstance that the individual is significantly impaired and is at risk of causing bodily harm, that person is incapable of comprehending the distinction between fantasy and reality. Therefore, a clinical intervention such as hospitalization is required to ensure that the individual is safe and returns to a stable state of functioning. Once the individual's body is no longer vulnerable and in a state of anxiety, their cognitive process may then proceed healthily. Ultimately, the person needs to assert themselves in a situation and make a conscious decision to discern between fantasy and reality.

The person's anxiety is a reactive signal to inhibit further movement in a perceived dangerous situation. The dangerous situation in this circumstance is the individual's unconscious content becoming conscious. The person produces verbal cognitions and images from a fantasy that relates to their feelings more so than reality. Thus, what is the purpose of the individual's fantasy-produced cognitions and images?

The researcher construes that the individual's verbal cognitions and images are a sign that they are not being true to themselves. Furthermore, it is an indication that the individual is in a dangerous predicament regarding their psychological development. Their response to their cognitions and imagery needs to be discerned and reality-tested. This conscious act, the decisive encounter, is a critical moment for the individual to respond to their signs from the unconscious by either psychologically developing or deteriorating. The individual needs to make the distinction if the fantasy is real or not in the external world. This may result in the person autonomously and adaptively changing to fulfill their needs and wishes, or maintaining a habitual response that is dependent on their enduring attachments.

Beck (1985) stated that individuals who repeatedly fantasized a situation gained insight that fantasies "contribute[d] to achieving skills and overcoming anxiety in normal life situation as well as in the cases of psychopathology" (p. 211). Furthermore, individuals discovered that they could improve their overall functioning and reduce anxiety. Also, "one of the key ingredients in creating the future is repetition. Repetition causes one to focus on the goal and generate interest in creating it" (Beck, 1985, p. 229).

It is interesting to note that repetition is integral to an individual's personality development, and that repetition can be either healthy or unhealthy for an individual. If a

person has a repertoire of poor coping strategies in response to an emotional crisis, and is unwilling to make changes or adaptations for their True Self, then the person is unable to resolve the underlying psychological conflict. The individual's movement towards growth and awareness is dependent on that person's conscious decision to remain in a state of anxiety and overcome the inhibitory reactions. The individual's fantasy-induced verbal cognitions and images may then be reality-tested, and applied as a repetitive act that will contribute to skill acquisition, self-confidence, and overall functioning. Thus, that person overcomes anxiety, and maladaptive cognitive processes that prevent one from attaining goals and relationships (with themselves and others) in life.

It seems counter-intuitive to remain in a state of anxiety when it is a clear signal to protect oneself from danger. However, an individual is a conscious being that can make clear distinctions about what constitutes a danger, and how to proceed in attaining the desired outcome in an environment. Therefore, what is the purpose of an individual's cognition and the psyche's capacity to create images as a spontaneous reflex in *response* to a reactive signal such as anxiety? An emphasis on the individual's unconscious addresses this question.

Psychodynamic theory. In the data collection, the prominent focus was an individual's state of ego-functioning during the clinical encounter, and how emotional crisis was a reaction-formation event that caused physiological and psychological changes. At the beginning of the chapter, the researcher introduced the psyche's structure: the conscious, pre-conscious, and the unconscious. In consideration that anxiety is commonly produced by an individual as an inhibitory reaction to protect them from danger, and that images often arise as a response to their emotional upset, the

researcher discusses the importance of fantasy-produced images derived from the unconscious. Thus, the researcher elaborates on several concepts derived from psychodynamic theorist Carl Jung.

According to Jung (1964), an individual's emotional upset involves the habitual (repetitive) complexes that "are the tender parts of the psyche, which react most quickly to an external stimulus or disturbance" (Jung, 1964, p. 11). As a response to the emotional upset, imagery is produced by the individual's unconscious that is directed towards the person's loss of Self (the archetype of unity). Jung (1964) stated that imagery has "a particular significance, even though they often arise from an emotional upset" (p. 11), because latent in their psyche are archetypes, their patterns and images of inherited potentials, that can be revealed and actualized through imagery or behavior to restore the Self. Thus, imagery is a direct expression of the individual's unconscious and is, in fact, *part of that person's reality* despite the temporary disruption in consciousness (Jung, 1964), and is key to transforming a psychological conflict that can resolve an emotional crisis by Self restoration.

Jung (1997) stressed the importance of acknowledging an individual's emotional upset, and exploring the symbolic content in a constructive manner where "problems are approached through questions of meaning and purpose" (p. 12) with an emphasis on future implications. In addition to an individual's understanding of their symbolic content, the content is influenced by cultural and universal aspects (Chodorow, 1997, p. 12). As the individual's mind explores and focuses on symbolic content produced by an emotional upset, they are led "to ideas that lie beyond the grasp of reason" (Jung, 1964, p. 4) that condemn or suspend movement towards Self.

Active imagination is a useful method that focuses on the individual's fantasies with the therapist's intention to facilitate and nurture symbolic play. Symbolic play occurs when the individual functions in a transcendent manner, no longer bound by the limitations of the mind. The individual can restructure early origins that are latent in their complexes— the repressed emotional themes of their life that cause emotional upsets— and apply it in the future towards the inner movement to Self.

Symbolic play is spontaneous where emotional upsets "are enacted symbolically" (Chodorow, 1997, p. 5) and the individual is in control. The person has a sense of mastery of their imagined and inherent abilities. Hence, active imagination (or a constructive/synthetic method) "presupposes insights which are at least potentially present in the [individual] and can therefore be made conscious" (Jung, 1997, p. 47). What was previously unconscious and repressed by the individual "becomes conscious in the form of a living process of growth" (Jung, 1997, p. 79) via symbolic play and active imagination.

With the assistance of a therapist who supports their symbolic play in a safe and secure environment that lessens the person's anxiety, an individual can transcend their current state of pain to a place of Self restoration and healing. The therapist motivates the individual by maintaining their focus on the source of their emotional crisis, the unresolved and repressed psychological conflict, by providing a psychotherapeutic task that reveals and actualizes their innate potentials to restore and heal the Self. A mutually-agreed upon psychotherapeutic task that aligns with the person's motivation for resolution will place them at the core of the encounter, because they are responsible for symbolically transforming their psychological conflict in accordance to their Self. The

therapist, who facilitates unconscious-conscious dialogue in a constructive manner, nurtures and promotes the individual to recognize their creative inherent potentials to adaptively and authentically restore their Self and resolve the emotional crisis. A psychodynamically oriented task is crucial to transforming a psychological conflict, because within a person's painful state of being is the latent answer of how they can resolve their emotional crisis and transcend to a state of higher functioning that re-establishes the mind-body connection that was initially separated to ensure immediate survival in their environment.

Chapter Four: Single-Session Art Therapy

Within this chapter, the researcher presents theological and art therapy concepts in order to draw connections between the content that further elaborates on a subjective account of emotional crisis and states their theoretical and methodological assertions. From this, the researcher composes single-session art therapy – a clinical treatment modality that utilizes a psychodynamic approach with a psychoanalytic perspective. First, theological and art therapy concepts are introduced from these key authors: theologians Thomas Keating, Daniel Helminiak, Patricia O'Connell Killen and John de Beer; creative arts therapist Shaun McNiff; expressive arts therapists Paulo Knill and Stephen Levine; art therapists Judith Rubin, Cathy Malchiodi, and Catherine Moon. A discussion of the content follows, where the researcher elaborates how an individual's imagination in art therapy practice can be framed as the therapeutic task of "getting rid of the separation between the conscious and unconscious" (Jung, 1997, p. 47) during an emotional crisis to restore stability and the Self. Consequently, the researcher concludes how art therapy is a clinical modality for acute crisis work that facilitates, nurtures, and promotes the individual's inherent creative potential to resolve a psychological conflict non-destructively and adaptively for psychological and spiritual development of their Self.

Theological Influences

When someone experiences an emotional crisis, that person may question "the meaning, purpose, and value" (O'Connell Killen & de Beer, 2011, p. 1) of their Self because their *three primary needs*: security and survival, power and control, and affection and esteem (Keating, 1999), are unfulfilled. People feeling emotional crises can be perceived as them having spiritual crises, because they anticipate the loss of and

separation from their needs in their psychosocial environment which reactivates repressed psychological conflicts.

A person's *feelings* are embodied by bodily sensations and perceptions, because it is a spiritual movement towards or away from the Self. The tension from the emotional crisis influences their "ability to order events and name feelings" (O'Connell Killen & de Beer, 2011, p. 30). Thus, when a person experiences an emotional crisis, they may be temporarily unable to identify and express related feelings in response to the event. They protect themselves against an emotional crisis by repressing their feelings with an *addictive process*, but because feelings are embodied, the person's body and mind become stiffened (O'Connell Killen & de Beer, 2011, p. 34). However, an individual's drive "for meaning is stronger than the drive for physical survival" (O'Connell Killen & de Beer, 2011, p. 45), which makes them capable of foregoing their addictive processes even when they experience anxiety from immediately perceived threats during an emotional crisis.

When an individual allows themselves to experience the feelings associated with an emotional crisis, their desire and need to be in a psychosocial environment increases. As the individual seeks assistance and support, that person is searching for an answer that is beyond their comprehension. It is the start of an embodied movement towards their spiritual development. Despite the pain involved, the individual does not repress their feelings or suppress the body, mind, and spirit; instead they decide to use their body and mind as a movement towards addressing the psychical tension that is causing an imbalance. The individual's drive for physical survival becomes secondary to the drive

for meaning because they seek affirmation and validation from others who will support their Self.

A supportive and safe environment, such as a therapeutic clinic, is an external resource for an individual because a therapist can motivate them to interpret the meaning of an emotional crisis separate from an environment that perpetuates their additive processes. In this circumstance, the therapist conveys clarification questions “to establish the scene clearly and describe the action in the sequence that it occurred” (O’Connell Killen & de Beer, 2011, p. 30). The therapist can then motivate the individual to "connect feeling and body sensation" (O'Connell Killen & de Beer, 2011, p. 30), a *movement towards insight*, to restore psychological and physiological stability. Thus, the individual seeking assistance and support during a difficult moment is searching for the restoration of their body, mind, and spirit, and their Self.

If an individual follows the movement towards insight, it leads them to a new path. Furthermore, it changes their habitual way of perceiving and understanding the world, and their place in it (O’Connell Killen & de Beer, 2011, p. 17). When an individual acknowledges their feelings by giving shape and form to them, it is conveyed “in the language of imagery” (O’Connell Killen & de Beer, 2011, p. 35). The language of imagery is not limited to the visual senses; it also includes auditory, olfactory, tactile, and gustatory senses (O'Connell Killen & de Beer, 2011, p. 36-37). Each person’s imagery symbolizes their lived experience, and captures “the totality of [the] felt response to reality in a given situation” (O’Connell Killen & de Beer, 2011, p. 36-37).

The individual travels from the experience of the emotional crisis “through feeling to image to new ideas and awareness that can change and enrich” (O’Connell

Killen & de Beer, 2011, p. 37) the Self. The search for meaning transforms the pain, if that person chooses to acknowledge the feelings that are in response to an emotional crisis. As they allow themselves to experience the emotional crisis with an embodied connection, the feelings embody their search for meaning in a symbolic language. The symbolic language (imagery) is the speech of the Self where one "can begin to learn from it" (O'Connell Killen & de Beer, 2011, p. 33) with a movement towards insight.

Therefore, an emotional crisis resolution is within oneself. Due to an emotional crisis bringing about a temporary instability in the individual, they are unable to perceive the situation in an objective manner. They are focused on protecting themselves from dangers and threats, and are in a state of anxiety. Thus, they temporarily lose focus on perceiving themselves as the *subject* experiencing pain. As a result, they may see themselves as *an object that is being subjected to pain*. In this circumstance, the individual's pain (feelings) becomes the subject. Again, it is the person's decision to avoid the pain by engaging in compensatory, repetitive patterns or seek support. If the individual avoids the pain, they become complacent towards asserting themselves as a subject. They do not learn from the experience, further separate from an embodied connection, and are most likely to continue habitual, maladaptive coping strategies.

If the individual seeks support, it is the desire and need to search for meaning in the presence of another. The person transcends the pain and drive for survival. In the presence of another, the person is affirmed and supported as the subject where there is a transformation of the pain with imagery and the speech of the Self. Each person's emotional crisis resolution requires them to be in a relationship with feelings, because the

feelings embody the search for meaning and are the key to an answer (O'Connell Killen & de Beer, 2011, p. 45) to restoring the Self and healing psychological conflict.

An individual, who practices *cognitive reflexivity*, may consciously decide to transcend the initial and inhibitory reaction to an emotional crisis. It is the passageway that relates to the process of choosing an alternate path to prevent further loss of the Self. The researcher construes that occurrence is spiritual development, because the person creates and reality-tests the internal adjustments in the environment. Spiritual development can be conceptualized as adapted from Helminiak's five-stage model (1987, 1996, 2015):

1. Conformist stage: the person's worldview is influenced, accepted, and approved by external forces (enduring attachments).
2. Conscientious conformist stage: the individual develops the awareness that life involves decision-making, and begins to express *authenticity*. The person starts to adhere less to the inherited worldview from the conformist stage of spiritual development. However, the individual continues to accept conformist aspects and complies with enduring attachments.
3. Conscientious stage: the individual becomes aware and gain insight that they are ultimately responsible for decision-making and authenticity for their meaningful reality. The person is attentive, intelligent, reasonable, and responsible for creating their meaningful reality and actualizes their inherent capacities and potentials. Helminiak considered this as the first stage of spiritual development because it involves the individual's dynamic human

spirit, the four transcendental precepts, and the four characteristics of spiritual development.

4. Compassionate stage: the individual experiences a more pragmatic and authentic relationship with their emotions. Furthermore, they may leave behind conformist aspects of their previously inherited worldview. As a result, the person experiences compassion for themselves and others where their complexities and underlying psychological conflict may be resolved.
5. Cosmic stage: the individual actively balances authenticity and the permeation of their past, concrete self in a state of transcendence. They are willing to change and consciously expand their awareness, insights, abilities, and commitment towards an authentic way of being and becoming.

Helminiak's spiritual development model and Erickson's psychosocial development crisis models are similar, in that an individual's being is initially dependent on others, and as the individual develops *consciousness*, decision-making processes become necessary to assert themselves in the environment. The individual's assertion involves autonomy and the success of fulfilling their needs in a conscious manner that maintains their True Self. An individual experiences tension as one spiritually develops in life. The spiritual challenge between autonomy and dependency requires a person to make *distinctions* and a conscious decision about how to fulfill needs in the external world that will remain congruent with their internal world. Thus, the person needs to learn how to actively master and control the environment to facilitate an inner movement towards the Self.

The person's primary need at this juncture, the conformist stage, is survival and security of the body. The individual is dependent on external forces, such as attachment figures and objects, to fulfill the needs as a healthy False Self. Due to the individual being in a state of biological dependency for survival, the person complies with the external reality, partially because one does not have control or power in the circumstance. Thus, enduring attachments are necessary for the individual to survive.

The conscientious conformist stage can be characterized as the individual's developing consciousness. To fulfill these needs, the person is required to make conscious decisions towards fulfillment. The individual has the cognitive reflexivity to fulfill these needs autonomously towards survival and security, power and control, and affection and esteem. The individual's need for (a) survival and security can be re-framed as safety in the environment; (b) power and control as mastery of the environment; and (c) esteem and affection as self-confidence grows while attaining specific goals. As such, an individual's "habitual patterns of perception, cognition, [and] interrelation" (Sperry, 2012, p. 78) with the environment and others are prominent at this stage. It is this stage in which the distinction between the False Self can be made as the individual consciously decides to either remain dependent on others or assume autonomy.

The individual can continue to comply with enduring attachments to fulfill their needs without feeling untrue to themselves as the healthy False Self. Thus, the individual adapts in compliance with enduring attachments and the altered environment in which their internal reality remains congruent via superego. However, if they comply with the environment and willingly choose not to make adaptations in compliance with enduring attachments, they develop compensatory processes as an entrenched unhealthy False Self

to fulfill their needs. Thus, the individual chooses to remain dependent on enduring attachments. Their unhealthy False Self maintains compensatory processes that impede upon their spiritual development and leads to the separation of an embodied connection in an emotional crisis. Compensatory processes are influenced by the individual's complexes and can be observed as that person's poor coping strategies or skills to fulfill their pleasure principle to avoid pain and reality-testing. Thus, they depend on enduring attachments to attain goals, and if the goal is not attained, the person chooses not to assert themselves in the environment. Therefore, the individual experiences tension between their internal and external reality that causes separation from the body, mind, and spirit which stunts their Self development.

If the individual's unhealthy False Self does not change, that person continues to adjust to the environment without asserting themselves. The compensatory processes continue and their complexes are not resolved. Hence, the individual continues to defend and censor repressed material through their unconscious to avoid pain. However, their unconscious motivation will continue to covertly influence their decisions throughout life. An individual's repressed feelings "have to be allowed to pass through awareness to be left behind for good" (Keating, 1999, p. 25).

An individual is capable of resolving an emotional crisis if they decide to allow the unconscious material to become conscious, and assert these changes and adaptations in the environment that will uphold their True Self. An individual has to become aware of their repressed material and unconscious motivations to gain the insight necessary to become an authentic being true to their Self. However, they are responsible for processing and expressing emotions, and questioning their human condition and needs

(Keating, 1999). This process requires the individual to be in a state of vulnerability, because for them to release the unconscious' pressure towards the conscious, a final encounter needs to be consciously initiated. This decisive encounter enables them to be in a state of adaptedness where that person can explore the dynamics of the unconscious, gain insight towards how to change and adapt, and how to assert themselves towards fulfilling needs in a healthy, authentic manner. As a result, the individual's spiritual development is facilitated and nurtured.

An individual has the spiritual capacity and potential to determine who they ought to be in a normative and constitutive (decisive) manner. If they decide not to separate from the pain, an embodied connection needs to be restored to the body, mind, and spirit. Then, the individual's movement towards insight leads to cognitive reflexivity where they transcend their painful state of being. They can then make a distinction between fantasy and reality by reality-testing. A decisive encounter between their False Self and True Self is initiated, and is the conscientious stage in spiritual development. The individual gains insight towards *how* a need is to be fulfilled in an autonomous manner instead of what should be done in a dependent and complacent manner.

The compassionate stage can then be understood as the individual's self-confidence that they have the capabilities and potential to succeed in an autonomous manner. Their habitual processes come to a halt as the person perceives that they are not in immediate danger. Their unresolved complexes can be addressed and transformed as the individual makes the distinction between what is the past, present, and future in a healthy, non-self-destructive manner.

The individual makes the distinction that compensatory, repetitive ways of being functioned as survival and safety measures as a dependent being. They become open and flexible towards the development of adaptive processes in response to an emotional crisis. Then, the individual can comprehend themselves as the subject of an emotional crisis, and comprehend that their compensatory and addictive processes were a means of protecting themselves from threat and danger. They can then move forward from past enduring attachments, and diversify their lifespan experiences by developing adaptive skills to master their environment towards fulfillment. The individual proceeds with their spiritual development as they place themselves in a space that is conducive to a movement towards insight. In this way, they are able to transcend the emotional pain if they decide to be in a state of vulnerability and adaptedness that they will survive and remain safe despite the pain. In addition, the individual transcends maladaptive compensatory processes in a non-destructive manner.

The cosmic stage is the individual's self-transcendent moment where they shift from an objective being to a subjective being. The person becomes the *subject* rather than the object of what they are doing or going to do next, and actively moves towards subjectivity and being. The individual commits to actualizing their inherent capabilities and potential, and affirms their being in the internal and external world. Also, their speech of the Self emerges via imagery due to the restoration of an embodied connection. The separation between the unconscious-conscious and fantasy-reality becomes synthesized as a whole. This progression means that the individual is no longer fragmented, and this allows them to restore and heal the Self.

An individual's *psyche* is the substrate of their spirit, and the psyche either constrains or supports the individual's spirit in an emotional crisis. The unconscious exerts pressure towards the conscious, and causes pain for the individual. The individual experiences the loss of the Self because they do not know *how* to affirm and assert their True Self. The individual's cognitive reflexivity— the imagination— is temporarily limited as the body compensates cognitive and affective functioning to restore physiological functioning to ensure immediate survival. The person's body is a meaningful reality (Helminiak, 2015), because it is the vessel of their spiritual development.

It is the individual's imagination that affirms or condemns their Self development. If the individual's needs are not being internally and externally fulfilled, they experience the loss of the Self. If they do not resolve an underlying psychological conflict in a constructive manner, it leads to the development or continued maintenance of their addictive processes and future, similar emotional crises.

Art Therapy Influences

An emotional crisis is the individual's "limitations of imagination" (Atkins in Eberhart & Atkins, 2014, p. 42) that impede their movement towards insight. The individual's emotional pain "takes the form of fantasies that are stereotypical, compulsive, repetitive and destructive of self and others" (Levine, 1997, p. 2). As mentioned previously, an individual's response to being in a state of anxiety elicits an image. This image is the speech of the Self, *poiesis*, and is archetypal. It is a symbolic representation of the individual's needs and wishes from the unconscious. Thus, it is *archetypal imagery* in that it harnesses "a potential with contents that are not given until they are filled in

with lived experience" (Corbett & Stein, 2005, p. 52). Therefore, the individual needs to reality-test a fantasy to make distinctions of *how* to affirm and assert oneself in reality to gain fulfillment. Also, their imagery-produced fantasies can reflect the "archetypal human needs that must be met for development to proceed normally" (Corbett & Stein, 2005, p. 52).

Security and survival, power and control, and affection and esteem may be considered as archetypal human needs and are expressed through archetypal imagery during an emotional crisis. Furthermore, archetypal imagery influences an individual's personality development and cognitive processes whether they are consciously aware of it or not. As a result, an individual's spiritual development towards their Self has archetypal significance (Jung, 1964; McNiff, 1992). Therefore, the therapeutic ideal in response to an emotional crisis is to free the person's imagination and introduce possibilities of a more fulfilling life. They have the imaginative capacity and potential to engage and transform their patterns, experiences, and emotions.

Poiesis is an imaginative and creative practice that allows an individual to shape material and provides numerous, inherent possibilities to heal the psyche (Levine, 1997). The arts can elicit emotions, circumvent personality defenses, and bring certain parts of the unconscious into awareness. The "healing and transformation of experience" (Atkins in Eberhart & Atkins, 2014, p. 38) is an inherent creative force within an individual. As such, poiesis can render an individual's world new through imagination. Thus, the individual can transform dynamic forces that are rooted in a particular time and/or place (McNiff, 1998, 2015; Wender, 2008) in a transcendent manner.

Art is an agent that motivates the individual to address and respond to an emotional crisis. Art enhances the individual's recovery (McNiff, 1992) from the loss of the Self. It is a *transitional space* where the psyche's dynamic forces can be released and contained as objects, where their experience of an emotional crisis can be symbolically represented and transformed by conversing with their psychological conflict. They can then experience themselves as a *subjective being* instead of an objective being. Thus, "art gives a voice to suffering [… and] one lets go of attachment to the former security and is willing to face the void" (Levine, 1997, p. 23).

An individual's *art-making* and *imagery* is the expression of their habitual patterns and painful experiences that may otherwise be difficult to articulate verbally. Expanding upon the notion that art is a language of emotion, Arrington (2001) stated that art-making is an ancient and universal language that is motivated by play, the desire to soothe and enrich a person's system, and the need to express "inner experiences and sacred feelings" (p. 6). In this way, art-making is symbolic play that transcends the individual's limitations of imagination. Through poiesis, they can symbolically represent and transform the nameless and mostly unconscious knowledge of their patterns and experiences. Poiesis is the speech of the Self, and with symbolic play, the individual can restore and heal the Self.

The individual's process and product of poiesis (art-making, and imagery) is a vessel for communication that links "individual to family, family to culture, and culture to ageless humanity and collective divinity" (Arrington, 2001, p. 6). The power of poiesis offers the individual a way to examine issues with a realistic perspective and a metaphoric lens towards an affirmation of their True Self. Thus, the expressive arts in

psychotherapy can heal "the imaginal depths" (Levine, 1997, p. 4) of the psychological conflict that stifles their psyche in an emotional crisis.

However, if the individual uses the art as an agent to further avoid pain and aestheticizes it as a compensatory/addictive process, then it is not therapeutic in this circumstance. If art-making is used as a means to distance and separate oneself from pain, there is no space for symbolic transformation. The person does not gain insight and merely separates from the pain instead of moving towards it. They do not affirm their Self, and do not commit to spiritual development as they remain complacent towards fulfilling their needs and wishes authentically and autonomously. Thus, the individual perpetuates their limitations of imagination, stunts spiritual development, and moves further away from their True Self. They have to willingly participate with the intention of growth and change, not symptom relief as it perpetuates their False Self system.

It is important to note that imagination is not solely based on the sense of sight. Imagination also involves hearing, smell, taste, and touch. Art-making engages with the imaginative capacities. Art-making is a primary process of inquiry where new knowledge arises via an embodied connection, thus enhancing the artist's subjective meaning of being and becoming in the world. Art-making is a biological, psychological, and spiritual process that "enables [an individual] to receive deep psychic material" (Knill et al., 2015, p. 26). The Self "experiences itself more deeply" (McNiff, 1992, p. 2) as the imagination "is an instrument of faith" (Moon in Farrelly-Hansen, 2001, p. 29) that either condemn or affirm resolution.

When an individual chooses to engage in poiesis, it is an act of faith that they will survive the pain and affirm their Self. Their commitment towards spiritual development

is an unknown process that ultimately manifests in being and becoming in the world (Moon, 2002). The individual must be in a state of vulnerability and adaptedness to transcend their pain. They have the latent ability "of expressing the state of constant growth, and [the] change of human feeling and life itself" (Julliard & Van Dan Heuvel, 1999, p. 114). Therefore, poiesis is based on what is found rather than what was lost. As a result, the symbolic representation and transformation of pain via art-making and imagery have the capacity and potential to free the imagination.

Initially, the individual may not be able to articulate an emotional crisis, but through art-making, they can give shape and visual form to their inner experiences, and become more verbally articulate when discussing their imagery (Malchiodi, 2012; Naumburg, 1966). Furthermore, art-making is cathartic, because the kinesthetic act of creating imagery requires bodily sensations and perceptions. Therefore, the person's repression of unconscious material is *released* by the body leading to an awareness that may no longer suppress the Self. The psychical tension is manifested physically through art-making and imagery that the individual can perceive, become aware of, and gain insight into the psychological processes that affect their ego-functioning. In addition, the individual inherently activates their creative capacities and potential to resolve adverse life events with resiliency and resourcefulness. Therefore, art therapy is a creative psychotherapeutic modality that offers a healing experience to improve a person's overall functioning and well-being.

Art therapy leads to "a speeding up of the therapeutic process" (Naumburg, 1966, p. 4). It is the individual's decision whether to pursue this creative psychotherapeutic modality that can motivate their healing experience, resiliency, and resourcefulness.

There are two theoretical considerations in art therapy that the researcher believes are important to discuss that align with the scope of this thesis. The first theoretical concern is the role of the individual's imagination and fantasy-produced imagery in art therapy practice. The second theoretical concern is the role of verbalization in art therapy. These theoretical considerations extend into methodological practice, and the researcher presents their interpretation of them in the methodological section.

Theoretical considerations. David Maclagan (2005), an art psychotherapist, believes that the individual's imagination in art therapy ought to be restored and revived as a therapeutic task (p. 24). Whether or not the individual mentally, verbally or pictorially expresses internal imagery, the imagery resonates and originates from their fantasy and imagination. These fantasies and discovered images motivate the person in art-making. The individual and the therapist address the presenting psychological issue and "its subsequent working-over" (Maclagan, 2005, p. 24) with their fantasy and imagination. Furthermore, Maclagan (2005) stated that imagination "enters into every aspect of our psychological life: it colours our perceptions, it recreates our memories, it contributes to shaping and solving problems" (Maclagan, 2005, p. 24). Also, imagination is not only the means to create art, but is also "a principal means of responding to them" (Maclagan, 2005, p. 23). As such, an individual's imaginal capacities and potential are influenced by their fantasy and ought to be acknowledged by art therapists.

David Mann (2006), a consultant psychoanalytic psychotherapist, responded to Maclagan's (2005) contribution. Mann (2006) suggested that "current art therapy practice shows little influence from classical psychoanalysis" (p. 37), and because of that, it is a challenge for them to converse with other clinicians about their work. Additionally, Mann

(2006) stated that if an individual's imagination is stifled, it is influenced by adverse childhood developmental experiences or feelings where "fantasy and imagination have become places of anxiety" (Mann, 2006, p. 35) that can come into play during an art therapy task as they might feel threatened or perceive immediate danger of unconscious material becoming conscious.

From a psychoanalytic perspective, Mann (2006) also purported that individuals who engage in art-making and produce imagery can develop a habitual, repetitive defense mechanism “to avoid pain, depression, or anxiety” (Mann, 2006, p. 35). Thus, art-making and imagery can dampen the individual’s creativity and imagination if it is used as a maladaptive internal adjustment. Furthermore, Mann (2006) purported that “if the patient’s imagination is in need of revitalization, it might be useful to assume the patient’s anxiety is at work both during and after painting” (Mann, 2006, p. 35).

He stated that conversation between the art therapist and the individual is significant because of their state of anxiety during an art therapy task. A person's "imagination finds all kind of vehicles or mediums for expression and the medium should not be equated with the psychological process directly" (Mann, 2006, p. 34) until conversation occurs to confirm and validate the individual’s experience. Mann considered that a lack conversation between the therapist and the individual was a lost opportunity for affirming the integration that occurred in the art-making, and the lack could potentially be a defense mechanism influenced by anxiety and a reluctance to acknowledge the therapeutic relationship. In conclusion, Mann (2006) purported that "art therapists need to have some idea why they are doing what they do" (Mann, 2006, p. 34),

because there is communication gap when providing the psychotherapeutic task, and discussing the intention and results with the wider community.

Sally Skaife (2008), an art psychotherapist, commented on both Maclagan's (2005) and Mann's (2006) contributions. While Skaife (2008) agreed with the importance of the imagination and fantasy, she stated that the contributors accentuated the dichotomy "between the cognitive and the imaginative" (Skaife, 2008, p. 46), privileged the mind, and neglected the individual's body and perception in the therapeutic endeavor (Skaife, 2008, p. 46). Also, she noted that Maclagan separated the individual's imagination from perception, thus neglecting the body (Skaife, 2008). In regard to Mann, Skaife (2008) stated that "he regards conversation, in an attempt to understand, to be the desired end result of therapy and misses out anything about the process of making art in art therapy" (Skaife, 2008, p. 46).

Skaife (2008) made the distinction that Maclagan (2005) accentuated *art as therapy* as influenced by Edith Kramer, and that Mann (2006) emphasized art psychotherapy as influenced by Margaret Naumburg. Kramer and Naumburg were psychiatrists who were credited with pioneering the art therapy profession, and their contributions are discussed in the methodological section of this study. Skaife (2008) purported that art therapists ought to have a strong theory in which they can articulate “in the dominant language of logic, the intersubjective relationship between imagination, the perceptual, interpersonal relationships, the manifest symptom, images and the boundaried art therapeutic, performance space” (Skaife, 2008, p. 51-52).

Howard McConeghy (2011), an art therapist, suggested that art therapists need to change their thinking about psychotherapy. He stated that "psychotherapy suggests that it

is the emotional condition" (McConeghy, 2011, p. 23) of the Self, and in order to restore it, the individual's self-expression of their psyche's message needs to be comprehended and carried forth towards healing. "Art therapy is all about-organizing their experiences, having a direction and giving form to their expression" (McConeghy, 2011, p. 23). Furthermore, art-making gives shape and form to imagery that is derived from the imagination, which can be considered and called as spirit (McConeghy, 2011). The philosophical orientation, poiesis, is what gives art therapists "the power of penetration in psychological terms" (McConeghy, 2011, p. 23) that serves as a foundation for them to discuss their clinical work with others. It is important that art therapists actively communicate their work in a language that other professions can comprehend when they discuss art therapy as a treatment.

Maclagan (2005), Mann (2006), and Skaife (2008) contributed content that addressed the issues of art therapy, and the importance of an individual's fantasy and imagination in the therapeutic endeavor. Parallel to them is McConeghy, who believes that art therapists need to change their philosophy about psychotherapeutic practice, because an individual's images "are the answers of the psyche and therefore produce accurate pictures of psychic facts" (Jung in McConeghy, 2011, p. 23) to the individual's Self and their meaningful reality of "irreducible truths" (McConeghy, 2011, p. 23). Whether the individual conveys this through talk or their art, or both for that matter, it is speech of the Self where they converse imaginatively about their emotional condition through creative process and product.

The researcher believes that these matters in art therapy are influenced by a lack of art therapists explaining the philosophy, theory, and methodology of their clinical

work in a common language to which other disciplines can relate. With the recent developments in mind-body medicine and clinical neuroscience, art therapists have the opportunity to communicate their clinical discipline and explain how art therapy tasks assist individuals with the psychological conflicts which affect overall bodily and mental functioning without dichotomizing between verbal and non-verbal approaches.

Mind-Body Medicine and Stress

The researcher's analysis of the data collection led them to explore and discuss mind-body concepts with the goal of offering a contemporary account in contrast to the mostly outdated literature on emotional crisis generated from the systematic search inquiries and to elaborate on art therapy methodology. The mentalization approach in art psychotherapy and the 4-stage creative process model in brief psychotherapy provided the connections to explore mind-body medicine and stress, and clinical neuroscience. Several of those contributors focused on the interplay between the affective, cognitive, and physical states of functioning within clinical neuroscience, psychoneuroimmunology, psychosomatic, and oncology literature. The contributors discussed the physiological and psychological changes that affected the endocrine, immune, and nervous systems as a result of acute and unresolved chronic stress, which the researcher considers as consequences both during and after an emotional crisis.

The inclusion of the descriptive accounts of the endocrine, immune, and the nervous systems exceed the scope of this study; however, the researcher does not completely disregard the content and provides a brief summary on key concepts. First, the researcher provides a brief discussion of the nervous system with relevant mind-body connection concepts referenced in the text, *Art Therapy and Clinical Neuroscience*

(2008), edited by the psychologists Noah Hass-Cohen and Richard Carr. The researcher selected this text because it provides an introduction to art therapy and clinical neuroscience practice that align with the study's parameters. Then, they connect various mind-body concepts (*allostasis*, *allostatic load*, *stress*, *oxidative stress*, *archetypal separation anxiety*, and *resiliency)* from Gregory Fricchione's (medical doctor and psychiatrist) contributions, which complement general systems theory and crisis theory. The researcher's goal of elaborating on these concepts establishes the theoretical and methodological foundation of how art therapy can treat emotional crises.

The *nervous system* is integral to the overall functioning of an individual. It plays a key role in cognition, homeostasis, regulation of endocrine and immune systems (cardiac, and smooth muscles), and the muscle fibers/cells surrounded by connective tissue that receives afferent and sends efferent information (skeletal muscle) to and from the brain. The mind-body connection occurs in the nervous system, and relevant studies focus on the management and regulation of cognitive and affective states, and the remediation of stress in an interpersonal therapeutic context.

The *central nervous system* is comprised of the brain (brainstem, diencephalon, cerebrum, and cerebellum) and the spinal cord. The central nervous system "innervates the body organs and their extremities through the peripheral nervous system" (Carr & Hass-Cohen, 2008, p. 22).

The *peripheral nervous system* is comprised of the afferent and efferent fibers (skeletal muscles) that are located in spinal and cranial nerves. This system produces the involuntary and voluntary responses to the environment which is divided into: (a) the *autonomic nervous system* which then divides into the *sympathetic nervous system* and

the *parasympathetic nervous system;* and (b) the *somatic nervous system* where sensory neurons either send or receive signals to and from the central nervous system.

The autonomic nervous system involves the individual's involuntary responses to the environment, restores homeostatic balance, and regulates the cardiac muscle (the heart and pumping of blood), and smooth muscles (the bladder, intestines, and stomach along with the supporting tissue of blood vessels). The sympathetic nervous system functions include regulating the heart rate, respiration rate, and blood pressure necessary for action in response to an environmental danger or the tension "to avoid a psychosocial conflict" (Carr & Hass-Cohen, 2008, p. 22). In addition, the sympathetic nervous system is involved in everyday functioning and adaptations “to relational and environmental situations” (Carr & Hass-Cohen, 2008, p. 22). The common concept is the flight or fight response.

The parasympathetic nervous system reduces the sympathetic nervous system's response to a threat, and "returns a person to a more relaxed, ordinary functioning" (Carr & Hass-Cohen, 2008, p. 22). In addition, the parasympathetic nervous system involves the digestive, defecation, and urination processes.

The *sympathetic-parasympathetic balance* shifts "a person between mild variations of excitation and relaxation states" (Carr & Hass-Cohen, 2008, p. 23), and is a normal occurrence to the daily functioning of an individual.

The somatic nervous system involves the voluntary movement of muscles, organs, and reflex movements (muscle/motor actions) that convey “sensory information to the central nervous system” (Carr & Hass-Cohen, 2008, p. 23). The sensory process of voluntary movement involves afferent and efferent signals to and from the central

nervous system to allow “physiological and psychological changes to unfold” (Carr & Hass-Cohen, 2008, p. 22) in response to environmental and psychosocial threats.

If an individual is unable to resolve an emotional crisis, it can "shift the person away from the integrated feelings and thoughts" (Carr & Hass-Cohen, 2008, p. 24). In addition, an individual may experience a diminished sense of control and mastery in response to threats. Their body compromises overall functioning as a reaction-formation of stress, and affects their health, well-being, memory, and cognition.

If an individual successfully resolves an emotional crisis, that person attains sympathetic-parasympathetic balance. The central nervous system can resume regulation of the endocrine and immune systems instead of compromising the individual’s overall functionality to compensate for the lack of adaptive internal adjustments. Thus, restoring homeostatic balance allows for physiological and psychological changes to unfold within the individual – a theme that is supported by the systematically procured literature on this topic. As emotional crisis was commonly associated with stress, the researcher presents additional information that augments a contemporary perspective.

Mind-body concepts. An emotional crisis is a special case of stress because it is an acute separation challenge that makes an individual vulnerable on an affective, cognitive, and physiological level which produces archetypal separation anxiety. The initial reaction-formation of stress is the individual's allostatic ability to maintain homeostasis through biological mechanisms that are regulated by the nervous system. There is a temporary sympathetic-parasympathetic imbalance due to allostatic loading which is done to support the body's physiological functioning and autonomic (autonomic nervous system) ability to act in a dangerous situation. In addition, an individual may

produce signs of anxiety, such as an increased heart rate and respiratory rate which is the result of their involuntary response (sympathetic nervous system functioning) towards environmental danger or psychosocial conflict.

To restore homeostasis, an individual is required to separate from the allostatic threat that influences their allostatic loading. If they are unable to separate from the allostatic threat in a voluntary manner (somatic nervous system) that yields adaptive physiological and psychological changes (via sympathetic nervous system), and oxidative stress increases. In addition, archetypal separation anxiety contributes to allostatic loading, and may increase as the person anticipates and avoids the pain of separating from an enduring attachment.

Furthermore, if the individual unsuccessfully adapts to the acute stress, it will transition to chronic stress as the allostatic loading is maintained due to the prolonged exposure of the allostatic threat. As a result, their body will continue to dysregulate the regulatory systems to “compensate for over-activation of a physiological response” (Frichionne, 2015, p. 310). Therefore, the body maintains a maladaptive allostatic response as the allostatic load increases physiological and psychological instability which can lead to oxidative stress.

Oxidative stress reflects an imbalance in the individual's natural ability to repair damage and adapt to stress that may lead to "cardiovascular, cerebrovascular, and renal disease" (Frichionne, 2015, p. 310) as free radicals, heart shock, and protein gene expression are produced on the cellular level of metabolic activation. In addition, psychosocial stress inflicts oxidative stress on a person's body and regulatory systems

(especially the immune system) in which the effects may be transduced on a cellular level as an allostatic threat (Fricchione, 2015, p. 310-311).

If the individual is successful in separating from the allostatic threat, that person restores sympathetic-parasympathetic balance and thereby displays resiliency. The characteristics of resiliency are: (a) a positive attitude and the motivation to attain goals; (b) adaptive coping strategies that reduce anxiety and fear; (c) a willingness to seek social support and/or resources to maintain stability and safety; (d) the cognitive ability to perceive an alternative meaning of their interpretation (meaning) of the adversity or stress; and (d) the "capacity to integrate a sense of purpose in life along with a moral compass, meaning, and spiritual connectedness" (Fricchione, 2015, p. 311-312). Their voluntary action diminishes the primal inhibitory responses (involuntary responses such as increased heart and respiratory rate), and adapts physiologically and psychologically in a flexible manner. This promotes and facilitates the person's inherent ability to create adaptive physiological and psychological changes to restore homeostasis; however, it requires them to concentrate on a repetitive activity that ceases the "everyday thoughts and concerns" (Fricchione, 2015, p. 305) that cause stress. Examples of repetitive activities include breathing, meditation, and prayer, all of which yield anti-oxidation effects (Fricchione, 2015).

Despite the initial homeostatic imbalance in an emotional crisis, a person has the inherent potential and capacity to separate from an allostatic threat and resolve maladaptive physiological and psychological responses. Therefore, an individual can persevere through their emotional crisis if they intentionally act resiliently and repetitively towards adaptive change. Developing and adhering to adaptive changes

promotes and facilitates mind-body connectivity, which helps to prevent similar emotional crises in the future. Overall, the mind-body approach supports the data collection and it extends to art therapy as a clinical modality.

Art therapy is a mind-body treatment modality because it re-establishes an individual's sympathetic-parasympathetic balance using a *relaxation response* that reduces archetypal separation anxiety, encourages their resiliency capabilities to overcome the repressed psychological conflict in an emotional crisis, and prevents future, similar crises from occurring. Furthermore, an art psychotherapeutic task creates a relaxation response for the individual as their art-making is a behavioral act that involves their mind-body connectivity. Lastly, the art-making and created imagery can be used in the therapeutic relationship as a constant, internal, adaptive adjustment in a supportive environment to support and encourage their expression and Self development.

Art therapy as a mind-body medicine. Cathy Malchiodi, an art therapist, extensively discussed art therapy as a *mind-body intervention* throughout her contributions. The researcher selected her edited text, *Handbook of Art Therapy* 2nd ed. (2012), because the content is conveyed in an introductory manner that is comprehensible for those who are not familiar with art therapy.

Malchiodi (2012) stated that

> Images and image formation, whether mental images or those drawn on paper, are important in all art therapy practice because through art-making clients are invited to reframe how they feel, respond to an event or experience, and work on emotional and behavioral change. In contrast to mental images, however, art- making allows an individual to actively try out, experiment with, or rehearse

the desired change through a drawing, painting, or collage – that is, it involves a tangible object that can be physically altered (p. 18).

Thus, art therapy interventions involve an experiential affect-sensory event that promotes the individual's resiliency and intentionality of resolving an emotional crisis. Art therapy interventions can motivate a person in connecting with the "therapeutic surroundings and can also provide relief through the expression of emotions [with the individual's] kinesthetic and voluntary actions required to make and complete the art" (Carr & Hass-Cohen, p. 24).

Mind-body interventions promote a secure attachment style and an enriched environment (Fricchione, 2015; Malchiodi, 2012) in which to resolve an emotional crisis. Several mind-body interventions include Eye Movement Desensitization and Reprocessing (EMDR), imagery/guided imagery, relaxation techniques, rituals, sensory-motor sequencing, mindfulness meditation, myths and prayer (Carr & Hass-Cohen, 2008, p. 26). The intervention's focus is on "the remediation of stress and restoring a sympathetic-parasympathetic balance by teaching clients experiential practices" (Carr & Hass-Cohen, 2008, p. 26). Furthermore, mind-body interventions "are effective in buffering [an individual] against stress and in building resiliency" (Fricchione, 2015, p. 316) that leads to adaptive resolution of an emotional crisis.

Rossi et al. (2011a) stated that communication "between mind, body, gene, and environment" (p. 51) is disrupted by adverse life events (acute trauma) or chronic stress. As a result, the individual experiences an emotional and physical crisis that affects their mind-body connectivity. For an individual to resolve a crisis that affects mind-body connectivity, that person is required to facilitate an adaptive response that activates their

"deep psychobiological source of human resilience and resourcefulness" (Rossi et al., 2011a, p. 51). Heightened consciousness and creativity characterize the individual's inherent capacity and potential to respond to an acute trauma or chronic stress adaptively. Art-making optimizes an individual's relaxation response, and is a repetitive, adaptive behavioral act that allows an individual to gain insight, and affirm their resiliency and resourcefulness despite life challenges.

The practice of creating art is experienced as tension and excitement (due to the sympathetic nervous system). An emotional crisis may render "a person without words and making it necessary to work directly with non-verbal, emotional systems" (Carr & Hass-Cohen, 2008, p. 32-33). Furthermore, the individual anticipates the pain involved in addressing an emotional crisis because of the potential loss of an attachment figure or enduring attachments that fulfills their needs or wishes. This is referred to as that person's archetypal separation anxiety, which is produced as an initial reaction to an emotional crisis. The individual's reflexive response to the archetypal separation anxiety is archetypal imagery that carries emotionally salient information that was formerly repressed in the unconscious. The individual's voluntary act of art-making, such as painting or drawing, activates the somatic nervous system which elicits sensory information via afferent and efferent nerves to and from the central nervous system. Thus, art-making is a relaxation response for them, and restores an embodied connection that enables that person to access their inherent resiliency and resourcefulness for spiritual change.

It was standard for art therapy to be dichotomized as two psychotherapeutic approaches: art as therapy and art psychotherapy (Gussak & Rosal, 2016; Lusebrink,

1990). Art as therapy was extensively discussed in Edith Kramer's literature (1958, 1971, 1979, & 2000). Kramer (2000) coined the metaphor, the *Third Hand*, which is described as "the art therapist's functioning wherein artistic competence and imagination are employed in the empathic service of others" (Kramer, 2000, p. 47). The Third Hand motivates the individual's "creative process along without being intrusive, without distorting meaning or imposing pictorial ideas or preferences alien to the client. The Third Hand must be capable of conducting pictorial dialogues that complement or replace verbal exchange" (Kramer, 2000, p. 48). In addition, the therapist ought to "adapt to each individual's pictorial handwriting" (Kramer, 2000, p. 69).

The therapist needs to ask themselves these questions continuously: (a) what can be reasonably expected from the individual that may elicit a change for the better from the artwork; (b) what could be the first step to actualize change for the better; (c) how can pictorial intervention (imagery) provide movement for an individual to set a change in motion, and (d) what should be done to facilitate and nurture this process (Kramer, 2000, p. 69). In summary, the art therapist facilitates, nurtures, and supports an individual's creative process. Art as therapy is based on the premise that the individual's relationship and experience with the creative process are therapeutic in themselves (Kramer, 1958, 1971, 1979, 2000; Lusebrink, 1990). The therapist's tasks for administering art as therapy align with supportive brief psychotherapy as represented throughout this study.

To further elucidate art as therapy with a psychoanalytic perspective, the individual's imagery may be influenced by the id during the creative process. However, the ego is the dominant psychical agent during art-making. The person's id forces are transitioned to "an inner harmony and also harmony in the expression" (Lusebrink, 1990,

p. 12) of a psychological conflict. The individual's conscious act of art-making expresses their feelings which can be explained in words which can elicit awareness of the human condition and processes that affect ego-functioning (Ulman, 1975; Lusebrink, 1990).

It is important to note that the individual's speech of their Self (poiesis) is not reduced by words. The individual's subjective experience is transcribed into words that further affirm and validate their spiritual development and healing of the Self. The individual reality-tests their emergent and embodied knowledge with the therapist, and asserts themselves in the environment. Thus, the individual affirms and consolidates the therapeutic experience that elicits awareness and growth because the art as therapy task triggers their inherent imaginative capacity to heal the Self.

The goal of art as therapy is to encourage and empower the individual to produce an object that has symbolic meaning and elicit awareness that can bring about a movement towards insight. Thus, art as therapy is a supportive psychotherapeutic modality that can promote a re-establishment of an individual's stability, integrates the psychical agents to strengthen the Self, and promotes awareness. The art as therapy task has been understood to provide the individual with a sense of Self, faith, and self-confidence to spiritually develop in accordance with their True Self.

Margaret Naumburg is an influential figure in art psychotherapy. Naumburg (1966) stated that during art-making, an individual's "thoughts and feelings are derived from the unconscious and often reach expression in images rather than words" (Naumburg, 1966, p. 1). Thus, an individual's imagery is a *symbol* of the Self. Furthermore, the individual "has a latent capacity to project his inner conflicts into visual form" (Naumburg, 1966, p. 1). The therapist's task is to motivate the individual to

explore and discover the inner meaning of the imagery with the goal of gaining awareness and insight that is congruent with that person's interpretation. The individual becomes an active participant in their own healing experience, willingly choosing to strengthen ego-functioning by being in a relationship with their unconscious, and assuming an independent stance in therapy (Naumburg, 1966, p. 8). Therefore, the individual's expression of feeling and insight is the primary aspect of therapy (Landgarten, 1981; Lusebrink, 1990).

The art psychotherapy task aligns with anxiety-provoking brief psychotherapy. The therapist's primary goal is to uncover the individual's repressed material, wholly incorporate the psychical agents (id, ego, superego), and actively engage in unconscious-conscious dialogue with the individual to support their movement towards insight. The person's id is acknowledged, and as a result, their unconscious motivations are illuminated throughout art-making and imagery. The individual's unconscious motivations have a covert influence on their ego-functioning, and if it is not fulfilled in congruence with the True Self, it leads to the further loss of a Self. Art as therapy and art psychotherapy supply the therapeutic tasks that the therapist provides for an individual. These are methodological tasks that are informed by the therapist's theoretical influences, and are based on what will currently work best for the individual in a collaborative manner.

"Emotional crisis fragments the perceptual processes, which can be restored through the concrete enactment in a visual expression involving sensory modalities" (Lusebrink, 1990, p. 15). Therefore, the individual's conscious decision to stay with their anxiety during art-making is an affective, cognitive, and physiological act "to resolve

ambiguity in their emotional life" (Lusebrink, 1990, p. 15). The individual's creative act that involves the imagination, poiesis, contributes to a "sense of control and mastery" (Lusebrink, 1990, p. 15) of their personality and spiritual development.

The individual's imagery is "a tangible, permanent record" (Lusebrink, 1990, p. 9) that leads to control and mastery, and a new component of their Self. Through "line, form, color, and location" (Lusebrink, 1990, p. 10) in imagery, the person's physical manipulation of psychical tension is given form via art-making and facilitates unconscious-conscious discourse between "inner and outer reality" (Lusebrink, 1990, p. 10).

The individual's willingness to increase their anxiety is in fact *motivation* to perceive and manifest their meaningful reality in an alternative manner. It is an inner movement that is being revealed and actualized in the external environment. The individual assumes responsibility and acts autonomously to assert oneself with the support of the therapist. The person's imagery derived from art-making is the expression of inner experience and external representation of their meaningful reality. Their imagery and verbalization about their psychical structure increase their awareness of it, but it also "reflects a shift in the functioning of the personality" (Lusebrink, 1990, p. 13) that leads to discovery, exploration, and insight.

When the person experiences an emotional crisis, their psychical structure is temporarily imbalanced due to the tension between the unconscious and conscious. However, it is not only the individual's mind that becomes unstable, but the body as well. In order for a psychological conflict to remain repressed in the unconscious, the individual's body is required to inhibit the process of unconscious-conscious discourse.

As a result, the body contains the psychical tension at the cost of the person's affective, cognitive, and physiological functioning.

By maintaining the repressed psychological conflict, the psychical tension exerted from the unconscious becomes transduced on a cellular level which affects the person's mind-body connectivity and communication. Consequently, the body is required to suppress the nervous, endocrine, and nervous systems to maintain the repression of a psychological conflict, and prevent latent emotionally salient information becoming conscious. As a result, the body compensates for this act of repression because it inhibits unconscious-conscious discourse.

As supported by several authors, inflammation, oxidative stress, and chronic illnesses are influenced by inadequate coping strategies or a lack of adaptive responses to an emotional crisis (Fricchione, 2015; Fricchione & Peteet, 2015; Rossi et al., 2011a, 2011b; Selye, 1976). The individual's ego-functioning may weaken or strengthen during an emotional crisis depending if unconscious-conscious discourse occurs. If the person increases their anxiety and allows the process of a repressed psychological conflict to become conscious, the body releases the psychical tension that no longer suppresses vital physiological systems and overall functioning. This shift, by allowing unconscious-conscious discourse to unfold, may reduce an individual's symptoms and lead to an adaptive process of searching and practice of adequate coping strategies to resolve an emotional crisis.

When a person releases the psychical tension and relieves the body's suppression on overall functioning, their mind and body will no longer be in a state of anxiety and will shift from ensuring immediate survival to adaptively addressing an emotional crisis.

Consequently, their ego-functioning improves as opposed to the person maintaining repression with inadequate coping strategies that may cause a further loss of ego-functioning. Thus, the person's shift from immediate survival to thriving in their environment allows for a new psychological and physiological process that may reduce symptoms of inflammation, oxidative stress, and chronic illnesses. Furthermore, it will allow the individual to discover and actualize their potential and capacity for change and healing in an unpainful state of being.

"If therapy means to heal, and hopefully to cure, then art may really be the ideal medicine for the human soul, the best way for the spirit to know and to actualize the Self" (Rubin, 2010, p. 92). As active participants in the therapeutic encounter, the therapist and individual facilitate and promote an invitational, authentic presence within a nurturing transitional space (Levine, 2003) that encourages unconscious-conscious discourse. Within the transitional space and *trusting the process*, an individual discovers new insights towards their imaginative capacities for change and healing.

Art therapy is a mind-body psychotherapeutic modality that encourages the individual to take purposeful action within a safe and controlled environment (Carr & Hass-Cohen, 2008; Malchiodi, 2012) to explore and implement internal adaptive adjustments. The individual develops a sense of control and mastery, and mediates their affect regulation towards re-establishing sympathetic-parasympathetic balance. Furthermore, the individual's art-making process and imagery may address and transform underlying psychological conflicts that were previously repressed.

The concept of poiesis, as an expressive arts practice, is a process-based perspective that encourages therapists to perceive their clients as unique, and to honor the

gifts and challenges that they have throughout life (Levine, 1997; Eberhart & Atkins, 2014). Throughout the person's art-making and within archetypal imagery that may arise via unconscious-conscious discourse, they can develop an awareness of latent emotionally salient information that can emphasize their strengths and competencies for resolution. In an unpainful state of being with the therapist, the individual's shift from maintaining repression to releasing the psychical tension in a safe and controlled environment may lead them to address an underlying psychological conflict to resolve an emotional crisis.

The entire experiential practice—process, product, and therapeutic relationship—trigger the individual's latent healing abilities by re-establishing mind-body connectivity and connection. Therefore, an art therapy task provides a supportive environment for the individual to express emotions and repetitively practice adaptive affect regulation in a relational and situational context. The person's healing experience transforms their painful state of being that was influenced by a repressed psychological conflict, and liberates the body, mind, and spirit to restore, express, and heal the Self.

Methodological assertions. The researcher discusses art therapy as the psychotherapeutic modality of this study, and it does not imply that art therapy is the best or most effective psychotherapy. Imagery-based practice, whether it is verbally or pictorially conveyed, involves a creative process that synthesizes an individual's inherent imaginative capabilities and potential towards healing. Furthermore, the individual's practice of giving voice and form to what was previously abstract (unknown, unconscious) into concrete expression and representation has to be reality-tested based upon their competencies, strengths, and challenges.

The psychotherapeutic intervention must be mutually-agreed upon between the therapist and the individual. The therapist is accountable for implementing tasks or a process that is congruent with that person's motivation and that can be completed. It is important for the therapist not to limit themselves with dichotomies, because the focus ought to be on optimizing the individual's healing experience by being in a relationship with one another. The questions of "what can be done?" and "how can it be done?" are part of the collaborative process which invites the individual to be an active participant and a high level of participation from the therapist.

The principles of single-session therapy align with the researcher's proposed psychotherapeutic approach as they established single-session therapy as the clinical context in which art therapy can be offered to individuals. The researcher adapted Bloom's (1997) Focused Single-Session Therapy phases: "introductory material, middle identification and development of important themes, the planning period, and the gradual closing" (Bloom, 1997, p. 71) and combined it with Rossi et al.'s (2011a, b) 4-stage creative process to present a tentative, preparatory account of providing SSAT.

It is important to note that a dichotomy may still exist and prevail between verbal therapy and art therapy; traditional psychotherapy and brief psychotherapy/single-session therapy; supportive brief therapy and anxiety-provoking brief psychotherapy, and art as therapy and art psychotherapy. The researcher asserts that these dichotomies limit psychotherapeutic practice and flexibility towards providing a healing experience for individuals who seek it. These approaches ought to be a guideline of psychotherapeutic practice that exists on a continuum to inform the choices of therapists and individuals in developing a mutually-agreed upon healing experience.

Phase one: inauguration. The individual inaugurates the therapeutic encounter by accessing a clinic or service as a response to an emotional crisis. The person decides and acts on seeking assistance and support as opposed to perpetuating habitual coping responses/strategies. Therefore, their healing experience begins before the therapeutic relationship. The individual chooses an alternative solution to address the pain that was precipitated by the emotional crisis. The person who initiates the therapeutic encounter chooses autonomy rather than complacency. Therefore, "the therapist has every right to expect the patient to get to work, to describe the problem, and to begin moving towards its resolution" (Bloom, 1997, p. 70).

Administrative tasks, such as introducing the individual to the services and history-taking for initial data collection, are implemented throughout this phase. The primary data collection enables the therapist to establish a tentative hypothesis, identification of potential maladaptive patterns, potential adaptive coping strategies, and strengths of the individual (Bloom, 1997). The initial data provides the therapist with information to prepare appropriate services and support.

The individual inaugurates their spirit towards the unknown to begin something new. It is a search for an alternative way to address the emotional crisis. The individual and therapist “seek to identify the problem” (Rossi et al., 2011a, p. 64) and the life transitions “that are at the source of the patient’s conflicts” (Rossi et al., 2011a, p. 64). The individual introduces their body, mind, and spirit to the unknown to begin a healing experience for the Self.

Phase two: invocation. The therapist meets with the individual to discuss their request for assistance. An initial interview process takes place, such as the individual

addressing their issue, motivation for assistance, and perception of the precipitating event. The therapist's role in this phase is affirming the individual's therapeutic work; determining ego-functioning and ego strength; exploring, raising, and modulating levels of anxiety (Bloom, 1997); assessing the individual's motivation (whether it is for symptom relief); assessing the individual's self-confidence (for instance, exploring their schema) (Bloom, 1997), and identifying enduring unresolved issues that may influence the present issue (Bloom, 1997).

If the individual does not regard the issue as psychological and/or ego-functioning is significantly impaired where physical risk and harm may occur to themselves or others, the therapist implements crisis intervention. Such instances involve psychiatric care and hospitalization to ensure that the individual and others are protected and safe.

It is recommended that the therapist is economical with their words and participation in this phase. Since the individual initiated the therapeutic encounter, it is important that the therapist maintain that the person is responsible for communicating (Bloom, 1997, p. 70). Also, the therapist ought to "keep factual questions to a minimum [because] the most important information will emerge in the normal course of the interview" (Bloom, 1997, p. 71). The therapist employs open-ended questions to determine ego-functioning and tolerance for ambiguity. Furthermore, the therapist ought to remain open and flexible at this stage of inquiry as the individual discusses their psychological processes and influences.

The therapist and individual identify a core issue. The person's psychological problem may be a *nuclear conflict* or a *focal conflict.* A nuclear conflict is "a dormant and repressed conflict originating during crucial developmental period in early life"

(Bloom, 1997, p. 69); whereas a focal conflict is "a preconscious derivative of these deeper and earlier nuclear conflicts, which is able to explain much of the clinical material in a therapeutic interview" (Bloom, 1997, p. 69). The identification of the conflict may influence the creative process in Phase Three, because the individual may require a more supportive approach to develop ego-strength before addressing the source of a nuclear conflict.

The therapist presents a tentative interpretation of the individual's language, such as highlighting key word and phrases. The individual is encouraged to assert themselves whether or not the tentative explanation regarding their psychological issue aligns with their understanding. The therapist promotes a space where that person can assert themselves, and for the person to experience anxiety in a place that will not yield danger or threat. The therapist ought to provide a nurturing space (Winnicott, 1960) for the individual's spirit to incubate.

The individual invokes their spirit by requesting assistance from a therapist during a moment of pain and suffering. The invocation phase involves the person's "characteristic conflicts, drama, emotions, and symptoms" (Rossi et al., 2011a, p. 65) that are the results of an unsuccessful emotional crisis resolution. The therapist provides support for the individual during "this typically difficult stage of [their] natural cycle of creativity, problem-solving, and healing (Rossi et al., 2011b, p. 416).

***Phase three: evocation*.** The therapist continues to hypothesize collaboratively as to how the individual situates themselves in their internal and external reality, and what processes can help make a shift towards healing. The therapist presents two or three ideas to the individual. The individual needs to choose "which ideas to explore and how to

explore them" (Bloom, 1997, p. 70). The therapist does not need to rush the therapeutic process or be concerned about presenting a grand idea, because a simple idea that the individual can successfully experience can lead to "a single observation [that] can have the patient hold it for weeks" (Bloom, 1997, p. 70). The psychotherapeutic modality that is implemented at this stage is a strategic, creative process that is similar to a "behaviour modification – repertoire of talking, sharing, [and] questioning" (Bloom, 1997, p. 72) that expresses the individual's spirit.

As for the therapist implementing a creative process in the session, the goal is to increase the individual's self-awareness in one area of life that "can have an important impact on the adequacy of his or her functioning" (Bloom, 1997, p. 72). Therefore, a supportive approach is necessary for them to gain an objective, accurate appraisal of the emotional crisis that places them as the *subject* instead of the object and can engage in the process of illumination. If the individual does not choose an anxiety-provoking psychotherapeutic approach that will lead to insight, they still have the opportunity to gain awareness that may result in insight after the initial therapeutic encounter. Thus, it is important to consider what the individual is motivated to accomplish and capable of achieving. The creative process ought to align with their motivation and competencies and be adapted if necessary to ensure that the individual remains the *subject* of the session instead of being an object of anxiety.

The psychotherapeutic modality/crisis intervention will vary according to the administrative functionality and capabilities of the clinic, the interdisciplinary team/approach of the clinic, the therapist's competencies, and experience, the individual's motivation, and the amount of time to complete the therapeutic task. Regardless, the

therapist at this phase ought to adopt a more active participatory role to optimize and validate the healing experience. If the individual experiences a high level of anxiety during the process, the therapist is encouraged to offer an empathic remark and adapt the encounter to ensure that the person still has the mastery and control to complete the goal successfully.

The researcher presents a tentative art therapy continuum with the intention to provide a theoretical and methodological foundation to motivate therapists who are interested in providing art therapy services in a time-limited manner. They discuss art (as) therapy first, followed by art psychotherapy.

Art (as) therapy: supportive brief psychotherapy.

- The individual identifies the issue as a focal conflict or nuclear conflict but is not ready to address their repression and the feelings associated with it.
- The person is motivated to search for the meaning of their painful state of being. They may also seek symptom relief from anxiety, cessation of pain, and the desire and need for psychosocial connection.
- The individual's signs of strain include a relatively-impaired ego-functioning that makes it initially difficult for the person to comprehend between fantasy and reality. The therapist assesses the individual's ego-functioning by asking anxiety-provoking questions with the intent to determine if they are capable of sensing and perceiving the emotional crisis in a different environment. The purpose of the anxiety-provoking questions is to assess whether they can confront, clarify, and interpret their unconscious content and feelings in an altered environment. The person does not respond well to the therapist’s

anxiety-provoking questions and is not willing to remain in a state of anxiety. However, the individual is still able to be in a state of vulnerability and adaptability in the presence of the therapist.

- The individual requires less structure in the session as the therapeutic focus, and objective, are rooted in nurturing and empowering their Self. They are unable to tolerate ambiguity, so the therapeutic structure is premised on art-making and the therapeutic alliance. This establishes a supportive environment that will promote the individual's movement towards Self. The therapist needs to focus on the individual's integration of the ego and superego and ensure that defense mechanisms are not employed throughout the session with the psychodynamic technique, active imagination.
- With the therapist, the individual learns to reduce and modulate anxiety, restore ego-functioning, support the body to transition the mind and spirit adaptively, and incubate their imaginative capacities to develop ego-strength further.
- The individual's unconscious energy is released during art-making, and the body and mind are no longer inhibiting their creative capabilities. The person's ego and superego are the focus for conversation (reality-testing) regarding the imagery. The individual's id is integrated throughout art-making, and is represented by the superego.
- The person's art-making expresses and nurtures their Self via imagery to restore ego-functioning, and increases their self-confidence. The art-making re-establishes the individual's bodily sensation and perception towards an

embodied connection. The integration of the psychical agents elicits the individual's inherent wisdom, and promotes creative solutions for problem-solving. Thus, the individual's art-making is a vehicle to express their Self.

- The individual's personality and spirit are instruments of faith that one has the self-confidence and inherent ability to address an emotional crisis in an adaptive manner congruent to their Self. The individual's healing experience carries salient information regarding a nuclear conflict even though the therapeutic encounter focused on a focal conflict in the here-and-now moment. The person and therapist reality-tests the solutions to establish a meaningful reality. By reality-testing, the person enacts the art-making, the art ownership, and the reality created and discussed in the session.
- The individual's healing experience transforms their suffering and the limitations of imagination due to the release of explicit unconscious content via art-making. The creative process is therapeutic in itself. The individual's repressed material is not uncovered, but the unconscious content is integrated towards awareness and movement towards a Self where the ego is adaptively strengthened. The individual transformed their Self from a painful state of being, and experienced an alternative and repetitive solution to create adaptive internal adjustments for spiritual development. In addition, the healing experience is emotionally salient information, and may lessen or prevent habitual, maladaptive coping strategies to occur in future emotional crises. Furthermore, it promotes the individual to seek assistance and support in similar circumstances. The individual then reality-tests outside of the session.

Art psychotherapy: anxiety-provoking psychotherapy.

- The individual identifies the psychological issue as a nuclear conflict, and is willing to address their unconscious motivations and repressed feelings.
- The individual is prudently active towards their search for meaning, cessation of pain, and asserts their desire and need for psychosocial connection.
- The person's ego-functioning in temporarily impaired, and can interpret and clarify the emotional crisis with the support of the therapist. The individual responds well to anxiety-provoking questions and tolerates ambiguity. The individual is willing to remain in a state of anxiety and place oneself in a state of vulnerability and adaptability.
- The individual and the therapist actively address and transform the person's suffering to a meaningful reality with a movement towards insight (O'Connell Killen & de Beer). The individual's repressed content is uncovered, and the person trusts the process that they will persevere in the endeavor.
- The individual requires more structure in the session as the therapeutic focus and objective are rooted in psychoanalytic and psychodynamic principles. The individual and therapist need to remain focused to ensure that the person completes the therapeutic task. Furthermore, the therapist needs to make sure that the individual does not become anxious, because there is a possibility that the person will use art-making and imagery as a compensatory process to avoid pain. If the individual experiences anxiety, the therapist needs to adjust the therapeutic task and re-focus the person to achieve the mutual goal.

- The therapist needs to actively (a) reduce and modulate the individual's anxiety; (b) restore stability; (c) incubate the spirit; (d) challenge the person to express the Self; and (e) support the person's spiritual movement towards the Self that will lead to purposeful action during and after the session.
- The individual's unconscious energy is released during art-making. The individual's id is the primary focus for expression and verbalization for conversation (reality-testing) regarding the imagery. Their ego and superego are distinctions of the id; therefore, challenging and addressing the id is the source of a nuclear conflict that they repressed in the unconscious. The unconscious is contained in the imagery via art-making.
- The individual's art-making expresses and challenges their personality development, and perturbs the False Self system. The art-making increases their bodily sensation and perception towards the embodied communication of body, mind, and spirit. Their imagery is the affirmation and verification of the individual's healing experience between the unconscious and conscious. Their personality and spirit is an agent of authenticity to their True Self. Thus, the person's imagery is an agent of change and transforms their suffering.
- The person is empowered and displays self-confidence that they have the inherent ability to be authentic in congruence with their Self. The individual's healing experience transforms the nuclear conflict and it carries emotionally salient information for future emotional crisis resolution of other nuclear or focal conflicts.

- Thus, the individual heals by being in a relationship with their Self and unconscious content. The individual and therapist reality-test the solutions to establish a meaningful reality. The individual then reality-tests outside of the therapeutic encounter.

The therapist is required to remain focused on the subject of the session: the individual. It is normal for an individual to employ defense mechanisms, whether consciously or unconsciously, to avoid pain. The therapist needs to reduce the defense mechanisms and maladaptive coping strategies, and promote the *repetition* of adaptive strategies and skills. The individual decided to pursue an alternative path to address pain as he/she inaugurated the encounter, and the therapist ought to provide support to motivate the individual to develop the skills he/she requested to resolve the emotional crisis. Thus, the therapist must to keep the individual's focus on themselves, to ensure that the healthy coping strategies and adaptive skills are repeated in a psychosocial environment in which the person's intentions and actions are affirmed and witnessed.

The therapist needs to actively avoid detours, and remain focused. Free association is a psychoanalytic technique that encourages a person to state whatever comes to mind without censorship. While free association is a clinical technique that helps an individual to dialogue in a permissive manner without restrictions, unconscious mannerisms (defense mechanisms) can come into play. In consideration that emotional crisis is a result of systematic, repetitive, unsuccessful resolution attempts, it is integral to reduce the maladaptive repetition and increase adaptive repetition. Therefore, free association is not recommended as a clinical technique in single-session therapy, which

influenced the researcher to promote the psychodynamic technique, active imagination, as it keeps the focus on the individual and is goal-oriented.

As mentioned in the previous section, active imagination involves the therapist focusing on the psychological work (imagery) itself. Therefore, active imagination is a clinical technique in which the creative process is centered on the individual's imagery (produced object via art-making or mentalization), and the therapeutic relationship is focused on the individual (the *subject*). Free association can lead to a rise in anxiety and defense mechanisms because the individual and therapist can situate themselves in a complacent state and maintain maladaptive, habitual, repetitive ways of being.

In a single-session therapy setting, free association is not appropriate because it may lead the individual away from autonomy and direct their imaginative capabilities towards a resolution that is not congruent with their meaningful reality of a fulfilling life. Free association can influence the individual to shift from a subject to an object, and they *talk to it* (the imagery) as if it is a subject itself. Active imagination focuses on the individual as the subject, and encourages them to *speak about it* **(**the imagery) as an object that was created by the subject (the person).

The individual evokes their spirit by expressing their True Self in a creative process that encourages imaginative capacities. The therapist bears witness to this event, and actively participates in the individual's "initial resolution of the conflict, problems, and symptoms" (Rossi et al., 2011a, p. 65) from the previous phase. In addition, the therapist validates the solutions that emerged during the creative process (Rossi et al., 2011b, p. 417).

Phase four: proclamation. The therapist ought to affirm and verify the individual's progress and goals to ensure that the body, mind, and spirit are carried forward in future experiences to prevent similar crises from occurring. All aspects of an individual manifest a meaningful reality; therefore, the body, mind, and spirit are symbolic languages influenced by cognition and imagery. The individual remains the subject provided that the therapist is prudently active in focusing on the person with their *language* (congruent with the person's verbal and non-verbal imagery). The therapist ought to provide an adaptive environment for the individual so that repetition can occur in an affective, cognitive, and physiological manner.

The individual proclaims their spirit, and the revitalization of the body and mind. With the support of the therapist, the individual consolidates the healing experience. The person's psychological conflict and related affective and cognitive symptoms are reframed into signals and resiliency (Rossi et al., 2011b, p. 418). The individual and therapist discuss the healing experience, and may engage in a follow-up session if required. The individual then "returns home to reality test the new problem and symptoms solutions" (Rossi et al., 2011a, p. 65) that were discovered in the previous phase.

In summary, the therapist must explore how to challenge the individual, and modulate signs of anxiety to ensure that they have a healing experience that incorporates imagination. Also, the therapist ought to be flexible in adapting the creative process to ensure that the individual is not disabled by anxiety that will promote or maintain defense mechanisms. The therapeutic aim is directed towards the individual's awareness and potential insight as to what and how the loss of the Self manifested. In addition, an

individual's insight into their perceived loss influences them to grow spiritually and psychologically as the Self is transformed and healed by meaningful action.

Both parties need to be actively prudent in reality-testing the expression and verbalization of the individual's spirit and creative capabilities. Sometimes words do not convey the whole inner truth or completely express the individual's meaningful reality, but are a conscious movement to carry the person forward in life. It is an acquisition of the skill of knowing what to do and how to assert oneself in the psychosocial environment. The therapist needs to affirm and validate the individual's competencies and potential for creating a fulfilling life. As such, the individual must reality-test their imagination with body and mind, and proclaim the healing experience towards finding the path of their Self.

Summary

The researcher's synthesis of SSAT as a clinical modality is informed by the research findings, and tentatively based on the selected psychotherapeutic, theological, and medical literature that was presented throughout the thesis. SSAT is influenced by psychoanalytic principles, and an experiential psychotherapeutic practice where the therapist strives to incorporate all aspects of the individual to provide a healing experience where their True Self can emerge and be witnessed with one another. The individual's mind can recognize anxieties as a signal of growth and awareness, rather than a signal of threat and danger that suppresses physiological functioning (immune, endocrine, nervous system) to ensure immediate survival. Their body can release the repressed content that the mind initially censored to restore mind-body connectivity and communication, and re-establish overall functioning in an unpainful state of being. The

individual's spirit is then freed that inevitably gives breath to the mind and body – initiating an inner and outer movement where they can recognize and actualize imaginative capacities and potential with resiliency and resourcefulness.

The individual can perturb their false-self system by *reflecting* and *adaptively responding* to anxiety with an inner and outer movement of creating a meaningful reality. The individual acknowledges and addresses the repressed content that influenced their motivations, affect, cognition, physiological symptoms, and psychological conflicts. If a person chooses to perpetuate the False Self, or unsuccessfully resolves an emotional crisis – that person continues to experience a loss of the Self. The mind, body, and spirit become repressed, and the individual separates on all these levels that cause internal and external disharmony. To deny and avoid pain is repressing their True Self (also their true image). Their pain embodies the loss of a meaningful reality that occurred due to an adverse life event, but it also incorporates infinite meaningful realities (the id's fantasies) that can restore and revitalize their imagination.

An emotional crisis limits the individual's imagination, but it does not entirely oppress their spirit. The individual who decides to seek assistance to resolve an adverse life event has a resilient spirit and the inherent strength to preserve pain in order to move towards their creation of a meaningful reality. Although the individual experiences pain, their body and mind are held together by spirit as they restore and heal the Self. They need to experience and actively engage in their intellectual capabilities that lead to insight which then leads to action. Essentially, emotional crisis resolution is when an individual's body, mind, and spirit move towards the cure that is within themselves, when they use

unconscious-conscious dialogue to transform and adaptively resolve a psychological conflict non-destructively.

Chapter Five: Conclusion

One result of this study is to reinforce the researcher's belief that it is important for communities to offer time-limited services because of the acute, sudden, and unexpected occurence of emotional crisis and the consequences of unsuccessful resolution. Similar to an individual who visits an emergency medical clinic as a result of an acute, life-threatening event that endangers their survival, an acute psychological upset – an emotional crisis can have the same impact. What is different, however, is that it is much easier to see a physical wound with physical symptoms, such as loss of blood, than a psychological one with mental symptoms that can potentially become physical if not immediately treated. Just as emergency and walk-in clinics are available for physically life-threatening situations, there ought to be mental healthcare services that offer and administer acute treatment for an acute psychological injury that is potentially life-threatening. The significant gap in the systematic literature is that there is not a clear connection between an individual's imagination and how it renders a temporary loss in their mind-body connection that affects physiological, affective, and cognitive functioning. Unsuccessful resolution of an emotional crisis means that a psychological conflict will continue to be repressed, and be continually re-activated by a precipitating factor that threatens their survival. If the individual does not receive the immediate support that they need while in an emotional crisis, they can continue a habitual repertoire of maladaptive internal adjustments and experience worsened health.

Time-limited community services are essential, in conjunction with time-unlimited services, because there is an understanding that an immediate life-threatening event needs to be addressed right away since the individual cannot wait and put it on

hold. If there is no immediate, direct mental health care access when acute life events occur, then that person will develop and maintain a homeostatic state resistant to change which may lead to overall deterioration of their being. To prevent future, similar emotional crises from occurring and worsening physical and mental health, individuals need immediate access to external supports and resources when they cannot resolve the issue in a usual manner that restores homeostasis. It is a decisive moment when an individual decides to seek assistance in a painful state of being, and community resources must be ready at this moment because a person is more receptive to change—healing has already begun.

It is imperative that clinicians continue to develop their clinical practice inclusively and constructively as disciplines are becoming more integrated into the community. The researcher's engagements with the published topic and supplementary literature lead them to revisit psychoanalytic concepts to develop and reflect a diverse and contemporary clinical treatment modality that places the individual at the core of the clinical encounter. The researcher establishes a philosophical, theoretical, and methodological foundation for SSAT, and highlights the importance that clinicians need to *talk about* their clinical practices and articulate why and how it works to others who are not familiar with the topic and psychotherapeutic task. In this study, single-session therapy and art therapy were the specializations of the researcher's interest in treating emotional crisis. Future research can include case studies, cohort studies, and randomized controlled clinical trials which could further affirm and validate that a creative process optimizes an individual's experience of healing an emotional crisis.

The healing experience is tailored to and focused on the inherent strengths and creative capabilities for incipient growth and awareness, with an authentic and constitutive movement towards insight to the Self. The therapist ought to be an active participant in the decisive encounter to (a) assess, monitor, and reduce the individual's anxiety to ensure that compensatory processes are not maintained through clarification, interpretation, and confrontation questions when appropriate; (b) ensure that the therapeutic task can be successfully attained and completed; (c) provide a developmentally supportive environment that promotes the repetition of adaptive internal adjustments; (d) ensure that the individual remains focused on the subject by talking about the therapeutic relationship, art-making, and imagery; (e) affirm, validate, and actively reality-test the individual's incipient growth and awareness which will lead to movement towards insight into the Self; (f) remain open and flexible to adjusting the therapeutic encounter based on a continuum of what will work best for the individual in the current moment; (g) have faith and confidence that an individual's change is part of a larger process; (h) ensure that the individual gains a repertoire of skills to assert themselves in a non-self-destructive manner that can be maintained outside of session; (i) recognize that it is not words or imagery that perpetuate suffering – it is the imagination that places restraints on their cognitions (thoughts and/or emotions that are conveyed as mental/verbal imagery, pictorial imagery) that do not give speech to the Self; (j) discuss the individual's personal experience of the decisive encounter; (k) mutually determine if a follow-up or additional appointments are required; (l) provide additional resources and supports that will encourage the individual to continue their healing experience outside of the session; (m) respect and acknowledge the individual’s search for meaning; and (n)

recognize that the person is the expert on their life. Thus, the therapist places the individual at the focus of their own healing experience because their essential subjectivity emerges from symbolic play and active imagination. This approach allows the person to visit the depths of their psyche via imaginative capacities in a transcendent state of consciousness in the witnessing presence of another.

An emotional crisis is a narrow, yet decisive, moment that requires the person to either make a conscious choice to authentically and healthily resolve a psychological conflict, or maintain a maladaptive way of being that perpetuates similar, future crises occurring. A person's underlying psychological conflict is a symbolic representation of their unmet needs and wants, otherwise known as fantasies, which can become a reality if they consciously and decisively heal their emotional pain. To adaptively resolve a psychological conflict, the person needs to be in a relationship with their pain, because it has significant spiritual meaning that can lead to a deeper understanding of their being. By being in a relationship with their pain, the individual can experience a movement towards insight that fully integrates their past, present, and future selves to synthesize their True Self. Within all persons is their True Self, but to give life to it, they must be open, willing, and flexible to giving breath to their psychological conflict, which causes intense pain, uncertainty, and anxiety.

A repressed psychological conflict causes intense pain, uncertainty, and anxiety because it disrupts the person's habitual way of being on a physiological, cognitive, affective, and spiritual dimension. This habitual way of avoiding a psychological conflict is the False Self, and it does not imply that an individual is deliberately choosing to inhibit their True Self, but rather is the implicit understanding that to survive and fulfill

certain needs and wants, they must comply with their psychosocial and environmental dynamics. If the person continues to repress a psychological conflict, it is a decision to survive in their environment, even though they do not adaptively, authentically, and healthily move towards their True Self in a conscious and congruent manner. The person's constant repression of a psychological conflict, whether enacted unconsciously or consciously, requires them to exert their own physical, mental, and spiritual energies to maintain their False Self. Thus, their survival is mainly conditioned, and when their survival is threatened by a perceived loss or separation of needs or wants, it causes temporary instability.

The nature of an emotional crisis is the individual's loss of Self that separates their body, mind, and spirit in a moment of acute and intense pain. The unexpected and sudden rise in pain is the result of the individual's body and mind no longer maintaining the repressed unconscious content of a psychological conflict. It is a moment of special ascendency where the individual must decide how to proceed with their spiritual development – as a dependent or autonomous being. An emotional crisis limits the individual's body and mind, and presents a spiritual challenge. It is a symbolic manifestation that the person's psychological and spiritual development is in a dangerous predicament.

An individual's body takes precedence when providing acute treatment, because if their automatic thought or image is a fantasy that has not been reality-tested, the individual may be motivated to cease the pain with a distinct loss of ego-functioning and a separation from reality. As a result, the individual may cause harm to themselves or others due to anxiety, and feel vulnerable due to suppressed physiological and

psychological functioning. In such a vulnerable state of being, an individual may decide to act impulsively to cease the pain, and usually defaults to a regular repertoire of coping strategies. An individual's automatic internal adjustments and anxiety protect them from pain. However, if the pain is too great for an individual to bear, they may seek to physically end the pain. The individual's decision is not irrational – it is human nature to withdraw from pain and move towards a fulfillment of their wishes and needs (such as "I want this pain to end"), but the decision is made during a moment of intense psychic and physiological instability. The individual's unconscious experiences a steady intensity that temporarily inhibits their ego and superego functioning, and causes internal and external tension in themselves and their environment. As a result, their immediate sensation, perception, and cognitive abilities are inhibited in their moment of crisis.

When a person experiences an emotional crisis, there can be a cognitive and affective impairment that affects their reality functioning. In this aspect, an individual's ego-functioning, such as their decision-making and perceptual capabilities, is temporarily impaired. The individual's psychic energy is directed towards the withdrawal or cessation of pain as regulated by the pleasure principle. As a result, there is an imbalance between the unconscious and conscious that affects overall functioning and well-being. Consequently, the individual exhibit signs of strain as the id, ego, and superego attempts to avoid an underlying psychological conflict by compensating bodily and mental functioning to maintain repression.

The individual's habit to avoid psychological conflicts can lead to the loss of Self. This occurrence can be construed as an emotional crisis because the tension between the unconscious and conscious causes an individual to experience affective, cognitive, and

physiological instability. The psychic energy of the unconscious exerts pressure towards the conscious, and causes the person to experience a momentary disruption in ego-functioning. An individual's complexes are expressed through emotions (affectivity) and imagery that are symbolic content of the language of the unconscious. In this circumstance, the individual's cognitive processes are regulated by the pleasure principle vis-a-vis the id and its fantasies— the needs and wishes to cease pain and seek pleasure— that can be relayed to that person as imagery.

The person's drive for spiritual meaning and understanding can surpass their drive for physical survival while in an emotional crisis. Anxiety is a physiological reactionary signal for the individual to halt forward movement or exercise caution when a precipitating factor triggers a psychological conflict that threatens their survival, safety, needs, and wants. When anxiety is produced, the person must then respond to the immediate perceived threat in their psychosocial environment. Their response is usually automatic due to learned behaviours and actions that are habitually maintained; however, their response can also be voluntary and idiosyncratic in that different actions seem reasonable in response to the sudden change in their psychosocial environment. It is common that a fleeting image or memory is produced in the individual's body and mind when anxiety occurs, and this image influences their corresponding response to the emotional crisis.

Imagery produced by anxiety is a sign from the depths of the person's psyche— the unfolding of their emerging spirit that was previously oppressed when the psychological conflict was repressed and suppressed by their mind and body. Their imagery is unconscious, and can be made conscious if they are willing to remain in a

painful state of being. The imagery is an automatic response to the reactionary signal of anxiety, and contains crucial information about the origins of their emotional crisis. Therefore, understanding a person's imagery in response to an emotional crisis is important, because within the imagery is their unconscious motivation to fulfill their needs and wants. By staying in a state of anxiety, an individual can understand the symbolic meaning of their imagery and how it influences their conscious decision to resolve an emotional crisis.

If the individual consciously decides to allow the unconscious content to become conscious, the content is then relayed through imagery-based verbal cognitions and behavior. Thus, the individual's fantasies are reality because it is part of their internal world and Self. For an individual to assert oneself in an emotional crisis, the fantasy-produced images need to become conscious, synthesized, and reality-tested.

As mentioned previously, a person's enduring attachments are developed in childhood, and have a lasting effect throughout their life in a way that is not bound by time or space. Therefore, their complexes and fantasies are latent in that person's personality, and are expressed cognitively whether or not the individual is aware of it. An individual can experience an emotional crisis when a wish or need is not being fulfilled. The psychic tension that a person experiences in this situation may be construed as that person's cognitive processes regarding how they will assert the id via ego-functioning and superego in the environment without compromising their True Self. In the circumstance that the individual does not succeed in this endeavor, that person can perceive the environment as a danger to their Self. This is due to their perception that the environment altered in response to their reality-testing. Regardless of whether the

individual's emotional crisis was influenced by an external or internal stimulus, the person separates from the Self.

For them to restore their Self, that person needs to re-establish an embodied connection. An embodied connection involves their sensation and perception of their self, relationships, and the environment in the context of their feelings about a psychological conflict. Thus, it requires them to establish the connection between body, mind, and spirit by being in a relationship with their pain. Then they can move towards a healing experience that invokes that person's inherent creative capacities and potential to live life once more. This is a movement towards insight, and it requires the individual to have faith that their True Self will prevail from the separation of the False Self and enduring attachments. Then, they are required to engage in an authentic and decisive encounter with their feelings.

There are several outcomes that may result from an emotional crisis, and each one is dangerous because it requires an individual to be vulnerable and in a relationship with their emotional pain in a way that can manifest psychosomatic symptoms and oxidative stress. One outcome is to inhibit the body, mind, and spirit in an attempt to repress the emotional pain and seek temporary relief. This decision does not lead to change for the better, as they continue to perpetuate a system that is not faithful to their being. The outcome of this decision may result in maladaptive coping strategies, such as substance use and impulsive acts such as self-harm and suicide. If they do not allow themselves to become vulnerable and adapt to their internal and external realities, they will become complacent and depend on their psychosocial environment to fulfill their desires and

needs. Thus, they place conditions on themselves and others to establish a meaningful reality at great physiological, affective, and cognitive cost.

Another outcome is to willingly adapt to the psychosocial environment, and develop a repertoire of skills to ensure that they remain true to the image that they hold for themselves. To a certain extent, they are still dependent on the psychosocial environment and specific relationships to fulfill their desires and needs. They choose to adapt and change for a better that is congruent with their meaningful reality, and gain awareness regarding the emotional pain. The outcome of this decision is that the individual becomes vulnerable and strives for adaptive coping strategies that lead to a meaningful reality where body, mind, and spirit are integrated. It is an act of faith that they have the inherent capacity and potential to create a fulfilling life.

The last outcome is for a person to become vulnerable and adapt internally and externally to their psychosocial environment. In contrast to the other choices, this decision requires them to intentionally adapt and change themselves from within and assume autonomy towards creating a meaningful reality that is congruent with their Self latent in the psyche. This decision requires them to address their emotional pain and gain insight towards a healing experience that will give breath and life to the body and mind. It is an act of authenticity that they actualize their inherent capacity and potential to transform and heal the pain as they strive towards a fulfilling life.

Despite the outcome, it is important to comprehend that when a person is in a painful state of being, they are not at their best. An emotional crisis temporarily limits their sensation and perception of Self as they re-establish a relatively stable state of functioning. They lose their self-confidence that they can achieve a fulfilling life and

focus on the moments when they were unsuccessful instead. As spiritual beings, a person needs to feel that they belong and will search for a place that affirms and validates their becoming and being.

The researcher (a) elaborated on the nature of a person's emotional crisis; (b) clarified the person's reality during an emotional crisis; (c) introduced a spiritual perspective to complement the physiological and psychological perspectives of an emotional crisis; and (d) reviewed the mind-body medicine literature to show that an art therapy task in a time-limited setting, one that focuses and places the individual at the core of the experiential practice, offers a healing experience and successful resolution of a psychological conflict by actively promoting unconscious-conscious dialogue with the imagery that arises as an automatic response to an emotional crisis. Regardless of which clinical treatment modality is offered in an acute setting, it is important to understand that within the individual's pain, their repressed psychological conflict holds the medicine to restore their mind-body connectivity and Self from an emotional crisis.

Overall, the researcher provided a systematic account of emotional crisis in the time-limited literature that focused on art therapy as a clinical discipline. The researcher deconstructed, analyzed, and synthesized the literature with the goal to present an interdisciplinary theory of an individual's emotional predicament, the subjective reality of an emotional crisis, that can be applied in an interdisciplinary context with art therapy as a psychotherapeutic treatment. By using influential psychotherapeutic, theological, and medical concepts to discuss theoretical and methodological methods of treating an emotional crisis with art therapy, especially mind-body medicine as a contemporary link

to the outdated literature, the researcher conversed in a language that can apply in an interdisciplinary context with other clinicians.

Future Research Directions

Although this study is the basis for future research, the researcher discussed SSAT in its experimental and conceptual stages, because the methodological application of this treatment modality will be influenced by various factors that include but are not limited to: the community and its resources, the organization's mandate and vocation, and the therapist's psychotherapeutic orientation. Regardless, there is value inherent in providing a single session of art therapy (Filip, 1994). Randomized clinical control trials and case studies for this subject will be the next research step to confirm the hypothesis that art therapy is an appropriate clinical modality to treat an individual's emotional crisis. As such, the principles of time-limited art psychotherapy practice could be enhanced by descriptions of actual practice in future research.

The researcher believes that in an emotional crisis, we must not place limitations and conditions on ourselves, because that will perpetuate our pain and suffering. We inhibit the unfolding of our spirit when we repress our feelings. Our feelings are the unarticulated, yet embodied wisdom of what we must do to free our imagination. We will never know what we are capable of if we continue our conscious repetition of our False Selves and its repertoire of compensatory processes. We must be actively and repetitively committed to our deliberate and intentional creation of our True Selves. This will give breath to our body, mind, and spirit where life will emerge once more.

Additionally, the researcher asserts that we must look within ourselves to visit the depths of the psyche. It is an inner journey that requires us to be in an unmediated,

transcendent state of self-presence. Our search for meaning will always be latent within us, and the medicine for healing from our pain is there as well. We must attend to our feelings, make distinctions, be reasonable and kind to ourselves by recognizing that we are growing and learning how to succeed, and be responsible for our authentic being and becoming in the world. We must be committed and open to ourselves as we explore and discover our inherent capacities and potential for a fulfilling life. We must look into ourselves to free our limitations of imagination and restore the Self with mind-body medicine – our inherent healing potential for transforming suffering to create a meaningful reality.

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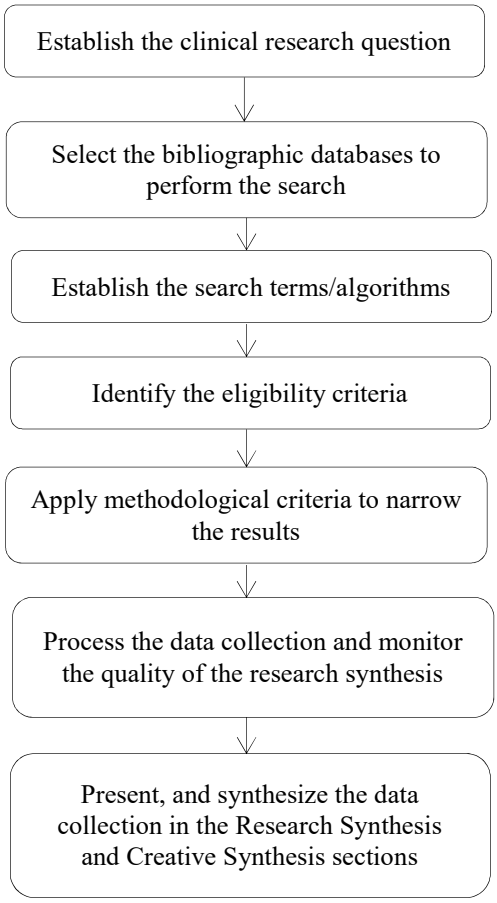
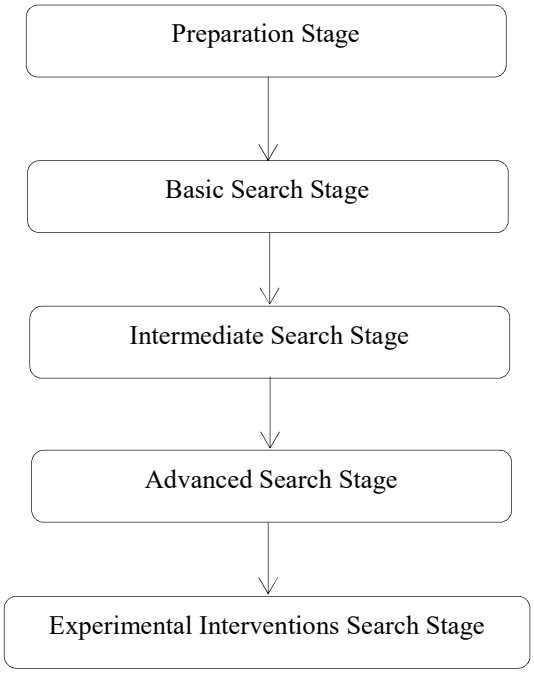
Appendix A

The Research Synthesis Procedure



Appendix B

The Research Synthesis Search Stages



Appendix C

The Research Synthesis Search Algorithms