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Artful Healing: Exploration of a therapeutic intervention set in the college campus art museum

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Artful Healing: Exploration of a therapeutic intervention set in the college campus art museum

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Report

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Dedication

To my family and fiancé. This project could not have been completed without your love, support, and the constant supply of hot tea and encouragement.

Abstract

Artful Healing: Exploration of a therapeutic intervention set in the college campus art museum

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College students in the United States are often characterized by their creativity and openness to new experiences, however, for an increasing number of students the prevalence of depressive symptoms pose considerable emotional and psychological challenges. An additional concern for these affected students is that many will face barriers to care, and overburdened college counseling centers currently struggle to meet the growing demand. This study seeks to address the growing need for treatment of depressive symptoms in college students through an innovative intervention that integrates narrative approaches with therapeutic art-viewing to take treatment out of the counseling center and into an alternative space: the college art museum. While some previous research has touched on the healing potential of museum-based interventions, there is limited research exploring its use for treatment of depressive symptomatology with the college student population. This mixed-methods study pilots a five-week group intervention designed to help students re-author negative life-stories using art objects as

points of discovery for personal narratives. Participants will be drawn from a convenience sample of students from the University of Texas at Austin. Validated pre- and posttest measures will be collected and data analyzed using paired sample *t*-tests in order to evaluate improvement in symptom severity. Additional qualitative data gathered over the course of treatment and in the exit interview will be explored for relevant themes using phenomenological methodology.

Table of Contents

INTRODUCTION 1

INTEGRATIVE ANALYSIS 5

College Student Population 5

College Students and Depression...6

Etiology of depression 8

Treatment of depression in college students..11

Barriers to treatment 12

Narrative approaches 13

Narrative coherence 14

Narrative identity 16

Life-Stories 17

Narrative therapy 18

Narrative therapy practices 19

Arts-based therapies...21

Art-viewing as a therapeutic tool 24

Museums as healing spaces 28

Group work 31

PROPOSED RESEARCH STUDY 33

Statement of Purpose 33

Research Questions and Hypotheses 34

Method 38

Intervention 38

Participants....41

Data Collection Procedure 43

Measures 44

ANALYSIS AND EXPECTED RESULTS 47

Preliminary Analyses 48

Types of Analyses....48

Expected Results....50

DISCUSSION....51

Summary....51

Implications 51

Limitations....52

Future Directions 54

Appendices....55

Appendix A: Outline of treatment plan 56

Appendix B: Pre-screening Survey 58

Appendix C: Patient Health Quetionnaire-9 (PHQ9) 63

Appendix D: The Awareness of Narrative Identity Questionnaire (ANIQ)....65

Appendix E: Items from COPE Inventory....67

Appendix F: Interview Guide 69

References....70

INTRODUCTION

Often described as an invaluable opportunity for personal growth and exploration, the college or university experience can be an exciting time for many students across the United States. Researchers have noted the sociability and creativity in this population, with everyday experiences and social interactions serving as source for ingenuity and identity development (Pachucki, Lena, & Tepper, 2010). For others, however, the usual challenges inherent to the college years can be psychologically and emotionally devastating. Today, students in higher education are reporting some of the highest levels of emotional distress in decades, with depression and related symptoms chief among complaints (Ibrahim, Kelly, Adams & Glazebrook, 2013; Lewin, 2011). It is theorized that the experience of depression in this population can be traced to several potential causes, including having a limited understanding of internal experiences and emotions, as well as adopting and internalizing negative, self-defeating personal narratives (Hunt & Eisenberg, 2010; Santa Rita, 1998).

Administrators have attempted to address the growing concern over students' psychological needs, making campus-wide efforts to promote mental health care as a part of overall well-being (Jones, Watt, Levine, & Watt, 2017). Though more students are seeking out treatment than in previous years, the troubling truth is that many will not receive the care they need (Kirsch, Pinder-Amaker, Morse, Ellison, Doerfler, & Riba, 2014). In part this is due to a shortage of services over-taxed campus counseling centers are able to provide (Jones et al., 2017). However, many students also exhibit low help-seeking behaviors, citing stigma associated with traditional mental health services (i.e., individual psychotherapy) as a primary reason for not requesting help (Meyer, Morrison, Lombardero, Swingle, & Campbell, 2016).

There are many approaches to treating depressive symptoms, however the unique developmental needs of college students and the nature of the etiology associated with their psychological distress has inspired researchers to seek out innovative modes of treatment that connect with students (Mobley, 2008). Narrative therapy and the practices inherent to this approach appear to be well-suited for helping emerging adults change negative self-beliefs maintained through personal narratives imbued with helplessness and hopelessness (Rodriguez, Bayon, Palaotarrero, & Liria, 2014). The use of art-viewing in group interventions to facilitate this process of narrative change exhibits much promise. For example, researchers have observed that viewing artwork enables personal exploration by providing a safe avenue for viewers to externalize difficult emotions or experiences (e.g., Camic & Chatterjee, 2013; Lanceley, Noble, Johnson, Balogun, Chatterjee & Menon, 2011).

Viewing art can also be helpful for disrupting cognitive habits and automatic functioning, encouraging mindful introspection and meaningful engagement with others who are sharing in the viewing experience (de Botton & Armstrong, 2013). Thus viewing and responding to art as a group provides participants with valuable opportunities to experience social connectedness and interpersonal dialog, with art serving as a basis for metaphor, self-reflection and novel encounters that are essential for promoting change (Matto, Corcoran, & Fassler, 2003). Meanwhile, the museum space itself holds much therapeutic promise in its role as a cultural insititution, one that asks visitors to contemplate, “who we are, who we were, and who we might become” (Smith, 2014a, p.12). And as a therapeutic setting, the art museum also challenges stigma associated with traditional mental health care settings (Bennington, Backos, Harrison, Reader, & Carolan, 2016; Hamil, 2016).

To date, however, there has been no investigation into the healing potential of an art-viewing intervention for college students that has been designed to take advantage of the therapeutic potential in campus art museums. This is particularly salient given the growing need to provide mental health services to students in spite of limited resources. Furthermore, the use of an innovative setting is an answer to the call for colleges and universities to explore new avenues for providing effective, efficient care to an ever-increasing number of students (Weatherford, 2017). The current study presents an explorative look at the feasibility and potential usefulness of providing a novel form of treatment that complements the unique needs of this populations and expands options for care.

Grounded in narrative and art therapy approaches as well as museum education practices, this group intervention is designed to help students change negative, self-defeating personal narratives into positive, affirming life stories for improved emotional well-being. The integration of practices drawn from narrative therapy and museum education provides opportunities for students to experience agency, self-efficacy, and hopefulness (Adler, 2012; Bennington, Backos, Harrison, Reader, & Carolan, 2016); Payne, 2006; Salom, 2008). Art-viewing as a therapeutic modality supports the use of projective techniques to provide participants with a psychologically safe distance where they can reflect upon and explore their personal narratives (Matto et al., 2003). This distance also creates opportunities for greater openness to the experience and expression of emotions as students safely engage with their life-stories and identities (Scott, 2003; Spencer, 2012). As a shared group experience, this intervention fosters a sense of belonging among participants as well as the development of distress management skills that include reframing, externalization of problems, communicating with others, and

construction of alternate possibilities. These positive psychological factors should contribute to the improvement of depressive symptomatology over the course of treatment, improving students' mental well-being by the conclusion of treatment. To determine whether this goal is met, effectiveness of treatment will be analyzed using pre- and posttest measures of the targeted constructs, including depressive symptomatology and sense of belonging. A follow-up interview after the conclusion of treatment will also be used to investigate the students' experiences with the museum space and art-viewing in a therapeutic context, further illuminating the mechanisms of personal change that can occur with these modalities.

As a pilot intervention, this study will hopefully serve as a model for future research inquiries while contributing to the extant literature on college mental health care, narrative therapy, and art-viewing as therapeutic modality.

INTEGRATIVE ANALYSIS

College Student Population

As more individuals seek out opportunities in higher education, college students in the United States constitute a growing and increasingly diverse population. According to a recent report by the National Center for Education Statistics (2017), approximately 20.4 million students are expected to attend national colleges and universities in the Fall 2017 semester, reflecting an increase in enrollment of about 5.1 million since the year 2000. This student population reflects an increasingly diverse group of individuals from various backgrounds and walks of life, with a recent survey from the American College Health Association (2012) indicating that 24.4% of surveyed students identify as being a member of a racial or ethnic minority group, while 8.5% reported being an international student and 7.8% reported having a sexual orientation other then heterosexual. Additionally, women are expected to account for the majority of college and university students in fall 2017, with roughly 11.5 million females attending the fall 2017 semester, compared to 8.9 million males (National Center for Education Statistics, 2017).

College students in the United States are often characterized by their curiosity, creativity and openness to new experiences (Komarraju, Karau, & Schmeck, 2009; Lingo & Tepper, 2010), and while they pursue a formal education for intellectual and professional development, many are also on a path of personal-professional discovery and identity development (McEneaney & Gross, 2009). Researchers have noted a connection between sociability and creativity in college students, with everyday experiences and social interactions serving as source for ingenuity and personal growth (Pachucki, Lena, & Tepper, 2010). Recently, college and university administrators have recognized the value of a “creative campus”, which is defined as a college environment

that nurtures curiosity and innovation (Florida et al., 2006; Pachucki, Lena & Tepper, 2010). It has been suggested that a creative campus supports personal and professional development by promoting creativity, and colleges and universities are encouraged to use the arts as an important way to engage students and strengthen campus communities (Cole, Sugioka, & Yamagata-Lynch, 1999; Lingo & Tepper, 2010).

College Students and Depression

While attending college provides unique opportunities for academic and personal growth, many students face emotional and psychological trials as they navigate the higher education experience. These students often struggle with adjustment during their college years, particularly in the domains of personal relationships, availability of resources, academics, the college environment, expectations of self and of others, diversity, and life transitions (Hurst, Baranik, & Daniel, 2013; Mackinnon et al., 2014). For college students in a life stage increasingly referred to as "emerging adulthood", additional challenges include identity formation (for example, deciding on a major of study and making career choices), navigating the transition from a state of full dependence on parents to a state of semi-dependence or independence, creating social relationships in a different environment, managing the financial burden of increasingly high college tuition, and leaving their primary support system of family and friends (Arnett, 2006). Recognizing the importance of mental wellness is especially critical for college students, given the many stressors and difficulties they experience (Hurst, Baranik, & Daniel, 2013). High levels of stress and feelings of alienation are linked to decreased academic performance, negatively impacting students and their colleges (Grasgreen, 2011). Primarily, these

stressors increase college students' vulnerability to several psychological issues, most notably the experience of symptoms of depression (Ibrahim et al, 2013).

Depression is among one of the most commonly occurring mental health disorders in the United States, and it is defined as a state of emotional distress characterized by moods of sadness, emptiness, isolation, or irritability which have a negative effect on the individual's ability to function (American Psychiatric Association, 2013). Many students with symptoms of depression also feel anxious and lonely, and often experience a limited sense of belonging while attending college (Strayhorn, 2012). Additionally, it is estimated that nearly seventy-five percent of all lifetime cases of a depressive disorder appear in affected individuals within the general population by age 24 (Kirsche et al., 2014). Given that college students are typically within this age range and facing the numerous challenges outlined above, it is unsurprising that depression and associated symptoms have been recognized as one of the most common and considerable health concerns for contemporary college students (Lyubomirsky et al., 2003; Vredenburg et al., 1988). The statistical numbers of students experiencing depressive symptoms is discouraging. Recent national surveys involving more than 30,000 participants have indicated that 15.4% of college students report having been diagnosed with or treated for depression within the past 12 months, while another 28.4% of students indicated impairment of daily functioning due to the experience of depressive symptoms such as fatigue, amotivation, and hopelessness (American College Health Association, 2011). Other studies suggest the number of affected students is much higher, with nearly 34% of surveyed students reporting symptoms of depression within a three-month period ("Anxiety and Depression Association of America", n.d.).

The college years have proven to be a peak age period for depression onset, especially for the occurrence of first episodes (Cuijpers et al., 2016), and research has linked this high endorsement of depressive symptoms to decreased academic performance, negatively impacting both students and their colleges (Grasgreen, 2011). Mental disorders such as depression often result in a cascading series of negative socioeconomic outcomes (Berndt et al., 2000; Mowbray et al., 2006; Andrews, 2006), and college students experiencing symptoms of depression are at a particularly elevated risk of dropping out (Hysenbegasi, Hass & Rowland, 2005; Kessler, Foster & Stang, 1995). Even more concerning, the emotional suffering induced by depressive symptoms is associated with an elevated risk of self-harm and suicide for some members of this population (Spear, 2017; Xiao et a., 2017).

Etiology of depression

As one of the most prevalent mental health issues facing college students, depression in this population has been well researched across disciplines such as psychiatry and psychology. Over the past century, many theories have been offered to explain the causes and development of depressive symptomology based on a range of biological, psychological and social-cultural models (Schwartz & Schwartz, 1993). Psychology researchers have proposed several cognitive theories to help explain the etiology and maintenance of depression, all of which share a general concept that the ways in which persons attend to, interpret, and recall negative life events contributes to the possibility that they will experience depression (Lakdawalla et al., 2007). The development and maintenance of depression has been linked to deficits in emotional-regulation skills (e.g., Aldao, Nolen-Hoeksema, 2010; Berking et al., 2008; Hofmann,

2014), while limited self-awareness on emotional and psychological levels serves to limit skill-building. For example, Salters-Pedneault et al. (2006) found that deficiencies in the ability to identify and accept emotions, effectively modify negative emotions, and examine emotionally distressing situations were highly associated with the experience of affective distress and disorders. Rumination, avoidance, and suppression were identified as some of the most commonly occurring maladaptive strategies for coping with difficult emotions, leading to increases in depressive symptoms according to a meta-analysis of affect-related psychopathologies (Aldao, Nolen-Hoeksema, & Schweizer, 2010).

While no one etiological theory for depression is unanimously accepted, there is much evidence suggesting that depressive symptoms and a lack of perceived mental well-being is associated with life-stories that are incomplete, confused, have negative or tragic outcomes, or are otherwise reflect some form of maladjustment (Santa Rita, 2008). Given that college students are actively engaged in the formation of their personal and professional identities—the creation of their life-stories—while being at elevated risk for the experience of depressive symptoms, it is helpful to conceptualize the development and maintenance of emotional distress from the perspective of personal narrative.

For individuals experiencing symptoms of depression, negative life-stories are likely to be characterized by their repetitive nature, where the same pessimistic and adverse themes resurface throughout an individual's personal narrative (Santa Rita, 1998). The impact of these repeating, negative life-stories is far-reaching for affected individuals. Researchers exploring themes of core conflict in relationships have demonstrated that persons will often generate similar negative, repeating story patterns in multiple areas of their lives (Luborsky et al., 1992). Some researchers have hypothesized that individuals may be repeating a ''nuclear script,'' with early childhood and other

formative experiences creating a schema that is reproduced over the individual's lifespan (Csikszentmihalyi & Beattie, 1979; Tomkins, 1979). Thus negative repeating scripts work to keep the individual 'stuck', maintaining their experience of depressive symptoms.

This maintenance of distress is further enabled through silencing, an environmentally-based process that prevents possible changes to an individual's negative personal narrative. The concept of silencing, or "enforced silence", is thought to reflect a broader cultural phenomenon in industrialized mass societies that emphasizes privacy and anonymity, rising out of environments characterized by dissimulation or a lack of openness (Lister, 1992). These environments contain an organizational culture that emphasizes values such as achievement and individualistic coping, while members are either directly or indirectly discouraged from openly discussing experiences of stress or depression. A perceived lack of personal and social authority is often associated with the process of silencing, as individuals may be silenced due a feeling of being 'unauthorized' to be the creators of their own life stories (Santa Rita, 1998). With a prevailing emphasis on academic success and competition, the campus climate at colleges and universities may be silencing students from openly acknowledging their own mental wellness, let alone sharing their distress with others. Students may feel that in order to live up to the cultural values of their institutions they are not able to "author" their own stories, or there may be a sense that self-stories are imposed by others, which can be distressing to the individual (Santa Rita, 1998).

Treatment for depression can be elusive. Though demand for mental health services on campus has increased, a large number of students delay or do not even attempt to seek help (Lewin, 2011). This is mirrors help-seeking behaviors in the general population, where delays in treatment for mood disorders already range from 6 to 8 years for the general population (Kirsche et al., 2014). Given the combination of early onset and prolonged untreated symptoms of depression in college students, this delay in psychological care increases an already high personal and societal burden of mental illness (Kirsche et al., 2014).

Just as there are a number of theories theorizing the psychopathology and maintenance of affective disorders and distress, there are as many different approaches to the treatment of depression and depressive symptoms. However, the specific developmental and personal needs of college students makes them a unique group when considering mental health care and possible treatment options (Benton, 2006). Providers working with this population are encouraged to be flexible, culturally sensitive, creative, and collaborative, adapting treatment plans and theoretical approaches based on the specific needs of the students given their presenting concerns and goals for care (Eichler & Schwartz, 2010). The call for creative and engaging treatments that appeal to this population has been answered by college mental health providers who explore arts-based approaches, with results demonstrating that the integration of verbal processing and arts-based intervention tools encouraged participation in group treatment and nurtured deep engagement in the process of change (Boldt & Paul, 2011).

Barriers to treatment

Several studies have identified two key barriers to mental health treatment in college student population: limited access to campus psychological services and stigma around mental health which negatively impacts help-seeking (Hunt & Eisenberg, 2010; Kirsche et al., 2014; Pedrelli et al., 2015). For many students who do desire treatment for their symptoms, the ability to receive treatment on campus is critical given many do not have resources such as time, transportation or finances to venture out into the community for treatment (Cornish et al., 2017; Eisenberg et al., 2009). However, as college counseling centers struggle to keep pace with the rising demand for mental health treatment there is a shortage of staffing and financial resources for students seeking care (Xiao et al., 2017). Over the past several years, college counseling centers have been pressed to find new ways to handle these growing demands for services, all the while maintaining a quality standard of care (Weatherford, 2017). College counseling centers are forced to prioritize these limited resources, often using waitlists and other methods of managing access to care. In a recent survey, 88% of counseling center directors reported that students asking for help may not receive timely treatment, with 75% of counseling centers no longer offering weekly individual therapy appointments and 35% of centers actively using waitlists to manage the number of students requesting care. (Reetz, Barr, & Krylowicz, 2014; Cornish et al., 2017) This suggests that students hoping to receive treatment for depressive symptoms often face long waitlists and lengthy intervals between sessions when they approach their campus counseling centers (Mistler, Reetz, Krylowicz, & Barr, 2012).

Another critical barrier care is social stigma around mental health, which deters students from seeking out help. In their 2015 study examining students' willingness to

disclose mental health concerns to primary care providers, Meyer et al found (2016) found that college students were often worried about what others might think of their experience with symptoms of depression, and 26% of survey participants indicated they would not disclose depressive symptoms to primary care providers. Another 13% of respondents expressed ambivalence about disclosure. This is consistent with other findings that indicate perceived public stigma (the belief that others might hold negative views towards those with mental health needs) is a greater barrier to help-seeking than personal stigma (Eisenberg et al., 2009). Furthermore, results of Vogel, Wade and Hackler's 2007 study of college students established that perceived public stigma around mental illness is predictive of internalized stigma (self-stigma) towards counseling. Their mediation model also demonstrated that self-stigma predicted attitudes toward help-seeking, and ultimately, openness to seeking counseling services. Additional research suggests that traditional psychiatric or psychological settings associated with mental health care treatment may also be stigmatized (Acton, 2013). Thus, psychological services that are limited to traditional spaces, such campus counseling centers, may not be used by students who are concerned with perceived public stigma.

NARRATIVE APPROACHES

Narrative is often defined as an account of connected events—a story—which allows for individuals to construct meaning around their experiences (Clandinin & Connelly, 2000). In this framework, the idea of the self is not fixed and realities are subjective, being both personally and socially constructed (McCarthy & Archer, 2007). This postmodern viewpoint challenges the concept of absolute truths, suggesting that an individual's experience and knowledge is in fact provisional (Payne, 2006). Ultimately,

narrative is a core element of the healing process across psychotherapy practices, as clients share their personal stories with clinicians and seek to make meaning from events, feelings, and memories (Rodríguez et al., 2014). The use of narrative in within this therapeutic context is informed by concepts such as the relevance of language and discussion in human interactions, as well as existential theories involving self-agency and empowerment (Avdi & Georgaca, 2007a, 2007b; Polkinghorne, 2004; Wallis, Burns, & Capdevila, 2011). Human psychology is thought to have a storied structure, such that human experiences and interactions can be expressed and understood through personal narratives, which also serve as an organizing principle for behaviors and actions (Sarbin, 1986). Clinical research examining narrative-based approaches have demonstrated effectiveness of these interventions in reducing or improving depressive symptoms (Vromans & Schweitzer, 2011).

Narrative coherence

In the framework of narratives, coherence describes the extent to which parts of a text are related to the text as a whole (Linde, 1993), with the understanding that the term "text" captures many types of sources of content, including oral, visual, and written communication. Coherence is manifested in three domains: context, chronology, and theme (Reese et al., 2011). The contextual domain addresses the "when and where" of a narrative, effectively establishing a setting for the story. The chronological, or temporal ordering, dimension of coherence reflects the ability to accurately and clearly describe the order of events and experiences over time. The third dimension of coherence imparts information on the relevance and meaning of the story: the theme. As Reese et al (2011) note, "The thematic dimension is assessed through the inclusion of a high point and a

resolution, accompanied by affective and evaluative information. The story as a whole must also be sufficiently on topic and developed for the emotional point to be clear."

For a personal narrative to be coherent, the order of events must be sequential and logical, events must be situated in both time and place, and the narrative must be detailed enough to meaningfully link components together (Waters & Fivush, 2015). Hallford and Mellor (2017) describe modified forms of the dimensions of coherence, as applied personal narratives: temporal coherence, causal coherence, and thematic coherence. Temporal coherence is defined by how remembered events are chronologically related to other life events. Causal coherence indicates how an individual links life experiences together, creating meaningful associations, such as causal connections between experiences and self-identity. Thematic coherence reflects an ability to identify similarities between experiences and overarching motifs in order to create integrative interpretations of life events and situations. The authors also address a fourth dimension of coherence: culture (Hallford & Mellor, 2017). This dimension captures the socio-cultural influence on perceptions of how one's life "should" be, including what life events are to be considered as significant. For emerging adults, including college students, the ability to construct a coherent account of personally significant events is particularly critical (Waters & Fivush, 2014). Narrative coherence is an important element of psychological well-being during this transitional period of identity development, where formative experiences and interpretations occur on a regular basis in the college environment.

Narrative identity

During the formative years of late adolescence and early adulthood, individuals begin to formulate an understanding of their life-stories in a "process of evolution", where connections are made between their past, present and future self to create identity and a sense of purpose (Tang, 2017). Over time, personal narratives help situate the self within the complex social systems individuals inhabit, a form relational self-understanding defined by Singer (2004) as a narrative identity. The ability to integrate autobiographical memories into a "continuity of experience" while making meaning out of those past and present experiences is what allows individuals to develop a narrative identity (Hallford & Mellor, 2017). It is important to emphasize the distinction between "narrative" and "narrative identity". Because personal narratives are filtered through the individual's interpretations and perceptions of how experiences are connected, these "meaning-laden" qualities make a story not only a set of facts, but a unique reflection of the person themselves (Pasupathi & Hoyt, 2009). This reflection simultaneously constructs and captures the essence of a person's narrative identity.

While every individual's narrative identity is complex and intersectional, some positions may prove more dominant than others. This can leverage a very strong influence on the individual's sense of self (Guilfoyle, 2015). While dominant narratives encourage identity-stability, this may leave the individual vulnerable to a limited view of life options or possibilities and stuck in an undesired or problematic sense of self (Guilfoyle, 2015). Regardless, coherence and narrative identity are two important factors contributing to an individual's life-story,

Life-Stories

Linde (1993) defines a life-story as the collection of all personal narratives and discourses, and the connections and interpretations made between them, that are contained within an individual's lifespan. She states that two criteria exist for life-stories. First, the stories contained within a life-story must primarily make a point about the individual his or herself, and not a broad point about the world or others. Second, the stories withing a life-story are "tellable", and can be shared repeatedly over time (Linde, 1993). The life-story theory of narrative posits that an individual's ability to meaningfully integrate personal experiences contributes to positive psychological adaptation and bolsters emotional and psychological well-being (Bauer, McAdams, & Pals, 2008; Polkinghorne, 1991; Singer, 2004). Hallford and Mellor (2017) describe self-awareness and personal identity as being intimately related to an individual's perception of the continuity of experience and the integration of memories in a way that is cohesive. In other words, the narrative must "make sense" for the individual, does not have gaps, and is varied enough to reflect the complexities of experiences. Because of this broad integration of experiences, life-stories represent not only how individuals see themselves, but also how they wish to be perceived by others (Tseng, 2017). Life-stories thus shape an individual's worldview and, ultimately, their self-identity (Linde, 1993).

As they go through one of the most formative stages in their lifespan, college students are especially well poised to benefit from an understanding of this connection between life-story and identity, with each day bringing new opportunities to experience their personal narratives in-progress. Awareness of life-stories can promote a sense of agency and self-efficacy, and is also indicative of emotional well-being (Hallford & Mellor, 2017). Interestingly, the relationship between awareness of life stories and mental

health may be mediated by coherence. Emerging research suggests that a stronger awareness of life stories may be predictive of higher levels of depressive and anxiety symptoms only when an indvidual's perceived narrative coherence is low (D. Hallford, personal communication, January 28, 2018).

Narrative therapy

Developed in the early 1990s, narrative therapy is a psychosocial form of individual or group therapeutic intervention that recognizes an individual's life experience as a story-in-progress that can be viewed and understood from diverse perspectives and with many potential outcomes (Archer & McCarthy, 2007; White & Epston, 1990). Narrative therapy invites individuals to develop more complete, coherent, and meaningful narratives from incongruent or disconnected descriptions of experience (Payne, 2006). The theoretical foundation of NT rests on narrative and socio-constructivist ideas that suggest reality is not objective and directly accessible to individuals through their senses, but is instead constructed inter-subjectively through language, meaning-making, and narrative description between individuals. (Anderson, 1997; Berger & Luckman, 1966; Gergen & Kaye, 1992). As noted by Don Redmon, director for Mercer University's Center for the Study of Narrative, "[Narrative therapy] really is about celebrating and appreciating each person's unique story and helping them frame it in a way that is more self-affirming and less self-defeating" (Phillips, 2017). This is reflective of the three underlying principles of narrative therapy, which state that narrative therapy is respectful, non-blaming, and views the client as the expert of their own story (White & Epsten, 1990).

In treating depressive symptoms, where an emphasis on positive emotions and self-efficacy is critical for healing, NT is a particularly useful therapeutic approach that encourages the client to 're-author' their life-stories by focusing on positive interpretations and possibilities (Seo et al., 2015). This involves a process of "story repair", where problematic, negative self-narratives are refashioned by the individual to be more coherent, complex, and inclusive (Avdi & Georgaca, 2007a, 2007b). This process is supported by the therapist who serves as an audience for the client's story, receiving and reflecting the shared information, while acting as a "co-editor" of the refashioned narrative in-progress (Rodríguez et al., 2014). Critical to the therapeutic process is the clinician's ability to use double-listening strategies to recognize when a client is divided between the narratives which form their multifaceted identities. With double-listening, the therapist focuses on both the "problem-saturated story" (White & Epston, 2005, p. 88) where the client is a "constituted subject" stuck in a negative life-story, and the in-progress positive or preferred narrative where the client is constructed with self-agency, able to live as they wish (Guilfoyle, 2015).

Narrative therapy practices

In narrative therapy, change is elicited primarily through the exploration of how language is used to create and maintain problems (Rice, 2015). Several key practices are used to support the movement towards change: externalizing, identifying unique outcomes, and using outsider witnesses (Payne, 2006). Externalizing is a linguistic device that seeks to differentiate the person from their problem or destructive behavior in an effort to interrupt the assumption that these challenges are intrinsic to their being (White, 2007). For example, an externalizing statement might be that an individual is

experiencing depression, as opposed to saying that an individual is depressed. Often in narrative therapy, metaphors are used within the context of externalizing problem-saturated stories. These metaphors serve as “compressed visual images” in the discussion around problems that can help distance the individual from an internalized perspective and introduce alternate possibilities (Payne, 2006, p. 46). This relates to another key practice in narrative therapy: the identification of unique outcomes.

Defined as a process of exploring contradictions or considering alternate possibilities, examining unique outcomes allows individuals to entertain a different or broader perspective on their personal narratives and the challenges they face (White & Epston, 1995). This practice is often exercised via reframing, a technique which encourages people to view some aspect of themselves, their problem, or situation in a new light (Matto et al., 2003). This new perspective can then generate alternate actions, feelings and cognitions that complement the new frame of reference (Bertolino & O’Hanlon, 2002).

The use of outsider witness is another fundamental practice of narrative therapy. In this practice, someone close to the individual in treatment is invited to sit in during a narrative therapy session and listens as the individual shares their new, developing story. The responses and comments made by these outside witness can often illuminate unrecognized or undervalued aspects of the story. Thus, the sharing of stories with responsive audiences is a powerful means for individuals to be heard and recognized, affirming their belonging in the community (Payne, 2006). Within a group therapy context, fellow group members may serve as “outside witnesses” as members support each other in exploring alternate possibilities and re-authoring narratives (McCarthy & Archer, 2007, p.441).

ARTS-BASED THERAPIES

The visual arts have served as a vehicle for communicating human experience and creativity throughout recorded history, while psychology offers a means of understanding and explaining human nature. These two disciplines have shared a long and fascinating relationship, reflecting a complex history of two practices invested in the human experience. Following the introduction of psychoanalytic theory at the turn-of-the-century, artists have drawn inspiration from the concepts of the subconscious and ego, while viewers rely on these same concepts for informing the consumption and interpretation of artworks (Walsh, 2013). According to Penna (2000), “Art is a symbol and a substitute that is capable of producing real emotions.” Works of art can therefore be situated in the liminal space between the reality of unconscious desires and the imaginary world of fulfilled desires, bringing uninterpretable thoughts and emotions to the surface. In this way, both art and psychoanalysis provide a means to understand individuals within the context of their life experiences and stories (Penna, 2000). Many psychologists have been fascinated by the connection between art, creativity, and human thought and function, perhaps most notably psychoanalyst and art historian, Ernst Kris (Papiasvili and Mayer, 2011). Kris shifted the paradigm of psychological understandings of art from the individual intentions and states of the artist and onto to the work of art itself as an object (Kris, 1952) and developed the concept of ‘‘regression in the service of the ego”, wherein the ego functioning relaxes to allow primary processes to surface (Papiasvili & Mayer, 2011). This psychoanalytical perspective on the function and role of art has not only informed the conceptualization of creative expression as a means of understanding of human experience, but drives its use as a powerful source of healing.

Within the context of therapeutic tools, art has long been recognized for its potential to heal emotional wounds, increase understanding self-understanding and empathy for others, foster self-reflection, reduce symptoms, and alter behaviors and thinking patterns to improve physical and psychological health outcomes (Camic, 2008). Traditionally, creative therapies have been closely associated with the professional discipline of art therapy, an integrative mental health profession where practitioners are trained not only in psychotherapeutic theory but in the use of artistic materials and mediums in order to improve cognitive and sensory-motor functions through the process of art-making and creative process (American Art Therapy Association, 2017). However, the use of art in therapeutic contexts is not limited to the domain of art therapy and enjoys broad applications across many disciplines (Gillam, 2013). For example, Stuckey and Nobel (2010) reviewed numerous studies of creative therapies, including visual arts-based interventions, and found that creative engagement was associated with positive health outcomes, particularly in decreasing anxiety, stress, and mood disturbances.

For college students, arts-based approaches appear similarly helpful. Varied papers have explored the appeal and efficacy of art therapy interventions and groups for the treatment of various mental health concerns among college students, such as depression, anxiety, trauma, and disordered eating (e.g., Boldt & Paul, 2011; Mercer, Warson & Zhao, 2010; Sandmire, Gorham, Rankin & Grimm, 2012; van der Vennet & Serice, 2012). Although research with college students is not extensive, generally these approaches are thought to be especially well-matched to the developmental and interpersonal challenges faced by this population, while also taking advantage of their openness to creativity and ingenuity (Boldt & Paul, 2011; McEneaney & Gross, 2009; Pachucki, Lena, & Tepper, 2010)

A parallel to the healing processes of arts-based therapies can be made to those of narrative therapy discussed earlier in this proposal. Narrative therapy recognizes that sharing stories is among the most powerful means by which people construct and express meaning in their life experiences, with the ability to change undesired or dysfunctional stories at the heart of the therapeutic process (Colbert et al., 2013). Elegantly paralleling this process, talking about art is another form of personal storytelling, with participants in arts-based therapies discovering that stories woven through art inspire the imagination of new possibilities and solutions for their personal narratives (Feen-Calligan, 2008). As Matto, Corcoran & Fassler (2003) explain, "Art therapy methods enable the construction, deconstruction, and reconstruction of client narratives, and stimulate the expression of stories about the problem and its solutions."

While the efficacy of creative engagement is well-documented, the primary modality used in expressive therapies involves the client's creation or performance of artistic products such as drawings, sculptures, poems or dramatic scenes (e.g., Blomdahl, Gunnarsson, Griffiths, 2005; Guregard, & Bjorklund, 2013; Matto, 2005; Schnetz, 2004). The primary mechanism of change is thus hinged on the act of art-making in traditional creative therapies, where problem areas are "revealed" through the art-making process (Matto et al, 2003). This reliance on production of a creative artwork may complicate the use of art as a therapeutic tool. Researchers have found that individuals may be distracted by the art-making process, especially if they are unfamiliar with the creative mediums, and may become frustrated or self-conscious (Boldt & Paul, 2011; Wadeson, 1980). Nonetheless, art remains a powerful tool for personal exploration and narrative change, and this study proposes the use of an alternative modality with the potential to connect and resonate with a broader range of participants: the act of art-viewing.

Art-viewing as a therapeutic tool

For many individuals living in fast-paced contemporary societies, viewing artwork invites individuals to slow down, recalibrate, and consider ideas, values and other sources of personal meaning and importance (Bennington, Backos, Harrison, Reader & Carolan, 2016). de Botton and Armstrong (2013) argue that art is helpful for breaking cognitive habits and automatic functioning, while simultaneously nurturing mindful introspection and meaningful engagement with others. They identify seven therapeutic functions served by the act of viewing art: remembering, hope, sorrow, rebalancing, self-understanding, growth, and appreciation. While the research is still fairly limited around viewing art as a therapeutic modality, evidence suggests that it can be a useful tool for promoting emotional growth, well-being, and the amelioration of depressive symptoms (Nanda, Gaydos, Hathorn, & Watkins, 2010). There are several means in which the act of viewing art is thought to provide symptom relief in persons experiencing emotional distress, including depressive symptoms.

Clark (1995) promotes projective techniques in therapy as a powerful tool for enhancing the therapeutic experience as it allows clients to explore elements of themselves that perhaps may be too challenging initially. By encouraging clients to evaluate and a characterize an external object—the projective object—projective techniques a more accessible, less-burdensome means for individuals to access thoughts, feelings, values and experiences (Holman et al., 2016). In psychoanalytic frameworks, it is assumed that individuals dislocate both conscious and subconscious feelings, ideas, thoughts on to the projective object, heavily informing the individual's interpretations and responses (Pinto, 2014). These projections ultimately reflect the ways in which a person internally understands and relates to the world (perception), as evidenced in how

they assess outside objects (apperception). The direction of interpretation is thus a reflection of their broader associational patterns and schemas, as influenced by these powerful, deeply-rooted emotions, experiences, and memories (Pinto, 2014). Research involving the use of projective techniques with art-viewing as a modality have demonstrated positive results, such as in Chan, Ngai and Wong's 2012 study where the use of photographs to support narrative therapy externalization techniques helped group participants de-identify themselves from their issues with substance abuse.

Often, these entrenched emotions and cognitions can be very challenging to address openly, as they may be cognitively distant, difficult, under-processed, or suppressed, but projective techniques enable a psychologically safe method of approach (Wiehagen et al., 2007). Numerous testing instruments have been developed to capitalize on the exploratory power of projection, perhaps most famously the Rorschach inkblot test and the Thematic Apperception Test, which involve the interpretation of images (Donoghue, 2000; Korchin, 1976). Relatedly, art-viewing can serve a similar psychological function by serving as a vehicle for personal interpretation and exploration of consciousness (Holly, 1996). Lending additional support to the use of art for projective strategies, Vick and Strauss (1997) found positive correlational relationships between depression and anger identified in artwork by participants and self-reported feelings of anger and depression.

Viewing art can operate through projective frameworks on several therapeutic levels. For example, Lanceley, Noble, Johnson, Balogun, Chatterjee and Menon (2011) found that the dual process of externalization and self-projection through objects, including artwork, provided emotional relief for cancer survivors. In this model, art can serve as a basis for metaphor and self-reflection. This then encourages introspection and

dialog when direct conversation alone may leave individuals feeling too vulnerable or overexposed. As a vehicle for projective techniques, art-viewing promotes the externalization of incoherent or unrecognized thoughts and emotions, creating an "intermediate area of experience" where the viewer is able to reflect and connect with a representation of their unconscious (Winnicott, 1971). This potential space represents the liminal area of consciousness between an individual's inner and outer reality, where objects or stimuli are experienced in the external world as the individual simultaneously transforms the stimuli—imbuing it with meaning—and is transformed by the stimuli (Jemstedt, 2000).

Potential space creates room for discovery and growth which occurs in a dialectical fashion between the internal and external. Objects are imbued with deep personal meaning and imagination from an individual's internal world, and interacting with these objects also allows for an interaction with an otherwise non-physical, intrapsychic realm. As Spencer (2012) notes, "Viewing art opens us up to affect, thought, and spiritual experience. New things happen to us. We may not welcome or like it. It may surprise or alarm us." Those viewing art are asked to be comfortable with discomfort (Beckett, 1992), paralleling one of the therapeutic challenges underscoring many approaches to eliciting change in clients (e.g., Leite & Kuiper, 2008). While therapeutic spaces should always be supportive, perhaps it will not always be a comfortable space as growth often happens through discomfort. Art-viewing invites individuals to accept this challenge, supporting their internal exploration by serving as a mode of reflecting on themselves and others (Spencer, 2012). Viewing art creates a metaphorical canvas on which individuals can place their own experiences and emotions, and in the process, see where there are opportunities to learn, grow, and change.

In clinical applications, several papers have highlighted the use of art-viewing strategies to complement the treatment of varied mental health issues. Miller (1993) found that incorporating art history elements (including art-viewing, contemplation of content and meaning as well as historical context) into art-making processes helped reduce anxiety in out-patient psychiatric populations, suggesting the incorporation of art viewing facilitated the therapeutic process by enriching the patients' experience through increased meaning-making. In 1996, Alter-Muri used images of famous artworks with clients and found that art-viewing helped form a connection between client art and art reproductions, promoted group cohesion, and served as a medium of psychological integration. Additionally, Matto (2005) used art-viewing to facilitate difficult conversations with adults seeking treatment for substance abuse, noting that, "Viewing art had the potential to facilitate the transfer of previously threatening stimuli associated with trauma and substance abuse to verbally accessible memory, so that the material could be cognitively processed and integrated." More recently, Mosek & Gilboa (2016) used art-viewing strategies used art-viewing as a therapeutic modality designed around integrating psychodynamic and narrative group approaches for fostering resilience and self-awareness to reduce compassion fatigue in members of helping professions. And another study described improved psychological well-being and perceived social support among adult participants in a weekly group intervention held at a local art museum, where the setting and the art objects were integral components of the treatment plan (Bennington, Backos, Harrison, Reader, & Carolan, 2016). Psychological well-being and social support were assessed using qualitative inquiry, with themes of hope, self-understanding, growth, and appreciation emerging from participant responses.

To date, there are few studies exploring the use of art-viewing as a therapeutic modality for college student populations, and to the best of this researcher's knowledge, none have explored this approach for the treatment of depressive symptoms in this population. However, there is evidence to suggest promise in the use of this modality. Treating late-adolescent females for depression, Scott (2003) found that arts-based projective techniques in therapy provided participants with a psychologically safe distance from individual issues, thereby creating opportunities for greater openness to the experience and expression of emotions. Wilkström (2001) used art-viewing in a group intervention with undergraduate nursing students in Sweden, and discovered that the ambiguity in the selected paintings invited the exploration of personal narratives which promoted the discovery of the students' personal knowledge of empathy. For college students who feel challenged in expressing their personal narratives, perhaps due to silencing for example, projective techniques provide an entry point for initiating difficult dialogs.

Museums as healing spaces

One of the main barriers to care faced by college students is stigma associated with mental health and traditional treatments (Eisenberg et al, 2009; Owen, Thomas, & Rodolfa, 2012; Van Lith et al., 2017). However, art museums and galleries can serve as non-stigmatising settings for therapy as these are not traditional institutions where diagnosis and treatment of mental health problems occur, an important distinction for individuals who may be vulnerable to feelings of shame or criticism around seeking therapy (Camic & Chatterjee, 2013). Therefore, the college or university campus art

museum may serve as a non-stigmatized, low-cost and readily available setting for delivering psychotherapeutic treatments.

According to the College Art Association, more than 700 institutions across the United States have art museums or exhibition galleries serving their campus communities, usually at no cost to students, faculty, or staff (Glesne, 2012). The use of campus art museums to support formal education and help students meet course objectives is well-documented, but many museums also strive to integrate themselves as a vital component of everyday campus life. In this way, campus art museums seek to provide students with a space for both individual and social reflection, introspection, inspiration, and enjoyment (Glesne, 2012). By upholding this supportive spirit, campus art museums have already positioned themselves as venues for students to potentially access some of the psychologically healing functions of viewing art discussed earlier in this proposal. The implementation of a therapeutic program designed to help college students within this environment thus builds on the institutional goals of the campus art museum, and provides an excited new avenue for mental health care that challenges stigma associated with traditional treatment settings. As Scott (2003) observes, "The use of creativity as well as projective techniques in therapy provides a safe distance from individual issues, which, in turn, can result in clearer and more voluntary expression of emotions, a reduction of the stigma associated with therapy."

Surprisingly, there are no studies to date that explore the healing potential of campus art museums as spaces for therapeutic interventions with college or university students. However, there are studies with other adult or adolescent populations that demonstrate the promise of this alternative setting. Peacock (2012) noted that museum education and art therapy shared complementary goals for art-viewers and suggested a

partnership between practitioners in both disciplines to use the museum as a place where individuals could engage in meaning-making and personal growth. Within communities, McNiff (2009) considered the practice of art therapy in shared spaces such as museums to represent an innovative method of expanding the therapeutic contexts. The environment of the museum provided a “mutuality of influence and inspiration” among participants, which he credited as the most beneficial feature of a program incorporating art therapy in the museum. Similarly, Camic & Chatterje (2013) found that museums and art galleries could serve as spaces for programs that encourage cultural activity, engagement and interaction to improve overall public mental—and physical—health. Museums are thought to contribute to wellness in several key ways, particularly through promoting relaxation, emotional and cognitive change, and personal introspection (Camic & Chatterje, 2013).

These themes of emotional awareness and improved well-being are echoed in additional studies exploring the use of museum spaces. In their work with senior adults, Bennington et al (2016) discovered that the art museum provided a safe space for participants to explore emotions, thoughts, and memories. Their qualitative data also revealed improved well-being and social connectedness for participants, while viewing, discussing, and visually responding to art was found to generate shared themes that matched the functional categories described by de Botton and Armstrong (2013). In their pilot project of a museum-based art therapy intervention with disadvantaged youth, Treadon, Rosal, & Wylder (2006) noted the power of museums to build emotional awareness and foster interpersonal connection. Through a collaboration with their campus art museum, community teens were invited to participate in a seven-week intervention where they could develop emotional awareness and interpersonal

understanding. The researchers lauded the success of their pilot project and encouraged further research into museum-based therapeutic approaches (Treadon et al., 2006). Spencer (2012) beautifully summarizes the healing potential that is innate to the art museum setting: "Viewing art involves at least a moment of recognition about ourselves; we connect with our present and our past in a different way….Participants have personal resonance with the artworks that—when shared with the group—offers multiple views for everyone."

Group work

When considering the increasing need for mental health care among college students and the limited resources typically available on campuses, a group approach is viewed as an efficient and effective means for providing treatment to this population (Weatherford, 2017). Several studies have observed the effectiveness of a group counseling across many different categories of college students (Burlingame, MacKenzie, & Strauss, 2004), with the social nature of this treatment providing healing benefits for participants, particularly in interpersonal domains. Jacobs, Masson, Harvill and Schimmel (2012) highlight the power of groups to nurture feelings of commonality and foster sense of belonging in participants through shared experiences. Sense of belonging is particularly important for college students, as deficits in feelings of connectedness and community are associated with depression and poor academic outcomes (Strayhorn, 2012). When there is an absence of belonging, students often become less interested and engaged in ordinary life activities (Weiss, 1973). In contrast, a strong sense of belonging is associated with many positive outcomes for college students, such as retention, achievement, and development of resilience. Frequent, positive interactions with others

on campus creates a supportive network that can support the college experience (Strayhorn, 2012). Group psychotherapy has been found to help satisfy this fundamental need to belong, fostering social connectedness and helping students find commonalities in the experiences shared between group members (Jacobs et al, 2012).

Relatedly, group process also provide a safe space where members can learn from each other, practice new skills or behaviors, and receive helpful feedback. For Yalom and Leszcz (2005), who view this interpersonal process as a fundamental vehicle for change in the therapeutic setting, another benefit of group participation is in the ability for members to have corrective emotional experiences. These experiences serve to challenge internalized beliefs about the self and past relationships through meaningful, in-the-moment relational experiences that disconfirm unhelpful, negative beliefs. This perspective on the mechanism of change complements the narrative approach, particularly in the goal of reconstructing negative narratives. It also complements the aforementioned museum-based approach, which to date has predominantly used group work as the method of treatment delivery (e.g., Bennington et al., 2016; Treadon et al., 2006; Mosek & Gilboa, 2016).

PROPOSED RESEARCH STUDY

Statement of Purpose

The current study aims to develop and evaluate a pilot of a 5-week group intervention set in the campus art museum that designed to address the growing need for psychological care among college students. Additionally, this study hopes to further elucidate the ways in which viewing art might serve as a psychologically restorative, healing process for college students. This experiential and personal growth group seeks to improve depressive symptoms and promote emotional well-being through art-viewing in a museum space, an innovative approach that is consistent with calls for creative, non-traditional approaches to mental health treatment with this population. The proposed intervention has been designed from an integrative perspective. Therapeutic goals, practices and techniques have been adopted from narrative approaches that support individuals in creating new, positive life-stories in contrast to previously held, negative personal narratives maintaining the experience of depressive symptoms. Strategies to facilitate interactions with artworks have been drawn from the disciplines of art therapy and museum education. Finally, a group format has been selected as an optimal vehicle for delivering the intervention, as the shared experience of group work fosters universality and connectedness in students as they construct preferred personal narratives.

The proposed mixed-methods study will take advantage of a quasi-experimental group pretest-posttest design in order assess the potential of an innovative arts-based group intervention for improving symptoms of depression among college students. As a pilot study, primary objectives are to explore feasibility of recruitment, randomization, retention, assessment procedures, and the implementation of this novel intervention. In keeping with recommendations for best research practices, this study shall not attempt to

claim generalizable causal inferences (Leon, Davis, & Kraemer, 2011). Given the limited resources available to staff this preliminary study, a control group will not be utilized and sample size will be restricted by what is reasonable for the sole researcher to handle.

This pilot study aims to collect a variety of data, including demographic information, and the Patient Health Questionnaire (PHQ-9) will be used as a validated measure of depression to assess participant symptoms prior to and following treatment. Results will be analyzed with paired sample t-tests, comparing pretest measures to posttest measures for participants in the study, to determine if the intervention improves (reduces) self-reported symptoms of depression. Data gathered during sessions and from participants' exit interviews will be analyzed using phenomenological methodology to explicate the ways in which the museum setting and processes of therapeutic art-viewing are experienced by college students. Given that there is little research in this area, the findings of this current study will contribute to the broader understanding of how this modality might be used to support college mental health care and encourage further inquiry.

RESEARCH QUESTIONS AND HYPOTHESES

Research Question 1: To what extent does participation in the proposed museum-based, art-viewing intervention improve depressive symptoms in college students?

Hypothesis: Participation in the intervention will result in statistically significant improvement in depressive symptoms when comparing pre- and post-treatment scores on the PHQ-9 measure.

Rationale: Studies have demonstrated the effectiveness of art-viewing interventions in promoting emotional well-being in adult populations (e.g., Bennington,

Backos, Harrison, Reader, & Carolan, 2016; Camic & Chatterjee, 2013). Currently, there are no studies to date that have explored the efficacy of art-viewing, museum-based interventions for college student populations. However, results of a meta-analysis that compared treatment for depression in college student populations to non-college adult populations showed no significant difference, suggesting that effects found in adults coping with depressive symptoms are likely generalizable to college students (Cuijpers et al., 2016). Furthermore, arts-based therapeutic approaches are recognized as being especially well-matched to the developmental and interpersonal challenges faced by college students (McEneaney & Gross, 2009). In light of these findings, it is reasonable to assume that the proposed art-viewing group intervention will reduce depressive symptoms in student participants.

Research Question 2: To what extend does participation in the proposed intervention increase awareness of narrative identity?

Hypothesis: Participation in the intervention will result in increased awareness of narrative identity when comparing pre- and post-treatment scores on the ANIQ measure.

Rationale: Singer (2004) describes "narrative identity" as a means for individuals to position their life-story within complex social systems, while an awareness of this identity is associated with psychological well-being (Hallford & Mellor, 2015). College students are beginning to form and understand their narrative identities (Tseng, 2017), however, they may not yet be conscious of the extent to which they are relying on these life-stories to construct their sense of self. The proposed intervention invites participants to directly engage with their life-stories through viewing art and exercising Narrative Therapy practices that emphasize personal storytelling, meaning-making, and re-authoring of personal narratives (Matos et al., 2009; Payne, 2006). It is reasonable to

assume that engaging in these practices over the course of the intervention will increase awareness of narrative identity and its role in mental wellness.

Research Question 3: To what extent does participation in the proposed intervention improve coherence of personal narratives?

Hypothesis: Participation in the intervention will result in improved narrative coherence when comparing pre- and post-treatment scores on the ANIQ measure.

Rationale: Coherence of personal narratives has been linked to psychological wellness (Adler, 2012; Baerger & McAdams, 1999), with the ability to make meaning out of life-stories contributing to healthier self-concepts (Linde, 1993; Singer 2004; Tseng, 2017). The Narrative therapy practices used in the proposed intervention emphasize the development of coherence in personal narratives by asking participants to specifically address chronology, context, and themes as they work towards re-authoring their life story. This should support the development of more coherent narratives by the end of treatment.

Research Question 4: To what extent does participation in the intervention promote the adoption of the following skills for managing distress: reframing (trying to see things in a new light), acceptance (coming to terms with the reality of the situation), and seeking of social support (getting help from others)?

Hypothesis: Participants will endorse increased use of the described distress management skills as measured by comparing pre- and posttest scores on related subscales of the COPE instrument.

Rationale: As discussed earlier in this proposal, three key narrative therapy practices are used in this intervention: externalizing, identifying unique outcomes, and using outsider witnesses. These practices are conceptually almost identical to strategies

found in what Craig, Miner, Remtulla, Miller, and Zanussi (2017) identify as the functional coping categories of problem-focused and emotion-focused techniques. Skills associated with these beneficial strategies include externalization of problems (client recognizes they are not their problem), reframing and perspective taking, verbalization of feelings and thoughts with others (Bettis et al., 2016; Meaney-Tavares & Hasking, 2013; Penland et al., 2000). By actively practicing these skills through the lense of personal narrative, participants will recognize them as strategies for interpreting and responding to future situations and challenges. Additionally, social learning between group members is a key therapeutic element of group work (Yalom & Leszcz, 2005). It is reasonable to assume that as some participants adopt these practices for interpreting life events and responding to challenges, this will support other members in learning these skills through the shared group experiences in the museum.

Research Question 5: How do participants experience the art-viewing and museum-based components of this intervention in relation to their personal explorations of life-stories, narrative identities, and mental wellness? Furthermore, what does it mean for them to engage in this exploration within a public space?

Rationale: To address this question, a qualitative approach based in phenomenological methodologies is essential. Scholars across disciplines embrace both art and museums for the therapeutic potential they offer through opportunities for exploration, reflection, and engagement in community (e.g., de Botton & Armstrong, 2013; Treadon et al., 2006; Williams, 2010). For some, it is in the ambiguity of objects and the multiple interpretations therein that inspire the process of contemplation and growth (e.g., Spence, 2012; Wikström et al., 2001). However, little research has explored how the public nature of the museum space is related to the therapeutic experience. This

study seeks to deepen the discourse on how art-viewing and museum spaces function in a therapeutic context, particularly for college students, who are just beginning to understand their sense of self and the life-stories that contribute to their narrative identity.

METHOD

The current mixed-methods pilot study will use a combination of quantitative and qualitative data to explore the effectiveness of an innovative art-viewing intervention for improving symptoms of depression and emotional well-being. Quantitative data will be gathered using pre- and posttreatment measures in order determine the effects of an innovative arts-based group intervention for improving symptoms of depression among college students. Secondary dependent variables of interest, including awareness of narrative identity, narrative coherence, and adoption of practices used in the intervention, will also be measured with pre- and posttreatment data. Results will be analyzed by comparing participants' scores on validated measures gathered prior to first treatment session and those gathered at the conclusion of treatment. Approval to collect the data required for the study will be obtained through the Institutional Review Board at the University of Texas at Austin.

Intervention

The current proposed group intervention consists of five weekly, 90-minute sessions held at UT's campus art museum, the Blanton Museum of Art. The number of sessions was chosen in order to maximize student participation by being cognizant of fast-paced academic calendars and hectic student schedules, which make brief counseling approaches ideal (Eichler & Schwartz, 2010). Research also supports the efficacy of brief treatment models, with clinically significant changes in symptoms of acute distress,

including depressive symptoms, abating within five treatment sessions (Lopes et al., 2014).

Students who have agreed to participate and who meet inclusion criteria for the study will be sorted into cohorts composed of five to eight members, in keeping with the ideal size for group therapy interventions (Jacobs, 2012). Because there will be only one group facilitator for this pilot study, a maximum number of six cohorts will be formed in order to ensure no more than two cohort groups are run per day. This has been identified as the maximum number of cohorts per day that the facilitator can reasonably handle, which should help prevent fatigue that might compromise treatment intregrity across cohorts. While an attempt will be made to randomly sort participants into cohorts, some flexibility will be necessary based on the participants' schedules. However, once cohort assignments have been finalized, membership will remain constant throughout the course of treatment. These cohorts will collectively be referred to and analyzed as the treatment group for this study.

In order to provide consistency over the course of treatment and control for variation in facilitation of the group process, the researcher will be the sole treatment facilitator for each cohort. To further support treatment fidelity, the facilitator will follow an outline and checklist to ensure the same session goals and objectives are met for each cohort. All cohorts will receive treatment within the same semester period in order to control for variation of timing within the academic calendar.

The current, proposed study uses the modality of art-viewing to help college students experiencing symptoms of depression identify unwanted, negative personal narratives, and empower them to change these old narratives into desired, positive narratives. The intervention is based on theories of change outlined in the therapeutic

model of Narrative Therapy (White & Epston, 1990), and moves participants towards the following goals: 1) translate lived experiences into verbalized stories for enhanced self-awareness; 2) experientially engage with personal stories to access emotions and discover new understandings of lived experiences; 3) reflect on and construct new meanings associated with new emotions and stories that emerge, thereby reconstructing personal narratives that reflect new intra- and interpersonal perspectives. The group work strives to improve symptoms of depression by targeting negative self-appraisals, such as feelings of hopelessness, helplessness, worthlessness or guilt. These particular symptoms have been selected as they are frequently occurring themes in negative personal narratives that work to keep a person "stuck" in their poor affective state (Rodríguez Vega et al., 2014). To support achievement of therapeutic goals, each session will use artworks as tools for helping students recognize and identify emotions, name problem narratives, externalize, make meaning, imagine alternate possibilities, and re-author life-stories.

Many interventions that incorporate art-viewing use pre-selected images as points of departure for dialog and exploration (e.g., Spencer, 2012; Feen-Calligan et al., 2008). The present study makes use of the Personal Response Model proposed by Williams (2010) that allows participants to choose works of art for themselves based on prompts or questions provided by the group facilitator. Participants are invited to explore the galleries for a determined amount of time, select an image that best captures their response to the prompt, and visit the selected works as a group for discussion. This use of prompts and guiding questions supports content focus and greater fidelity to the therapeutic goals of each session, while still supporting agency and self-direction in the therapeutic journey. This is in keeping with the objectives of the narrative therapy model, which similarly espouse agency and empowerment (Phillips, 2017).

The proposed intervention also seeks to capitalize on the benefits innate to group work, which include making meaningful connections with others, experiencing commonality, vicarious learning, and development of interpersonal skills (Jacobs et al., 2012). The facilitator will use techniques such as linking and drawing out to encourage student-student connections that might form in the group setting. In turn, connections between group members will nurture sense of belonging and contribute to the formation of supportive networks that can promote personal growth and higher self-concepts (Strayhorn, 2012). The group treatment plan has been inspired by the work of White (2007) and Carlson (1997), and more recently in the work of Bennington et al (2016) and Mosek & Gilboa (2016). See Appendix A for the treatment outline.

Participants

The researcher will recruit participants from a convenience sample of undergraduate students attending the University of Texas at Austin. Potential participants will be recruited using a pre-screening questionnaire in Qualtrics, a secure survey website. The survey will be distributed electronically using two primary venues: the Educational Psychology (EDP) subject pool and the UT Events Calendar. The survey will be distributed through the EDP subject pool, which is composed of several hundred students enrolled in Educational Psychology undergraduate lecture classes each semester ("Subject Pool Participants", 2017). Additionally, the researcher will share a link to the Qualtrics pre-screening survey on the University of Texas Events Calendar, which posts research participation opportunities to the university community. It is expected that the electronic survey will be an effective mechanism for accessing participants.

In the pre-screening questionnaire, individuals will be asked several questions relevant to the nature of this study, including whether or not they are experiencing depressive symptoms, their current participation in psychological or psychiatric treatment, their interest in receiving treatment on campus, and their current engagement in creative arts activities. Additional key demographic information will also be collected in the pre-screening survey, including year in school, gender, veteran status, ethnic/racial demographics, and major. See Appendix B for the initial recruitment survey.

To be eligible for participation, respondents must be at least 18 years of age and be currently enrolled in a college or university. Students will be selected if they self-report experiencing symptoms of depression and are not currently receiving treatment. For the sake of keeping the pre-screen survey as brief as possible while remaining diagnostically helpful, the survey will use the 10 depression assessment questions from the PHQ-9. Relying on the cut-off scores recommended by the measurement's developers, potential participants must indicate a minimum score of 5 for depressive symptomology (Pfizer, n.d.). Students who endorse symptoms that meet criteria for a severe affective disorder (e.g., a score >19 on the PHQ-9 items), or who express active suicidal ideation, will be referred to the UT Counseling and Mental Health Center for care. Given that student safety is a priority, and that the proposed study has not been designed specifically suicide prevention or for the treatment of severe affective disorders, these students will not be eligible for inclusion in the current study.

Eligible participants will be identified from the results of the questionnaire and invited to participate in the study. Those who agree to participate will then meet with the researcher for a pre-intervention meeting to determine appropriateness of fit for the group, a best practice recommended by the Association for Specialists in Group Work

(Thomas & Pender, 2008). Appropriateness of fit is recognized when an individual's "needs and goals are compatible with the goals of the group" (Thomas & Pender, 2008). Finally, these selected participants will be randomly assigned to a treatment cohort. The researcher has chosen this method of randomization given the potential challenges to recruiting enough diverse participants in order to block by characteristics such as race/ethnicity or even gender. Additionally, the researcher recognizes that adjustments to the cohort rosters may need to be made in order to accommodate student schedules and other logistical considerations.

Data Collection Procedure

Data will be collected at five points in the study: pre-screening for participant selection, immediately prior to treatment, during treatment, immediately post treatment, and in a follow-up interview. The initial pre-screening survey will be administered electronically and will be used to determine eligibility for participation and will have collected demographic information from students who agree to participate. Quantitative data will be collected at two key points during the study in order to assess change in depressive symptoms: at the start of treatment (at the beginning of session one) and immediately after treatment (at the conclusion of session five). These pre- and post-test measures will be administered to participants in both the treatment group and the control group. Qualitative data will be collected in the form of facilitator session notes following each group meeting and in a follow-up exit interview with each participant after completion of treatment. The exit interview will be scheduled within two weeks of the treatment's conclusion to assess the students' experiences with the intervention. The following measures will address the pilot study's research questions.

Measures

Demographic variables: Demographic information will be collected in the pre-screening survey, such as age, current number of enrollment credits, gender identities and ethnic/racial identities. See Appendix B for the pre-screening survey.

Patient Health Questionnaire (Kroenke, Sptizer, & Williams, 2001): The PHQ-9 is a 10-item, self-report inventory designed to assess for the presence of depression, as operationalized in the DSM-IV diagnostic criteria for Major Depressive Disorder (Bettis et al., 2016). The PHQ-9 is one of the most commonly utilized measures for depressive symptoms among researchers and clinicians, and has been used in college and university settings to document rates of mental health disorders and to identify those in need of mental health treatment (Roth, Isquith & Goia, 2005; Vitaliano, Maiuro, Russo & Becker, 1987). Additionally, studies have suggested that the psychometric properties of the PHQ-9 are on par with that of another commonly used measure of depression, the Beck Depression Invertory (BDI-II) (e.g., Schutt et al., 2016; Titove et al., 2011). The PHQ-9 also demonstrates several advantages over the BDI-II, notably that the criteria for clinically significant change is met more frequently on the PHQ-9 (Titov et al., 2011).

The PHQ-9 asks participants to rate the severity of depressive symptoms as experienced within the past two weeks using a Likert-type scale with four options: 0 – not at all, 1 – several days, 2 – more than half the days, 3 – nearly every day. Responses on the inventory are totaled to yield a severity rating, with established cutoffs indicating mild, moderate, moderately severe, and severe symptom levels. The PHQ-9 has acceptable diagnostic properties at a range of cut-off scores between 8–11 (Manea, Gilbody, & McMillan, 2012). Studies on reliability and validity of the tool indicate it has sound psychometric properties, with high internal validity across two adult test

populations demonstrating an average Cronbach's alpha of .88 (Kroenke, Sptizer, & Williams, 2001). Test-retest reliability was also excellent (r= 0.84). Additionally, the measure demonstrates good construct and criterion validity, with individuals scoring high (≥ 10) on the PHQ-9 being 7 to 13.6 times more likely to be diagnosed with depression by the mental health professional. Individuals who scored low (≤ 4) were less than 4% likely to having depression (Kroenke et al, 2001). See Appendix C for this measure.

Awareness of Narrative Identity Questionnaire (Hallford & Mellor, 2015): The current study involves the facilitation of narrative change in participants, particularly around their narrative identity. Developed in 2015 by Hallford and Mellor, the Awareness of Narrative Identity Questionnairre (ANIQ) is a self-report measure designed to measure awareness of narrative identity and perceived coherence of autobiographical memories as reflected in chronological ordering of memories, causal associations, and recognition of unifying themes. Participants respond to statements based on a broad perception of self and use of personal memories, rather than relating responses to a specific memory, situation, or experience. Items in the questionnaire include, "My memories are like stories that help me understand my identity" and "When I recall events and experiences across my lifetime, I can see consistent patterns in the way that I think, feel, and act." Participants are asked to indicate their level of agreement with items on an eleven-point scale ranging from 0 (completely disagree) to 10 (completely agree).

The ANIQ has a 20-item, four factor structure verified through the developers' confirmatory factor analysis. Hallford and Mellor (2015) reported that criterion validity was established through association of the dimensions of narrative coherence (temporal, causal, thematic) with qualitative measures of coherence in study participants. They also reported high test-retest reliability for the measure (r = .72-.79) and high internal

reliabilities for the subscales (α = .86-.96). The ANIQ thus appears to represent a valid and psychometrically means of measuring awareness of narrative identity and memory. See Appendix D for this measure.

The COPE Inventory (Carver, Scheier, & Weintraub, 1989): The COPE Inventory is a multidimensional, 60-item self-report instrument designed to assess several conceptually different ways that individuals respond to distress. The instrument has contains several scales that measure distinct categories of coping, such as problem-focused coping, emotion-focused coping, and dysfunctional or problematic coping. The developer of the measure has indicated that selected scales may be used in order to measure specific coping behaviors or skills, and has provided a scoring protocol for each scale (Carver, n.d.).

In order to assess for the participants' adoption of Narrative Therapy practices used in the intervention, twelve items have been drawn from the COPE Inventory from the following scales: positive reinterpretation, acceptance, and seeking of emotional social support. Participants select responses on a 4-point Likert-type scale, from 1 (I haven't been doing this at all) to 4 (I've been doing this a lot). Scores are summed, with higher scores indicative of more frequent use of these coping strategies. The scales for positive reinterpretation (α=.72), acceptance (α=.62), and seeking emotional social support (α=.90) have an average Cronbach's α of 0.75, indicating fair internal reliability (Cook & Heppner, 1997). Construct validity is high according to analyses of psychometric properties (Cooper, Katona & Livingston, 2008), and test-retest correlations at 6-weeks for the three subscales indicate moderate test-retest reliability: positive reinterpretation (r=.63), acceptance (r=.61), and seeking emotional social support (r=.74) (Carver et al., 1989). See Appendix E for this measure.

Exit interview: After the conclusion of treatment, the researcher will conduct a one-on-one follow-up with participants in order to learn more about their experiences with the treatment. The goal of the interview will be to dive deeper into the students' experiences while viewing art and reconstructing their personal narratives to learn more about the therapeutic qualities of this modality. A semi-structured interview format will be followed, with several content-focused questions used to guide inquiry with each participant. See Appendix F for the interview guide.

ANALYSIS AND EXPECTED RESULTS

Mixed-method, quasi-experimental designs using repeated measures are commonly used in group work research (Boyle, Whittaker, Eyal, & McCarthy, 2017). A similar design was used for the current pilot study, the primary objective of which is to test the ability to run a therapeutic group in the museum setting and generate a broad inspection of the benefits of this treatment approach with members of the population of interest. To date, much of the research examining art-viewing as a therapeutic modality has been almost exclusively qualitative in nature (e.g., Bennington et al., 2016; Mosek & Gilboa, 2016). While qualitative studies generate rich information on the personal experiences of participants, the present pilot study seeks to also contribute to the literature on the potential effectiveness of this treatment approach. A mixed-methods design is thus ideal for answering the present study's research questions, as the data gathered reflects both these quantitative and qualitative inquiries (Mayoh & Onwuegbuzie, 2013). It is the researcher's hope the information gleaned from the present study can be used as a starting point for future larger scale, experimental studies that can speak to the generalizability of the efficacy of art-viewing interventions.

Preliminary Analyses

The initial analyses of quantitative data will include calculations of descriptive statistics for demographic variables as well as means and standard deviations for the measures administered to study participants. total sample size, number of groups, and the number of participants per group will be reported. Prior to hypothesis testing, data will be analyzed using ANOVA to determine whether significant differences in variables of interest are present between groups on the demographic variables (e.g., age, race/ethnicity, year in school, etc.). Additionally, given the group nature of the intervention and the quasi-experimental design of the pilot study, assumption of independence will be violated for the sample. ICCs will be calculated to determine the variance in the outcome measures that can be attributed to clustering, as recommended by McCarthy et al (2017) for small samples group research.

Types of Analyses

For the quantitative inquiries this pilot study seeks to address, paired sample t-tests will be used to evaluate the statistical significance of differences between pre- and posttreatment responses. The precedent for using this statistical approach is found in similar studies that have examined the effect of art therapy treatments and other therapeutic treatments that involve comparisons of before-and-after observations (e.g., Allum, 2015; Gussak, 2007; Rietveld & van Hout, 2017; Shannonhouse et al., 2014).

For research question one, which investigates the primary outcome variable of interest (PHQ-9 scores indicating presence of depressive symptoms), the researcher will follow Shadish, Cook, and Campbell's recommendation to add an additional pretest measurement to reduce threats of maturation and regression to the mean (2002). Because the PHQ-9 was included in the recruitment survey, students who participated in treatment

will thus have provided two pre-treatment PHQ-9 scores. The researcher will conduct a paired sample t-test between the two pretreatment scores in order to determine if there is a significant difference that might indicate the presence of a confounding effect, such as natural improvement—or worsening—of symptomatology over time. Research questions two through five will be addressed using paired sample t-tests to evaluate the statistical significance of differences between pre- and posttreatment responses. Effect size (ES) of the pre- and post-treatment changes on the primary outcome measure of interest (depression) will be calculated using Cohen's d equation. Depression has been selected as the primary outcome measure given that improvement in depressive symptomatology is the primary goal of this pilot intervention. It is important to note that for small samples, Cohen's d is a positively biased estimator of ES and a correction must be made depending on the final sample size: either a 4% reduction in effect when the total sample size is 20 or a 2% when N = 50 (Durlak, 2009).

To address the qualitative research questions, data gathered over the course of treatment in the form of post-session group notes and in the one-on-one, post-treatment interviews will be analyzed using phenomenological methods of inquiry. Phenomenological methodology is recognized as being particularly well-suited to a mixed-methods design due to its strengths in describing the nature of lived experience (Mayoh & Onwuegbuzie, 2013). A phenomenological approach will allow the researcher to gather and analyze rich descriptions of the participants' experiences with the art and museum components of the intervention, synthesizing shared themes that capture the essence of the phenomenon in question (Moustakas, 1994; Creswell, 2013). Analysis will begin by individually reviewing all the notes from each session and follow-up interviews, transcribing recordings when applicable, making analytic notes, and mapping shared

patterns and motifs. Connections will be made between the lived experiences of each participant, and emergent themes will be drawn out.

Expected Results

It is anticipated that this pilot study will be composed of a small sample size given the limitations around recruitment and intervention implementation. However, it is expected that measured outcome variables for this pilot study will see statistically significant improvements when comparing pre-treatment scores to post-treatment scores due to the therapeutic potential of the intervention. It is important to, again, emphasize the pilot nature of these data and hazard against inferring efficacy beyond the scope of the small sample; as Leon, Davis & Kraemer (2011) state in their exposition on the role of pilot studies in clinical research, these preliminary studies are intended to guide the design and implementation of larger scale efficacy studies. The researcher hopes to find positive results in both the quantitative and qualitative areas of this inquiry that can be used to inform a more ambitious, larger scale study.

DISCUSSION

SUMMARY

The need for novel interventions that address the unique needs of college students is clear given the rising need for mental health care across college campuses. As college counseling centers struggle to meet demands, the exploration of new avenues and modalities for treatment may provide a means to help improve the experience of symptoms of depression among college students. By exploring how an art-viewing group intervention run in the campus art museum can improve students' emotional well-being, this study provides valuable pilot data to inform the use of an innovative course of treatment tailored for this increasingly diverse population. Results of this study can be used to support a larger-scale experimental study in the hopes of identifying a new mode of treatment that is effective, efficient, and easy to deliver.

IMPLICATIONS

The findings of the current pilot study could have implications within the realm of college mental health, as it may suggest a new method of providing mental health services to an increased number of students in efficient, effective ways. If proven to improve depressive symptoms, this intervention demonstrates that successful treatment on campus can occur outside of college counseling centers. Additionally, the group protocol could be manualized for use by trained art or museum educators in partnership with the counseling center to provide care for students. For example, a student who requests counseling, but is not in severe distress, could be referred to the proposed group intervention for treatment. This helps free up resources at college counseling centers, allowing them to focus on students in greater distress or who need more specialized care.

Additionally, for students who might not otherwise seek mental health treatment due to stigma associated with traditional mental health services, learning about this alternative setting might encourage help-seeking. The proposed group intervention can thereby provide universities with opportunities to support students who otherwise might not have requested help. Finally, this pilot could also serve as a model for other universities with campus art museums to use in supporting mental health care and well-being for their students.

LIMITATIONS

This current study is not immune to several important limitations including the nature of the study's non-experimental design, possible confounders, and unknown covariates. And as this is a pilot study and not a true randomized experiment, generalizability of findings to the broader college student population is not possible.

One of the most challenging limitations of the study design involves sampling. Indeed, the complex processes of participant selection and coordination are among the unique challenges inherent to conducting research in group work (McCarthy et al., 2017). It will be difficult to secure enough participants to effectively power the study, and the availability of only one group facilitator innately limits the number of individuals who can be treated. While recruitment will occur through both the EDP subject pool and the university's campus calendar, it is expected that most participants will come from the subject pool. This suggests that the sample will reflect a very specific portion of the UT population (students enrolled in undergraduate educational psychology courses), and these students may already be more open to therapeutic experiences. Additionally, the study could be at risk of self-selection bias due to the art component of the intervention

having an influence on those who volunteer for the study; it is possible that students who already have an appreciation for the arts will be more likely to participate. As with nearly all intervention studies, attrition is expected and the researcher will attempt to oversample to offset this drop in participation.

Another limitation may also exist with the measures selected for this study. The use of self-report measures may be susceptible to inaccurate reporting due to many factors, such as social desirability or a desire to please the facilitator, however research suggests there is no systematic bias as a consequence of using such self-report scales in outcome studies (Lambert et al., 1996). Additionally, the ANIQ is a new instrument that has not been rigoursly tested across populations, thus findings on this measure should be interpreted along with other corroborative data, such as evidence from the study's qualitative sources.

Finally, some potential confounding variables to consider when reviewing outcome measures of this study include elements of the museum space (e.g., the peaceful atmosphere), the facilitator's skills, the nature of the novel experience itself, and any comorbid presentations in the participants. It is possible that findings could, in part, be attributable to these external, difficult to quantify variables. As such, the qualitative component of the study hopes to reveal more detailed information on how students experienced the healing process and what they consider to be the primary therapeutic mechanism, if any. Findings might also be vulnerable to the presence of comorbid personality disorders in participants, as this treatment was not designed with these complex presentations in mind and may not adequately serve someone experiencing bipolar disorder, for example. Lopes et al (2014b) acknowledged this possibility in their study comparing narrative therapy and CBT treatment groups, and excluded participants

if comorbidity with personality disorders were detected. In the proposed study, the researcher will note any participants where this might appear to be the case in order to test for any unusual variation in their self-reported outcome measures, but will not exclude participants or remove them from treatment unless safety of participant indicates this is the best course of action, as doing so may be harmful to group cohesion.

FUTURE DIRECTIONS

A larger scale research effort would be the next step in determining efficacy of this innovative treatment. The pilot study results could justify greater investment of resources (e.g., additional facilitators, more cohorts) in order to support a randomized control design that uses a larger sample of students. Future studies could also propose a predictive model of depressive outcomes based on variables such as levels of narrative coherence, ability to externalize, and preference for visual texts over written or oral texts. It would also be useful to explore how student attitudes towards the arts impact receptiveness and response to the intervention, in the event that appreciation of the visual arts turns out to be moderating factor.

Appendices

Appendix A: Outline of Treatment Plan

Appendix B: Pre-screening Survey

Appendix C: Patient Health Questionnaire-9 (PHQ-9)

Appendix D: Awareness of Narrative Identity Questionnaire (ANIQ)

Appendix E: Items from COPE Inventory

Appendix F: Interview Guide

Appendix A: Outline of treatment plan

Week 1 - Introductions

Goal: Getting to know one another, creating a safe space, drafting a group contract, introduction to viewing art and expressing self

Therapeutic practices/interventions: active listening; reflecting, facilitative questioning, and strategies for viewing/talking about art.

Activities: 1) Introductions; 2) Adoption of group contract by discussing members' expectations and planned activities; 3) Participants find artworks as a reflection of identity or parts of identity; 4) Looking at art as a group to begin practicing introspection, identifying emotions, communicating responses, and actively listening,

Week 2 – Naming the problem

Goal: Re-cap from previous week; Naming the problem; Externalizing; focusing on coherence, social support

Therapeutic practices/interventions: facilitative questioning, reframing, projection/externalization, elicit alternate possibilities from participants.

Activities: 1) Using a preselected work of art, participants create and share a story about the artwork; 2) Participants find a work of art that reflects their problem-saturated narrative; 3) Compose a brief story about this artwork; 4) Process stories--do they make sense? What more can we find?

Week 3 – Relative influence questioning; deconstruction of unique outcomes

Goal: Re-cap from previous week; Participants identify influence of problem on life and their influence on life of the problem; support agency and self-efficacy, participant values and key memories.

Therapeutic practices/interventions: facilitative questioning, reframing, projection and externalization, elicit alternate possibilities from participants.

Activities: 1) Find a work of art that reflects some aspect of self individual does not like/desire; 2) Reframe and/or consider alternate possibilities; 3) Process as group--what more might be considered?

Week 4 - Focus on Coherence and Narrative Identity

Goal: Exploring self through a story

Therapeutic practices/interventions: facilitative questioning, reframing, projection/externalization, elicit alternate possibilities from participants.

Activities: 1) Find a work of art that reflects something about your past, present, and future; 2) Share with group, explore meaning; 3) Homework: develop narrative about artwork as it relates to self, bring following week

Week 5 - Life-stories, starting your next chapter...

Goal: Farewell meeting—Performance (sharing re-authored stories); reflection on personal and group processes

Activities: 1) Participants find their paintings, read their re-authored stories; 2) Share responses to stories; 3) Identify one way that each person in the group has contributed to the authorship of this story.

APPENDIX B: PRE-SCREENING SURVEY

A. Consent to participate, to be prepared per IRB instructions (participants must indicate "yes" to proceed.
B. You must currently be enrolled/attending a college/university to be eligible for this study. If you are not, please close this survey.
C. You must currently be 18 years or older to to be eligible for this study. If you are not, please close this survey.

The next few questions ask for some information about you:

1. Name:
2. Age:
3. Email address:
4. Phone:
5. Preferred method of contact:
6. Major/Program of study:
7. Year in school
    a. Freshman
    b. Sophomore
    c. Junior
    d. Senior
    e. Graduate Student (including medical students, law students, etc.)
    f. Other (please describe):
8. Number of credits you are currently enrolled in:
9. Are you a student veteran?
    a. Yes
    b. No
10. To which gender identity do you most identify?
    a. Female
    b. Male
    c. Gender non-conforming
    d. Self-identify as (please describe):
11. Sexual Orientation:
    a. Heterosexual
    b. Gay/Lesbian
    c. Bisexual

d. Transgendered
e. Questioning
f. Other (please describe):

12. Race/ethnicity (please choose all that apply):
    A. Arabic/Middle Eastern Descent
    B. Asian
    C. Black, African-American
    D. Hispanic, Latina/o, or Spanish origin
    E. Native American, American Indian, Alaska Native
    F. Native Hawaiian or other Pacific Islander
    G. White
    H. Multiracial/multiethnic
    I. Other (please describe):

13. How often do you participate in arts-related activities (i.e., drawing, visiting museums, attending concerts, playing music, etc.)?
    a. less than one time a month
    b. two or three times a month
    c. once a week
    d. more than once a week

For the next few questions, think back over the last *2 weeks*. How often have you been bothered by any of the following problems?

14. Little interest or pleasure in doing things
    a. Not at all
    b. Several days
    c. More than half the days
    d. Nearly every day
15. Feeling down, depressed, or hopeless
    a. Not at all
    b. Several days
    c. More than half the days
    d. Nearly every day
16. Trouble falling or staying asleep, or sleeping too much
    a. Not at all
    b. Several days

c. More than half the days
d. Nearly every day

17. Feeling tired or having little energy
a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

18. Poor appetite or overeating
a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

19. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down
a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

20. Trouble concentrating on things, such as reading the newspaper or watching television
a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

21. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual
a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

22. Thoughts that you would be better off dead or of hurting yourself in some way
a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

23. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

a. Not difficult
b. Somewhat difficult
c. Very difficult
d. Extremely difficult

The next few questions are about your current mental health care:

24. Have you been diagnosed with any mental health issues?
    a. Yes
    b. No
    If so, please describe diagnosis(es):
25. Are you currently participating in regular therapy sessions (e.g., 1 or more sessions a week)? Please include both individual and group therapy sessions.
    a. Yes
    b. No
26. Are you currently taking any psychiatric medications?
    a. Yes, please describe:
    b. No
27. Are you aware of your campus counseling center and/or any mental health services provided at your college or university?
    a. Yes
    b. No
28. Have you considered seeking out care at your campus counseling center?
    a. Yes
    b. No
29. Have you used your campus counseling center?
    a. Yes
    b. No
30. If you have **not** used your campus counseling center, what are some reasons why you have not gone? Please describe.
    a. Yes
    b. No
31. Would you be interested in participating in a five-week, art-viewing group to help improve mood?
    a. Yes
    b. No
32. If you would not be interested in participating in the group, would it be alright to contact you later in the semester with a follow-up questionnaire?

a. Yes
b. No

APPENDIX C: PATIENT HEALTH QUETIONNAIRE-9 (PHQ9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
    a. Not at all
    b. Several days
    c. More than half the days
    d. Nearly every day
2. Feeling down, depressed, or hopeless
    a. Not at all
    b. Several days
    c. More than half the days
    d. Nearly every day
3. Trouble falling or staying asleep, or sleeping too much
    a. Not at all
    b. Several days
    c. More than half the days
    d. Nearly every day
4. Feeling tired or having little energy
    a. Not at all
    b. Several days
    c. More than half the days
    d. Nearly every day
5. Poor appetite or overeating
    a. Not at all
    b. Several days
    c. More than half the days
    d. Nearly every day
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
    a. Not at all
    b. Several days
    c. More than half the days
    d. Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

   a. Not at all
   b. Several days
   c. More than half the days
   d. Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

   a. Not at all
   b. Several days
   c. More than half the days
   d. Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way

   a. Not at all
   b. Several days
   c. More than half the days
   d. Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

1. Not difficult
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

APPENDIX D: THE AWARENESS OF NARRATIVE IDENTITY QUESTIONNAIRE (ANIQ)

Instructions: Everyone has memories about the experiences they have had over their lifetime. Sometimes these memories can be used to create stories about our lives. The following statements refer to how you might use your memories to understand the kind of person that you have been, the person you are, and the person you expect to become.

You can respond to the statements on a scale from 0 (*completely disagree*) to 10 (*completely agree*), with a higher score indicating stronger agreement. Please try to answer the questions broadly, and in relation to how you generally use your personal memories, rather than trying to relate them to specific circumstances or experiences.

1. My memories are like stories that help me understand my identity.
2. I use my stories about my life to work out the kind of person I am.
3. The experiences from my past make the story of who I am.
4. My sense of self is embedded in memories of my life.
5. When I think over my life, I can observe how there is a story that tells me who I am.
6. I can put the events of my life in order of when they occurred.
7. Knowing the order in which my life events occurred is easy for me.
8. When I'm thinking back over experiences I have had, I know when they occurred in my life.
9. I have a good awareness of the sequence in which events and experiences in my life happened.
10. When I think about experiences in my past, I find it easy to remember what came before and after them.
11. I understand how the story of my life has unfolded.
12. I understand how my life experiences are associated with one another.
13. Things that have happened over the course of my life are meaningfully tied together.
14. I am aware of how events in my life are interrelated.
15. I can understand how experiences in my life have occurred, with one thing leading to another.

16. When I think or talk about experiences in my past I can see themes about the kind of person that I am.
17. I can perceive common themes about who I am across memories of my life.
18. I notice themes in the personal memories of my life that relate to the kind of person that I am.
19. When I recall events and experiences across my lifetime, I can see consistent patterns in the way that I think, feel, and act.
20. There are clear themes relating to who I am that can be found in my personal memories.

Scoring (sum totals)
Awareness subscale: Items 1 to 5
Temporal Coherence subscale: Items 6 to 10
Causal Coherence subscale: Items 11 to 15
Thematic Coherence subscale: Items 16 to 20
Items within each subscale are summed, with a possible range of 0 to 50.

Appendix E: Items from COPE Inventory

Instructions: These items deal with ways you've perhaps been coping with feeling down, sad, or depressed over the past two weeks. If you have **not** been feeling down, sad, or depressed, thinking about how you would cope with those feelings today. Each item says something about a particular way of coping with these feelings, and asks to what extent you've been doing what the item says. Don't answer on the basis of whether it seems to be working or not—*just whether or not you're doing it or would do it*. Use these response choices: 1 – I haven't been doing this at all; 2 – I've been doing this a little bit; 3 – I've been doing this a medium amount; 4 – I've been doing this a lot).

Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

Have you been feeling down, sad, or depressed in the last two weeks? __YES __NO

1. I look for something good in what is happening.
2. I learn to live with it.
3. I try to see it in a different light, to make it seem more positive.
4. I discuss my feelings with someone.
5. I learn something from the experience.
6. I try to get emotional support from friends or relatives.
7. I get used to the idea that it happened.
8. I get sympathy and understanding from someone.
9. I accept that this has happened and that it can't be changed.
10. I try to grow as a person as a result of the experience.
11. I talk to someone about how I feel.
12. I accept the reality of the fact that it happened.

Scoring
Scales (sum items listed, with no reversals of coding):

Positive reinterpretation and growth: 1, 3, 5, 10
Acceptance: 2, 7, 9, 12
Use of emotional social support: 4, 6, 8, 11

The developer of this scale denies that there is an "overall" score on this measure and recommends no particular way of determining whether a given individual has a dominant coping style (Carver, n.d.).

APPENDIX F: INTERVIEW GUIDE

Students who participated in the group intervention will be invited for a 45-60 minute follow-up interview. The goal of the interview is to explore the student's experience with the intervention, museum space, art-viewing, and personal narrative changes, if any. The interview will be conducted in a private room, one-on-one with the researcher. With participants' consent, interviews will be recorded.

Introduction to follow-up session. The researcher will meet the student in the appointed room in the Sanchez building on UT's campus and identify herself. The following script is a template for this interaction.

Researcher: Thank you again for agreeing to participate in this follow-up interview about your experiences in "A Healing Space".

This interview will take about 45 to 60 minutes. If you'd like to end the interview at any time and for any reason, that's also okay. I'd also like to record our interview today, so I can take notes later. If you would not like to be recorded, that's okay too. Thank you again for participating in my study, and if you have any questions or concerns after today, please feel free to reach out to me or my faculty supervisor, Dr. Ricardo Ainslie.

Interview questions

1. How did the group meeting in the museum influence your decision to participate?
2. What did you initially expect from this experience?
3. How would you describe your experience in the group, and was this different from your expectations?
4. In what ways did you find viewing art helpful?
5. What was it like being in the museum galleries?
6. How did being in the museum change ways you thought about yourself or others?
7. Think back on one work of art you selected to share with the group--what was meaningful about that experience and why?
8. What are some skills or strategies you learned from the group experience, if any?
9. What are some things you learned about yourself from the experience, if anything?
10. Is there anything else you would like to tell me your experience?

Conclusion. The following script is a template for this interaction.

Researcher: Those are all the questions I have for this exit interview. Thank you for your time and help today.

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