FACILITATING INNER-STRENGTH BUILDING IN ADOLESCENT GIRLS WITH DEPRESSIVE SYMPTOMS THROUGH EGO STATE THERAPY AND CREATIVE EXPRESSIVE ART IN THERAPY

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DECLARATION

I wish to declare that this study, **FACILITATING INNER-STRENGTH BUILDING IN ADOLESCENT GIRLS WITH DEPRESSIVE SYMPTOMS THROUGH EGO STATE THERAPY AND CREATIVE EXPRESSIVE ART IN THERAPY,** is my own work, that all sources used were acknowledged by means of complete references, and that this thesis was not previously submitted by me at another university.

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D. Blumenau

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ABSTRACT

Depression has become an epidemic in the 21th century, and the age of those presenting with depressive symptoms continues to drop to early adolescence. Research and statistics have also shown that adolescent girls are more susceptible to experience depression than adolescent boys. As the current approaches to the treatment of depression have some short-comings, this research study proposed an additional framework to the treatment of depression in adolescents. This framework was based on the implementation of the Ericksonian principle of utilisation, namely, utilising and building upon the client's assets and strengths in therapy. It was also based on the SARI model of ego state therapy as it expanded on phase one of the SARI model and enhanced its implementation in dealing with adolescent girls with depressive symptoms. Part of Phase 1 of the SARI model includes hypnosis for inner strength building. Hypnosis is a technique which has been used in this study. This framework was further based on the implementation of creative expressive art in therapy. The objectives of this study were to develop and describe a framework which aimed at facilitating inner strength building in adolescent girls with depressive symptoms, as well as to propose guidelines for the implementation of this framework. Inner strength is defined as that part of the psyche that remains intact, vibrant and resourceful, even as the client presents with symptoms of distress. Due to the lack of research regarding the building of inner strength in adolescent girls with depressive symptoms through ego state therapy and creative expressive art in therapy, this study aspired to address this gap. A qualitative approach has been used for this study. The design employed was that of multiple case study. The data was collected from five different sources, namely, audio recordings and transcriptions, observation, reflections, documentation and artefacts. Thematic analysis was used to analyse the material. For the purpose of the research, three participants were chosen. Each participant attended nine therapeutic sessions based on the framework suggested by this study. It became evident at the outcome of the sessions, that throughout the process, the participants felt that their inner strength grew and their depressive symptoms diminished.

This research contributed to the world of theory and practice by proposing a unique, practical and brief framework for the treatment of depression in adolescent girls. It is recommended that further research be conducted in order to evaluate this framework in different conditions.

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CHAPTER 1: BACKGROUND AND RATIONALE

1.1 Introduction

This chapter is the starting point of the researcher's exploration of the facilitation of inner strength building with adolescent girls who present with depressive symptoms, through the usage of ego state therapy and art. In this chapter, the researcher discusses the condition of depression and the conventional methods of psychological treatments. The researcher also presents a less well-known psychotherapeutic method, ego state therapy, as well as its benefits. The principles of the Ericksonian approach to therapy will be mentioned, as well as the SARI model which is used for the treatment of trauma and for inner strength building. This research study explores the concept of inner strength and how it can be built through hypnosis and creative expressive art in therapy, bearing in mind the theoretical frameworks of Erickson and ego state therapy. Finally, the gap in the literature was explored and the benefits of this study were outlined.

1.2 Discussion of research problem and motivation for this study

1.2.1 Problem statement

Depression is the most widespread mental disorder, the "common cold" amongst psychological disorders (Akhtar, 2012; Amini et al., 2018; Opie, O'Neil, Jacka, Pizzinga, & Itsiopoulos, 2018; Ranney et al., 2018; Singh et al., 2018; Van Grieken, Van Tricht, Koeter, Van den Brink & Schene, 2018). This disorder, which is becoming an epidemic in the 21st century, is a major threat to psychological health and it is the leading cause of mental disability (Ciobanu, Brodard, Antonietti, Genoud & Brandner, 2018; Olorunju, Akpa & Afolabi, 2018; Petersen et al., 2018; Singh et al., 2018). While the number of people affected by a twelve-month-long major depressive disorder, as documented in the DSM-V (American Psychiatric Association, 2013), may not be more than one out of a hundred, Akhtar points out that one in every two people will experience a depressive episode at least once in a lifetime (Akhtar, 2012). Others estimate that the lifetime prevalence of major depressive disorder is at 2-20% of society (Ribeiro, Ribeiro & von Doellinger, 2018). According to Devi (2012), depression is five times more common in children living in this generation, than those living fifty

years ago.

While previously, depression mostly affected people from mid-life and older, the age of onset has now fallen to early adolescence (Akhtar, 2012; Rhew et al., 2017; Singh et al., 2018). In fact, the DSM-V, after mentioning that depression may appear at any age, states that the likelihood of onset increases substantially with puberty (American Psychiatric Association, 2013). Other researchers seem to be of the same opinion as the DSM-V (Little, Olsson, Youssef, Whittle, Simmons, Ycel, Allen, 2015; Padilla Paredes & Calvete Zumalde, 2015; Perloe, Esposito-Smythers, Curby, & Renshaw, 2014; Silk, Siegle, Lee, Nelson, Stroud, & Dahl, 2014; Stikkelbroek, Bodden, Kleinjan, Reijnders, & van Baar, 2016; Yeatts, Martin & Petrie, 2017).

For the sake of clarification, the concept adolescence refers to the years between the onset of puberty to the stage of being socially independent. The most common definition of the chronological age is between 10-18 years of age (Curtis, 2015).

There are a few reasons that could explain the increase in depression at the adolescence phase. First, biological maturation, cognitive restructuring and psycho-social transformation during adolescence may be a contributing factor to the increase in depression (Duarte, Pinto-Gouveia & Rodrigues, 2015; Minev, 2018; Da Silva & Fritz, 2012; Nisar, 2018). Second, the adolescent phase is often characterised by an increase in stress, as well as psychopathology (In-Albon et al., 2017). Stress and depression are highly correlated (Kevereski, Dimovska, & Ristevski, 2016). Third, alongside other changes, adolescents often experience a decline in their self-esteem (Louw, Van Ede, & Louw, 1998; Minev, 2018; Woods & Scott, 2016), emotional instability, outbreaks, intense mood swings and negative emotions (Jankowski et al., 2018; Louw et al., 1998). Fourth, the fact that adolescents are inclined to focus on themselves can contribute to a higher experience of anxiety, shame, guilt and embarrassment than that experienced by children (Louw et al., 1998). Fifth, as a result of the adolescent striving for autonomy, there is often increased parent-child conflict, as well as an end to the parents' meaningful roles as mentors (Louw et al., 1998). Lastly, this increase may be linked to a rise in testosterone and estradiol, which is the form of the hormone oestrogen (Silk, Siegle, Lee, Nelson, Stroud, & Dahl, 2014). All the reasons above could possibly explain the increase in depression amongst adolescent boys and girls.

According to several researchers, depression is more common in females than it is in males (Cavanagh, Wilson, Caputi & Kavanagh, 2017; Ribeiro, Ribeiro & von Doellinger, 2018). Some research show that girls, in particular, seem to experience an increase in feelings of depression during adolescence (Rhew et al., 2017; Wijnhoven et al., 2014). However, other researches maintain that the prevalence of depression amongst men is not any less than in women, except that men show different symptoms, such as alcohol intake, irritability, risk-taking behaviour, and aggression, as opposed to the depressed mood found in women (Cavanagh et al., 2017). Nisar (2018) found the opposite of the conviction that the prevalence of depression in females is greater than it is in males. He states that depression is related to pessimistic thinking. Adolescent boys think more pessimistically than adolescent girls, hence boys were found to score higher with depression than adolescent girls.

However, regardless whether depression is higher amongst girls or boys, adolescence is a critical and crucial age for them to be helped with their psychological well-being (Minev, 2018; Da Silva & Fritz, 2012; Yeatts, Martin & Petrie, 2017). First, this is the case when adolescents are at a crucial phase of identity formation, as failing to achieve identity formation results in them not being ready to enter the challenges of adulthood (Erikson & Erikson,1990). Second, it is during this period that adolescents consolidate their attitude towards their future career and life (Nisar 2018). Third, it is during this relatively short period that adolescents need to acquire the necessary skills for the demands of life (Minev, 2018). Lastly, untreated depression in children usually persists into adulthood (Olorunju et al., 2018; Woods & Scott, 2016).

Depression is a challenging condition due to the fact that it is debilitating, affecting the sufferer's cognitive, health and social domains (Jankowski et al., 2018). Depression also affects the sufferer's family and society, as well as creating social costs (Amini et al., 2018; Milan & Carlone, 2018; Opie et al., 2018; Van Grieken et al., 2018; Wehrenberg, 2010). Amongst adolescents, depression also causes an increase in cannabis and alcohol use, for its self-medicating effect (Rhew et al., 2017), as well as an increase in peer violence (Ranney et al., 2018). Depression affects their interpersonal relationships, as well as impacting on their self-evaluation (Jankowski et al., 2018).

According to research, the most effective way of treating depression is through a

combination of psychotherapy and medication (Aarons, Levin & Taub-Da Costa, 2012; Brogan & Greenblatt, 2016; Clark, 2008; Ribeiro et al., 2018; Wehrenberg, 2010). The most common psychological methods of treating depression and depressive symptoms during the 20th century were psychoanalysis, which later evolved into psychodynamics (Ribeiro et al., 2018), and cognitive behaviour therapy (CBT) (Beck, 2011a; Bernecker et al., 2016; Brogan & Greenblatt, 2016; Ribeiro et al., 2018). Both of these treatment modalities have shown a 50%-60% positive response rate, which is a similar response rate to medication. However, remission was found to be lower than 30%, which is the remission rate for medication (Brogan & Greenblatt, 2016).

Emmerson (2007) maintained that each method of treatment has its own limitations. Psychoanalysis relies mainly on dream interpretation, free association and the analysis of transference reactions as a main tool, the result of which is that many hours of treatment are required (Sand, 2012; Prochaska & Norcross, 2010; Reiser, 1994; Ribeiro et al., 2018). This makes therapy lengthy (Emmerson, 2007) which presents a problem in modern times, as health care is often dependent upon third-party payers who demand cost-effective therapy (Brogan & Greenblatt, 2016; Driessen et al., 2015; Watkins & Watkins, 1997; Zeig & Gilligan, 1990).

From a humanistic perspective, psychoanalysis is viewed as a system that dehumanises people. It views human beings as objects which consist of defensive and instinctual energy. This view is too deterministic, negating the subjective experiences and freedom of choice unique to human beings (Prochaska & Norcross, 2010).

On the other hand, the empirical-behaviour tradition, namely CBT, while showing immediate therapeutic results, has done so by ignoring subliminal processes, namely subconscious activities, which are responsible for certain behaviours and thought processes (Emmerson, 2007; Ribeiro et al., 2018) as is evident from various works by CBT practitioners, such as Beck (2011b); Kuyken, Watkins and Beck (2005); Simons et al. (2010) and Wright, Thase, and Beck (2014). CBT therapists focus mainly on cognitive techniques, such as problem solving, and on restructuring distorted and irrational beliefs. They also focus on behavioural techniques, such as exposure to phobias (Beck, 2011; Midgley et al., 2018; Bohman, Santi, & Andersson, 2017; Bourne, 2015; Greenberg, 2010; In-Albon et al., 2017; Prochaska & Norcross, 2010).

This means that their scope of operation is limited. In other words, CBT focuses on the unwanted symptoms and not the causal disturbance. Since CBT does not focus on past issues, “the child within” may remain unhealed. The injured-self, which is the part of one’s psychological make-up that was previously hurt, is then avoided. This causes the client to be removed from that part which is able to feel deeply and richly. Even though the client is able to function, a part of the self has been detached (Emmerson, 2007). While CBT may show immediate therapeutic results, the permanence of the results of CBT is a matter of controversy (Emmerson, 2007). CBT intervention strategies, generally speaking, focus only on symptom reduction and do not place emphasis on the emotional domain (Studer & Aylwin, 2006). Despite the fact that CBT may enable the client to perform adequately, the internal emotion associated with a traumatic episode may not have been treated. This untreated emotional disturbance is likely to prevent the client from fully engaging in many of life’s joyous experiences (Emmerson, 2007).

Against this backdrop, the problem statement can be expressed as follows: Since the existing standard routes for the treatment of depression and depressive symptoms have limitations, alternative treatment options may be explored. One overlooked (Da Silva & Fritz, 2012), yet appropriate approach to treating depression, may be ego state therapy (Emmerson, 2007; Hartman, 1995; Phillips & Frederick, 1995; Watkins & Watkins, 1997). Hence, the researcher proposed a framework as a treatment plan, for adolescent females, which falls within the broader model of ego state therapy, as is explained below. The reason for choosing girls over boys in this study was that this model of therapy had been previously implemented by the researcher in the treatment of adolescent girls, with a high rate of success.

1.2.2 Research rationale

Ego state therapy is a therapeutic modality which has steadily developed over the past three decades. It aims to establish a faster treatment approach to therapy, which could offer both the speed and efficacy of CBT and the depth of psychoanalysis with long lasting results (Emmerson, 2007; Hartman, 1995). Empirical efficacy studies which demonstrate its validity have already been published (Barabasz, Barabasz, Christensen, French & Watkins, 2013; Da Silva, 2010; Da Silva & Fritz, 2012; Emmerson, 1999; Emmerson & Farmer, 1996; Forgash & Knipe, 2012; Watkins &

Watkins, 1997). This treatment modality was found to be effective and practical.

Ego state therapy is based on the premise that the global personality is composed of separate parts, “a divided self” rather than being a homogeneous whole (Emmerson, 2007; Hartman, 1995; Da Silva & Fritz, 2012; Phillips & Frederick, 1995, p. 1). These parts, which all human beings possess, are referred to as “ego states”. The therapist works directly with the ego state that can best benefit from change, rather than merely working with an intellectual, talkative state (Emmerson, 2007; Da Silva & Fritz, 2012; Phillips & Frederick, 1995). Ego state therapy offers a “causal solution” and not merely a coping strategy, because it uses the unwanted symptom to find the causal disturbance (Da Silva & Fritz, 2012; Emmerson, 2007, p. 195). When the causal trauma has been resolved, the symptoms may automatically disappear. Once the disturbed ego states have been settled, positive emotion may be experienced, leaving the client feeling integrated, alive and able to enjoy living (Emmerson, 2007; Phillips & Frederick, 1995; Da Silva & Fritz, 2012).

It is important to note that Milton Erickson (1900-1980) had a major influence on ego state therapists (Fourie, 2009; Hartman, 2002; Phillips & Frederick, 1995), as their philosophies and thinking shared similar principles, such as ego strengthening, a brief approach to therapy, and hypnosis as an important tool in therapy (Fourie, 2009). As a result of the similarity between the ego state paradigm and the Ericksonian paradigm, ego state therapists like Zeig, Frederick, Phillips and Watkins have utilised many of the principles of Ericksonian hypnosis and integrated them into their own paradigm, thereby strengthening their own theoretical framework (E. Fritz, Personal Communication, November 4, 2014; Phillips & Frederick, 1995). This may be observed in the book ‘Empowering the self through ego state therapy’, authored by Maggie Phillips and Claire Frederick (2010). The Ericksonian framework is based on the concept of utilisation and mobilisation of the client’s strengths, assets and internal resources (Battino & South, 2005; Dagirmanjian, Eron & Lund, 2007; Fourie, 2009; Phillips & Frederick, 1995; Short, Erickson & Erickson-Klein, 2006; Yapko, 2006; Zeig, 2013). Erickson believed that the unconscious mind contains all the essential resources that a person needs in order to solve her own challenges (Erickson, Rossi & Rossi, 1976). Erickson also used hypnosis as his main tool in therapy (Erickson & Rosen, 1982; O’Hanlon, 1987).

As mentioned above, ego states are parts of the personality which together form the homogeneous whole, creating the global personality (Watkins & Watkins, 1997). Each ego state has its own age, role, feeling of power or weakness, emotion, logic, skills, and other personal traits. The various ego states enrich a person's life and facilitate more productivity and joyfulness. Some ego states are resourceful and helpful states which assists a person's functioning (Phillips & Frederick, 1995). These are the ones that could help adolescent girls deal with their emotional challenges (Da Silva, 2010). However, an ego state harbouring pain can cause unrest and unwanted emotional reactions (Hartman, 1995). So too, when ego states are in conflict with each other, the person feels divided and torn (Phillips & Frederick, 1995).

Referring back to the discussion regarding the effectiveness of CBT, it can now be understood that when the presenting problem requires the healing of a traumatized part of the personality, healing a conflict between ego states, or where it needs to be alleviated through gaining access to lesser used ego states, CBT might be inefficient (Emmerson, 2007). In other words, symptom relief may not be enough to address fully psychological distress, such as depression.

Phillips and Frederick (1995) and Phillips (2008) suggest the "SARI model" as a method of implementation of ego state theory. The **SARI** model consists of four phases, namely, **S**afety and stabilization, **A**ccessing the trauma and related resources, **R**esolving traumatic experiences and re-stabilization and personality **I**ntegration. They maintain that the first phase of the SARI model is essential in the therapeutic process since a person has to achieve first a sense of internal and external safety before attempting to deal with other therapeutic endeavours. If this is not achieved, the therapeutic process may be disrupted, as the client may be overwhelmed by stimuli she is not equipped to deal with and may not be able to recover from a re-traumatising regression (Da Silva, 2010; Frederick & McNeal, 1999; Phillips, 2008; Phillips & Frederick, 1995). This phase includes addressing the client's needs in terms of various risks and disturbances, such as suicide, anxiety, sleep disturbance, substance abuse and others. As part of the above, "ego strengthening" or "inner strength building", plays an important part (Da Silva, 2010; Phillips & Frederick, 1995, p. 38; Phillips, 2008). In addition, in order for the therapeutic process to be effective, "experiences of calmness, clarity and mastery need to occur early in treatment" (Phillips & Frederick, 1995, p.

82). This can be made possible by starting to build inner strength at the first phase of the therapy. Phillips and Frederick (1995) add that most clients require inner strength building at the beginning of the therapeutic process in order for them to be strongly committed to therapy, to help them retain hope and to allow for the possible dissociated trauma to "emerge from behind amnestic barriers" (Phillips & Frederick, 1995, p. 82). They state further that when inner strength building takes place, there may be enhanced self-esteem, clarity of thinking, an ability to self-soothe and to problem solve, as well as increased insight. In this way, the client does not need to develop absolute dependency on the therapist as the client will be able to motivate herself to tackle the difficult task of solving her own problems (Phillips & Frederick, 1995).

Phase two, three and four of the SARI model will be elaborated on. Although all three of these phases also use inner strength, inner strength building is predominantly used during stage one, namely, safety and stabilisation (Phillips & Frederick, 1995). To the best of the researcher's knowledge, no research which discusses the use of the SARI model with school-going, adolescent girls exists. The researcher contends that this may be a useful model to be implemented with adolescent girls, as it could help to build inner strength, which can assist their development (Da Silva, 2010). It would be important to mention here that ego state work can be done both in and out of a state of hypnosis, however, it is mostly conducted when the client is in hypnosis (Emmerson, 2007).

Inner strength is a common phrase often used by individuals, who are not familiar with psychological terminology, when describing their consciousness of internal resources which they are able to access (Frederick & McNeal, 1999). However, as part of psychological terminology, "inner strength" is a concept used as part of ego state theory and therapy (Emmerson, 2007; Frederick & McNeal, 1999; Phillips & Frederick, 1995). Emmerson (2003, p. 210; 2007, p. 210) defines inner strength from an ego state theory perspective, as "the ego state manifestation that apparently all persons have". When communicating directly with this state under hypnosis, "this ego state claims to have been born with the person and claims to have wisdom concerning the best direction for the person" (Emmerson, 2003, p. 210; 2007, p. 210). It normally speaks with a strong, clear voice and may call itself by other names, such as 'inner

self' or 'spiritual self'" (Emmerson, 2003, p. 210; Emmerson, 2007, p. 210). Along similar lines, Allen and Allen (2004, p. 101) state that it is the part of the person that is the essence of the person, a "voice of wisdom and of truth that is so often lost within the clamour and the clatter of the world", namely, the constraints and demands of life. Emmerson (2003) adds that it is the part of a person that cannot be removed and its nature and role cannot be changed, however, it can be expanded to take on a greater role in terms of its interactions with other ego states. Emmerson (2007) and Hartman (Personal Communication, April 5, 2013), state that the inner strength part can be considered as the spiritual part of the personality. As a working definition for the purposes of this research, inner strength may be defined as that part of the psyche that remains intact, vibrant and resourceful, even as the client presents with symptoms of distress.

Taking the evidence presented in the previous paragraphs into consideration, it can now be appreciated that the lack of attention attributed to inner strength building by many psychological modalities including psychoanalysis and cognitive behaviour therapy, is the basis of one of the strong objections that ego state therapists would have to those forms of therapy (E. Fritz, Personal Communication, November 4, 2014). One way of building inner strength is through ego state therapy in hypnosis, and another way may be through creative expressive art therapy.

Various researchers maintain that the use of creative expressive art in therapy is useful and has proven to be successful due to the fact that creative expressive art has the power to bring about neural integration of brain pathways. This integration brings about awareness and regulation between rational thoughts, affect and behaviour (Van Lith, Quintero, Pizzutto, & Grzywacz, 2018). The following advantages and gains appear to be a result of this principle.

Creative expressive art in therapy can be utilised in helping people make changes in their lives, guiding them towards a more fulfilling path, in reducing depression and in achieving a happier existence (Blomdahl, Guregård, Rusner, & Wijk, 2018; Green & Drewes, 2013; Moosa, Koorankot, & Nigesh, 2017; Rahmani, Saeed, & Aghili, 2016). Art therapy is a way to express emotions non-verbally, which enables people to deal with past negative experiences by containing them in the safety of the presence through the use of symbols (Van Lith, Quintero, Pizzutto, & Grzywacz, 2018). Prior to

verbal development, children learn to interact with their environment through their sight, touch and other senses (Darewych, 2015). Art is important for a child for her thinking processes, perceptual and emotional development and social awareness (Darewych, 2015). Current evidence shows that art therapy is a beneficial approach for vulnerable children (Chin et al., 2017). At times, it is the only approach to therapy with adolescents who cannot express themselves through any other way, but through art (Briks, 2007; Chin et al., 2017; Green & Drewes, 2013). A therapeutic environment which incorporates art is known to help children with their self-esteem, to solidify their self-concept and to reduce depression (Blomdahl et al., 2018; Darewych, 2015). The use of art has also been shown to promote wellbeing and reduce anxiety (Blomdahl et al., 2018; Roghanchi, Mohamad, Mey, Momeni, & Golmohamadian, 2013; Strader-Garcia, 2012). Studies which focus on healing childhood trauma through the usage of art, found that the children's stress levels improved as a result, their anxiety diminished and they were able to self-regulate their emotions (Van Lith et al., 2018). The researcher proposes that the benefits of creative expressive art in therapy would be equally as helpful with school going-adolescent girls.

The value of inner strength in ego state therapy and in the Ericksonian approach has already been demonstrated. It is now appropriate to explain the importance of inner strength building in relation to hypnotic interventions in the area of depression in particular. According to Yapko (2006a), clinical evidence shows that hypnosis can contribute greatly to the treatment of depression. However, hypnosis in treating depression has been controversial because of the potential of its weakening of the client's defences and increasing the risk of suicide (Frederick & McNeal, 1999). Ego strengthening through hypnosis, however, has been found to be of value with many suicidal clients (Frederick & McNeal, 1999). Ego strengthening enables the client to experience relaxation, inner-peace, calmness and inner strength (Phillips & Frederick, 1995).

Ego strengthening scripts have been used in helping clients with issues of low self-esteem and self-derogatory thoughts (Frederick & McNeal, 1999). The importance of inner strength building as the first step in ego state therapy has been mentioned. The researcher contends that the need to first work on inner strength is particularly important when working with individuals who are suffering from depression. The

reason for this is that depression is often linked to low self-esteem (Blomdahl, Guregård, Rusner, & Wijk, 2018; Holopainen & Emmerson, 2002; Jankowski et al., 2018; Minev, 2018). Improving low self-esteem, which naturally occurs through inner strength building (Frederick & McNeal, 1999) could contribute to addressing symptoms of depression (Guregård et al., 2018; Minev, 2018). Results of a recent study confirm an association between stronger inner strength and lower levels of depression (Boman, Gustafson, Hggblom, Santamki, Fischer, & Nygren, 2015).

1.2.3 The gap in the literature and the current study

Existing research within the ego state theoretical framework that implements inner strength building focused on various topics, including inner strength building in general (Frederick, 1996); inner strength building in hypnosis (Calnan, 1977); inner strength building with individuals who were sexually abused (Fourie, 2009); inner strength building to address anxiety (Frederick & Kim, 1993); inner strength building for general practitioners (Frederick, 1993b); inner strength building for therapists (Da Silva, 2010); techniques for inner strength building (Frederick, 1993a); and inner strength with immature ego states (Fredrick & McNeal, 1993).

However, there seems to be a lack of focus on depression or depressive symptoms and inner strength building. While Holopainen and Emmerson (2002) provide guidelines for ego state therapy and the treatment of depression, they do not focus on inner strength building. A recent study on the relationship between inner strength and depression, while pertinent to this research topic, does not relate to a framework of implementation of inner strength building in the treatment of depression and makes no reference to ego state therapy (Gust et al., 2014).

Consequently, there seems to be a limited amount of evaluative studies available regarding the application of Ericksonian and ego state approaches with regard to inner strength building. Guse, Wissing and Hartman (2006) deal with a prenatal hypnotherapeutic programme and Fourie (2009) discusses a positive framework with which to treat sexual abuse. While these studies do apply Ericksonian and ego state theory approaches, they do not focus on inner strength building for the treatment of depressive symptoms.

Further, some researchers maintain that although inner strength is vital for the

therapeutic process, it has not yet received enough scientific attention (Fourie, 2009). They call for more focus on the utilisation and mobilisation of the client's strengths and assets during the therapeutic process (Fourie, 2009; Da Silva & Fritz, 2012).

As can be seen, the proposed study, which focused on the facilitating of inner strength building in adolescent girls with depressive symptoms, contributed to closing the gap in the existing literature. The proposed study also aimed to make a practical contribution in terms of developing and describing a unique framework, as well as proposing guidelines for its use.

1.3 Aims and objectives of the study

The purpose of this study was to propose a framework for the facilitation of inner strength building in adolescent girls with depressive symptoms. This served to expand on phase one of the SARI model and enhance its implementation in dealing with adolescent girls with depressive symptoms.

1.3.1 Research question

How can ego state therapy and creative expressive art in therapy be integrated to facilitate inner strength building in adolescent girls with depressive symptoms?

1.3.2 The objectives of this study

To develop and describe a framework which aims at facilitating inner strength building in adolescent girls with depressive symptoms.

To propose guidelines for the implementation of this framework.

1.4 Research design and methods

1.4.1 Research approach

This study followed a qualitative approach. Qualitative research typically studies people or systems in their natural environment through observation or interaction with them, while focusing on their personal, subjective meanings and interpretations of their experiences. In qualitative research an attempt is made to try and see things from the eyes of the participants. The emphasis is on the depth and quality of the information

elicited (Holloway & Wheeler, 2010; Levitt et al., 2018; Maree, 2007; Yin, 2012). In other words, qualitative research is a multi-perspective approach to social interaction. It aims to describe, make sense of, interpret or reconstruct peoples' experiences in terms of the meaning that they attach to the experiences (Leedy & Ormrod, 2014). In keeping with the principles of Merriam (1990), the researcher prefers a research paradigm matching her own character (her appreciation for understanding in-depth complex cases), as well as the nature of the research (Maree, 2007; Yin, 2012). To this end, a qualitative research approach was implemented.

1.4.2 Research design

The researcher suggests case study as an appropriate research design. Case study research is a form of qualitative research, exploring a real-life system through detailed data collection involving multiple information sources and reporting a case theme (Creswell & Creswell, 2017). Case studies can provide deep, comprehensive and contextualised understanding (Ritchie, 2014). A case study may be a multisite study, which explores multiple cases, or a within-site study, exploring only one case (Creswell, 2013). Multiple case study increases trust in the findings (Fourie, 2009; Merriam & Tisdell, 2015), as well as providing greater confidence in the findings (Yin, 2012). For the purpose of this research, the researcher will, therefore, conduct a case study research, involving multiple case studies. No formula exists as to the exact number of cases required for a multiple case study. Common multiple case study would require two or more cases aimed at replicating the same findings (Yin, 2012). Consequently, three participants were obtained to take part in this study, namely, young females, who desire to recover from depressive symptoms.

1.4.3 The participants

The criteria of the participants were that they should be female adolescents between 14-18 years of age. They should present with depressive symptoms as listed in the DSM-V. This was established by the researcher during a preliminary interview with the participants. The researcher asked them questions about their depression, based on the DSM-V. This assisted in determining whether they had depressive symptoms. The sampling was purposeful, namely, the researcher had put a community notice on the South African Jewish website, in order to obtain participants from as similar a

background as possible, as well as for the sake of convenience, as these participants were from the area in which the researcher has a private practice. This was followed by a screening phase to see which of the volunteers were suitable for the research (Holloway & Wheeler, 2010; Yin, 2014). Only three girls were chosen and the rest were referred for treatment elsewhere.

1.4.4 Ethics

A range of ethical issues become pertinent when conducting research on humans or animals (Bryman, 2016; Polit & Beck, 2010; Richards, 2015). According to Dhai and McQuoid-Mason (2010), there are four fundamental principles which the researcher needs to adhere to while proceeding with the research: Respect for autonomy, non-maleficence, beneficence and justice. These will be adhered to throughout the research. According to the HPCSA (Health Profession Council of South Africa) as per the HEALTH PROFESSIONS ACT, 1974 (ACT NO. 56 OF 1974), research with people below the age of 18, would require consent from the parents and assent from the child, it would require confidentiality and it would have to prove to be beneficial for the child. The researcher will adhere to these regulations (Bryman, 2016; Richards, 2015).

1.4.5 Procedure

The researcher will commence with an interview followed by therapeutic sessions consisting of a combination of creative expressive art in therapy and hypnosis focused on building inner strength.

1.4.6 Data collection

The data collection took place throughout the process of the sessions (Remenyi, 2012). Data consisted of audio recording and transcription of the interview and the rest of the therapeutic sessions (Guest, Namely & Mitchell, 2013). Observations and field notes of the participants' language, feelings and behaviour was done by the researcher and by the participants' main caregiver (Patton, 2015). Documents/reflections on the process was done by the participants, by the researcher and by the participants' main care giver (Patton, 2015). Lastly, the creative art that the participants created, served as artefact which was used to view the possible shifts or

evolvements that took place within the participants (Creswell, 2013; Patton, 2015).

1.4.7 Data analysis

Within qualitative research designs, the particular style of analysis that the researcher believes best matches this study is that of thematic analysis. It is a method of analysis used for identifying and reporting patterns or themes within data. It often goes further to interpret aspects of the research topic. It is regarded as a useful and flexible approach to qualitative analysis (Braun & Clarke, 2006). Six phases of analysis were executed: 1. Familiarising with data; 2. Generating initial codes; 3. Searching for themes; 4. Reviewing themes; 5. Defining and naming themes; 6. Producing the report (Braun & Clarke, 2006). Thematic analysis was applied to all three sources of data, namely, the therapeutic sessions, participant's reflections, and the art effect. The researcher had paid specific attention to themes that allude to each participant's current and evolving inner strength.

1.4.8 Research trustworthiness

Lincoln and Guba (1985, p. 289) designed a framework for qualitative researchers to use in order to enhance the trustworthiness of their study, which is still popular in qualitative reports (Creswell, 2013; Merriam & Tisdell, 2015). Following these guidelines ensured the authenticity of the findings. The measures suggested were: **credibility**, namely, the researcher had ensured that the conclusions indeed stemmed from the data (Maree, 2007) and that the findings were confirmed by the participants (Treharne & Riggs, 2015); **dependability**, namely, the degree to which the reader would be convinced that the findings did occur as the researcher presented them (Maree, 2007) and that they can be replicated by other researchers (Treharne & Riggs, 2015); **confirmability**, namely, the researcher carefully and considerately paid attention to the process of data analysis and to the reporting of the findings (Lincoln & Guba, 1985). The researcher also made sure that the findings were clear of the researcher's bias, interests, motivations and intentions (Treharne & Riggs, 2015); **transferability**, namely, the degree to which the data and context of this research study may be generalised to the wider population (Maree, 2007; Treharne & Riggs, 2015). These were adhered to in this research study.

Credibility was established through prolonged engagement with the research

participants and the triangulation of the relevant data sources (Creswell, 2013; Treharne & Riggs, 2015). Dependability and confirmability were established through extensive auditing of the research process (Creswell, 2013). Dependability was also achieved through member checks (Maree, 2007). Transferability depended upon the researcher providing a thick description of the research findings (Creswell, 2013).

1.5 Scholarly contribution

The gap in existing literature dealing with the contribution of inner strength building in treating depression has already been highlighted. In terms of a contribution on the theoretical level, the researcher envisages that this study will help to fill this gap and thereby contribute on three levels. For clinicians, and in particular, for educational psychologists, this study aims to suggest a method to approach inner strength building in adolescent girls with depressive symptom, which will enhance the realm of applied psychology.

In terms of scholarship, the combination of ego state therapy with creative expressive art in therapy, as well as hypnosis to build inner strength in adolescent girls with depressive symptoms, which also provides a novel conceptual approach through integrating these modalities on a theoretical level. On a practical level, the advantage of this method for clients is that it is brief and positive, while at the same time penetrating to the core of the issue.

1.6 Conclusion

Chapter 1 introduced the study by providing an overall view of this study's content. It dealt with the problem statement in reference to the prevalence of depression, in terms of frequency, gender and age, as well as the severity of this condition. In this chapter, different treatment methods of depression were elaborated upon, including their limitations. The research rationale elaborated upon ego state therapy together with the SARI model and the Ericksonian approach which will all be utilized in this study. The importance of building inner strength amongst adolescent girls with depression was also discussed. The importance of inner strength building as an introduction to any treatment and the utilization of it through the process of therapy was mentioned. The gap covered by the study was discussed, as well as the research aim and question. Lastly, this chapter discussed the methods used in order to carry out this research with

ethics and trustworthiness.

CHAPTER 2: DEPRESSION IN ADOLESCENTS-LITERATURE REVIEW

2.1 Introduction

While depression poses a challenge to mental health for people of all ages, in the past, it mostly affected people from mid-life and up, now the age of onset has fallen to early adolescence (Rhew et al., 2017; Singh et al., 2018), so much so that depression is currently the third leading cause of illness, disability and suicide amongst adolescents (Willis, Mavhu, Wogrin, Mutsinze & Kagee, 2018). Research shows that rates of depression are much higher in adolescent girls than in adolescent boys (Padilla Paredes & Calvete Zumalde, 2015; Perloe, Esposito-Smythers, Curby & Renshaw, 2014). The seriousness of adolescent depression can be more fully appreciated when bearing in mind that, poor mental health is closely related to other health and developmental conditions in young people, as will be demonstrated in this chapter (Flisher, Hetrick & McGorry, 2007; Jankowski et al., 2018; Rhew et al., 2017; Rubin & Beevers, 2011).

Chapter 2 will attempt to conceptualise to the reader all aspects of depression with a special focus on adolescents' depression. This will include the DSM-V criteria, definition, and subtypes of depressive disorders. The DSM-5 will further be consulted regarding the severity of depressive episodes and the appropriate differential diagnosis. Prevalence and consequences of depression, in general, and more specifically, amongst adolescents will then be elaborated upon. This will be followed by a discussion of the causes of depression amongst the wide population, with an additional focus on adolescents. Lastly, strengths and limitations of existing treatment approaches will be examined in order to assess the justification of formulating a new treatment model.

2.2 Conceptualising depression in adolescence

In order to research depression in adolescence, it is important to have a clear scientific definition of depression and its sub-types, taking into account the severity of the depressive episodes and paying attention to a differential diagnosis to ensure accuracy. The DSM-5 (American Psychiatric Association, 2013) is the latest version

of the Diagnostic and Statistical Manual, compiled by the American Psychiatric Association, which is the most definitive source to consult on the subject. Following is a selection of references to the DSM-5 which pertain to the research topic.

2.2.1 The definition of depressive disorders

The DSM-5 groups disorders sharing depressive symptoms together under the heading of depressive disorders. The feature common to all of these disorders is “the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function. What differs among them are “issues of duration, timing, or presumed etiology” (APA, 2013). Depressive disorders include “disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorders and unspecified depressive disorder” (APA, 2013).

2.2.2 Diagnostic criteria for major depressive disorder

As the focus of this research study is young females with depressive symptoms relating to major depressive disorder, it is appropriate to present the DSM-5’s diagnostic criteria for major depressive disorder. Before listing the criteria, it is important to note that the DSM-5 includes five conditions that need to be met in order to arrive at a diagnosis.

Five or more of the symptoms need to be present for an uninterrupted two-week period. These five must include depressed mood, or loss of interest or pleasure. The symptoms are as follows:

A. The symptoms cause substantial distress or impairment in important areas of functioning.
B. The symptoms are not linked to the effects of a substance or a different medical condition.
C. The depressive symptoms are not better explained by a psychotic disorder.
D. The absence of a manic or hypomanic episode.

The DSM-5's list of diagnostic criteria for major depressive disorder

1. Depressed or sad mood for most of the day, nearly every day, indicated by the sufferer, namely, he/she reports feeling sad, empty, hopeless, or reported by others, namely, others saying about the sufferer that he/she appears tearful. In children and adolescence, it can be irritable mood. [1]
2. Markedly diminished interest or pleasure of all or most activities, for most of the day and almost every day as reported by the sufferer or by others.
3. Significant loss or gain of weight, namely 5% of body weight gained or lost in a month. Or an increase or decrease of appetite, almost every day.
4. Hyper insomnia or insomnia almost every day.
5. Psychomotor agitation or retardation almost every day which is observable by others, namely, restlessness or slowness.
6. Loss of energy or fatigue almost every day.
7. Feeling of worthlessness or excessive or inappropriate guilt almost every day.
8. Reduced ability to think or concentrate or indecisiveness as reported by self or others, for almost every day.
9. Recurrent thoughts about death or having suicidal ideation or attempts or plans.

(American Psychiatric Association, 2013, p. 160-161).

2.2.3 Subtypes of depressive disorder

Other than **major depressive disorder, there are other subtypes of depressive disorders, namely, disruptive mood dysregulation disorder which** refers to the presentation of frequent and extreme lack of control of anger and persistent irritability in children and adolescence. This disorder lasts for at least 12 months. **Persistent depressive disorder** (dysthymia) is a more chronic form of depression. The diagnosis would be applicable if the mood disturbance persists for at least two years in adults and one year in children. **Premenstrual dysphoric disorder** is a disorder that begins

[1] The usage of the terms: him/her, he/she, himself/herself is often used as an inclusive terminology. However, at times, only the term "her" or "she" was used, when the language became too lengthy otherwise and ultimately, this research involved adolescent girls.

sometime following ovulation and lasts for a few days of menses. This disorder has a marked impact on functioning. **Substance/medication-induced depressive disorder and depressive disorder due to another medical condition** are disorders that were either induced through substance abuse, prescribed medication or medical conditions (American Psychiatric Association, 2013).

2.2.4 Severity of depressive episodes

In order to understand fully a particular case of major depressive disorder, attention must be given to other factors that are recorded in the diagnostic code. These factors include the level of severity from mild, moderate to severe, the presence or absence of psychotic features, and whether it is a case of partial or full remission. Specifiers, such as anxious distress, melancholic features and seasonal patterns are also recorded (American Psychiatric Association, 2013, p. 169).

2.2.5 Differential diagnosis

An important component of disorder diagnosis is differential diagnosis, which ensures that a diagnosis is not confused with overlapping symptoms of a different disorder. Major depressive disorder may be confused with other conditions sharing similar symptoms; these are the manic episodes with irritable moods, as well as depression induced by medication, substances or bipolar disorder, ADHD disorder, adjustment disorder with a depressed mood, and lastly, periods of natural sadness (American Psychiatric Association, 2013).

2.3 Prevalence and severity of depression in the general population and in adolescents

2.3.1 Prevalence and severity of depression

Depression is the most widespread mental disorder amongst psychological disorders (Brogan & Greenblatt, 2016; Ribeiro et al., 2018; Stark et al., 2018). This disorder is becoming epidemic in the 21st century, and it is the number one threat to psychological health and the leading cause of disability (Brogan & Greenblatt, 2016; Ciobanu et al., 2018; Olorunju et al., 2018; Petersen et al., 2018; Singh et al., 2018). A slightly different view is found by the World Health Organisation who predicted that depression

will become the world's third largest cause of disability by 2020 (Devi, 2012; Ribeiro et al., 2018). One in two people will experience an episode at least once in their life time (Akhtar, 2012).

Major depressive disorder, colloquially known as "depression" is debilitating, expensive, often chronic, not easily cured and sometimes even a fatal condition (Brogan & Greenblatt, 2016; Devi, 2012; Murphy, Sarris, & Byrne, 2017). The economic burden caused by depression in the USA is said to be over $83 billion per year, when taking into account direct medical costs, workplace costs and suicide-related costs. Despite its high occurrence, many people with depression struggle to access adequate care. There is a worldwide shortage of trained mental health professionals to deal with the rise of depression. There is a need to come up with new strategies in order to provide effective and efficient treatment for depression (Brogan & Greenblatt, 2016; Yeung, Feldman, & Fava, 2010). While mental disorders comprise a major part of the burden of disease the world over, limited data exists on the epidemiology of major depressive disorder in South Africa.

A nationwide household survey on depression was conducted between 2002 and 2004. The World Health Organization Composite International Diagnostic Interview (CIDI) was used to establish a diagnosis of depression. The participants included 4,351 adult South Africans of all racial groups. The results showed that the prevalence of major depression was 9.7% for lifetime and 4.9% for the 12 months before the interview. Depression was experienced at substantially higher levels among females and among respondents with a low level of education (Tomlinson, Grimsrud, Stein, Williams & Myer, 2009). When comparing with data from other countries, South Africa has lower rates of depression than the USA but higher rates than those of Nigeria (Tomlinson et al., 2009). Another study about depression in the workplace in South Africa states that at least one in four workers were diagnosed with depression, and that the main ages that were affected were people between the ages of 25-44 (Stander, Bergh, Miller-Janson, De Beer, & Korb, 2016). These findings are the first step in documenting the extent of the need for therapeutic interventions in an area which is under-funded by mental health services and research facilities in South Africa (Tomlinson, Grimsrud, Stein, Williams, & Myer, 2009). Research done in the Western Cape in South Africa shows even higher rates of depression. Amongst adults, the rate

of depression reached 25%, and amongst children and adolescents the rate was found to be 17% (Kleintjes, 2006). The likelihood of onset of depression, as well as other mental disorders, increases substantially with puberty.

2.3.2 Mental disorders amongst adolescents

Mental health disorders are the most widespread illnesses amongst young people across all societies. Most mental health disorders begin between the ages of 12 to 24 (Little et al., 2015; Padilla Paredes & Calvete Zumalde, 2015; Perloe, Esposito-Smythers, Curby, & Renshaw, 2014; Silk, Siegle et al., 2014; Stikkelbroek, Bodden, Kleinjan, Reijnders, & van Baar, 2016; Yeatts, Martin, & Petrie, 2017). Rates of mental disorders among the youth in the Netherlands are said to be at 8%, which is the lowest rate globally, and in California it is as high as 57%. All other 11 countries that were researched in terms of mental health disorders fall between the above two scores. These findings are evidence for the overwhelming reality of mental disorders affecting youth (Patel, Flisher, Hetrick, & McGorry, 2007). Since depression is the most widespread of all mental disorders, the following section will focus on the prevalence of depression amongst adolescents.

2.3.3 Prevalence and severity of depression amongst adolescents

Even though in the past, depression mostly affected people from mid-life and up, the age of onset has now fallen to the early teens (Rhew et al., 2017; Singh et al., 2018), When children reach puberty, rates of depression increase significantly, hence depression becomes a serious problem during this developmental phase (Little et al., 2015; Minev, 2018; Padilla Paredes & Calvete Zumalde, 2015; Perloe, Esposito-Smythers, Curby, & Renshaw, 2014; Silk et al., 2014; Stikkelbroek, Bodden, Kleinjan, Reijnders, & Van Baar, 2016).

According to Schmidt and Laessle (2014), rates of depression in adolescents is at 17.9%, and if assessing depression in adolescents by a self-rating scale, then 42% of adolescents reported significantly depressed mood for a period of at least two weeks (Schmidt & Laessle, 2014). The prevalence of depressive symptoms was found to increase from 3 to 18% between the ages of 15 - 18 (Padilla Paredes & Calvete Zumalde, 2015). Major depression prevalence doubles up from childhood to the age of 13-14 (8.4%) and doubles up again between the ages of 17-18 (15.4%) (Perloe,

Esposito-Smythers, Curby, & Renshaw, 2014).

According to many opinions, depression is more common in females (Cavanagh et al., 2017; Rhew et al., 2017; Ribeiro et al., 2018; Wijnhoven et al., 2014). Substantial research indicates that rates of depression are higher in adolescent girls than in adolescent boys (Padilla Paredes & Calvete Zumalde, 2015; Perloe, Esposito-Smythers, Curby, & Renshaw, 2014). Some researchers maintain that the rates are twice as much in adolescent girls than it is in adolescent boys (Schmidt & Laessle, 2014).

In addition to the severe symptoms that the depression itself causes, adolescent, depression needs to be seen as symptomatic of future challenges, as most people who suffer from depression later on in life, experience their first episode during the developmental phase of adolescence (Padilla Paredes & Calvete Zumalde, 2015; Olorunju et al., 2018; Woods & Scott, 2016). Furthermore, research shows that experiencing depression during childhood or adolescence becomes a risk factor in developing depression as well as anxiety, bipolar disorder, substance abuse and suicidal tendencies later on in life (Lawrence, Nangle, Schwartz-Mette, & Erdley, 2017).

Along with general poor mental health issues, depression is closely related to other health and developmental conditions in young people. These include lower educational achievements, delinquency, interpersonal challenges, substance abuse, poor sexual health, violence and suicide; suicide being the leading cause of death in youth nowadays as well as unemployment upon requiring a job (Flisher, Hetrick & McGorry, 2007; Jankowski et al., 2018; Rhew et al., 2017; Rubin & Beevers, 2011). Depression in adolescents also was found highly correlated with somatization, namely, adolescents complaining of headaches, gastrointestinal pain, nausea, cardiovascular impairment, fatigue or dizziness (Scharf, Mayseless, & Rousseau, 2016; Schmidt & Laessle, 2014).

From the above-mentioned information one can conclude that the high prevalence of depression in adolescents is a reality that demands attention and appropriate intervention strategies. It is with this understanding in mind that the researcher sees the importance of working with adolescent girls who suffer from depressive symptoms.

2.4 Etiology of depression in adolescence

In order to gain a rich understanding of depression in adolescents, it is helpful to be aware of the context of depression in general before focusing on the adolescent-specific context. There are a number of biological and psychological contributing factors which enhance vulnerability to depression which will be specified and elaborated upon, starting with factors pertaining to society in general followed by those specific to females and adolescents.

2.4.1 Biology and genetics

Botha and Dozois (2015) explore a few models that attempt to explain depression. They start with the biochemical model which states that depression is an illness, which is caused by biological factors that take place outside of the individual's control. Some of these factors include genetic vulnerability, incorrect functioning of neurotransmitters and decreased activity in the prefrontal cortex. Other researchers also seem to share the opinion that depression has a biological basis (Brogan & Greenblatt, 2016; Jankowski et al., 2018; Van Roekel, Verhagen, Engels, Rutger, & Kuppens, 2018). Botha and Dozois (2015) add that this model, unintentionally causes depression sufferers to assume less responsibility for their recovery. Other models are based on the understanding that family history of clinical depression is likely to predispose a person to depression genetically, but only when triggered by a stressor (Dopheide, 2006; Vrshek-Schallhorn et al., 2015). There are studies that suggest that genes create plausible pathways in the brain, which shape emotional and behavioural aspects. However, even though genetics alone can bring about depression, the chances of suffering depression when the biological predisposition already exists together with the combination of being exposed to an adverse environment, is significantly higher (Brogan & Greenblatt, 2016; Little et al., 2015). In order to understand how dysfunction can cause depression one needs to be aware of the basics of brain anatomy.

2.4.1.1 Brain dysfunctionality

As the foetus develops, its brain builds thousands of brain cells, called neurons, every minute. When the infant reaches two years of age, it has approximately a hundred billion of them. Those neurons bond into neurological networks. While the number of

neurons does not increase from the age of two and onwards, the number of connections between neurons does increase throughout one's lifetime. Each neuron can connect to thousands of other neurons. It is through these connections that cognition, learning and memory becomes possible, as they are the conduits along which the electrical impulse of the thoughts travels. The message is sent from one neuron to the next through chemicals named neurotransmitters. We have more than a hundred kinds of them and they all need to be in perfect balance in order to work efficiently (Cozolino, 2006).

2.4.1.1.1 Neurotransmitters' transmission

A well-established neuro-biological hypothesis for the cause of depression is the monoamine hypothesis. It maintains that an alteration in levels of monoamines, including serotonin, norepinephrine and dopamine, is the cause of depression (Brogan & Greenblatt, 2016; Dean & Keshavan, 2017). Research is showing that the main and most impactful neurotransmitter involved in depression is serotonin (Little et al., 2015; Van Roekel et al., 2018; Vrshek-Schallhorn et al., 2015).

This alteration in monoamines could be due to the following three factors. Firstly, too little communication due to a lack in a specific neurotransmitter (Brogan & Greenblatt, 2016; Wehrenberg, 2010). Secondly, too much communication overloads the brain with activity as in a stress situation, where too much adrenalin and cortisol are being released. Over time the brain's supplies of neurotransmitters are depleted (Brogan & Greenblatt, 2016; Wehrenberg, 2010). Lastly, when there is too little of the one neurotransmitter, the brain may compensate for it by creating more of another, hence, imbalance comes about (Brogan & Greenblatt, 2016; Wehrenberg, 2010).

2.4.1.1.2 Causes for neurotransmitter imbalance

There are various reasons that were found to be related to the neurotransmitter imbalance. One of them is being born without a sufficient supply. This is typically the case of a person who is depressed throughout his/her whole life as a result of being born with an insufficient supply of serotonin, which is a neurotransmitter responsible for happiness (Wehrenberg, 2010:14). Difficult life circumstances can contribute to lower or higher than normal supplies of neurotransmitters (Brogan & Greenblatt, 2016; Cozolino, 2014, Perry, 2008). Trauma or illness can also cause this imbalance (Brogan

& Greenblatt, 2016; Cozolino, 2014, Perry, 2008, Wehrenberg, 2010), as well as chronic stress (Brogan & Greenblatt, 2016; Cozolino, 2014, Perry, 2008, Wehrenberg, 2010), poor sleep and poor nutrition (Brogan & Greenblatt, 2016; Bourne, 2015; Wehrenberg, 2010) and lastly, the lack of attachment to a parental figure at a young age (Cozolino, 2014; Perry, 2008). In the case of depression, there are a few neurotransmitters that are involved, namely, serotonin, GABA, dopamine, glutamate and norepinephrine. However, the main one that is directly responsible for depression is the depletion of serotonin (Brogan & Greenblatt, 2016; Wehrenberg, 2010).

2.4.1.1.3 Common consequences and symptoms that result from serotonin depletion

Serotonin depletion impacts the human being on a few different levels, some of which will be discussed below. Firstly, ***on a physiological level,*** the sufferer may encounter problems with sleep; appetite issues; aches and soreness; carbohydrate cravings; digestive problems; addictions; low libido; muscle tension; bladder problems; attention issues, as well as memory issues (Braverman, 2004; Schmidt & Laessle, 2014). Secondly, ***on a personality level,*** the sufferer may struggle with issues such as co-dependency; impulsiveness; lack of artistic appreciation; lack of common sense; loner behaviour; phobias; perfectionism; obsessive compulsive disorder; masochistic tendencies; paranoia; self-absorption and shyness (Braverman, 2004). Thirdly, ***on an emotional level,*** the sufferer may encounter low moods; persistent lack of pleasure; school avoidance; a persona of being happy; comfort eating; withdrawnness (Parker & Eyers, 2009); irritability; feelings of worthlessness; feelings of guilt; recurrent thoughts of death and suicide (American Psychiatric Association, 2013; Vrshek-Schallhorn et al., 2015); rumination (repetitive negative thinking), and challenges with impulse control (Wehrenberg, 2010).

While biology and genetics are obviously dominant forces in depression, outside forces, such as environmental factors also need to be taken into account. These factors will now be examined.

2.4.2 Environmental factors

Research found that negative emotionality, or in other words, difficult temperament in infancy, is a risk factor for the later development of depression. It was found that

negative emotionality is related to both genetic and environmental factors (Auslander, Sterzing, Threlfall, Gerke, & Edmond, 2016; Schumann et al., 2017). They add that negative emotionality often negatively affects the relationship between the mother and the infant. This fact, in its own right, is impactful in terms of the further development of a neural pathway of psychopathology by the infant's brain (Schumann et al., 2017). In addition, lack of attachment to a parental figure at a young age predisposes the individual to depression (Perry, 2008; Taryan, 2003).

Similarly, Lim, Rice, and Rhoades (2016) also maintain that major depressive disorder results from the complex interplay between genetics and environmental factors. They listed environmental risk factors, such as family abuse and maltreatment, runaway and homeless youth, street victimisation, interaction with challenging peers, stressful life events and traumas, which all raise the chances of a person succumbing to depression (Lim, Rice, & Rhoades, 2016). Other environmental risk factors that can bring about depression are relationship breakdowns, bereavements and lack of a support system (Akhtar 2012).

2.4.3 Personality factors

Personality traits can also predispose a person and contribute to having depression, namely, having a pessimistic approach to life, as well as rigidity and perfectionism (Levin et al., 2012; Nisar, 2018). Botha and Dozois (2015) add that depressed individuals were found to have distorted cognitive schemas. Cognitive schemas can be viewed as a group of related thoughts and associations that are triggered by an event. These schemas are usually formed in childhood, when the brain's capacity is not mature enough to reflect rationally on people's behaviour and events, hence these schemas are often rigid and illogical (Botha & Dozois, 2015). Aaron Beck popularized this viewpoint in the late 1960s, maintaining that a depressed person suffers from a negative cognitive triad which includes a pessimistic view of himself/herself, his/her environment and the future (Simons, Man Kit, Beach, Cutrona, & Philibert, 2017). Abela, Fishman, Cohen and Young (2012) also state that self-criticism is a personality trait that can contribute to depression. They add that a dependent personality is another trait that can contribute to having depression. Similarly, Botha and Dozois (2015) discuss that people with depression often have negative thinking distortions, namely, they have biases against themselves. They minimise their achievements and

accomplishments, they amplify personal failures and they personalize neutral statements and events.

Along similar lines, some researchers also speak about the pessimistic attributional style of the depressed individuals as the main contributing factor for depression. They based their study on the work of Seligman (1991), who discussed three basic dimensions of faulty attributional styles (Jesudas, Kamble, & Duggi, 2014; O'Sullivan, O'Sullivan, O'Connell, O'Reilly, & Sarma, 2018). The three mistaken attributional styles are those which focus on internal, stable and global aspects of events (Habib & Khan, 2016; O'Sullivan et al., 2018). People with a pessimistic attributional style, see negative events as their own fault (internal), they believe that negative events will last for an extended period of time and that their defeats are permanent (stable). They also believe that negative events will undermine everything they do (global) (Habib & Khan, 2016; Jesudas et al., 2014; O'Sullivan et al., 2018). It is important to note that depressed children tend to make the same mistaken attributions, or cognitive distortions, as depressed adults do (Jesudas et al., 2014). It is believed that the first possible source for pessimism is genetic and the second possible cause is the child's environment in which the parents are impactful in terms of how the child views things, in an optimistic or pessimistic manner (Jesudas et al., 2014).

In addition, as part of an integrated model for understanding depression, specific vulnerability-risk interactions were studied (Kushner, Bagby, & Harkness, 2017). Adolescent five-factor model personality traits were examined in order to see whether or not these traits would moderate the associations between early sexual, emotional and physical mal-treatment and recently experienced life events. For the study, 110 adolescents with major depressive disorder were selected. In the case of physical maltreatment, a positive association was found between dependent interpersonal events and extraversion. Moreover, introversion has generally been found to be a risk factor for depression. However, in adolescents already suffering from depression, extraversion was shown to generate more opportunities for conflict, resulting in a higher risk of depression. In the case of adolescents who had been sexually maltreated, independent events were found to have a positive association with agreeableness and a negative association with extraversion. These vulnerability-risk interactions have substantial implications when it comes to understanding the role

played by stress generation mechanisms in cases of depression. This study demonstrates the extent of the relationship between personality traits and depression (Kushner, Bagby, & Harkness, 2017).

Botha and Dozois (2015) maintain that these explanations of the causes of depression, although credible, bring about public stigma towards the depression sufferer, emphasising personal responsibility, as opposed to biological and even more so, contextual contributing factors, which assume no responsibility towards the sufferer. It is for this reason that anti-stigma programs refrain from emphasising personality factors.

2.4.4 Life events and circumstances

When aiming to gain a broad understanding of depression, it is important to note that even factors which are external to the individual, such as life events and circumstances, can be contributing factors for depression. These factors include chronic health conditions or somatic complaints (Dopheide, 2006). Akhtar (2012) regards insomnia and living a life of social isolation, which increases loneliness, to be contributory causes of depression. Brain strain, which refers to the phenomenon of the brain gradually becoming overloaded with stress until it loses its ability to cope, also naturally leads to depression (Levin, Aarons, & Taub-Da Costa, 2012). Alcohol and drugs, which are often used to cope with stress and depression, can in fact, lead to even greater depression (Dopheide, 2006; Satre, Leibowitz, Sterling, Lu, Travis, & Weisner, 2016).

2.4.5 Causes specific to females

Depression in females is more common than in males (Cavanagh et al., 2017; Ribeiro et al., 2018) as a result of hormone sensitivity. This refers to the brain's sensitivity to hormones which have an effect on the brain chemistry and create feelings of change such as anxiety, agitation and irritability (Dopheide, 2006). This pertains to women suffering from depression related to premenstrual stress and post-natal depression (Levin et al., 2012), as well as to women during pregnancy and menopause (Akhtar, 2012).

In addition to hormonal sensitivity, developmental and psychological factors play a

greater role in depression amongst women, than they do in men. Gender identity and role can negatively impact women's feelings about themselves in relation to others (Habibi, Mokhtar, Ghanbari, Nooripour, & Motabi, 2016). The place of women in society is in constant doubt. For centuries, women felt challenged to find their role in a world that is predominantly male orientated and they have been a target for torture and exploitation, physically, mentally and sexually. Currently women still face bias and discrimination. Working women often face mental stress, sexual harassment, as well as safety challenges in the workplace and in many instances, they are also challenged by having to manage the work, as well as the home burden (Feldhahn, 2013; Hayes, 2018; Joshi, 2015). Women are prone to be negatively affected by social factors because women are more relationship-oriented than men (Habibi et al., 2016). This is most true in the context of a marital relationship. Marital maladjustment threatens women's self-concept, as a result of a commonly held belief that a woman's worth is measured only in terms of her role in marriage and motherhood. Women often resort to the suppression of their needs, emotions and opinions, in an attempt to maintain a balance in their family relationships. Another social challenge that can impact on women and causes depression is the fact that in many cultures, women are regarded as being unequal to men, which results in self-silencing. In summary, marital maladjustment and self-repression directly increase the risk of depression in woman (Habibi et al., 2016). Understanding the causes of depression unique to women is important, as this study deals with depression in adolescent females. The following section will focus on the causes of depression specific to adolescents.

2.4.6 Causes of depression specific to adolescence

2.4.6.1 School pressure

Experiencing school pressure is increasingly being linked to depression in adolescents. Individuals experience anxiety and pressure when there is a discrepancy between what they perceive as the recourses available to them and the demands of the situation (Ciobanu et al., 2018; Moksnes, Løhre, Lillefjell, Byrne, & Haugan, 2016). Several aspects related to the school environment may be anxiety provoking for adolescents. These include the demands of academic performance, school/leisure conflict (Moksnes, Bradley Eilertsen, & Lazarewicz, 2016; Moksnes et al., 2016), pressure that parents apply to their adolescent children for high performance (Quach,

Epstein, Riley, Falconier, & Fang, 2015), school rules and troubled interaction between teachers and peers. Although exposure to some stressful situations is part of human development, stressors remain a concerning threat to the development and emotional wellbeing of adolescents. Stressors that are related to the academic performance of the adolescent, perceiving school work as highly demanding, and/or negative interactions with teachers were shown to be related to psychological complaints, including depressive symptoms (Moksnes et al., 2016; Undheim & Sund, 2005).

2.4.6.2 Social pressure and acceptance

Human beings develop based on their mutual interaction between individuals and their social environment (Rueger, Malecki, Pyun, Aycock, & Coyle, 2016). At this age, one of the most important things for adolescents is their peer group and gaining acceptance by their peers (Louw et al.,1998). It is at this age, when adolescents start to spend more time with their peers, that they are very motivated to obtain and defend their social status (Silk, Siegle, Lee, Nelson, Stroud, & Dahl, 2014). Sensitivity to social evaluation has been found to be a risk factor for the development of depression. This sensitivity increases with pubertal maturation (Ciobanu et al., 2018; Silk et al., 2014). At the same time, social support seems to be linked to a reduction of depression and anxiety (Undheim & Sund, 2005; Rueger et al., 2016).

2.4.6.3 Social media

Social media, such as Facebook and Twitter, have rapidly become a part of adolescents' lives, with extremely high usage (Cleland, Woods, & Scott, 2016; Walrave, Ponnet, Vanderhoven, Haers, & Segaert, 2016). Thus currently, a major part of the adolescents social and emotional development takes place while on the internet and on the phone (O'Keeffe & Clarke-Pearson, 2011). Most adolescents and young adults experience uneasiness when they feel a risk of missing out on their peer's rewarding experiences. If they do not know what their friends are doing on an on-going basis, they feel out of the loop. Those who have a high need to stay continually connected with others, may experience negative consequences in their general functioning, physical and mental health (Baker, Krieger, & LeRoy, 2016). Evidence is increasingly showing the link between social media usage and problems with mental health in adolescents (Baker, Krieger, & LeRoy, 2016; Blease, 2015; Cingel & Olsen,

2018; Cleland Woods & Scott, 2016; Lin, Sidani, Shensa, Radovic, Miller, Colditz, & Primack, 2016). O'Keeffe and Clarke-Pearson (2011) explain the concept of Facebook depression. They state that this concept refers to depression that develops when adolescents spend a great deal of their time on social media sites. The intensity of the online world and the lack of privacy seem to be another cause of depression amongst adolescents (O'Keeffe & Clarke-Pearson, 2011). Chow and Wan (2017) also discuss the concept of Facebook depression. They point out the fact that people tend to portray their "good-self" on social media, which naturally causes envy and unavoidable social comparisons, which can lead to depression. Another reason for depression as a result of social media and internet usage is that it often results in social isolation which brings about depression (Puri & Sharma, 2016).

2.4.6.4 Sleeplessness due to social media

Research shows a link between social media and sleeplessness. Social media causes shorter sleeping duration, late sleeping and rising times, resulting in a higher level of tiredness during the day (Cleland Woods & Scott, 2016; Levenson, Shensa, Sidani, Colditz, & Primack, 2016). Power (2017) adds that children who constantly use their phone at night not only are constantly tired, and are unable to focus at school, but are also significantly less happy than their peers. Cleland Woods and Scott (2016) write that those incoming alerts during the night, interrupt sleep. It was found that 86% of teens sleep with their phone under the pillow or in their hand. adolescents also have a fear of missing out, which is why they try to be available all hours of the day and night to attend to all those incoming messages (Cleland Woods & Scott, 2016). Poor sleep could also be a result of lack of physical activity which is partly due to the available social media, as well as digital exposure before bedtime which interferes with the melatonin production and delays circadian rhythms. Lack of sleep is known to contribute to depression, anxiety and low self-esteem (Cleland Woods & Scott, 2016; Wong, Zhang, Wing, & Lau, 2017). All of these factors mean that modern adolescents are more challenged by sleep deprivation than those living in previous times, which contributes to the higher rates of depression being observed.

2.4.6.5 Cyberbullying and online harassment

Cyberbullying is the intentional usage of electronic media in order to spread false,

embarrassing and hostile information about another person, also known as electronic harassment (Barlett & Fennel, 2018; Selkie, Kota, Chan, & Moreno, 2015). The perpetrator can be an individual or a group who intentionally try to hurt the victim repeatedly and over a period of time, while the victim cannot easily defend himself or herself (Selkie, Kota, Chan, & Moreno, 2015). It is the most common online threat and risk for peers in the modern world (O'Keeffe & Clarke-Pearson, 2011). The most comprehensive world-wide study about cyberbullying found that 24% of young people between the ages of eight to 17 cyberbully others (Barlett & Fennel, 2018). Youth, who were targeted through cyberbullying, report profound psychological disturbances, such as depression, anxiety, isolation and suicide (Selkie, Kota, Chan, & Moreno, 2015; O'Keeffe & Clarke-Pearson, 2011), as well as externalized hostility, fear for their safety, poor sleep, social issues, somatic symptoms and delinquency compared with their non-victimized peers (Selkie, Kota, Chan, & Moreno, 2015).

2.4.6.6 Sexting

Sexting can be defined as sending, receiving and forwarding messages, images or photos through a cell phone, computer or other digital devices which expose parts of the body or the full body. These photos are rapidly distributed via the internet or cell phones. Surveys show that 20% of teens have had nude or semi-nude pictures or videos of themselves posted without their consent (Ibtesam, 2017; O'Keeffe & Clarke-Pearson, 2011). In essence, sexting is a product of sexual curiosity and poor judgment (Ibtesam, 2017). A growing number of adolescents continue to engage with sexting, hence the issue has become a recognised and widespread problem among parents, society and lawmakers (Ibtesam, 2017). The victims suffer emotional distress (O'Keeffe & Clarke-Pearson, 2011), humiliation and emotionally devastating repercussions, such as social alienation, depression and suicide (Drouin, Ross, & Tobin, 2015; Ibtesam, 2017). Sexting not only causes depression, but one of the precursors for engaging in sexting is depression (Temple et al., 2014; Van Ouytsel, Van Gool, Ponnet, & Walrave, 2014).

2.4.6.7 Lack of self-regulation

Stressful life events are a part of life. However, some adolescents will be able to get through them, and some teens will develop depression as a result. The question is,

what is the determining factor that would cause one to survive and another to collapse. Some maintain that the answer would depend on the ability to self-regulate (Stikkelbroek, Bodden, Kleinjan, Reijnders, & van Baar, 2016). Emotional self-regulation is the ability to manage one's emotions, to keep them in balance and to use appropriate methods of expression (Moilanen, Padilla-Walker, & Blaacker, 2018; Reed, 2012). Adolescents, who possess an adequate ability to self-regulate, often enjoy good social skills, high academic achievements, and limited involvement with substance abuse, delinquency, and sexual risk taking (Moilanen, Padilla-Walker, & Blaacker, 2018).

Adolescence is a challenging developmental phase accompanied by many physical, psychological and social changes, as well as evolvements (Moksnes, Løhre, Lillefjell, Byrne, & Haugan, 2016; Undheim & Sund, 2005). This stage is considered to be a "stormy period", hence, emotional self-regulation becomes more of a challenge than at any other age (Louw et al., 1998, p. 387; O'Keeffe & Clarke-Pearson, 2011). When people face a challenging event or period of time and have the ability to self-regulate their emotions, they will be able to get through the challenge. However, when this ability is lacking, one can expect the development of depression and/or anxiety (Stikkelbroek, Bodden, Kleinjan, Reijnders, & van Baar, 2016). To this end, it becomes evident that it is essential to assist the adolescent in building a strong inner strength to enable self-regulation (Da Silva, 2010; Frederick & McNeal, 1999), and thereby buffer against depression and anxiety (Stikkelbroek et al., 2016).

2.4.6.8 The decline in play

Technology usage has skyrocketed worldwide in the past century. As electronic devices become more and more entrenched in people's daily lives, technological interruptions and interferences are bound to occur. One of the ways technology interferes in children's lives is through causing a decline in play (Newsham, Drouin, & McDaniel, 2018). A link was found between the decline in play in children and teens and the increase in depression, anxiety, feelings of helplessness and narcissism (Grey, 2011; Newsham, Drouin, & McDaniel, 2018). Children are designed by nature to play (Parks, 2015). Children play at every opportunity. Throughout history, this kind of play took place outdoors and with other children (Grey, 2011). Accordingly, children acquire the attitudes and skills necessary for successful adulthood, as well as

creativity and learning perseverance from play (Grey, 2011; Parks, 2015). Play teaches children and adolescents how to get along with others, how to control their impulses, how to solve problems and how to regulate their emotions. In the absence of play, young people will lack the skills for healthy psychological development (Grey, 2011; Reed, 2012). This gives a richer understanding of the rise in depression in adolescents and demands that the lack of these skills is compensated for.

2.5 Correlates and consequences of depression

Depression can have widespread effects. According to Levin, Aarons and Taub-Da Costa (2012), depression is a lonely and unpleasant condition that jeopardises the whole family's emotional wellbeing. When a parent suffers from depression, there are often ripple effects to this condition, namely, the partner and children may develop a "secondary depression". As a result, the children might have psychological and educational difficulties later on in life. Yapko (2009) adds that children who live with a depressed parent are three times more likely to develop depression than children who do not. Wehrenberg (2010) states that individuals who suffer from depression function even more poorly at work, with their families and socially than people with other medical conditions. Often, depression leads people to self-medicate, hence they start abusing substances and drugs (Clark 2008). Clark (2008) writes further that "depression" is a misleading terminology. Upon mentioning this word, people tend to associate this with low moods only. However, depression is a debilitating condition that affects not only the persons' emotional state and interpersonal interactions, but much more than this. Depression affects ones' ability to concentrate. It can cause cognitive impairment, confusion and psychomotor retardation. Depression can also cause a student to fall behind at school and it can compromise his/her friendships (Parker & Eyers, 2009). Depression can cause the individual to lack energy and to be slowed down physically and mentally and feel as though he/she walks though "sand or molasses" (Parker & Eyers, 2009:83). Hence, it is evident that the consequences of depression can be far-reaching to both the sufferer and the family.

Having examined the causes and impact of depression in general, and in particular in adolescents, it is relevant at this point to explore the different approaches currently available for the treatment of depression.

2.6 Approaches to the treatment of adolescent depression

The standard approaches to the treatment of depression can be divided into three broad categories, medical, psychological and lifestyle-related. When suggesting a new treatment model, a comprehensive understanding of existing approaches to treatment needs to be attained. This is helpful in the sense that it provides a context for the research and enables the researcher to determine the value of a new model of intervention. A discussion of these three approaches follows.

2.6.1 Medication

Antidepressants are medications that aim to correct the levels of neurotransmitters in the brain in order to support a person who suffers from depression (Halappa et al., 2018). Antidepressants seem to be a common treatment of choice for fewer than 40% of adolescents that actually receive treatment for their depression (Lawrence, Nangle, Schwartz-Mette, & Erdley, 2017). The rates of usage of antidepressants keep increasing worldwide (Isacsson & Rich, 2014; Rheker, Winkler, Doering, & Rief, 2017). In America, six million scripts of antidepressants are written each year for adolescents. These numbers continue to rise annually. Many of these scrips are written by non-psychiatrist physicians. The literature about the usage of antidepressants for adolescents is complex and keeps evolving, with significant controversy (Lawrence et al., 2017).

Research on medication for children and adolescents shows that, as opposed to the major classes of anti-depressants (monoamine oxidase inhibitors, tricyclic antidepressants, selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors), only selective serotonin reuptake inhibitors (SSRI's) have proven to be effective in treating depression among youth. On average, 59 to 60.1% of youth respond to these antidepressants with symptom reduction (Lawrence, Nangle, Schwartz-Mette, & Erdley, 2017). Another study that measured the effects of antidepressants on adolescents, who met the diagnostic criterion for both depression and substance use, found that the medication reduced the depression, however, not significantly enough (Zhou et al., 2015). Studies which compare the effect of antidepressants with the effect of placebos found that there was always a significant difference between the two, with antidepressants being more effective. (Isacsson &

Rich, 2014; Lawrence et al., 2017; Zhou et al., 2015). Sarris, Gadsden and Schweitzer (2014) tested the effects of naturopathic medication for treating depression and anxiety and found positive results in terms of improving patients' moods, reducing their anxiety and perceived stress.

Research that compares the effectiveness of antidepressants on its own, to the effectiveness of antidepressants in combination with CBT treatment, to CBT treatment on its own and to the effectiveness of placebos found that after 12 weeks of treatment, the medication-only group responded 60.6% positively, the group using medication in combination with CBT responded 71% positively, the CBT-only group responded 43.2 positively, and the placebo group responded 34.8 positively. The group that used the combination of medication and CBT showed lower rates of relapse in terms of frequency and severity (Isacsson & Rich, 2014; Lawrence et al., 2017).

Despite the effectiveness of medication, many authors caution against relying too heavily on medication and warn of its side-effects (Bourne, 2015). Wehrenberg (2010) makes the point that although medication aids one to feel better faster than therapy, it is the therapy that aids one to change thoughts and behaviour in the long-term and teaches one strategy to use for the rest of one's life, without having to bear side effects. Along similar lines, Yapko (2001) writes that although medication is valuable, it is not valuable by itself. He adds that people suffering with depression, benefit more from therapy than from medication, since no amount of medication can teach coping skills, social skills, and enhance problem-solving skills, which are components essential to attend to in the treatment of depression. Devi (2012) adds that medication may help the symptoms, however, it does not address the cause, namely, the internal turbulence. According to Yapko (2001) medication increases people's learnt inability to self-soothe, as well as reinforcing the client's passivity. It can cause side effects, as well as habituation, and it may also cease to work. However, medication does have some treatment advantages, such as a faster rate of symptoms subsidation (Yapko, 2013).

Antidepressants are often accompanied with severe or debilitating side-effects, such as weight gain, daytime sleepiness, loss of interest in sexual activity, and dry mouth. This would explain the reason why many people terminate taking the course of their antidepressants themselves (Rheker et al., 2017). At times, the usage of

antidepressants may increase suicidal tendencies, particularly amongst children and adolescents. In addition, side effects of these drugs are a real concern for the developing foetus, should a pregnant woman use them. Khawam, Laurencic and Malone (2006), also discuss the side effects of antidepressant medication. They, too, believe that antidepressants can decrease compliance and delay recovery, and that they can increase suicide risk during the first month of taking them, as well as cause sexual dysfunction. Bourne (2015) writes that all drugs bring about unnatural changes to the body's physiology, with accompanying short- and long-term side effects. People tend to develop reliance on prescription drugs. Therefore, Bourne (2015) suggests exploring natural methods of treatment for depression and anxiety first, before going on to explore prescription drugs. Bourne (2015) adds that if, however, the sufferer's situation is severe and it hampers his/her functioning, he should not delay and should rather go and seek medical advice regarding pharmaceutical medication. While it is clear that medication can be helpful, and sometimes even critical, it is also clear that as a cure on its own it is insufficient. The following section explores the psychotherapeutic approaches currently in use.

2.6.2 Psychotherapeutic approaches

Driessen (2017) maintains that, since depression is a debilitating condition, it is highly prevalent and as it carries a financial burden to society, there is a pressing need for an efficacious treatment. He states that psychotherapy is an effective and important way to help people with depression. Hence the researcher will elaborate on some of the common therapies that are available for the treatment of depression. In particular, there will be an elaboration on cognitive behaviour therapy, as this seems to be the most common treatment method for depression (Birmaher, 2004; Dopheide, 2006; Driessen, 2017; Greenberg, 2010; Isacsson & Rich, 2014; Lawrence et al., 2017; Stikkelbroek, Bodden, Dekovic, & van Baar, 2013), followed by interpersonal psychotherapy, psychodynamic psychotherapy and Gestalt therapy (Driessen, 2017; Goldstone, 2017; Lawrence et al., 2017; Prochaska & Norcross, 2010).

2.6.2.1 Cognitive behaviour therapy

A major precursor to cognitive behaviour therapy is behaviour therapy. Prior to the late 1970s, behaviour therapy did not incorporate a cognitive aspect in it. As a result,

behaviour therapy was not fully effective in the treatment of anxiety and depression. This prompted the proposition of theories of emotional disturbance linked to distorted thinking, suggesting treatment models to correct unproductive thinking patterns. Aaron Beck, the founder of Cognitive Behaviour Therapy, was amongst the most influential of these theorists (Free, 2007). Although trained in psychoanalysis, his emphasis was not on probing the depths of the subconscious, but rather on focusing on clients' cognitive belief systems. Rather than seeing depression as a manifestation of repressed anger as in Freud's theory of melancholia, he saw the problem as the negative thoughts which clients had about themselves. He based his therapy partly on behaviour therapy and partly on cognitive science. Beck did not ignore the past, in fact, he considered it critical to identify original cognitive distortions and to correct them at their source (Greenberg 2010; In-Albon et al., 2017).

2.6.2.1.1 The basic concepts of CBT

Aaron Beck believed that thinking could be faulty in three ways - in the structure, the content and the process of thinking. The structural aspect of his theory includes automatic thoughts and schemes. Automatic thoughts are almost subconscious, transient thoughts. Schemes are permanent thought structures resulting from the interpretation of developmental experiences. The content of thoughts and schemes can be maladaptive in three areas - those pertaining to the self, the world and the future, known as the cognitive triad. Regarding the process of thinking, various distorted patterns may take root. Two examples are dichotomous thinking, which is the belief that if something is not perfect, it is not good at all, and personalisation, which involves taking full responsibility for an event in which one's role is only partial (Bourne, 2015; Free 2007).

2.6.2.1.2 The application of CBT to the treatment of depression

People with a negative cognitive style, when confronted with a stressor such as death, separation, conflict, immigration or trauma, may develop depression (Birmaher, 2004). A person who thinks negatively tends to feel more hopeless and helpless, which leads to feelings of depression (Brann et al., 2012; Phillips & Frederick, 1995; Yapko, 2006). Those who tend towards depression are prone to self-blame, without taking into account the possibility that what may have transpired may not have been their fault or

may be unrelated to them (Birmaher, 2004; Kraines, Krug, & Wells, 2017). In addition, they tend to believe that if something bad has happened, it will occur again. A CBT therapist helps the client to relate to an unfortunate incident more objectively. CBT also educates the client regarding the cause of negative thoughts and beliefs. Furthermore, it facilitates the development of new coping and problem-solving skills (Beck, 2011; Midgley et al., 2018; Bohman, Santi. & Andersson, 2017; Bourne, 2015; Greenberg, 2010; In-Albon et al., 2017; Prochaska & Norcross, 2010). The duration of CBT is between 12-16 weeks, during which time the client is trained to self-regulate his/her mood, think objectively, and thereby avoid future episodes of depression (Birmaher, 2004).

2.6.2.1.3 The effectiveness of CBT for adolescent depression

According to many researchers, CBT is the one treatment method with the best evidence-base for the treatment of depression (Driessen 2017; Isacsson & Rich, 2014; Lawrence et al., 2017; Midgley et al., 2018). Free (2007) maintains that cognitive behaviour therapy has been evaluated extensively, more so in comparison to biological therapies. The results show that CBT is no less effective than antidepressant medication, perhaps even producing slightly superior long-term results (Free, 2007). However, this does not prove that negative thinking is the sole or primary factor in the case of depression. Beck himself saw depression as an interaction of cognitive, behavioural and biological factors (Free, 2007; Ribeiro et al., 2018).

Other therapies also have been shown to reduce the chances of having more depressive episodes, namely, interpersonal psychotherapy, psychodynamic psychotherapy and Gestalt therapy. A brief discussion of these forms of therapy, together with their strengths and limitations will add context to the research topic.

2.6.2.2 Interpersonal psychotherapy (IPT)

IPT is a short-term treatment, developed in the early 1970s as a result of a collaborative research on depression, done by Klerman, who became the founder of IPT (Dewan, Steenbarger, & Greenberg, 2017; Prochaska & Norcross, 2010). As this theory and model of treatment proved itself effective in all age groups for the treatment of depression, it was later successfully applied to other mental conditions (Prochaska & Norcross, 2010). The assumption of IPT is that depression occurs within an

interpersonal context (Dewan et al.,2017; Prochaska & Norcross, 2010). The lack of skills to solve interpersonal conflict leads to depression (Reinecke & Davison, 2006). This approach integrates the psychoanalytic focus on childhood experiences, which maintains that attachment problems with a significant other early in life, could result in later interpersonal challenges. However, IPT focuses on current interpersonal challenges and aims to solve those, based on the approach of cognitive behaviour therapy that focuses on current environmental stressors (Dewan et al., 2017; Prochaska & Norcross, 2010). Hence, understanding of the root of the problem relies on psychoanalysis, and the practical approach relies on cognitive behaviour therapy, namely, dealing with the current challenges in the here and now.

IPT relates to the following four problem areas - “grief”, “interpersonal role disputes”, “role transition”, and “interpersonal deficits”, which refers to interpersonal challenges that can lead to depression (Birmaher, 2004, p. 181-182; Prochaska & Norcross, 2010). IPT aims to assist clients with their grief as it is an interpersonal problem that can lead to depression (Prochaska & Norcross, 2010). Role dispute refers to having incompatible expectations in a relationship, which, if this carries on for long enough, can lead to the development of depressive symptoms. Role transitions refer to changes within the social realm, such as marriage, and becoming a parent, which can provoke anxiety and lead to depression, as well as to biological changes which can also lead to depression. With both kinds of role transitions, IPT examines the quality of the support system available to the client. Interpersonal deficits refer to the client’s challenge to form and maintain interpersonal relationships which result in isolation and can lead to depression (Dewan et al., 2017; Prochaska & Norcross, 2010). IPT educates clients regarding depression, helps clients resolve these interpersonal problems and teaches them how to cope (Birmaher, 2004; Dewan et al., 2017; Prochaska & Norcross, 2010). Evidence from research about adolescents with depression, who were treated through interpersonal psychotherapy, shows that this treatment method is useful (Pu et al., 2017; Reyes-Portillo, McGlinchey, Yanes-Lukin, Turner, & Mufson, 2017). Research on women with depression, who were treated with IPT, also shows a clear reduction in their depressive symptoms, as well as an improvement in their social functioning, reduced loneliness, improved relationships with their spouses, and an improvement in perceived support (Duberstein et al., 2018). Research regarding the effectiveness of IPT with the general population, who suffer

from depression, also shows positive results (Ribeiro et al., 2018).

2.6.2.3 Psychodynamic psychotherapy

For many decades, psychodynamic therapy has been used for the treatment of depression (Driessen, 2017; Goldstone, 2017; Ribeiro et al., 2018). However, its efficacy has not been investigated as much as other forms of therapy (Driessen, 2017; Ribeiro et al., 2018; Leibovich & Zilcha-Mano, 2017). Psychodynamic psychotherapy aims to treat the "whole person" as opposed to merely the symptoms. It, therefore, focuses on unconscious conflicts, interpersonal issues and deficits at any of the stages of psychological development. It stresses the influence of early childhood relationships which create mental representations of the attachment figure, which in turn guides subsequent relationships. It views symptoms as expressions of unresolved feelings (Birmaher, 2004; Dewan et al., 2018; Prochaska & Norcross, 2010; Ribeiro et al., 2018). Traditionally, it is comprised of a beginning phase, where the therapist establishes a strong relationship with the client; the middle phase, which includes the interpretation of the clients' problems; and the termination phase during which the client separates from the therapist and lessons learnt during therapy are reinforced (Birmaher, 2004; Prochaska & Norcross, 2010). One of the key principles of psychodynamic therapy is the therapeutic alliance, which according to Freud is a pre-requisite for the treatment's success (Leibovich & Zilcha-Mano, 2017).

2.6.2.4 Gestalt therapy

Gestalt therapy is often used for the treatment of depression (Gonzalez-Ramirez, Carrillo-Montoya, Garca-Vega, Hart, Zavala-Norzagaray, & Ley-Qunez, 2017). This therapy is imbedded within the existential-humanistic and phenomenological paradigms (Gonzalez-Ramirez et al., 2017). Gestalt therapy is also called "the therapy of the situation" (Wollants, 2012, p. 1) as according to this therapy, it is the interaction between the person and the environment which creates experience and behaviour (Wollants, 2012, p. 1). Gestalt therapy emphasizes the human's capacity to actualise her potential (Gonzalez-Ramirez et al., 2017). Change takes place within the context of the experience. It is within the process of the experience that awareness and meaning emerge (Gonzalez-Ramirez et al., 2017). In Gestalt therapy, the person, in

his/her totality is considered, including aspects such as sensorial, emotional, intellectual, spiritual and social (Gonzalez-Ramirez et al., 2017; Oaklander, 1988). The treatment takes place in the here and now, by re-creating the experience, often through creative expressive art in therapy (Oaklander, 1988). Empirical evidence demonstrates fewer depressive symptoms within clients after being treated with Gestalt therapy.

2.6.3 Lifestyle factors that complement the treatment of depression

2.6.3.1 Exercise

There are countless benefits to physical exercising. Exercise leads to neurogenesis (neurological rehabilitation) in the hippocampus which is similar to the effect of antidepressants and electroconvulsive therapy (Yeung, Feldman, & Fava, 2010). It helps in releasing serotonin and endorphins which are neurotransmitters that counteract depression (Bourne, 2015; Yeung, Feldman, & Fava, 2010; Singh et al., 2018). There is a bi-directional correlation between depression and exercise, namely, lack of exercise is associated with higher levels of depression, and performing exercise reduces depression (Singh et al., 2018; Weinstein, Maayan, & Weinstein, 2015; Yeatts, Martin, & Petrie, 2017). Exercise also reduces hypothalamic-pituitary-adrenal overactivity and inflammatory processes, as well as improving the quality of sleep and regulating activity in the prefrontal cortex (Yeung, Feldman, & Fava, 2010). Exercise also brings about relaxation as it reduces cortisol levels and enhances a sense of well-being (Bourne, 2015). It is, therefore, most valuable when it comes to the treatment of depression. Approximately 85% of medical doctors maintain that exercising is essential in the treatment of depression. Many therapists who treat depression also support exercising. Many research studies in the past 25 years show the importance of exercising as part of the treatment of depression (Yeung, Feldman, & Fava, 2010; Weinstein, Maayan, & Weinstein, 2015). Research that was conducted with adolescents, who struggled with depression, and where a 12-week supervised intervention of aerobic classes was implemented, showed a significant reduction in their depressive symptoms (Brogan & Greenblatt, 2016). Another study that was performed with 26 adolescent boys and 28 adolescent girls, African-Americans, aged 9-12 years, also showed the correlation between an increase in exercise and a decrease in depression (Annesi, 2004).

2.6.3.2 Nutrition

The empirical link between depression and nutrition has already been astablished (Brogan & Greenblatt, 2016; Jorgensen, White, Sekikawa, & Gianaros, 2018). Nutrition is viewed as part of the holistic approach to healing depression (Bourne, 2015; Brogan & Greenblatt, 2016). The rationale is that if depression is caused partly by an imbalance in brain chemistry, it would make sense to rebalance this imbalance by using chemicals that are a part of our make-up design, namely, nutrients, instead of drugs (Brogan & Greenblatt, 2016; Holford, 2010). Similarly, Akhtar (2012) maintains that in the same way that good nutrition improves physical health, it also improves emotional wellbeing, since diet affects brain chemistry, which influences serotonin levels (Akhtar, 2012). In research that was conducted in three South Asian countries, 14,133 subjects presenting with self-reported depression over a period of twelve months were interviewed. Over 30 days, those who reported consuming less than 5 servings of fruits and vegetables per day were substantially more likely to report depression compared to those who had consumed five servings per day (Bishwajit, 2017). Hence, nutrition is one of the life style components that should not be ignored when dealing with depression.

2.6.3.3 Spiritual practice

In research literature, spirituality has been identified as being inversely correlated with depressive symptoms and suicide ideation (Portnoff, McClintock, Lau, Choi, & Miller, 2017). Lacking meaning in life is likely to leave a person feeling down. Evidence suggests that having a spiritual practice creates higher levels of hope, optimism and wellbeing. A spiritual practice can give meaning to life and can create a sense of connection to something bigger than the self. People have long turned to spiritual practice as a way of finding meaning and support when experiencing depression (Akhtar, 2012). For many, spiritual practice is the first place they turn to when confronted with depression, and it is used by many as a resource in addition to mental health care. In a recent poll, 78% of Americans reported religion as being important in their lives and 87% identified as believers in a higher power. Even a higher portion turned to spiritual practice or religious practice when distressed. 80% to 90% of people draw on spiritual or religious practice to cope with psychiatric conditions, 65% reporting that it helps to reduce symptoms, with 30% regarding it to be the most important

recourse, in particular, when symptoms worsen. When asked to rank the helpfulness of support sources, patients ranked personal prayer and meditation first, followed by health care providers, and then group spiritual activities, with family friends and other sources of support lowest on the list. In contrast, the proportion of people looking towards formal treatment for depression is surprisingly low, despite the fact that the condition is widely recognised, and effective treatment is known to be available. Therefore, the incorporation of spiritual practice into the treatment of depression is likely to make treatment more appealing to patients, and it may improve engagement and treatment response (Brogan & Greenblatt, 2016). Another study evaluated the effect of spirituality on depression and assessed people from three different countries - the United States, China and India. The researchers examined over 5000 participants. The findings were that a high level of personal spirituality decreased by half the possibility of having moderate depression (Portnoff et al., 2017).

2.6.3.4 Sleep

The link between sleep and depression has already been well established (Brogan & Greenblatt, 2016; Holford: 2010; Wolinska, Pawlak, & Mroczek, 2016). Lack of sleep is often due to insomnia. Insomnia includes difficulty in falling asleep, remaining asleep or early awakening (Brogan & Greenblatt, 2016). Sleep disturbance is mentioned as one of the American Psychiatric Association DSM-5's criteria for depression, and it is the most commonly reported neurovegetative symptom (Brogan & Greenblatt, 2016). In a particular survey conducted, over a quarter of the respondents, who were often sleep-deficient, reported low mood symptoms (Holford, 2010). A 2012 study found an association between mood and anxiety disorder and 42%-63% severe insomnia complaints. In an earlier study, in 2005, people who reported insomnia had 9.8 times more rates of association with significant depression than those without sleep challenges. Furthermore, lack of sleep has been associated with suicidality, the most severe symptom of depression (Brogan & Greenblatt, 2016). The question is whether insomnia is a cause of depression or one of the symptoms of depression. Studies show that lack of sleep can lead to depression (Brogan & Greenblatt, 2016; Wolinska, Pawlak, & Mroczek, 2016) and, in some cases, it is a symptom of depression (Brogan & Greenblatt, 2016).

2.7 Strengths and limitations of existing treatment approaches

The limitations and drawbacks of medication in the treatment of depression has already been discussed. In terms of psychotherapy, the most common psychological methods of treating depression and depressive symptoms during the 20th century was psychoanalysis, which today evolved into psychodynamic (DelMonte, 2012; Ribeiro et al., 2018) and cognitive behaviour therapy (CBT) (Beck, 2011a; Bernecker et al., 2016; Brogan & Greenblatt, 2016; Ribeiro et al., 2018). Emmerson (2007) maintains that each method of treatment has its own limitations. Psychoanalysis relies mainly on dream interpretation, free association, the exploration of wishes and fantasies, as well as the analysis of transference reactions as a main tool, the result of which is that many hours of treatment are required (Sand, 2012; Reiser, 1994; Ribeiro et al., 2018). This makes therapy lengthy (Emmerson, 2007) which presents a problem in modern times, as healthcare is often dependent upon third-party payers who demand cost-effective therapy (Driessen, Van, Peen, Don, Kool, Westra, & Dekker, 2015; Watkins & Watkins, 1997; Zeig & Gilligan, 1990). According to Yapko (2001), the effective forms of therapy are not those with a historical focus, but rather those which are skill building and goal oriented. Rather than focusing on the source of the depression, they focus on providing solutions to problems and the coping skills needed for managing symptoms. They view depression from a process- driven vantage point, attributing depression to the ongoing unhealthy interpreting of life experiences. This means that by the time depression manifests, this unhealthy perceptual and cognitive style is already well in place. Therefore, spending time in therapy, focusing on the cause of depression, is not effective. An additional limitation of psychodynamic therapy is that it is based on the "talking cure" (DelMonte, 2012). A few schools of thoughts hold a strong conviction that trauma, pain and stress are not held in the left brain, which is responsible for talking, but rather held in the right brain, in the limbic system (the feeling brain) and in the brain stem (the survival brain). These are the parts of the brain that need to be targeted in therapy rather than using the left brain through talking. However, doing so, causes therapy to be less effective, and, at times, even retraumatising the client (Levine, 1997; Levine & Kline 2008; Perry & Szalavitz, 2017; Van der Kolk, 2014).

On the other hand, the empirical-behaviour tradition, namely, CBT, while showing

immediate therapeutic results, has done so by ignoring subliminal processes, namely, subconscious activities which are responsible for certain behaviours and thought processes as is evident from various works by CBT practitioners such as Beck (2011b); Kuyken, Watkins, and Beck (2005); Simons, Padesky, Montemarano, Lewis, Murakami, Lamb, and Beck (2010); Wright, Thase, and Beck (2014). CBT therapists focus mainly on correcting distorted beliefs and changing negative thoughts (Bohman et al., 2017; Beck, 2011; Midgley et al., 2018; Bourne, 2015; Greenberg, 2010; In-Albon et al., 2017; Prochaska & Norcross, 2010), which means that their scope of operation is limited. In other words, CBT focuses on the unwanted symptoms, and not the causal disturbance. Since CBT does not focus on past issues, the child within may remain unhealed. The injured-self, which is the part of one's psychological make-up that was previously hurt, is then avoided. This causes the client to be removed from that part which is able to feel deeply and richly. Even though the client is able to function, a part of the self has been detached (Emmerson, 2007). While CBT may show immediate therapeutic results, the permanence of the results of CBT is a matter of controversy (Emmerson, 2007). CBT intervention strategies, generally speaking, focus only on symptom reduction and do not place emphasis on the emotional domain (Studer & Aylwin, 2006). Despite the fact that CBT may enable the client to perform adequately, the internal emotion associated with a traumatic episode may not have been treated. This untreated emotional disturbance is likely to prevent the client from fully engaging in many of life's joyous experiences (Emmerson, 2007).

Similarly, the client's personal explanation of his/her problems is often defined as immature, dysfunctional and irrational. Rather than enabling the client to deal with his/her feelings, the client is forced into accepting a rational approach which dismisses the client's own understanding of his/her problem. From a cultural perspective, the style of rational thinking employed by CBT therapists is often the preferred orientation of white male Europeans. However, it may not be the most compatible with those who subscribe to more diverse ways of knowing (Prochaska & Norcross, 2010).

A positive aspect of IPT is the fact that it produces results in a short space of time, as well as being a problem-focused psychotherapy (Prochaska & Norcross, 2010; Reyes-Portillo et al., 2017). However, one of its limitations is that it does not help suicidal ideation, which appears to be processed in a different brain pathway other than family

interpersonal functioning (Reyes-Portillo et al., 2017). Pu et al. (2017) also spoke about the usage of interpersonal psychotherapy and mentioned that it does not seem to reduce the risk for suicide. As mentioned above, suicidal ideation is one of the symptoms of depression (American Psychiatric Association, 2013).

From a psychoanalytical point of view, this modality seems to be severely criticised. They claim that IPT does not include the human's personality in their theory, and that it rather only focuses on changing technology. IPT has no interest in changing personality structures, only in symptoms-eluviation. There is no mention about the driving forces of the person's behaviour intra-psychically, only an over-focus on role disputes and interpersonal deficits. Clients are given an expert manual to guide their lives and behaviours (Prochaska & Norcross, 2010).

From a cultural perspective, this modality narrows down the interpersonal challenges to interactions with a spouse, family and community members. It fails to take into account contexts which can be problematic and which can cause depression and are not subject to change, such as social networks and community dynamics. An example of this, which overlaps with the focus of the study, is the case of higher rates of depression in women, which from a cultural perspective is linked to the fact that their roles are often oppressive. IPT practitioners focus on the role dispute but the real issue lies in re-defining the role of women. Rather than helping clients to adapt to roles that are restrictive and depressive, they could help them challenge the roles dictated to them by society (Prochaska & Norcross, 2010).

It is the conviction of the researcher that although interpersonal skills would help depression as they should assist social situations, nevertheless, more intensive work is still required with those who struggle with depression. This needs to consist of inner strength building and a more positive view of the self.

2.8 Conclusion

At this point, through consulting the DSM-5, the scope of depressive disorders has been defined, and its symptoms have been listed. Attention has been given to the subtypes of depressive disorders, the severity of various depressive episodes and the differential diagnosis for major depressive disorders. The prevalence of depression has been explored, and in the case of female adolescents, it has shown to be high.

The causes and consequences of depression in adolescence have been listed. Standard psychotherapeutic approaches have been explored, taking into account their strengths and limitations. The conclusion which can be drawn at this point is that it would be beneficial to explore and propose an alternative treatment model to better facilitate the treatment of adolescent females with depressive symptoms. This model is based on inner strength building through ego state therapy and creative expressive art in therapy. The background and context of inner strength, ego state therapy and creative expressive art in therapy will be explained, drawing on the relevant literature in Chapter 3.

CHAPTER 3: INNER STRENGTH BUILDING THROUGH HYPNOSIS AND ART IN THERAPY- LITERATURE REVIEW

3.1 Introduction

In this chapter, the theoretical framework which forms the basis for the study will be clarified. This includes an understanding of both the concept of inner strength and the implications for therapy with regard to depression. A thorough review of the background, definition and usefulness of hypnotherapy in the treatment of depression will be given. This is important because much scepticism is often aroused at the mention of hypnotherapy. Two main models of hypnosis that pertain to this study, Ericksonian hypnosis and ego state hypnosis will be explored in detail. The concept and background of art in therapy will also be clarified. The chapter will close with an explanation of the appropriateness of adolescent females as volunteers for this study.

3.2 Inner strength

3.2.1 Defining inner strength

From the beginning of modern psychology, practitioners and theorists stressed the importance of ego strengthening (Forgash & Copeley, 2007). Freud (1961), (cited in Forgash & Copeley, 2007, p. 91; Frederick & McNeal, 1999, p. 1) stated that his main goal for treatment was “to strengthen the ego … to widen its field of perception and enlarge its organization”. Other clinicians, who have subscribed to this idea, have also emphasised in varied ways the importance of strengthening and expanding the capacity of the client as a focal point of therapy (Forgash & Copeley, 2007; Frederick & McNeal, 1999).

Inner strength is a common phrase often used by individuals, who are not necessarily psychologically orientated, when describing their consciousness of internal resources which they are able to access (Frederick & McNeal, 1999). From a psychological point of view, “inner strength” is a concept used in ego state theory and therapy. Emmerson (2003, p. 210; 2007, p. 210) defines inner strength as follows: “The ego state manifestation that apparently all persons have”. When communicated with directly under hypnosis, “this ego state claims to have been born with the person and claims to have wisdom concerning the best direction for the person” (Emmerson, 2003, p.

210; 2007, p. 210). It normally speaks with a strong, clear voice and may call itself by other names, such as “inner self” or “spiritual self’” (Emmerson, 2007 p. 13). Along similar lines, Allen (2004, p. 101) states that inner strength is the part of the person that is the essence of the person, a “voice of wisdom and of truth that is so often lost within the clamour and the clatter of the world”, namely, the constraints and demands of life. Emmerson (2003) adds that it is the part of a person that cannot be removed and its nature and role cannot be changed. However, it can be expanded to take on a greater role in terms of its interactions with other ego states. Hartman (Personal Communication, April 5, 2013) stated that inner strength can be considered as the spiritual part of the personality. As a working definition for the purposes of this research, inner strength may be defined as that part of the psyche that remains intact, vibrant and resourceful, even as the client presents with symptoms of distress.

3.2.2 Lundman et al.’s (2010) conceptualisation of inner strength

In order to clarify further the concept of inner strength and to gain understanding as to the nature of inner strength, Lundman et al.’s (2010) conceptualization is useful. According to the authors, concepts of resilience, sense of coherence, hardiness, purpose in life and self-transcendence, are components of inner strength. However, they had not found studies focusing on what these concepts have in common. The objective of Lundman et al.’s (2010) study was to identify the underlying dimensions of these concepts in order to gain a comprehensive understanding of inner strength. A brief explanation of these concepts, in the view of these researchers, follows. *Resilience* is an ability to recover and rebalance after negative experiences. *Sense of coherence* is explained as a broad orientation which brings with it an enduring sense of confidence in the predictability and comprehensibility of one’s external environment, including an attitude that resources are available to meet these demands and that one finds meaning in this challenge. *Hardiness* is a result of personality characteristics which enable resistance to stressful events. *Purpose of life* or meaning in life is linked to the degree to which one experiences life as meaningful and has a sense of purposeful direction. *Self-transcendence* is an expansion of personal boundaries in terms of reaching out, achieving greater awareness of one’s own values and integrating one’s past and future in one’s present moment (Lundman et al., 2010). The following figure is the researcher’s visual representation of the Lundman’s

conceptualisation.

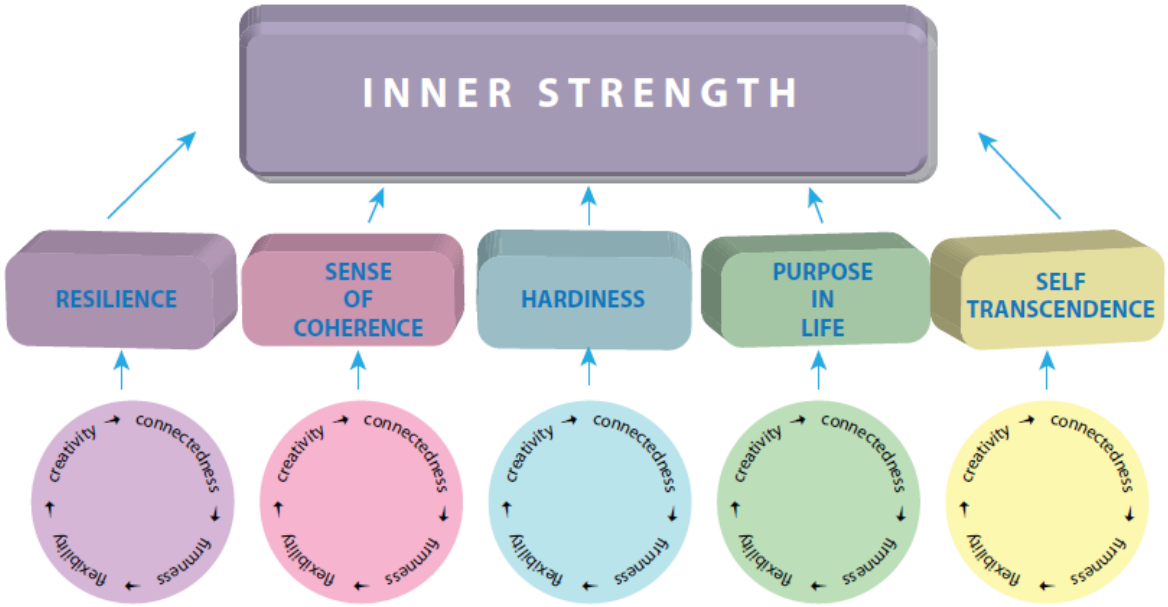

Figure 3.1. Inner Strength

The result of the research was the identification of four primary dimensions of inner strength and the conclusion that inner strength results from the interactions of these dimensions. The dimensions are: *connectedness, firmness, flexibility* and *creativity*. It is these dimensions that the five concepts related to inner strength have in common (Lundman et al., 2010).

3.2.3 Inner strength and ego strengthening

Ego strengthening is a therapeutic technique which helps to strengthen the person's ego and advance one's psychological functioning (Fredrick & McNeal, 1999). This means that one is able to have more self-awareness, one can organise one's behaviour better, and one can function with less self-criticism. Ego strengthening allows the person to uncover subconscious material and to associate it with conscious material (Fredrick & McNeal, 1999). Along the same lines, Brann, Owens and Williamson (2012) state that ego strengthening is anything which boosts the person's

inner resources, their self-esteem and their belief about themselves. This is done through methods such as building good therapeutic relationships between the client and the therapist, through hypnosis, as well as through utilising the client's internal resources. Ego strengthening techniques allow for the expansion of the boundaries of the inner strength part of the personality (Fredrick & McNeal, 1999). However, the researcher suggests that the relationship between ego strengthening and the inner strength part is actually circular. This is what is evident from the SARI model (see 1.2.2), which suggests building inner strength and then using this part that has been strengthened to resolve trauma, which brings about more ego strengthening (Phillips & Frederick, 1995).

3.2.4 Inner strength and depression

When working with depression or with any other dissociative disorders, such as anxiety, Obsessive Compulsive Disorder, post-traumatic stress and eating disorders, first and foremost, one needs to build inner strength (Alladin, 2013; Da Silva, 2009; Forgash & Knipe, 2012; Fredrick & McNeal, 1999; Phillips & Frederick, 1995). These conditions are often a consequence of trauma, which brings about maladaptive defences and symptoms that threaten to take over the person, while the victim often lives in a state of fear (Forgash & Knipe, 2012; Phillips & Frederick, 1995). Therefore, the experience of relaxation, mastery, enhanced self-esteem, a greater ability for self-soothing and clarity needs to take place early in the treatment process (Forgash & Knipe, 2012; Phillips & Frederick, 1995). Additional reasons for the necessity of ego strengthening in the beginning phase of therapy would be to assist the client to stand by his/her commitment to therapy, to hold onto hope (Phillips & Frederick, 1995), and to experience subconscious trauma that might emerge during therapy without having to block it (Fredrick & McNeal, 1999; Phillips & Frederick, 1995).

Ego strengthening was already considered to be a valuable therapeutic modality by Hartland in 1965 (Yeates, 2014). Hartland recognised that clients are unwilling to let go of their symptoms or defences as long as they do not have anything just as powerful to replace them with (Fredrick & McNeal, 1999; Phillips & Frederick, 1995). Amongst the many gains that Hartland (1971) mentioned in terms of inner strength building with clients, he adds that strengthening the persons' inner strength will mean a lower likelihood of relapse later on (cited in Fredrick & McNeal, 1999). Hartland claims that

within his practice, 70% of his clients improved through inner strengthening alone, and that these clients sufficed with short term treatment, namely, 20 sessions (Fredrick & McNeal, 1999). Along similar lines, another study among older women found a correlation between strong inner strength and being non-depressed. Furthermore, it was deduced that inner strength may serve as a protective effect against depression (Boman et al., 2015).

3.2.5 Inner strength, resilience and depression

Depression sufferers struggle with learnt helplessness (Brann et al., 2012; Phillips & Frederick, 1995; Yapko, 2006). The opposite of learned helplessness is resilience (Brann, Owens & Williamson, 2012). As seen above, resilience is closely related to inner strength (Lundman et al., 2010). Moe, Hellzen, Ekker, and Enmarker (2013) also see resilience as an integral part of inner strength. They view resilience as a personal trait that facilitates adjusting to difficulties or threatening situations. Resilience facilitates adaptive responses even in an adverse environment (Poole, Dobson, & Pusch, 2017). It facilitates the individual's usage of his/her abilities and characteristics to be able to bounce back, to cope well and function successfully in spite of significant challenges (Brann, Owens, & Williamson, 2012; Kapikiran & Acun-Kapikiran, 2016). Strong resilience can protect the person against psychological and physiological distress. As a result of this, resilience can facilitate a faster recovery after experiencing loss or illness (Kapikiran & Acun-Kapikiran, 2016).

Resilience is not a sturdy construct, a person can be resilient in one context and not in another, and moreover, in different phases of one's life one can experience different degrees of resilience to stressors. Resilience usually develops during early childhood as a result of good, supportive parents. This allows the child to develop good adaptation strategies to situations. It also allows for the formation of the correct physiological responses to stressors by the hypothalamic-pituitary-adrenal axis as the child gets supported and coached through challenging times (Brann, Owens, & Williamson, 2012; Poole, Dobson, & Pusch, 2017). It is recognised that resilience serves as a key in healing depression (Brann, Owens, & Williamson, 2012). Kapikiran and Acun-Kapikiran (2016) add that resilience also serves as a preventative measure for the development of depression. They write that multiple studies found meaningful negative correlations between depression and high psychological resilience.

When looking at descriptions written about inner strength by Frederick and McNeal (1999) and by Phillips and Frederick (1995), they seem to be similar to the above-mentioned definitions of resilience. Phillips and Frederick (1995) describe inner strength as partially originating from the deepest survival instinct of the personality. It can function in an environment of severe conflict and overwhelming trauma.

Often depression develops as a result of trauma (Kilicaslan et al., 2017; Phillips & Frederick, 1995; Da Silva & Fritz, 2012). According to Forgash and Copeley (2008), ego strengthening is particularly important for clients who have been through significant trauma and dissociation, as these have a serious impact on the development of the core of the individual. Frederick and McNeal (1999) add that psychotherapeutic techniques that are ego strengthening assist the person in feeling and accessing their internal resources. It is those internal resources that can assist the person to overcome the trauma and move on with life (Phillips & Frederick, 1995).

Another gain of using inner strength with those who struggle with depression follows. Clinical evidence shows that hypnosis can contribute greatly to the treatment of depression (Yapko, 2006). However, hypnosis in treating depression has been controversial because of the potential for it to weaken the client's defences and increase the risk of suicide (Frederick & McNeal, 1999). Ego strengthening through hypnosis, however, has been found to be of unparalleled value with many suicidal clients (Frederick & McNeal, 1999). Ego strengthening enables the client to experience relaxation, inner-peace, calmness and inner strength. Ego strengthening scripts have been used in helping clients with issues of low self-esteem and self-derogatory thoughts (Frederick & McNeal, 1999).

The researcher contends that the need to work on inner strength is particularly important when working with individuals who are suffering from depression. The reason for this is that depression is often linked to low self-esteem (Akhtar, 2012; Alladin, 2013; Holopainen & Emmerson, 2002; Kapikiran & Acun-Kapikiran, 2016) or to negative thoughts about the self (Yapko, 2006). Improving low self-esteem, which naturally occurs through inner strength building (Frederick & McNeal, 1999; Herber, 2006) could contribute to addressing symptoms of depression (Kapikiran & Acun-Kapikiran, 2016; Sharma & Agarwala, 2013). Kapikiran & Acun-Kapikiran (2016) also add that self-esteem is a mediator between resilience and depression, in other words,

the stronger the self-esteem, the stronger the resilience and the lower the depression will be.

3.2.5.1 Practical applications of ego strengthening

While many theoretical frameworks believe in ego-strengthening, not all theorists are in agreement with each other, both regarding theory and practice (Phillips & Frederick, 1995) as discussed below.

From a psychodynamic perspective, the ego gets strengthened and its control expands as a result of reaching resolution of early life conflict (Phillips & Frederick, 1995). Criticism of this approach is that it appears to lack certain elements that clients often need, namely, skills that teach clients about self-care, self-regulation, self-soothing and which assist clients with their self-esteem (Fredrick & McNeal, 1999).

Yapko (2006) also seems to disagree with the psychodynamic approach and adopts a more practical stance for the treatment of depression and for building inner strength. Striving to empower people is the goal of every therapy, and certainly the focus and primary goal in the treatment of depression. According to Yapko (2001, p. 10), in order to heal depression, the clinician should rather be goal orientated and focus on assisting the client to acquire essential coping skills, the ability to solve problems and have a positive cognitive style, which is considered to be “a process driven perspective”, as opposed to a historical focus approach. A historical focus approach explains the origin and roots of the depressive symptoms. This is considered to be an “event-driven perspective” which is not considered time well spent in therapy. His rationale is that often there is not a single event that caused the depression and by the time depression strikes most individuals, the risk factors, such as negative cognitive style, poor social skills, perceptual style and problem-solving ability are already well set. Yapko (2006, p. 76) adds that the way to build inner strength is through teaching a client a variety of skills which the client can integrate into her life in order to improve her life, bringing about “self-efficacy”. Yapko (2006) writes that the connection between “self-efficacy” and the enhancement in mood is well established by many research papers.

3.2.5.2 Ericksonian application of ego strengthening

Although the Ericksonian approach will be discussed at length later in this research study, it would be appropriate to mention his ego strengthening technique here. According to Milton Erickson, ego strengthening means helping the client find and use resources from the past, the present and the future (Yapko, 1990). The Ericksonian framework is based on the concept of the utilisation and mobilisation of the client's strengths, assets and internal resources (Havens, 2003; Phillips & Fredrick, 1995; Yapko, 2013). Erickson believed that the unconscious mind contains all the essential resources that a person needs in order to solve his/her challenges (Erickson & Rossi, 1976).

According to ego state therapy, ego strengthening implies the activation and mobilisation of inner resources (Fredrick & McNeal, 1999; Fredrick & McNeal, 1993). Fredrick and McNeal (1999) write that when the ego state part of the personality is activated hypnotically and is experienced by the greater personality, the positive effects on the personality are profound. From this perspective, building inner strength also involves increasing the interplay between resourceful parts of the personality, while extending their influence over less constrictive, less adaptive, more childlike states (Fredrick & McNeal, 1999; McNeal & Frederick, 1993).

In this study, the researcher will make use of the Ericksonian and the ego state theoretical frameworks in order to help build inner strength in adolescent girls who experience depressive symptoms. The researcher chose to be guided by the above-mentioned two modalities, due to the fact that these are brief approaches (Holopainen, & Emmerson, 2002; Phillips & Frederick, 1995) and they are asset based (Phillips & Frederick, 1995). Ego state therapy uses inner strength building methods which are intrinsic, namely, ego state aims to correct the core, (Holopainen, & Emmerson, 2002; McNeal & Frederick, 1996; Watkins, 1990) to heal the parts of the personality that experience emotions, such as being unloved, not special, unnurtured, misunderstood, hopeless and isolated (Holopainen & Emmerson, 2002; McNeal & Frederick, 1996; Watkins, 1990). As opposed to Yapko's (2006) suggestions that inner strength should be built through teaching the client coping skills, problem solving skills, social skills and positive cognitive style, the researcher contends that these skills are essential as a second phase in the treatment process, depending on the amount of sessions

allocated for the treatment. However, these CBT skills are insufficient to shift the person intrinsically and build an intrinsic inner strength to the extent that ego state therapy can (Holopainen & Emmerson, 2002). On this note, it would be appropriate to mention here that Kapikiran and Acun-Kapikiran's (2016) conviction that in order to prevent or treat depression of young people during college years, students need to be assisted with increasing their self-esteem, alongside optimism and resilience.

Since ego strengthening and inner strength building often takes place in the context of hypnosis, a discussion about hypnosis, together with definitions, history, its different models and its potential follows below.

3.3 Hypnosis

3.3.1 Introduction

Hypnosis is the oldest form of psychotherapy (Battino & South, 2005; Brann, Owens, & Williamson, 2012; Yapko, 2006). This phenomenon of hypnosis has existed since the commencement of recorded history. It is found in the folklore of ancient cultures and tribal ceremonies (Battino & South, 2005; Guse, 2014). Throughout history and in every culture, a 'trance-state' has been associated with healing (Brann, Owens, & Williamson, 2012, p. 31; Guse, 2014). Although hypnotic techniques are efficient and effective, these techniques have not been incorporated into mainstream medicine, as a result of an association with the mystical and the non-scientific (Brann, Owens, & Williamson, 2012; Yapko, 2006; Yapko, 2014). This is unfortunate, as hypnosis has the power of gaining the client's full attention, altering awareness, heightening responsiveness to social cues and suggestions, and improving communication between therapist and client (Brann, Owens, & Williamson, 2012; Guse, 2014; Yapko, 2006; 2014).

Hypnosis is not an independent form of treatment but rather it creates a mental state that enables appropriate treatment strategies (Brann, Owens, & Williamson, 2012; Parris, 2017; Yapko, 2012). It focuses attention on a specific topic and causes normal consciousness to fade, which reduces critical scrutiny and enhances the efficacy of therapy (Brann, Owens, & Williamson, 2012; Parris, 2017). This places a demand on the therapist to guide the process in an efficient manner (Brann, Owens, & Williamson, 2012). There is a widespread misconception that hypnosis involves losing control. In

reality, when used correctly, it helps clients gain control over unwanted symptoms and distress (Brann, Owens, & Williamson, 2012). Although hypnosis has been associated with the mystical and the non-scientific as previously noted, the effectiveness of hypnosis on certain problems has been demonstrated in sizeable clinical trials (Brann, Owens, & Williamson, 2012; Sehan, Harun, & Ahmad, 2016). Neuro-imaging studies such as PET and MRI demonstrate changes in brain patterns as a result of hypnosis, which is further evidence that hypnosis works and enables researchers to see how it works (Brann et al., 2012).

3.3.2 Hypnosis and hypnotherapy

It is important to differentiate between the terms ‘hypnosis” and “hypnotherapy”, as well as “hypnotist” and “hypnotherapist” (Hunter, 2010, p. 3). While hypnosis can be done by a lay hypnotist who has no advanced degree, hypnotherapy is done by a professional person who uses psychological techniques. Similarly, while the hypnotist gives many suggestions and hopes for results, the hypnotherapist tries to access the subconscious in order to identify the cause of a problem for the sake of facilitating healing and bringing about the resolution of problems (Hunter, 2010). For the sake of this study, the terms hypnosis and hypnotherapy will be used interchangeably.

3.3.3 The definition of hypnosis

Yapko (2012) writes that finding a definition for the phenomenon of hypnosis is not a simple task and that scholars have grappled with the definition of this concept and even long-time practitioners find it easier to explain this phenomenon, rather than to describe it. John Watkins, a seminal researcher and practitioner in hypnosis, captured the mystery of the phenomenon of hypnosis in an article titled “Hypnosis: Seventy Years of Amazement, and Still Don’t Know What It Is” (Watkins, 2009, cited in Yapko, 2012, p. 20). Watkin’s inability to define hypnosis after years of deep involvement in it, is certainly not due to the lack of research and consideration. The general struggle of practitioners in defining hypnosis is due to the complexity of this phenomenon and the attempts to untangle all the intricacies involved (Yapko, 2012); or as Fourie (2009) explained it “the struggle with the definition is most probably due to the fact that hypnosis is one word that describes many different kinds of experiences”. Nevertheless, there are several leading definitions of hypnosis from different time

periods.

The term hypnosis was originally coined by James Braid in 1842 to describe a phenomenon previously known as animal magnetism or mesmerism (as will be explained below). At first, he called this phenomenon, neurypnology, from the Greek, which means, nervous sleep (Battino & South, 2005; Yapko, 2017). Later, he adapted it to neuro-hypnotism, after Hypno, who was the Greek god of sleep. Thereafter, for the sake of brevity, he reduced it to hypnotism (Battino & South, 2005). Hypnotism means putting to sleep, to induce an altered state of consciousness characterized by deep relaxation and heightened suggestibility (Columbia Electronic Encyclopaedia, 2017). Braid defined hypnotism as "a peculiar condition of the nervous system induced by fixed and abstracted attention of the mental and visual eyes of a subject and concentration on a single idea without an exciting nature" (Battino & South, 2005, p. 12). It is evident that this definition views the client as a passive subject.

Some later definitions include defining hypnosis as a guided day-dreaming (Barrett, 1979, cited in Yapko, 2003), a state of relaxation with hyper suggestibility (Edmonston, 1991, cited in Yapko, 2003), a natural, altered state of consciousness (Tart, 1992, cited in Yapko, 2003). These definitions also view the client as a passive subject.

Hypnosis was officially defined in 1993, by the American Psychological Association (APA) as "a procedure through which a healthcare professional suggests a person to experience sensations, changes, perceptions, thoughts, or behaviour" (cited in Gonzalez-Ramirez, Carrillo-Montoya, Garca-Vega, Hart, Zavala-Norzagaray, & Ley-Quinez, 2017). This definition also views the client as passive, however, it does acknowledge the person experiencing the hypnosis.

Later theorists have regarded hypnosis as a process that is more client based. According to Milton Erickson, "hypnosis is a state of awareness, a very definite state of awareness, with special types of awareness. Hypnotic subjects are not unconscious in any sense of the word. Rather they are exceedingly aware of a great number of things and yet able to be unaware of an equally great number of things" (cited in Lankton, 1989, p. 11). Lankton (1989) explains that the word trance, used by Erickson to describe hypnosis, is derived from the Latin "trans", which means, across or beyond. This implies an out-of-the-ordinary experience. Erickson's definition seems to be

focusing on the experience of the client. This fits with Erickson's view of a therapist having a reciprocal relationship with the client, as opposed to the therapist holding all the power (Lankton, 1989). Fredrick and McNeal (1999, p. 27) define hypnosis as "a complex phenomenon that is influenced by inborn, psychodynamic, interpersonal, social, cognitive and even political factors". This definition focuses on the interaction of both the therapist and the client. Yapko (2012, p. 22) defines hypnosis as "a focused experience of attentional absorption that invites people to respond experientially on multiple levels to amplify and utilize their personal resources in a goal-directed fashion". This definition seems to be very much client based.

What is evident through the different definitions of hypnosis, is that the evolution of its conceptualisation has moved power from the hypnotist to the client. From the time of Mesmer, the first period of hypnosis (Radovancevic, 2009), the public believed that the hypnotist has the power to exert his will over the client. This is due to the fact that animal mesmerism alluded to the idea of power (Battino & South, 2005; Fredrick & McNeal, 1999; Green, Laurence, & Lynn, 2014). Even Jung, a disciple of Freud, who practiced direct suggestive hypnosis and even used Mesmeric methods, had abandoned the usage of hypnosis in therapy as he found it to be too authoritarian and too directive which affected the client's ego (Fredrick & McNeal, 1999).

In addition, the terms "operator" and "subject" that were used for many years regarding the therapist and client, added to the illusion that the hypnotist is in control of the hypnotic subject, and that the subject responds to the commands of the operator. However, it is an illusion to think that one can control another individual. There is no master-slave relationship in clinical hypnosis. The hypnotist cannot force the client to do what he/she does not wish to do. Hypnosis always requires the cooperation of the client, which explains Erickson's famous statement that "all hypnosis is self-hypnosis, while the therapist or hypnotist serves as a facilitator or as a guide" (Battino & South, 2005, p. 22; Fredrick & McNeal, 1999). The researcher's approach to hypnosis in this study is in line with this viewpoint.

3.3.4 Overview and historical background of hypnosis

Even though hypnosis has been used medicinally, as far back as recorded history, it is only since modern times that it has gained scientific credibility (Green, Laurence, &

Lynn, 2014). One of the earliest scientific studies of hypnosis was carried out by France Anton Mesmer (1734-1815), (Radovancevic, 2009), an eighteenth-century Viennese physician who exposed the concept of hypnosis to the medical community (Guse, 2014). Influenced by Newton's theory of the gravitational attraction of heavenly bodies to each other, he expanded Newton's ideas explaining that certain diseases resulted in hormonal imbalances in the body due to the power of gravity. He later added to this theory the idea that all people have magnetic forces that effect the bodies of others. This being the case, one could heal the sick person through the magnetism of another. He managed to heal with "animal magnetism" many patients who were not cured though traditional procedures (Battino & South, 2005, p. 3; Brann, Owens, & Williamson, 2012; Fredrick & McNeal, 1999; Green, Laurence, & Lynn, 2014; Stanbury, 2012). However, he himself was not aware of the psychological nature of this kind of therapy (Battino & South, 2005).

Mesmer's theory was met with scepticism (Green, Laurence, & Lynn, 2014; Roberts, 2016; Stanbury, 2012) and a royal committee was sent to investigate him. The conclusion was that there was no truth to his claims (Battino & South, 2005; Green, Laurence, & Lynn, 2014; Roberts, 2016). What they did not realise was that Mesmer's theory of animal magnetism provided the transition from symptoms being viewed in a religious light, namely, symptoms that were given religious explanations to symptoms being viewed scientifically (Green, Laurence, & Lynn, 2014). Despite this, many respected practitioners continued to use his methods due to the results its usage obtained. Amongst them was a radical but well-respected professor of medicine and writer by the name of John Elliotson (1791-1868) (Battino & South, 2005; Stanbury, 2012). James Esdaille (1808-1859) was impressed by Elliotson's writings on Mesmer's theory and became a believer in Mesmerism (Battino & South, 2005). With a hospital in India under his care, he was free to experiment with Mesmerism. Over a period of six years, he used "Mesmerism" to induce anaesthesia in patients for thousands of minor surgeries and over 300 major surgeries (Battino & South, 2005).

James Braid (1795-1860) was the first to offer a psychological explanation of the effectiveness of "Mesmerism". An English surgeon and writer, he was highly regarded by the British Medical Association. Through his research, hypnosis gained scientific acceptance, which makes him the father of hypnosis (Robertson, 2009). Aware of the

effectiveness of Mesmeric trances he rejected the notion of any kind of magnetism. He regarded hypnotism as a specific condition of the nervous system and as a way to heal sicknesses of which there was no physical evidence (Battino & South, 2005). Not wanting to be associated with “Mesmerism”, he named it hypnotism (Stanbury, 2012), from Hypno, the Greek god of sleep. The next outstanding figure in the world of hypnotherapy was Milton H. Erickson (1901-1980). He has been regarded as the most creative and innovative hypnotherapist worldwide (Erickson & Rossi, 1989; Havens, 2003), as will be explained later in this chapter. It is first necessary to consider contemporary models of hypnosis, before engaging in further discussion on the therapeutic applications of hypnosis.

3.3.5 Contemporary explanatory models of hypnosis

The way one views hypnosis would be the guiding theory for practicing it (Frederick & McNeal, 1999). There are quite a few models defining hypnosis. These views can be divided generally into two groups, namely, single-process theories and context-based theories. The single-process theory views hypnosis from the client’s point of view and not from a social point of view. The context-based theories explore hypnosis from a social standpoint, which includes both the therapist’s and the client’s perspective (Frederick & McNeal, 1999), hence, these are intra and interpersonal models. The various models are discussed below.

3.3.5.1 The neo-dissociation perspective: Hypnosis as a dissociative state

Hilgard’s neo-dissociation model (Hilgard, 1991; Hilgard & Hilgard, 1994) is one of the most influential viewpoints in the field of hypnosis (Fourie, 2009; Hartman, 1995; Phillips & Fredrick, 1995; Watkins & Watkins, 1997). This model is an “intrapersonal” one (Yapko, 2012, p. 49). Hilgard maintained that cognitive functioning is a result of the interaction of many “subordinate control systems” (Hilgard & Hilgard, 1994; Kirsch & Lynn, 1998; Phillips & Fredrick, 1995, p. 4). Those systems usually work in an integrated manner, under the control of the main system referred to as “executive ego”. Each cognitive system has its own attitudes, habits, interests and other qualities. In hypnosis, dissociation occurs, hence, each system separates from the others and each is able to communicate autonomously (Hilgard, 1991). From the above, it is clear that hypnosis is a dissociative state, due to the fact that the cognitive systems do not

work in an integrated manner.

3.3.5.2 Hypnosis as a passive or permissive state

This is a primarily intrapersonal model which debates whether or not the client is experiencing passivity or arousal during hypnosis (Yapko, 2003). Is the client's position defined as one of responding to the suggestions and directives of the therapist, or has the client got a choice as to which messages and suggestions of the therapist to accept and which to reject (Yapko 2003; Yapko, 2012). It seems that hypnosis is both a passive and permissive state. This model aims to explore this paradox.

3.3.5.3 Hypnosis as an altered state of consciousness

This is historically one of the early popular and accepted views of hypnosis as being an altered state of consciousness (Yapko 2003). This is another intrapersonal model that views hypnosis as a unique and altered state of consciousness, in comparison to one's ordinary state of consciousness (Kirsch & Lynn, 1998; Yapko 2012).

3.3.5.4 Hypnosis as a socio-cognitive phenomenon

This model is an influential and dominant model in the field of hypnosis today (Yapko 2003; Yapko, 2012). It represents a combined intra- and interpersonal approach (Kirsch & Lynn, 1998; Fourie, 2009). This model emphasises the role of hypnotic suggestions, which is the social involvement in the hypnotic phenomenon, namely, the interpersonal part of it. It also emphasises the role of the cognitive make-up of the client, including, the client's expectations, attitudes, beliefs, attributional style, and other cognitive processes which influence social responsiveness, referring to the intrapersonal part of it (Brann et al., 2012; Kirsch & Lynn, 1998; Yapko 2003; Yapko, 2012).

3.3.5.5 Hypnosis as a special interactional outcome

Hypnosis can be viewed from different points of view. Some researchers view it as an interactional outcome. As was accepted in previous times, the induction (the beginning phase of hypnosis) was something that was done to a subject, through the usage of formal scrips of suggestions. Reading out impersonal scrips suggests that the power

lies within the incantation rather than within the quality of the relationship between the therapist and the client (Yapko, 2012). Milton H. Erickson is credible for transforming this practice from an authoritarian-based approach to a client-based approach (Short, Erickson, & Erickson-Klein, 2006). According to this view, the success of the hypnosis depends upon a meaningful relationship, and interaction and attunement between therapist and client (Yapko, 2003; Yapko, 2012).

3.3.6 Hypnosis and its usefulness in treating psychological disorders

The usefulness and effectiveness of hypnosis for the healing of psychiatric disorders, depression being among them, is well recognised (Frischholz, 2013; Gonzalez-Ramirez et al., 2017). The researcher will refer to a few research articles in order to substantiate the above. Guse and Fourie (2013) researched a multiple case of five women, who were survivors of childhood sexual abuse, who received hypnotherapy for the sake of facilitating psychological wellbeing. The results were that three of these women's psychological wellbeing strengthened and two of the participants' pathological symptoms were reduced. Saltis (2016) reported the effectiveness of three sessions of self-hypnosis for analgesia with a severely depressed client. Untas, Chauveau, Dupr-Goudable, Kolko, Lakdja, and Cazenave (2013) determined the effectiveness of hypnosis on anxiety, depression, fatigue and sleepiness in people undergoing haemodialysis. Kellis (2011) reported on the effectiveness of clinical hypnosis and cognitive-behaviour therapy in the treatment of a young woman with anxiety, depression and self-esteem issues. Gonzalez-Ramirez et al. (2017) determined the effectiveness of hypnosis therapy and Gestalt therapy as depression treatments. Their conclusion was that therapeutic hypnotherapy is an effective treatment and it has relevance to depression, while other types of treatments tend to be slow and carry insignificant results. They also add that when researching the effectiveness of CBT with and without hypnosis for the treatment of psychiatric disorders, including depression, it was found that those who received treatment with hypnosis fared better than 75% of those who received therapy without hypnosis (Gonzalez-Ramirez et el., 2017). It seems that there is ample evidence that treating a psychological problem through hypnosis, is more powerful, more effective and it works deeper in the subconscious than the same psychological treatment without hypnosis. (Da Silva & Fritz, 2012; Yapko, 2017).

There are a range of benefits that accrue from utilising hypnosis. According to Hunter (2010), hypnotherapy seems to be effective for most people who suffer from mental anguish, as hypnotherapy is short-term, effective, practical and safe. Jensen, Adachi, Tom-Pires, Lee, Osman, and Mir (2015) add that hypnosis is also useful for pain control (Jensen et al., 2015; Milling & Randazzo, 2016), together with its low cost, relative to the cost of medication. Hypnosis can also increase a sense of wellbeing (Guse, 2014; Jensen et al., 2015) and it has a positive side-effect profile (Jensen et al., 2015). Hypnosis has been proven to be an effective tool in controlling the side effects of chemotherapy (Swift, 2016). Hypnosis has been successfully used for surgical anaesthesia since 1852 (Drouet, Deeper, & Chedeau, 2017).

Another benefit of hypnosis is referred to by Fredrick and McNeal (1999, p. 29). They state that in human experiences, particularly those which relate to difficulty, trauma and survival, informational substances, messenger molecules which communicate with the cells, flood the body. This results in a chemical outpouring of hormones. Through this process, information is stored within the physiological and chemical state at which the person is at that time. This *state -bound material,* which is stored on a psycho-physiological level, can be accessed through hypnosis. A person who, for example, may have been knocked off his bicycle by a car, in his conscious state may recall little of the trauma of the incident. He may not be able to get in touch with that experience unless he re-visits that physiological state.

At the same time, Hunter's (2010, p. 5) opinion is that "all hypnosis is self-hypnosis". This is because the hypnotherapist is viewed as a guide, facilitating the client's inborn ability to solve his/her own problems to achieve his/her goals. In other words, all hypnosis is guided self-hypnosis. When a hypnotherapist exerts too much power, he/she is at a risk of the client rejecting his/her suggestions.

In addition, Yapko (2006) maintains that any therapeutic benefit which may be derived from hypnosis would depend on a variety of interrelated factors. These are personal factors (such as the ability to focus, the ability to use imagination, the capacity to dissociate and client expectations). There are also interpersonal factors, namely, trust in the therapist or a sense of acceptance. In addition, there are contextual factors, namely, the comfort of the client on the chair, and the level of noise in the room.

3.3.7 Hypnosis and inner strength

Hypnosis is known and recognised for its effectiveness in assisting clients in expanding and extending their inner strength (Forgash & Copeley, 2007; Yapko, 2012). Yapko (2007, p. 16, cited in Guse, 2014) stated that hypnosis is an "approach that emphasizes the importance of understanding the structure of and pathways into the best and most adaptive aspects of human experience". As stated above, Brann et al. (2012) define ego strengthening as anything which boosts the person's inner resources, their self-esteem and their belief about themselves. Hence, ego strengthening should be used in all communication during hypnosis, in order to assist adaptive and helpful ideas to flourish. Hypnosis is an effective technique for inner strength building due to the fact that hypnosis increases suggestibility and decreases critical thinking as mentioned above (Brann, Owens, & Williamson, 2012). Hypnosis also assists with focused awareness on aspects of the client's strengths and through the post-hypnotic suggestions one can prolong the effect of ego strengthening even post the session (Guse, 2014).

Frederick and McNeal (1999) determined that the inner strength part could be activated hypnotically. They describe how strengthening the inner strength part assists with strengthening all the other ego states. According to them, inner strength building assists with self-soothing, as well as creating good healthy boundaries, with better self-regulating of emotions and with the maturation of other ego states. Heap (1988, p. 297, cited in Guse, 2014, p. 6) suggested that hypnosis can be associated with "growth psychology" rather than with "sickness psychology" due to its ability to enhance peoples' growth and health. Heap's idea of hypnosis seems to go along with the idea that hypnosis should or could be used for strengthening and growth.

Similarly, Yapko (2001) states that with hypnosis, the therapist should strive to amplify the clients' strengths rather than focus on diminishing weaknesses, while the hypnosis is viewed and used as client centred instead of being technique orientated. Yapko (2001) adds that many clinicians mistakenly think that hypnosis consists of techniques, ignoring the uniqueness of each client. However, according to him, hypnosis encompasses a wide variety of methods and concepts, the theme being that people harbour many subconscious strength and abilities. Hypnosis can assist in defining those assets and making them more accessible. Hence, Yapko seems to be another

researcher that finds value in implementing hypnosis for the purpose of inner strength building.

Finally, inner strength building should not be viewed as a once-off session. Every hypnosis session should include some inner strengthening (Brann, Owens, & Williamson, 2012; Frederick & McNeal, 1999; Phillips & Frederick, 1995). An unexperienced therapist can start with written scrips to read out to the client and as the therapist gains confidence and experience, scripts will no longer be necessary. The therapist will then be able to use ego strengthening in a natural way as part of his/her verbalization (Brann, Owens, & Williamson, 2012).

3.3.8 Hypnosis in the treatment of depression

The usage of hypnosis for the treatment of depression is relatively new. This is due to the fact that certain experts in hypnosis maintain that hypnosis can remove the defences people have established for themselves in order to cope with depression. It can also give depressed people the energy to actually act upon their desire to commit suicide, and can precipitate a psychotic reaction in depressed people. Therefore, there was no therapeutic rationale for the treatment of depression through hypnosis (Yapko, 2006). However, Yapko's conviction is such that if the therapist strives to treat people and not the labels, and if hypnosis is not used in order to amplify people's deficits and negative expectations, but rather to focus on peoples' resources and amplify positive expectations, then hypnosis is very helpful (Yapko, 2006). Yapko views hypnosis as an effective tool which allows the client to step out of their usual frame of reference, acquire new skills and perspective and thereby bring about change (Yapko, 2011; Yapko, 2017).

Yapko (2006) states that although hypnosis and depression seem to be two different domains, in actual fact there is much common ground between hypnosis and depression. With both, the narrower the focus, the more their intensity increases. Both involve social interactions and are greatly influenced by peoples' relationships. Both are a result of expectancy. In the case of depression, there is a negative expectation that relief will not be found, resulting in despair. Hypnosis, brings with it a positive expectation of being able to internalise the corrective message through hypnotic suggestions. In addition to this, both involve deep self-absorption in highly subjective

beliefs. Depression is a consequence of being absorbed in a way of being, that makes life burdensome and devoid of joy. Hypnosis consists of the person becoming absorbed in a more adaptive and positive frame of mind. In this way, hypnosis tackles the problem at its source (Yapko, 2006).

In addition, depression gets fed by the adherence to self-limiting and self-defeating beliefs, as well as negative attributions and interpretations of the world (Alladin, 2013; Jankowski et al., 2018; Yapko 2001; Yapko, 2006). In other words, depressed people suffer from negative 'rumination', 'chewing over' thoughts and feelings which are negative, out of context and self-evaluative (Alladin, 2013; Brann, Owens, & Williamson, 2012, p. 198). Yapko's conviction is such that the therapist should make the clients aware of the fact that they are using negative self-hypnosis on themselves (Alladin, 2013). The therapist should guide them out of this cognitive trap by assisting them to notice the positive in the negative, allowing them to feel self-liberated through hypnosis (Yapko, 2013).

As a therapeutic approach, hypnosis is suited for the treatment of depression. There are different ways of implementing hypnosis in the treatment of depression. According to Yapko (2006), effective treatment for depression does not need to have a historical focus and does not need to explain the origin of the problem. The most effective treatments are those that are goal-orientated, skill-building approaches and those aimed at developing solutions to problems (Yapko, 2006). Yapko also stresses the importance of empowerment in the treatment of depression, rather than delving into the past. He believes that the most effective way of empowering people is though hypnosis (Yapko, 2006).

As opposed to the above-mentioned opinions, other schools of thought believe that while empowering clients, building resilience and inner strength with those who struggle with depression is essential. It is also just as important to heal the past or the trauma which caused the depression. Brann, Owens, & Williamson (2012) maintain that with depression, there is often an underlying unrecognised trauma from the past. An alteration with the relationship of the client to the memories of the trauma has been a marker for improvement. Trauma or stress is set and stored in the amygdala (the part of the brain which contains memories of emotions) as a conditioned fear reflex. The trauma is reactivated through triggers. Rational examination will fail to uncover

the unconscious source of the fear reflex; hence, hypnosis is best suited to achieve this. Similarly, with depression, which can be seen as a state of learnt helplessness, there is an over-activation of the amygdala which communicates to the person that something is wrong without specifying what is wrong. At the root of this over-activation, there might be a subconscious trauma. Hence, the first step in treatment would be to reduce this autonomic response to fear, thereby reducing the over-activation in the amygdala, followed by facilitating healing for traumatic events from the past. This can be done best through hypnosis (Brann et al., 2012).

Similar to the approach above, the ego state approach and particularly the SARI model within this approach, advocate the healing of past traumas through hypnosis in order to heal dissociative symptoms, depression being amongst them (Emmerson, 2007; Fredrick & McNeal, 1999; Hartman, 1995; Phillips & Frederick, 1995; Da Silva & Fritz, 2012). Emmerson (2007) states that finding the trauma which causes the neurotic reaction is the strength of ego state therapy. A direct link could be made between the undesirable symptom and the originating, unresolved trauma that is beneath it and continues to cause the symptom. Once the link is made, resolution can begin immediately. Phillips and Frederick (1995, p. 101) elaborate on the SARI model, which is the treatment model of ego state therapy. The second phase of this model deals with accessing the trauma in hypnosis, or in their words - “accessing and reconstructing the source of the patient’s current dissociative symptoms”. Examples of dissociative symptoms would be anxiety related to a traumatic experience from the past, emotional instability which is not related to current circumstances, intrusive thoughts, imagery and behaviour, internal conflict and more. They write that when dealing with dissociative clients, uncovering and processing material which is related to current symptoms is a vital and complex part of the treatment.

In summary, hypnosis is an ancient, useful and effective form of therapy, embedded within a bigger context of therapy. The history of hypnosis, as well as different definitions and models of hypnosis, was explored. The usefulness of hypnosis in combination with inner strength building was looked at, as well as different approaches for the treatment of depression through hypnosis.

Since hypnosis usually takes place within a certain theoretical framework, the theoretical frameworks chosen for this study are those of Erickson and ego states

therapy, which are explored in the following sections.

3.4 The Ericksonian approach

3.4.1 Introduction

Milton H. Erickson (1901-1980) has been considered to be the most innovative and creative psychotherapist and hypnotherapist throughout the world (Erickson & Rossi, 1989; Havens, 2003; Zeig, 2013). He was known as an effective therapist who could motivate even his most “stuck” clients to implement change and growth (Dagirmanjian et al., 2007). He also had a profound influence on human endeavours such as clinical hypnosis, therapy, family psychotherapy, medicine and anthropology (Frederick & McNeal, 1999). It is thanks to him that there was a rejuvenation of the entire field of hypnotherapy, which may be attributed to his unique approaches (Battino & South, 2005) which will be discussed in this section. His therapeutic and experimental experience with the practice of hypnosis spanned more than 50 years. In his life-time, he gave various seminars and workshops around the world (Battino & South, 2005). Erickson also founded the American Society of Clinical Hypnosis in 1957. He edited the *American Journal of Clinical Hypnosis* from 1958 to 1968 and published more than 140 scholarly papers on various topics, but predominantly on the topic of hypnosis (Fourie, 2009; Zeig, 2013). At the time of his death, in 1980, he had written over 300 professional papers and he had hypnotised over 30,000 subjects. Today, there are 118 institutions that have been established worldwide for the further study and implementation of the Ericksonian principles and approaches to hypnosis, family therapy, brief therapy and psychotherapy (Short, Erickson, & Erickson-Klein, 2006).

In his personal life, he suffered from several constitutional conditions - colour blindness, tone deafness and dyslexia. He also contracted polio twice, at the age of 17 and 51 (Fredrick & McNeal, 1999; Rossi, Ryan, & Sharp, 1983). In his later years, he had severe, debilitating and painful arthritis which confined him to a wheelchair (Fredrick & McNeal, 1999). Due to his conditions, he experienced the world in his own unique manner. His efforts to heal himself led to Erickson’s personal rediscovery of many classical hypnotic phenomena and how to apply them in therapy (Rossi, Ryan, & Sharp, 1983).

3.4.2 Defining the Ericksonian approach to therapy and hypnotherapy

Despite Erickson's powerful ability as a hypnotherapist, who had cured the most resistant patients, he did not view the therapist as the one playing the most important role in the process. He argued that the character of therapy should be determined based on the ability, beliefs and needs of the patient. He challenged the use of pre-packed approaches to therapy and supported the use of any technique that would be most responsive to the patients' needs. (Feldman, 1985; Havens, 2003). In his view, the therapist's role was to create the correct climate for the patient to heal himself/herself. In fact, he contended that the therapists did not even have to know the nature of the issue they were attempting to resolve, so long as they would be able to motivate their patients to activate their own capacities and experiences to heal themselves (Havens, 2003).

Erickson achieved high rates of success with his clients, probably due to the fact that he broke many of the therapeutic rules of that era (Dagirmanjian et al., 2007). In his era, the most wide-spread therapeutic model was psychoanalysis, which Erickson studied and rejected (Feldman, 1985; Gunnison & Moore, 2003). While hypnosis at that time was viewed as shallow and "a poor alloy that would interfere with the pure gold of psychoanalysis", Erickson spent over 50 years doing clinical work and experimenting with hypnosis (Feldman, 1985, p. 154), using hypnosis as his main therapeutic tool (Rogers & White, 2017). Psychoanalysis also has a strong interpretive component, namely, the therapist has to interpret what the client says and does, in order to give the client insight into his/her subconscious, whereas Erickson often avoided interpretations (Feldman, 1985; Short, Erickson, & Erickson-Klein, 2006; Otani, 1989). Erickson's most innovative use of insight was to develop with the client an approach to cure, rather than to focus on the problem (Dagirmanjian et al., 2007; Short, Erickson, & Erickson-Klein, 2006). Furthermore, Erickson preferred to use indirect hypnosis approaches with clients, while utilising their unique characteristics and individualising the treatment for them. In his time, the most common hypnosis technique was that of direct hypnosis (Feldman, 1985).

Erickson was atheoretical and did not have structure, rules or a standardised method of treating. Rather, he believed in the uniqueness of each individual and he geared the therapy to the personality and the needs of that individual (Dagirmanjian et al.,

2007; Erickson & Rossi, 1989; Fredrick & McNeal, 1999; Yapko, 2006), instead of forcing his clients into a pre-existing theoretical mould (Battino & South, 2005). His motto was “every client is unique and deserves to be treated in a unique way” (Battino & South, 2005, p. 60). He never really shared the principles he used in therapy and hypnotherapy with other practitioners (Erickson & Rossi, 1989) as his conviction was that each therapist should have a unique treatment plan for each client (Battino & South, 2005). During the last year of his life, Rossi, his close follower, was able to elicit from Erickson information about the principles that guided Erickson and the way Erickson treated clients (Erickson & Rossi, 1989). A few of Erickson’s other followers, such as Gilligan, Lankton, Yapko and Zeig, among others, interpreted his work and derived principles which were common denominators of Erickson’s work (Fourie, 2009). Although each emphasised different aspects of Erickson’s work, there is general agreement on the common principles he used for his therapy (Frederick & McNeal, 1999).

The Ericksonian framework is based on the concept of utilisation and mobilisation of the client’s strengths, assets and internal resources (Havens, 2003; Phillips & Fredrick, 1995; Yapko, 2013). This principle is the essence of Erickson’s work, which is known as the utilisation approach (Battino & South, 2005). Erickson believed that the unconscious mind contains all the essential resources that a person needs in order to solve his/her challenges (Erickson & Rossi, 1976). Erickson also used hypnosis as his main tool in therapy (Erickson & Rosen, 1982; O’Hanlon, 1987).

It is important to note that Milton Erickson had a major influence on ego state therapists (E. Fritz, Personal Communication, November 4, 2014; Hartman, 2002; Fourie, 2009), as their philosophies and thinking shared similar principles such as ego strengthening, hypnosis as an important tool in therapy (Guse & Fourie, 2013; Phillips & Fredrick, 1995) and a brief approach to therapy (Phillips & Fredrick, 1995; Zeig, 2013). As a result of the similarity between the ego state paradigm and the Ericksonian paradigm, ego state therapists such as Zeig, Frederick, Phillips, and Watkins have utilised many of the principles of the Ericksonian hypnosis and integrated them into their own paradigm, thereby strengthening their own theoretical framework (E. Fritz, Personal Communication, November 4, 2014).

3.4.3 The Ericksonian principles

The following principles are the ones that guided Erickson with his therapy and hypnotherapy. These will also guide this study when implementing therapy and hypnotherapy.

3.4.3.1 Co-operation

Erickson used to function as an expert, but he never felt or made his clients feel that he was superior (Short et al., 2006). His belief was that both the therapist and the client need to agree to work together towards the desired goals and changes (Phillips & Frederick, 1995). This process of joining the clients, and leading them towards the achievement of their goals is called “pacing” and “leading” (Battino & South, 2005, p. 46).

3.4.3.2 Pacing

Pacing occurs when there is congruence between the client and the therapist’s posture, movements, expressions and speech (Battino & South, 2005; Gunnison & Moore, 2003). It is the therapist’s responsibility to try and pace as much as possible, as long as pacing stays outside of the client’s consciousness (Battino & South, 2005). Donald (1985, cited in Phillips & Frederick, 1995) states that verbal and non-verbal pacing tends to occur naturally between people who share deep rapport, as a form of mirroring. Pacing allows for the differences between the therapist and client to minimise. It allows the client to feel more trustful and assists the therapist to be more understanding (Phillips & Frederick, 1995).

It is also the therapist’s responsibility to then “lead” the client in a direction of a therapeutic change (Battino & South, 2005, p. 49; Feldman, 1985, p. 155), by introducing new possibilities (Short et al., 2006). These possibilities are supposed to be different from those the client has already entertained, however, they have to fit within the client’s behavioural and belief system (Phillips & Frederick, 1995).

Erickson was against the idea of controlling the client, rather he believed in co-operation and winning the client over in a strategic manner. His rationale was that “behaviour must be regarded by the subject as reasonable, the operator (therapist)

does not actually have control" (Short et al., 2006 p. 117). Erickson's conviction was not to give orders to clients, thereby turning them into helpless slaves, as slaves produce less than free workers do (Erickson, 1966, cited in Short, Erickson, & Erickson-Klein, 2006). This is the reason why it is important when making suggestions in therapy, that the client understands the purpose of these suggestions and how acting upon them would bring them closer to their goals (Fazio & Zanna, 1981, sighted in Short, Erickson & Erickson-Klein, 2006).

3.4.3.3 Action orientation

Erickson's therapy is an action-oriented therapy, both on the part of the therapist and on the part of the client. The therapist is supposed to lead the client towards change and in so doing he/she might direct the client to take some action towards the client's healing (Feldman, 1985). Research shows that when beliefs are formed as a result of a direct experience, they have a much more lasting effect than those formed based on second-hand information. This is the reason why Erickson believed in getting the clients to act upon their new learnings (Short et al., 2006). He maintained that to cure is having the required experience, which explains why Erickson believed in action (Short et al., 2006, Yapko, 2006).

3.4.3.4 Every human being is unique

In our conforming societies, peoples' uniqueness gets lost (Frederick & McNeal, 1999). Clients often feel that they have to feel and behave within the mould of others. Many therapeutic methods also follow pre-packed "cookbook" techniques (Frederick & McNeal, 1999). As opposed to this, a fundamental characteristic which is found throughout Erickson's teachings and therapy is a deep respect for the uniqueness and individuality of each human being (Short et al., 2006). Erickson said "each person is a unique individual" (Zeig, 1982, p. 8, cited in Feldman, 1985).

Being unique means that no person can be duplicated, as each person consists of a combination of dynamic expressions of objective and subjective influences. Each person has her own fingerprint, her unique DNA, her unique psychological defences, strengths and challenges, her own emotions, her own personality traits, her unique place in her family with the specific dynamics which come together in it. Each person has her own compelling responsibilities at different phases of her life and each person

has her unique spiritual sensibilities (Frederick & McNeal, 1999).

Hence, psychotherapy should be formulated to meet the individual's needs rather than tailoring the person to fit a hypothetical theory of human behaviour (Zeig, 1982, cited in Feldman, 1985). Erickson held the conviction that the practitioner should always allow clients to follow their own spontaneous way of doing things (Erickson, 1962b, cited in Short, Erickson, & Erickson-Klein, 2006). Doing so would facilitate the discovery of the client's inner resources (Short et al., 2006).

3.4.3.5 Each human being has generative resources

Erickson was very clear about the fact that each individual harbours unique resources and that those should be used in therapy. These resources are available for the person to assist with problem solving, living and healing. Resources are conscious and unconscious processes which reside in each human being and can be accessed in various ways. Some of these resources are innate or even instinctual, such as talents, ability and intelligence. Some of them come about due to normal development and exposure to different circumstances, and some develop as a response to stress, namely, to help one deal with stress (Frederick & McNeal, 1999).

In contrast with the traditional psychodynamic model, which used insight into the client's subconscious in a critical manner, Erickson's use of insight revolved around the client's self-appreciation. Similarly, while the traditional approaches used insight to focus on the nature of the problem, Erickson preferred to create insight in the client, in his/her ability to enjoy life. In almost all of Erickson's interactions with his clients, Erickson would strive to point out to them the resourcefulness and goodness of the mind. This approach of his served to orient the clients towards resiliency (Guse & Fourie, 2013; Short et al., 2006).

The reason why Erickson found it necessary to assist the clients in finding and connecting to their assets, strengths and resources is due to the fact that people often seem to dissociate from their resources. They need help in recognising, locating and activating them so that these resources can become available energies in people's lives. Many people struggle to access their resources due to maladaptive parenting, trauma, developmental challenges, physical illnesses and an impoverished environment, but it is these resources that are the key in healing and progress

(Frederick & McNeal ,1999).

3.4.3.6 The unconscious mind contains all the resources the client needs for problem solving

Erickson viewed the unconscious mind as a vast storehouse of resources and as a context for change, which could be used for healing (Feldman, 1985; Gunnison & Moore, 2003). In contrast to the traditional psychodynamic model, where the unconscious is viewed as a place full of negative forces, ideas and impulses which are so unacceptable to a point where they need to be repressed by the unconscious mind, away from conscious awareness, Erickson has a very different and positive view. Rather than distrusting the unconscious, as it harbours aggressive, hostile and sexual impulses, Erickson encouraged his clients and students to trust the unconscious mind as a positive force which is even wiser than the conscious mind. This is due to the fact that Erickson had a much broader view of the unconscious mind. According to him, all functions of the brain, which are outside of human awareness, namely, information processing, storage and retrieval processing, learnt neuromuscular responses, physiological self-regulatory mechanisms and more, are a function of the unconscious mind (Feldman, 1985).

3.4.3.7 The principle of utilization

Utilization is the most distinctive, the cornerstone and the defining hallmark of the Ericksonian approach (Battino & South, 2005; Phillips & Frederick, 1995; Short, Erickson & Erickson-Klein, 2006; Yapko, 2006; Zeig, 2013). Zeig (1992, p. 258) defined utilization as “the readiness of the therapist to respond strategically to any and all aspects of the patient or the environment”. Ericksonian philosophy could be condensed to one statement, which is, assisting clients in recognising the goodness of their body and mind. This is the essence of the concept of utilisation (Short et al., 2006).

Erickson utilized the client’s observable and non-observable behaviour (Brown, 1991). Non-observable behaviour means paying attention to the client’s words (Drouet & Chedeau 2017; Phillips & Frederick, 1995), what they say about themselves and utilising this information as needed (Phillips & Frederick, 1995). Erickson also utilized the client’s frame of reference (Phillips & Frederick, 1995), language, verbal style,

needs, preferences and social histories (Lankton, 1989). He further utilized the client's perceived needs, the client's environment, interests, values, expectations (Yapko, 2006), as well as the client's beliefs, unique personality, unique situation (Brown, 1991), symptoms, attitudes and the emotional responses of the client (Phillips & Frederick, 1995). Erickson believed that unconscious processes that are elicited during hypnosis can also be utilised for the client's benefit (Battino & South, 2005). Erickson even utilised the client's resistance to certain things in therapy. If, for instance, the client was resisting to share some important information with Erickson, Erickson would ask him rather not to share this information, thereby, breaking the resistance and getting the clients cooperation (Brown, 1991; Otani, 1989). Erickson held a strong conviction about the importance of utilising neurotic, obstructive and irrational qualities of the client, viewing it as being as important as utilizing their strengths. This is due to the fact that these pathologies are viewed as an essential part of the presenting challenge, hence they could provide some foundation for the treatment (Phillips & Frederick, 1995)

Utilization requires both acute observation of the client and flexibility, in order to be able to utilize whatever the client presents with (Brown, 1991). In his therapy, Erickson also utilized a variety of forms of communication. He used jokes, puns, riddles and stories in order for people to create their own meaning for the sake of change and evolvement (Brown, 1991).

Erickson strongly believed that "healing is the activation of inner resources during the process of recovery" (Brann, Owens, & Williamson, 2012; Short et al., 2006, p. 16). A great deal of therapy takes place through recognising and pointing out to the client, his/her resources and strengths while building on them incrementally. Erickson differentiated between treatment and healing. Treatment is an intervention, used from the outside in, as opposed to healing, which takes place within the individual, both on a biological and psychological level. It is the assets and strengths, and the resources of the individual which produce sustainable healing (Short et al., 2006). Milton Erickson (1900-1980) had a major influence on ego state therapists (Fourie, 2009; E. Fritz, Personal Communication, November 4, 2014; Hartman, 2002). A comprehensive introduction to ego state therapy follows.

3.5 Ego state therapy

3.5.1 The origins of ego state theory and therapy

The origins of ego state theory can be traced as far back as Freud's psychoanalytic theory. His theory is about understanding and unpacking the subconscious, in order to make conscious, the unconscious (Watkins & Watkins, 1979). He divided the personality into three parts, the id, the ego and the super-ego (Schmidt & Hernandez, 2007; Watkins & Watkins, 1979). The id, as one's subconscious, the ego as the consciousness and the super-ego as the conscience (Watkins & Watkins, 1979). Freud's follower, Paul Federn (1871-1950), developed the theory of personality-parts further (Barbieri, 2008; Seubert, 2018), by stating that the personality is in fact made up of many different parts, not only three parts, and that the parts assume and play different roles. Federn named these parts ego states, explaining that they encompass different states or modes of the "I" (Emmerson, 2006). While Federn developed the theory of ego state, he left it in the realm of theory and did not develop a therapy method to follow. Federn practiced his therapy as a psychoanalyst, based on the prevailing style of therapy at the time (Emmerson, 2006). Eloardo Weiss, an Italian psychoanalyst, underwent the process of psychoanalysis with Federn. Federn shared his views of the personality with Weiss, who, too, integrated this knowledge into his theories (Emmerson, 2006). Hence, Weiss also became part of the chain of theorists and practitioners who developed the ego state approach.

During World War ll, J. G. Watkins was serving as a chief psychologist of a large U.S. army hospital, where he was exposed for the first time to the phenomena of ego states (Watkins & Watkins, 1979). As he was using hypnosis as one of his treatment tools, he was then exposed more and more to the phenomenon of different parts of the personality emerging through hypnosis. However, Watkins had no theoretical framework through which to understand what he was experiencing until Weiss became Watkins' psychoanalyst and shared the ego state theory with Watkins (Emmerson, 2006). During this time and later, at the university of Montana, Watkins with his wife, H. H. Watkins, developed a theoretical rationale for understanding ego states. Their main contribution to the field was turning ego state theory into practice, namely, into therapy (Watkins & Watkins, 1979, Seubert, 2018). Their theory is based on the contribution of Paul Federn (Watkins & Watkins, 1979). Other psychologists who

contributed to this theory and therapy are Phillips and Frederick (1995), Hartman (1995, 2002), Morton and Frederick (1997), Frederick and McNeal (1999), and Emmerson (2003, 2006, 2007). This form of therapy is expanding rapidly (Emmerson, 2007).

3.5.2 Ego state personality theory

Personality is a difficult concept to describe. Many schools of thought have delved into this matter, attempting to describe the personality together with its essential dimensions and its development and functioning. These include Adler, Allport, Freud, Fromm, Erika, Horney, Jung, Maslow, May, Piaget, Rank, Rogers, and Sullivan, as well as the object related theorists, Kernberg, Kohurt, Mahler, and Winnicott (Watkins & Watkins, 1997). Ego state theory is one of the theories which attempts to describe the personality (Watkins & Watkins, 1997).

Ego state therapy is based on the premise that the personality is composed of separate parts, a divided self, rather than being a homogeneous whole (Alladin, 2013; Barabasz, Barabasz & Watkins, 2012; Phillips, 2004; Phillips & Frederick, 1995; Da Silva & Fritz, 2012; Watkins, 2009, Yapko, 2017). Each ego state has its own gender (Barabasz, Barabasz & Watkins, 2012), mood (Alladin, 2013; Watkins, 2009), role, mental function (Alladin, 2013, Seubert, 2018), age, feeling of power or weakness, emotion, logic, skills, and other personal traits (Phillips & Frederick, 1995). Different ego states may differ in values from each other (Hartman, 1995), and have their own physical sensations, memories, narratives (Forgash, & Knipe, 2012), their own identity and their own views of reality (Schmidt & Hernandez, 2007). They also contain their own idiosyncratic behaviour and experience, and they may act like a complete person (Hartman, 1995; Seubert, 2018; Watkins, 2009). Each ego state is separated by a boundary from other ego states (Barabasz, Barabasz & Watkins, 2012; Seubert, 2018) and views itself as “I”, and views its mental and physical content as “mine” (Hartman, 1995, p. 38).

Watkins’ definition of an ego state states that “an ego state may be defined as an organized system of behaviour and experience whose elements are bound together by some common principle and which is separated from other such states by a boundary that is more or less permeable” (Watkins & Watkins, 1997, p. 25; Watkins,

2009, p. 138). When one of these states is invested with a substantial energy of the person, it becomes 'the self' in "the here and the now" (Alladin, 2013; Watkins & Watkins, 1997, p. 26). At any given time, the state that takes all the energy of the person is considered "the executive", and it considers all the other states as "she" or "he" or "it". As energies flow from one ego state to another, the experiences and the behaviour of the person change (Watkins & Watkins, 1997). What causes a person to switch from one personality to another could be a memory, a situation, a thought, or a sensation (Emmerson, 2003, 2007). The average person has about five to fifteen ego states that are generally used during normal times. These are states that are close to the surface of the personality and they usually communicate well with each other. There are also states that are more in the subconscious and that do not commutate well with other states (Emmerson, 2003, 2007).

The various ego states enrich a person's life, and make it more productive and enjoyable (Phillips & Frederick, 1995). This is true as long as there is no conflict or dissociation within the personality, namely, between personalities, which can cause major distress (Alladin, 2013; Barabasz, Barabasz, & Watkins, 2012; Phillips, 2004; Phillips & Frederick, 1995). The study will later examine issues around dissociative states.

Some ego states are resourceful and helpful states which help a person function (Phillips, 2004; Phillips & Frederick, 1995; Schmidt & Hernandez, 2007; Seubert, 2018), while some states are maladaptive and rigid, maintaining the conviction that they are needed and that they are there to help, while in reality, they are sabotaging the person's growth and emotional development (Emmerson, 2003, 2006, 2007; Schmidt & Hernandez, 2007). Individuals are seen as having a multiplicity of parts, specific to the person, namely, different people might have different parts. Even parts that are similar from one person to the next, assume very individualistic roles which are different from person to person (Emmerson, 2006).

3.5.3 The formation of ego states

According to Frederick and McNeal (1999) and Phillips and Frederick (1995), all ego states are formed in order to help the person. Watkins and Watkins (1997) state that each ego state was probably developed in order to enhance the person's ability to

cope with some problem situation. Ego states are formed during the development of the personality, most of them are formed during childhood, some are formed during adolescence and even fewer are formed during adulthood (Emmerson, 2007). Ego states are actually neurological networks or pathways in the brain, made of dendrite and axon connections which are strengthened by synaptic firing. They are created through repetition and training (Emmerson, 2007; Forgash & Knipe, 2012; Schmidt & Hernandez, 2007).

3.5.3.1 Sources of ego states

The first source from which people obtain ego states is a pre-birth source. The resourceful ego states, namely, the inner strength, the inner wisdom, the inner love and the nurturer, are born with the person (W. Hartman, Personal Communication, February 16, 2014). Emmerson (2003, 2007) is also of the opinion that the 'inner strength' part is a resourceful part that is born with the person. Phillips (2004) mentions the nurturer part, and its importance and usage in healing trauma and dissociation. Frederick and McNeal (1999) also speak about resourceful ego states and mention the inner strength part, the inner love part and the inner advisor part. Phillips and Frederick (1995) discuss the inner strength part, as well as other resourceful parts. Phillips and Frederick (1995, p. 90) name them as "conflict-free ego states known as internal self-helpers". However, they do not mention where these states originate from.

The following three sources of ego states appear in Watkins (1992, 1997, 2009), Hartman (1995), Lemke (2007), Phillips (2004), and Emmerson (2003, 2006, 2007). These are ego states that emerge as normal development, as introjects of significant others, and those that are created as a reaction to trauma.

Ego states that emerge as normal development are forged through synaptic connections between neurons which develop through repetition. The more an action is rewarded, the more it will be repeated, and the stronger the synaptic connection will be, until eventually, this neurological network that was created over time becomes a proper ego state. For example, if a child is nurturing towards a parent and he/she receives positive feedback from the parent, the child may repeat those nurturing actions in order to receive more of the positive feedback (Emmerson 2006). In other words, a nurturing part is created or amplified.

Ego states as introjects of significant others develop when a child mimics a part of his role models, (most commonly, a part of a parent) and it becomes a part of his/her own personality (Hartman, 1995; Phillips, 2004; Schmidt & Hernandez, 2007; Watkins & Watkins, 1997). Introjects can be of a living or a deceased person, who are or have been meaningful in the person's life (Emmerson, 2007). A person is able to take on the role of the introject and mimic the way it speaks, feels and behaves (Emmerson, 2007; Schmidt & Hernandez, 2007). Introjects can be kind and helpful, especially if the person grew up amongst significant others who also were kind and helpful. An introject can also be intimidating and abusive, if this is the environment in which the person grew up (Emmerson, 2007; Phillips, 2004; Schmidt & Hernandez, 2007). One works with introjects in much the same way as with other ego states and one can change the role they play (Emmerson, 2007).

Some ego states are created as a response to being confronted with traumatic or frustrating situations (Barbieri, 2008; Da Silva & Fritz, 2012; Forgash & Knipe, 2012; Guse & Fourie, 2013; Phillips, 2004) and there is no existing ego state that has the capacity to respond (Emmerson, 2007). Watkins and Watkins (Watkins & Watkins, 1990; Watkins, 1992; Watkins, 1993) believed that many ego states were initially created in order to help a child cope with overwhelming trauma. According to them, there are only three options to deal with overwhelming trauma. Firstly, the person can separate himself/herself from reality and become psychotic. Secondly, a person can commit suicide, and lastly, the psyche can create dissociation, by compartmentalising the trauma into one ego state, so that the entire personality is protected from the trauma. Hence, trauma causes dissociation of parts within the personality (Barbieri, 2008; Watkins & Watkins, 1997). A discussion of the ego state spectrum is appropriate at this point.

3.5.4 The ego state spectrum

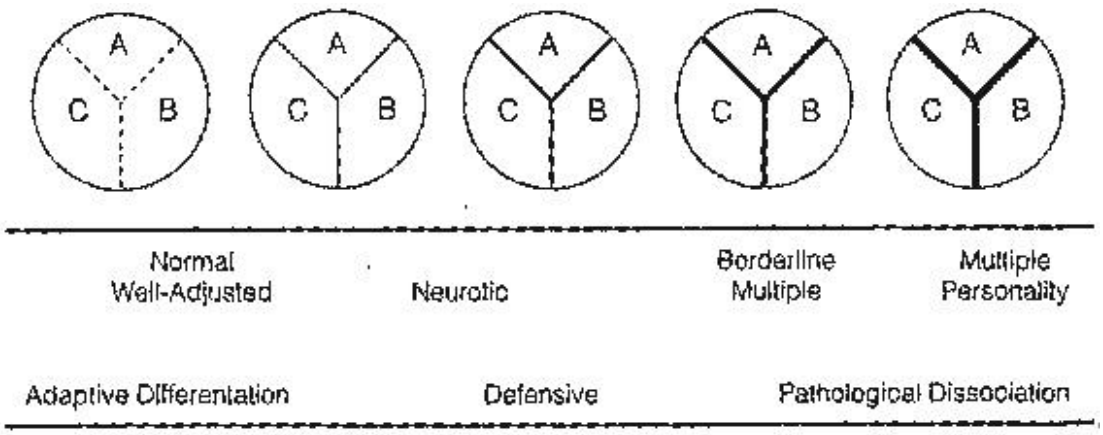

Figure 3.2. "The differentiation-dissociation continuum" (in Watkins & Watkins, 1997, p. 32).

Ego states can have different levels of integration with one another (Lemke, 2007; Phillips & Frederick, 1995; Da Silva & Fritz, 2012; Seubert, 2018). Ego states are viewed as having semi-permeable boundaries or membranes between one another (Frederick & McNeal, 1999; Lemke, 2007; Da Silva & Fritz, 2012; Seubert, 2018). The ideal thickness of the membrane is such that it is thick enough to provide separation, but it is thin enough to allow for communication between ego states (Frederick & McNeal, 1999).

If the personality is well-adjusted and integrated, the personality may be illustrated by the circle on the left, where there are dotted lines between each personality, representing the integration between the sub-personalities, as indicated in Figure 3.2 above. These sub-personalities are in communication with one another and they cooperate with each other (Phillips & Frederick, 1995).

Ego states and their function should not be confused with Dissociative Identity Disorder or according to the old terminology, Multiple Personality Disorder, although, the integration of ego states and Dissociative Identity Disorder are on the same continuum (Lemke, 2007; Watkins & Watkins, 1997).

3.5.5 The implementation of ego state therapy

Phillips and Frederick (1995) and Phillips (2008) suggest the *'SARI model'* as an effective method of implementation of ego state theory and resolving the issue at hand. The SARI model consists of four phases, namely, safety and stabilization, accessing the trauma and related resources, resolving traumatic experiences, and re-stabilization and personality integration. They maintain that the first phase of the SARI model is essential in the therapeutic process, as a person has to first achieve a sense of internal and external safety before attempting to deal with other therapeutic endeavours. If this is not achieved, the therapeutic process may be disrupted, as the client may be overwhelmed by stimuli she is not equipped to deal with and may not be able to recover from a re-traumatising regression (Da Silva, 2010; Frederick & McNeal, 1999; Phillips, 2008; Phillips & Frederick, 1995). This phase includes addressing the client's needs in terms of various risks and disturbances, such as suicide, anxiety,

sleep disturbance, substance abuse and others.

As part of the above, ‘ego strengthening’ or ‘inner strength building’ plays an important part (Phillips & Frederick, 1995, p. 38; Phillips, 2008). In addition, according to Phillips and Frederick (1995, p. 82), in order for the therapeutic process to be effective, “experiences of calmness, clarity and mastery need to occur early in treatment”. This can be made possible by starting to build inner strength at the first phase of the therapy. Phillips and Frederick (1995) add that most clients require inner strength building at the beginning of the therapeutic process in order for them to be strongly committed to therapy, to help them retain hope and to allow for the possible dissociated trauma to “emerge from behind amnestic barriers” (Phillips & Frederick, 1995, p. 82). They state further that when inner strength building takes place, there may be enhanced self-esteem, clarity of thinking, an ability to self-soothe and problem solve, and increased insight. In this way, the client does not need to develop absolute dependency on the therapist as she will be able to motivate herself to tackle the difficult task of solving her own problems (Phillips & Frederick, 1995).

Stage two of the SARI model consists of accessing and mastering the traumatic material that emerges. During this stage, sessions alternate between inner strength building, as in stage one, and reconstruction of traumatic material (Barabasz, Barabasz, Christensen, French & Watkins, 2013; Phillips & Frederick, 1995). Stage three of the SARI model is the point at which traumatic experiences are resolved. This stage also entails the ongoing reconstruction of traumatic material and consistent re-stabilisation through inner-strength building (Phillips & Frederick, 1995). Stage four of the SARI model brings about the integration of the ego states and the formation of a new future identity (Alladin, 2013; Phillips & Frederick, 1995). In addition, it entails the hypnotic interventions applied during the first three stages, including the inner strength building of stage one (Phillips & Frederick, 1995). It can be clearly observed that inner strength building forms the foundation of the SARI model. It is important to bear in mind that the usage of hypnosis appears throughout the SARI model in order to aid and facilitate the mastery of specific goals (Phillips, 2008).

The researcher contends that the most effective way of implementing ego state therapy with adolescents is thorough the use of art in therapy, as the visual arts facilitates the concretisation of the ego states. A discussion of creative expressive art

in therapy follows.

3.6 Creative expressive art in therapy

The word ‘art therapy’ emerged from the Latin word “arte”, which means crafts (Hoffmann, 2016, p. 197). The word ‘therapy’ is derived from the Greek and means ‘treatment’. Hence this term means therapy through art (Hoffmann, 2016). Art therapy is a wide term which includes various techniques, such as drawing, painting, singing, sculpturing, modelling, dancing, poetry, biographies, drama and creation of sand (Hoffmann, 2016). The focus is on correcting and preventing disorders, as well as on education and recreation (Gruber & Oepen, 2018; Hoffmann, 2016). The person who conducts this therapy is called an art therapist. This person needs to acquire knowledge of the visual arts, psychology and psychotherapy (Hoffmann, 2016). Since the concept ‘art therapy’ has legal implications which stipulate that one needs to obtain qualifications from specific universities, the researcher will be using legally accepted terminology for this type of art, which is ‘art in therapy’.

3.6.1 History and development of art in therapy

For thousands of years, healers have incorporated a variety of expressive arts into their treatment and therapy. In ancient Rome and Greece, comedy and drama where prescribed as a healing method for depression and anxiety sufferers (Degges-White & Davis, 2011). Tribal dances were often used for healing the planet and individuals (Degges-White & Davis, 2011; Van Westrhenen & Fritz, 2014). Contemporary Navajo healers still integrate music and sand-painting into their healing (Degges-White & Davis, 2011). McNiff (1998) states that in the popular mind, art has been perceived as a means for leisure and as an expression of emotion, and more recently, it has been perceived as a means for healing. However, it has not been appreciated as a mode of enquiry, as a source of information or as a means of systematically studying the human experience. This study aims to use the means of the art for the purpose of healing, namely, building inner strength, and as a means of investigation.

3.6.2 Art therapy as a mind-body approach

Therapeutic practices have been used throughout history. Wherever humans are born, live and die, there is pain and loss involved, and a need for the healing of wounds. In

pre-modern cultures, these practices aimed to address both the soul, or psychological dimensions, and the body of the sufferer. From an anthropological perspective, it is only relatively recently that purely physical treatments were developed. Not only was the soul seen as a part of the whole, but the body itself was related to as being animated. Therefore, the possibility of treating the body in isolation, and apart from the soul, was never taken into consideration. In other words, in separation from the aspect of meaning and value which the concept of *psyche* implies. This implies that treatment needs to incorporate both aspects of the human being, which a holistic approach, such as art in therapy provides (Knill, Levine, & Levine, 2010). Along the same lines, there is growing neurological evidence of the usefulness of art in therapy, particularly with victims of trauma (Gruber & Oepen, 2018; Van Westrhenen & Fritz, 2014). Trauma affects the visual and sensational memories stored in the brain, without a narrative manifestation of them. This would explain the reason why art in therapy, which uses vision and the senses, is useful and effective (Van Westrhenen & Fritz, 2014).

3.6.3 The benefits of art in therapy

Traditional talk therapy alone is usually unsuccessful in children and adolescents (Briks, 2007; Chin et al., 2017; Green & Drewes, 2013). Creative expressive art in therapy provides a safe context in which one can explore and express one's feelings, perceptions, thoughts and behaviour (Chin et al., 2017; Moosa et al., 2017; Rahmani, Saeed, & Aghili, 2016; Van Lith et al., 2018). Prior to verbal development, children learn to interact with their environment through their sight, touch and other senses (Darewych, 2015). Art is important for a child's thinking processes, perceptual and emotional development, as well as social awareness (Darewych, 2015). A therapeutic environment which incorporates art is known to help children with their self-esteem and with solidifying their self-concept (Darewych, 2015; Green & Drewes, 2013).

The use of art has also been shown to allow for the excess of thoughts, for reaching dreams, desires, joy and pain, as well as to acknowledge one's intentions and desires that will have no chance to be fulfilled in reality (Gatfield, 2017; Hoffmann, 2016; Maree, 2007). Art is a means of conveying what cannot be conveyed through conventional language (Maree, 2007; McNiff, 1998). Art is known for its efficacy in emotional regulation, as well as for its ability to promote wellbeing, and to reduce anxiety and depression (Darewych, 2015; Green & Drewes, 2013; Gruber & Oepen,

2018; Roghanchi, Mohamad, Mey, Momeni, & Golmohamadian, 2013; Strader-Garcia, 2012). Art can facilitate breaking away from established behaviour (Hoffmann, 2016). A study that measured the correlation between art therapy and prevention in people suffering from burn-out, found that after only one art therapy project day, the participants' mood had significantly improved (Gruber & Oepen, 2018).

This means of therapy is suitable for everyone, not just for creative people (Liebmann, 2004). In addition, it is especially useful for those who would not benefit from verbal therapies (Maree, 2007; Liebmann, 2004) as for certain people art and symbols is the only indirect form which facilitates the externalisation of their internal experiences (Hoffmann, 2016; Maree, 2007). For these individuals, art therapy becomes the 'treatment of choice' (Liebmann, 2004, p. 9; Maree, 2007). Expressive art has the power to help a person to transcend the mundane and to connect to parts of his/her personality which traditional talk therapy may not so readily reach. Art provides a means through which one can access inner feelings and the subconscious, and uses this to create a tangible product, namely, a sculpture, a painting, a story or a dance (Degges-White & Davis, 2011; Maree, 2007). Through art, people have the opportunity to carry out a more comprehensive self-exploration into their deepest, and often most hidden feelings and conflicts within the personality, and acquire more opportunity for self-expression than traditional talk therapy may allow (Degges-White & Davis, 2011). Moreover, through the incorporation of more active forms of therapy, clients often feel more invested, which gives them the motivation for growth and change (Degges-White & Davis, 2011). Under the vast umbrella of creative arts, there are various medias, each with its own therapeutic effect (McNiff, 1998).

3.6.4 The different forms of art therapy

3.6.4.1 Visual art

Visual art encourages people to express themselves (Gatfield, 2017; Liebmann,2004; Maree, 2007). It assists them to look into their emotions more critically, it allows for self-discovery and self-fulfilment, and can also empower people. Art therapy can assist with relaxation and can be used as a stress reliever, facilitating symptom relief and physical rehabilitation (Green & Drewes, 2013). The field of visual art includes many different kinds of art, such as painting, drawing, collage work, sculpturing and

photography (Degges-White & Davis, 2011). Drawing in therapy without therapist intervention is a powerful tool for self-expression and self-identity (Oaklander, 1988). The use of material such as clay also offers a tactile and kinesthetic experience (Oaklander, 1988). Many children with motor and perceptual challenges can benefit from these activities (Oaklander, 1988). The clay allows a sense of control and mastery, which helps those who are insecure and fearful. With clay, one cannot make a 'mistake', as this can be erased. The use of clay facilitates self-esteem strengthening (Oaklander, 1988, p. 67).

3.6.4.2 Music therapy

The first sense that a child develops in the womb is hearing. Young infants are highly tuned into their caregivers' pitch of voice, rhythm and contours. The attentive caregiver's voice and language assist with a healthy attachment between the infant and the caregiver, as well as allowing the infant to feel loved, understood and supported. When a child has been through abuse or neglect, these vital components in the child's developments are missing. Music therapists endeavour to assist with recreating this absent attachment and sense of support (Chin et al., 2017).

Music therapy is a form of interpersonal therapy in which the therapist assists the client to improve social, cognitive, psychological, emotional and behavioural functioning and their quality of life (Degges-White & Davis, 2011; Green & Drewes, 2013; Hoffmann, 2016). The use of music has proven itself effective where other approaches have failed. The use of music stimulates participation and concentration; it can also raise frustration tolerance. It allows for the disappearance of internal and external tension (Oaklander, 1988). In order to achieve therapeutic objectives and goals, music therapists use free improvisation, singing, poetry writing, listening to music, discussions on music, and movement to music. Music therapy nowadays is being used in hospitals, in cancer centres, at schools, in rehabilitation centres for addictions, and in psychiatric wards (Green & Drewes, 2013).

Music therapy has been used as a therapeutic technique since the first half of the 20th century. Musicians have volunteered to assist in hospitals with war veterans from World War I and II in order to bring about therapeutic relief. The healing and curative effect that this had on the sick was well recognised by the medical staff, hence, shortly

thereafter, these musicians were hired by the hospitals (Green & Drewes, 2013).

3.6.4.3 Expressive writing/poetry therapy

Poetry therapy has become an established method of treatment in the US since the late 1960s, being used in multiple settings such as clinics, hospitals and libraries (Ramsey-Wade & Devine, 2018). Poetry therapy means the intentional use of poetry, as well as other forms of expressive writing, for the purpose of healing and personal growth (Ramsey-Wade & Devine, 2018; Stepakoff, 2009). This can be done on a solitary basis or in a professional setting, such as therapy (Stepakoff, 2009). Poetry therapy can be differentiated from other forms of creative writing as it focuses on the product, namely the quality of the result, while expressive writing focuses on the process of writing and the therapy that it brings about (Ramsey-Wade & Devine, 2018).

Expressive writing has proven to be effective with a variety of challenges. These include clients who are dealing with ordinary developmental tasks, clients who have experienced major traumas, such as the World Trade Centre tragedy, and clients who are dealing with acute and chronic health challenges (Degges-White & Davis, 2011; Ramsey-Wade & Devine, 2018). Clients have shown marked improvement in their wellbeing through the tool of expressive writing exercises (Degges-White & Davis, 2011; Yaghoubi Asgarabad, Ahangi, Feizi, Sarmasti & Sharifnezhad, 2018; Stepakoff, 2009), as well as with poetry writing, which can assist in accessing and processing painful emotions (Ramsey-Wade & Devine, 2018).

The benefits of poetry therapy are numerous. Poetry therapy facilitates the transformation from silence to expression for those who tend to suppress their emotions (Stepakoff, 2009). It improves cognitive functioning (Yaghoubi Asgarabad et al., 2018), through enhancing self-expression, poetry therapy may enable independence from therapy. It also allows for a greater understaning of oneself and others. It promotes creativity and greater self-esteem. Poetry therapy can facilitate communication skills, as well as assist with releasing overwhelming emotions (Ramsey-Wade & Devine, 2018).

3.6.4.4 Dance-movement therapy

Dance-Movement Therapy is the psychotherapeutic use of movement and dance to

improve emotional, social, cognitive and behavioural functioning (Green & Drewes, 2013). According to Hoffmann (2016), this type of therapy facilitates physical, emotional and cognitive integration. As an expressive form of therapy, this type of therapy assumes that there is an interconnectedness between movement and emotion and it brings about balance and wholeness. This type of therapy is also used in all the settings mentioned above, namely hospitals, cancer centres, schools, rehabilitation centres for addictions, and in psychiatric wards (Green & Drewes, 2013).

3.6.4.5 Drama therapy

Drama therapy is the use of theatre techniques in order to promote personal growth and mental health (Green & Drewes, 2013), as well as to release repressed emotions, allowing for personal change while taking on a different social role, as well as reinforcing positive behaviour. Drama is a highly experiential therapeutic technique (Degges-White & Davis, 2011). Drama therapy is another form of creative expressive art therapy which is used in a variety of settings. These include prisons, businesses, hospitals, schools and mental health centres. The modern use of theatre techniques as a form of therapy began with psychodrama. The field has expanded to include role-play, theatre games, mime, group-dynamic games, puppetry and other improvisational techniques (Green & Drewes, 2013).

3.6.4.6 Bibliotherapy

This type of therapy involves the use of books and stories in order to prevent problems, validate issues, facilitate rehabilitation, and assist with general development (Hoffmann, 2016). According to Oaklander (1988), bibliotherapy not only involves the reading of stories, but also inventing stories by the therapist or the client, writing stories, as well as telling and recording stories. One often uses items to stimulate the formation of a story, such as puppets, pictures, or figurines (small objects) in a sand tray and drawings. Often the client will tell a story and the therapist would then use the same characters to manipulate the story in such a way that it would contain resolution to the client's problem.

3.6.4.7 Sand-tray therapy

Sand-tray therapy is an expressive and projective technique which allows the client to

unfold and process emotional issues with the aid of specific sand-tray material through non-verbal communication. This activity is led by the client and is facilitated by the therapist. The sand tray activity can provide a new solution for old problems. It also adds playfulness to a play therapy session and increases self-insight (Hartwig & Bennett, 2017).

This kind of therapy involves a spontaneous creation of a “miniature world” in a box filled with sand, which brings about internal transformation and integration (Hoffmann, 2016, p. 198; Maree, Ebersohn, & de Villiers, 2012). Oaklander (1988) explains that this type of therapy is suitable both for adults and for children. It can be used with dry or wet sand. The objects used in the sand tray represent real life. People create scenes or play out a situation in the sand tray and if photos are taken of these scenes, they can often be compared later on in the therapy process with new scenes, hence testifying to the client’s evolvement.

3.6.4.8 Movie therapy

The use of movie therapy is scientifically documented as a useful supplement to psychotherapy in both the USA and in Europe. It is used in several settings such as individual therapy, family therapy and group therapy. It is also used by different treatment modalities such as psychodynamic, cognitive behaviour therapy and systemic relational therapy (Basile, 2017).

Movie therapy is a technique used in therapy that is based on watching a part of or an entire movie. The conviction is that this technique has the power to assist the client in the emotional domain. This is done by the client internalising some aspects of the hero of the movie, which encourages the client to change his/her behaviour (Hoffmann, 2016).

In addition, movie therapy allows for clients to talk about their beliefs, thoughts and feelings when discussing the characters/caricatures of the movie. Movie therapy has been found to be a powerful and impactful tool in therapy for promoting emotional health (Yazici, Ulus, Selvitop, Yazici, & Aydin, 2013).

3.6.4.9 The use of art in therapy and the Ericksonian approach

As mentioned above, Erickson's main philosophy was the concept of utilisation (Battino & South, 2005; Phillips & Frederick, 1995; Short et al., 2006; Yapko, 2006; Zeig, 2013). The use of art in therapy fits this philosophy as art is often used as a means of healing for those who do not suit traditional talk therapy by making use of a different ability. Art includes the body in the therapeutic process. Art offers a variety of methods which can fit a variety of people with different interests and talents. Art also makes use of the different senses, which better addresses trauma.

3.7 Art in therapy with adolescents

Green and Drewes (2013) advocate the use of art in therapy with adolescents and they motivate it by stating that "art is an avenue of expression that is less threatening than verbal communication". Art also offers a means of facilitating a relationship with young people, who are often distrustful or withdrawn. Artistic expression allows for the externalisation of complex emotions. Of particular relevance to this study, the art process can play a major role in identity forming which contributes to the activation of inner healing, promoting ego strength and self-esteem. Through reflecting on the imagery of the art, adolescents can gain personal insight and connection with their feelings. As an active form of therapy, independence is promoted and resistances to therapy are reduced. Being symbolic by nature, a 'timeless' perspective is provided, which bridges aspects of past and present. This allows safe regression and resolution of previously unmet emotional needs.

3.8 Conclusion

This chapter provided the theoretical framework for a proposed intervention for female adolescents with depressive symptoms. The concept of inner strength building in general, and in particular in the treatment of depression has been discussed. The background of hypnotherapy and its role in Ericksonian hypnotherapy and ego state theory has been clarified. The roles of different forms of art in therapy and their effectiveness, particularly with adolescents, has been discussed. In the next chapter, the reseach methodology will be discussed, including the research approach, the design, data collection, and data analysis, as well as the content of the sessions with

the participants.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 Introduction

This chapter discusses the execution of the actual research with the participants. The researcher discusses the design and methods used for the research and elaborates on the contributions of qualitative research and the case study design. The procedure of implementing the therapeutic framework is presented. Thereafter, the methods of data collection and data analysis are discussed, followed by the ethical guidelines that this study adheres to.

4.2 Research aim

The aim of this research is to develop and describe a framework which aims at facilitating inner strength building in adolescent girls with depressive symptoms, as well as to propose guidelines for the implementation of this framework. To this end, a multiple case study design, within the qualitative approach, was executed.

4.3. Qualitative research

Prior to defining qualitative research, it is important to define the meaning of the word ‘research’. There are many definitions of research, however, the common denominator is that research is a systematic enquiry and an investigation into matters (Merriam & Tisdell, 2015). Qualitative research tends not to assume that there is one definition and one correct version to reality. It claims that multiple versions of reality can exist at the same time, even within a person himself/herself. These versions of reality are context dependent and each version should not be considered outside the context in which it was generated (Braun & Clarke, 2013, Merriam & Tisdell, 2015). A useful definition of qualitative research is that it uses words and images as data which are collected and analysed in different ways (Braun & Clarke, 2013; Merriam & Tisdell, 2015). This is in contrast to quantitative research which uses numbers as data that are analysed through statistical techniques (Braun & Clarke, 2013; Levitt et al., 2018; Merriam & Tisdell, 2015).

The term ‘qualitative research approach’ refers to both the paradigm and the framework through which the research is conducted, as well as the technique used.

The paradigm refers to the beliefs, values, assumptions and practices shared and used by a research community. The technique refers to the methods of data collection and data analysis (Braun & Clarke, 2013). This research study implemented an interpretive paradigm. An interpretive paradigm means that people interpret and construct their own reality based on their history and social interactions. This implies that there are multiple interpretations to one phenomenon (Merriam & Tisdell, 2015). The design of this study is of a case study. The techniques used within a case study design are also qualitative ones, namely, the methods of collecting the data are carried out through interviews, observations, reflections and artefacts.

There are also a few broad distinctions between qualitative and quantitative research approaches. Bearing in mind these distinctions may help to clarify the underlying nature of each research design. Quantitative research is generally deductive, and qualitative research tends to be inductive. This means that quantitative research tests a specific pre-established theory, as opposed to qualitative research which is open to any theory that may emerge from the data. It follows that quantitative research seeks to identify general patterns, while qualitative research, in addition to seeking patterns, focuses also on divergent findings (Braun & Clarke, 2013). Similarly, quantitative research, which seeks to simply test a specific theory, tends to generate more superficial information, which is adequate as long as the information is gathered from many participants, which consequently makes it technically reliable. Qualitative research, on the other hand, generates information from a small number of participants, but the data is detailed and rich (Braun & Clarke, 2013; Hesse-Biber, 2017; Levitt et al., 2018; Scholl; 2017). Hence, quantitative research is analytic by nature, as opposed to qualitative research which is more holistic (Murshed & Zhang, 2016). These distinctions between quantitative and qualitative research, naturally, have implications regarding the researcher. Quantitative research demands detachment and objectivity. However, in qualitative research, subjectivity and personal reflections are required (Braun & Clarke, 2013; Levitt et al., 2018). The difference between these research approaches also impact the duration of the research. A quantitative study can be completed relatively quickly, while qualitative studies often extend over a longer period of time as they require interpretations rather than following a structured formula.

Since this study is qualitative in nature, it relies on words, meanings, experiences and images. This study is also inductive by nature as will be clarified below. Therefore, it uses a holistic approach in terms of the variety of data collection and in terms of the variety of the activities utilised in one study. In order to facilitate the appropriate level of subjectivity and personal reflection, the researcher was personally involved in the study. In compliance with the requirements of qualitative research, this research was not done as a once-off task, but rather as an on-going process which was spread over a few weeks.

4.3.1 Research design and methodological orientation

This research implemented a multiple case study design to obtain data from three participants. Qualitative methods were used to collect and analyse the data. Since theory informs practice (Patton, 2015), this study was guided by literature about qualitative research and case study design. The broad aim of this study was to explore how inner strength can be built through art and ego state therapy, hence, the most suitable approach was the qualitative approach. Specifically, a qualitative approach that delved into explorations, personal experiences and meanings, which could facilitate answering the research question (Hesse-Biber, 2017; Reck, 2017).

4.3.1.1 Case study research design

In order to reach insightful conclusions, the design of a study must be carefully considered to ensure that the data generated answered the initial research question. The design is the route of getting from “here to there” (Yin, 2003, p. 20). Yin suggests a useful definition of a case study as “an empirical inquiry that investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are not clearly evident, and in which multiple sources of evidence are used” (Remenyi, 2012, p. 2). This definition may be broken down into four components. *Empirical inquiry* refers to the fact that a case study is based on primary data and not produced by secondary sources, such as library work. The primary data for this study is derived from the responses and observation of three participants (Hesse-Biber, 2017; Remenyi, 2012; Scholl; 2017). Secondly, c*ontemporary phenomena* exclude the use of historical cases as being the basis of case study. Generally speaking, a case study would not refer back in time beyond five

years. Therefore, in this study, there are current participants (Remenyi, 2012). Thirdly, r*eal life context* means that the researcher does not have control over the setting. In this study, the researcher has control over the setting in the therapy rooms, but not over the setting and the environment at home, to which the client returns after each session (Remenyi, 2012). Lastly, *'multiple sources of evidence'* implies that any information that can aid in answering the research question should be employed. Therefore, in this research, there is ample data that was generated from three different people in a number of different ways (Remenyi, 2012; Hesse-Biber, 2017).

A case study revolves around a story line running from the introduction to the research, covering the topic's background in the literature review, to the methodology, to the data collection and the data analysis, and finally the conclusions. The story needs to be articulated carefully and logically as it constitutes the line of argument, proving the research's value. Most importantly, the story must be reliable, implying a dependable description of all aspects of academic research, as well as conveying the logical path that the researcher followed throughout the research (Remenyi, 2012). When a case study has been conducted correctly, it makes a unique contribution as it provides the researcher with a deep and holistic understanding of the phenomenon within its social context, as well as the complexity and nuances of the subject of inquiry (Hesse-Biber, 2017).

4.3.1.2 A critical evaluation of the case study approach

When embarking on case study research, it is important to take a critical stance from an academic vantage point. Three critiques are reviewed here. Firstly, it is often the case, in case study research, that the researcher fails to adhere to systematic procedures or allows biased stand-points to influence the findings. However, this is likely to be the result of case study researchers not following clear methodological texts, which specify the procedures to be adhered to (Scholl; 2017; Yin, 2003). Therefore, in this study, the research procedures have been clearly specified and followed. Secondly, it seems unreasonable to draw general conclusions from a small number of cases. However, a case study is used to enhance a theoretical proposition and not to apply statistical information across the population. In other words, the case study is not intended to represent a sample (Scholl, 2017; Yin, 2003). The goal of this research is to enhance the theoretical knowledge of building inner strength through

ego state therapy and art in therapy, and not to generate any statistical value to the general population. Thirdly, an additional critique of case studies relates to the fact that they often take a long time and provide lengthy unreadable documents. The truth, however, is that this would be true in those case studies which require long periods of time in field work and detailed observational evidence (Yin, 2003). This research, although involving adequate field work and participants' observation, does not require an unreasonable amount of time investment, and is not expected to result in over-detailed observational information. The researcher, however, is aware that on account of the points raised, the case study being undertaken does entail difficulties.

Case studies are useful as they serve a diverse variety of research goals. Case studies can assist in testing an existing theory or they can assist in generating an original theory. In this study, the cases are there for the sake of expanding existing knowledge and application (Scholl, 2017).

4.3.1.3 Inductive and deductive approaches to research

In order to interpret a case study, one may utilise one or both of the following approaches to research, namely, inductive and deductive reasoning (Hayes, Stephens, Ngo, & Dunn, 2018; Stephens, Dunn & Hayes, 2018; Yin, 2016). Reasoning means deriving conclusions or inferences from evidence (Hayes et al., 2018; Stephens et al., 2018). In the case of deductive reasoning, one starts with the theory which one wishes to test. The method involves translating the theory into a hypothesis, collecting related data, using the findings to confirm or reject the hypothesis which results in the revision of the theory. In the case of inductive reasoning, the researcher draws inferences out of observations or findings, which results in a theory. (Bryman, 2016; Creswell & Creswell, 2017; Stephens et al., 2018; Yin, 2016). Inductive reasoning is usually used within qualitative research with the aim of generating a theory (Bryman, 2016; Creswell & Creswell, 2017; Yin, 2016).

It is important to note that even though it is helpful to define a theory as either deductive or inductive, it is more accurate to view the distinctions as tendencies rather than absolute distinctions. This is because deductive reasoning, incorporates a dimension of inductive reasoning at the stage when the researcher infers the implications of the observations, in order to revise the theory. Likewise, in the case of inductive reasoning,

once the findings have been converted into a theory, the researcher may want to investigate more, in order to establish the parameters of the theory. This dimension of inductive reasoning is called iterative, meaning weaving back and forth from theory to data (Bryman, 2016; Yin, 2016). The researcher, in her own practice, formed a theory or a hypothesis which maintains that using a framework that includes ego state therapy in combination with art therapy through certain activities, and in a certain order, would lead to inner strength building. The inner strength building will, in turn, help alleviate depression to a certain extent. The researcher checked this theory or hypothesis in her own practice with her clients. The hypothesis appeared correct. This is the deductive part of the investigation. The researcher subsequently performed an official study, which is this research, based on both deductive and inductive research principles. The researcher wanted to check for depression, based on the DSM-V criterion, as well as for inner strength based on the Lundman et al. (2010) principles, as well as looking for codes and themes that may represent any emotional evolvement of the participants through the process. Hence, this is theory following findings, which is a deductive research. The researcher also went through the raw data and looked for codes and themes that may not pertain to depression and inner strength, not knowing what would be discovered and what would evolve as the final analysis. Hence, the findings followed theory, which is inductive reasoning.

Therefore, three participants were observed in a controlled environment while using the framework, with the aim of reaching a hypothesis, confirming the researcher's theory, or expanding on existing theory. Elaboration of the participants is discussed below.

4.4 Participants

In qualitative research, the participants are chosen based on purposeful sampling in contrast to probability sampling, which assists the researcher in obtaining statistical inferences to a population (Bryman, 2016; Hesse-Biber, 2017). Purposeful sampling refers to the intentional selection of participants that would be most suitable in yielding applicable and plentiful information addressing the research problem under examination (Creswell & Creswell, 2017; Yin, 2016). Hence, the researcher needed to determine which type of purposeful sampling would be most useful for the study (Creswell, 2013). The type of purposive sampling that was chosen for this research is

referred to as “criterion sampling”, as the participants had to meet certain criteria in order to participate (Bryman, 2016). Therefore, the researcher put out a community notice on a local website, for the sake of convenience, as these participants were from the area in which the researcher has a private practice. This was followed by a screening phase to see which of the volunteers would be suitable for the research (Creswell, 2013; Holloway & Wheeler, 2010).

In terms of the sample size, the researcher had to determine that the chosen sample size would indeed bring about ample, rich information and would achieve saturation. At the same time, if there were too many participants, it might lead to information redundancy. Therefore, only three participants were selected from a bigger sample size, who in fact did not meet the criterion. The rest were referred for treatment elsewhere (Bryman, 2016; Merriam & Tisdell, 2015; Yin, 2016). The participants, who were included in the study, were three females, ages 14 to 16, English speaking, middle class, living and studying in the Northern Suburbs of Johannesburg. They all enjoyed creativity, suffered from depressive symptoms and were willing to participate in the study. Once the participants were chosen, data collection began.

4.5 Data collection

According to Merriam and Tisdell (2015), the idea that data is being collected is misleading. Data needs to be noticed by the researcher. Data comes about through asking, watching and reviewing, based on the requirements of the study (Merriam & Tisdell, 2015). In qualitative research, data is typically elicited from multiple sources (Creswell & Creswell, 2017). The three main sources of data for qualitative research are spoken evidence, written evidence and observations. Spoken evidence refers to evidence that is collected through conversation. Interviews are the most popular way of acquiring spoken evidence. Written evidence refers to formal and informal reports. Both are of considerable value to academic researchers and should be used wherever it is appropriate. Observation data refers to watching and observing people and their settings (Merriam & Tisdell, 2015; Remenyi, 2012). The value, richness and details obtained through observation is often missed and underestimated as observation data seems less structured than an interview or written evidence. (Remenyi, 2012; Scholl, 2017). In this study all three sources were utilised.

The following diagram represents the data sources that supplied material for this research study:

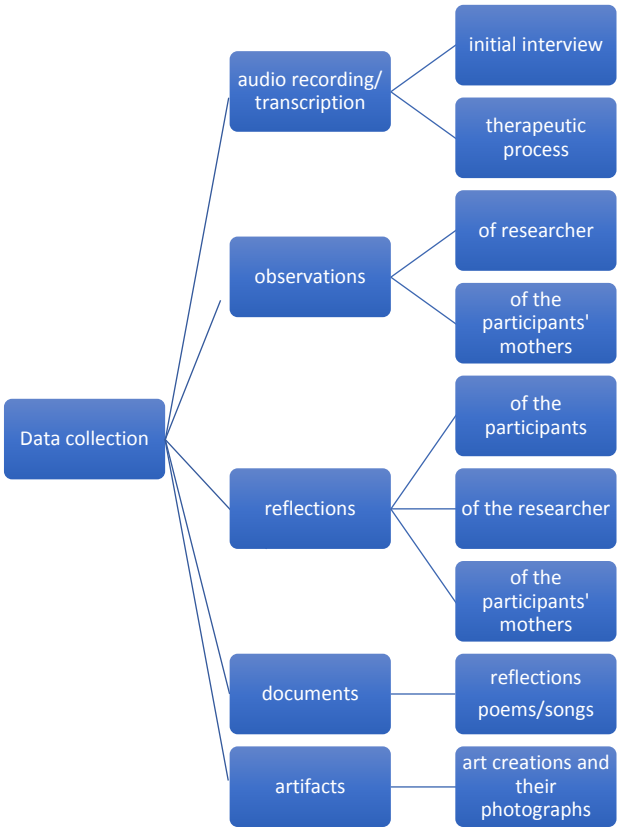

Figure 4.1. The sources for data collection used in this study

4.5.1 The interview

A commonly used method of data collection within qualitative research is an in-depth interview (Hesse-Biber, 2017; Merriam & Tisdell, 2015). An interview is defined as a "conversation with a purpose" (Merriam & Tisdell, 2015, p. 109). This interview is also known as an intensive interview. In-depth interviews are conversations conducted between the researcher and the participant which entail active asking and listening (Hesse-Biber, 2017; McClelland, 2017; Richards, 2015), or as Patton (2015, p. 462) put it, "an interview is a social interaction with the interviewer and the interviewee sharing in constructing a story and its meaning; both are participating in the meaning-making process. The interviewer facilitates the interviewees in subjectively creating their story" (Patton, 2015). An interview is useful as it may be the only source of

information for things that cannot be observed, such as feelings, thoughts, intentions, meanings and past events (Merriam & Tisdell, 2015).

In this study, the activities that took place during the first session, namely, the poems, the genogram and the lifeline, all entailed active asking and listening, as well as assisting the participant in creating and constructing her subjective story together with the meaning it carries for her. The interviews were recorded and transcribed (Creswell, 2013; Richards, 2015) and the participants were made aware of this (Patton, 2015).

Since this is a qualitative study, the questions that are asked during the interview should elicit a variety of answers which are not restricted to certain preconceived categories. The term “open-ended interview” refers to this goal (Richards, 2015, p. 47). Before asking any of the open-ended questions, the researcher needed to alert the participant by introducing the question. This is done through prefatory statements. This method allows the participant to be focused on the nature of the questions that are to follow and to organise their thoughts about the matter, prior to responding (Patton, 2015). Therefore, in this study, every group of questions was introduced first with, for example, “we are now going to discuss the family constitutions and dynamics”, or “we are now going to go through the experiences of your life” (Patton, 2015). After introducing each set of questions, the questions asked were all open-ended, namely, “please tell me about any happy experience you had between the age of three to six”.

There are three ways to structure an interview. An interview can be highly structured, semi structured or low structured (Hesse-Biber, 2017; Merriam & Tisdell, 2015). In this research, the interview was semi structured, which means that it relied on certain sets of questions which guided the participant to stay on the desired topic, but more loosely than with the highly structured interview. The interview allows the participant some latitude and freedom to discuss what interests her. The conversation flows more naturally, even into unexpected directions, however, soon enough, the participant is brought around to focus again on the topic (Hesse-Biber, 2017).

4.5.2 Observations

Observation is one of the key tools within qualitative research (Creswell, 2013b). It is the act of collecting information through the five senses of the researcher (Creswell, 2013b). The usefulness of observations is pointed out by Patton (2015, p. 379), “You

can observe a lot by just watching; watch what's there and what's not there". Observation includes observing interactions, activities, as well as what people do and say, while also noticing what was not said or done, as well as unspoken language (Creswell, 2013b; Patton, 2015; Hesse-Biber, 2017). At times, what is not present is as vital as what is present (Hesse-Biber, 2017). Observation needs to take place right through the session (Creswell, 2013b; Patton, 2015).

Bearing in mind the subjective nature of human perception, the question arises as to how observational data can be trusted (Merriam & Tisdell, 2015; Patton, 2015). The answer lies in the distinction between untrained observation and that of the skilled observer who, through the correct training and preparation, is able to achieve accuracy, authenticity and reliability in his/her observation (Merriam & Tisdell, 2015; Patton, 2015). Provided that the observer is well trained, there are various advantages to obtaining data through observation. Amongst these advantages is the fact that field work provides the opportunity to see what is often unseen by people naturally in the setting, including paying attention to things that have never been observed before. Field work observation generates questions that can be helpful during interviews with the understanding and interpretation of what is being observed (Patton, 2015). Lastly, field work enables the enquirer to gain access to sensitive issues which may not ordinarily be brought up in an interview (Merriam & Tisdell, 2015; Patton, 2015).

Naturalistic observations happen "in the field" (Patton, 2015, p. 332), therefore, in this study, the observation took place in the therapeutic rooms of the researcher which served as a field to the research (Creswell, 2013b; Patton, 2015; Merriam & Tisdell, 2015). The observation needs to be focused on the researcher's targets. Therefore, the researcher would need to clarify where the focal points of the intervention would be which would best answer the research question (Hesse-Biber, 2017; Merriam & Tisdell, 2015).

Observers are not only the researchers themselves. Observers exist on a continuum, from intense involvement in the study to being a mere spectator. There is a great deal of variation between these two polarities. An observer can also start off as a participant in order to experience being part of the study, and then gradually withdraw until he/she takes the role of an occasional observer from an onlooker's point of view (Creswell, 2013b; Patton, 2015; Merriam & Tisdell, 2015). In this study, the participants' main

caregivers were involved by being interviewed separately at the beginning of the process to provide background information. Therefore, each main caregiver was an occasional observer of their own daughter, at home or in other settings, noting the daughter's emotional and behavioural status, and noting if there were any changes and/or evolvements (Patton, 2015; Yin, 2003).

The observer needs to view observation as an opportunity and record the details of what they observed as soon as possible (Bryman, 2016; Hesse-Biber, 2017; Remenyi, 2012; Richards, 2015). This can be done through the process of field notes which can then be incorporated into transcripts (Hesse-Biber, 2017; Remenyi, 2012; Richards, 2015) or as in this study, into the researcher's reflections.

Since the observation needs to be focused on details that would aid in answering the research question (Hesse-Biber, 2017), the research question of this study is: "How can ego state therapy and creative expressive art in therapy be integrated to facilitate inner strength building in adolescent girls with depressive symptoms?" Hence, the observations focused on clues that may indicate if ego strengthening indeed took place. Therefore, the focus was on what was being said, phrases, quotes mentioned by the participants, which may contribute, as well as what was not being said (Hesse-Biber, 2017). The researcher also focused on facial expressions and the general energy of the participant (Patton, 2015), as well as their artefacts (Hesse-Biber, 2017; Olsen, 2012; Richards, 2015).

4.5.3 Documents

Documents can provide the researcher with information that cannot be achieved through the researcher's direct observation. Systematic documentation contains what one observes, hears and experiences (Patton, 2015). Documentation include official records, poems, songs, diaries, journals, letters, and blogs, as well as researcher-generated documents (Merriam & Tisdell, 2015; Patton, 2015; Yin, 2003). According to the above information, reflections are also included in the category of documents. According to Patton (2015), reflections may reveal aspirations, tensions, relationships and decisions.

Hence, in this study, the participants were asked to write about a half page or more of their reflections after each session (Creswell, 2013; Richards, 2015). The reflection

consisted of the following questions: How did you experience the session? Did the session help you make any shift in the way you see or feel about yourself? Did the session give you any new insight about the way you think or feel? How did you experience the activity in the session? How did you feel during the week following the session? Other reflections that this study incorporated were the main caregivers' reflections, as well as the researcher's reflections, which were all triangulated (Patton, 2015; Remenyi, 2012). The researcher's reflections contained her personal impressions of what took place during the sessions (Remenyi, 2012). All the documents/reflections were kept for the data analysis stage (Richards, 2015). Another form of documents which were used in this study were the poems or songs that the participants were asked to bring with them to the first session.

4.5.4 Physical artefacts

In all case studies, physical artefacts, are regarded as a reliable source of information and data (Hesse-Biber, 2017; Maree, 2007; Merriam & Tisdell, 2015; Olsen, 2012; Richards, 2015; Yin, 2003) and as objects of research in their own right (Merriam & Tisdell, 2015; Richards, 2015). Artefacts are usually three-dimensional items in the environment that represent or communicate something meaningful to the participants or to the setting (Merriam & Tisdell, 2015). Artefacts may be in the form of an instrument; a technological device; a work of art; creative objects; trophies or any other physical source of information (Maree, 2007; Merriam & Tisdell, 2015; Olsen, 2012; Richards, 2015; Yin, 2003). Artefacts also include photographs, which could enrich the case study and give more information about the participants (Merriam & Tisdell, 2015; Patton, 2015; Richards, 2015). After making the creative objects, the participant may manipulate them and explain what they represent (Olsen, 2012). Such methods can tap into the unconscious mind, allowing for another layer of data to emerge, as opposed to the old custom of using a prolonged interview as the main source of data (Maree, 2007; Olsen, 2012). Artefacts need to be gathered systematically, where the researcher can conduct an in-depth analysis of the data. The findings can lead the researcher into unforeseen areas, providing new knowledge (Olsen, 2012). Therefore, in this study, the participants created different types of art as part of the process which was photographed and analysed. Contained within the images one finds a descriptive narrative which reflects the therapeutic process (McNiff, 1998). The researcher

explored the trail of the artefacts in order to check for any inner strength evolvements (Creswell, 2013b).

4.6 The procedure and therapeutic process

The intervention consisted of seven sessions. These sessions are described below, including the objectives, rationale and the expected outcomes of the session. Figure 4.2 below provides an overview of the therapeutic process.

Figure 4.2. The therapeutic process

4.6.1 Pre-session 1

After receiving about ten replies to the advert, the researcher made a video call in order to speak to the main caregivers of each of the potential participants and to each of the potential participants themselves (Patton, 2015). During this video call, the

researcher screened prospective participants according to three criteria. First, the researcher used the DSM-V criteria for depression, for screening purposes, making written notes. Second, the researcher also enquired whether the potential participants enjoyed creativity, as creativity constitutes a large part of the intervention. This was done by asking both, the main caregivers and the participants about it. If a client does not enjoy the intervention, it will not work (Oaklander, 1988). Finally, the researcher also established whether the main caregivers and their daughters had a relatively good relationship, since the main caregivers also have a part to play in this research. This was achieved by asking both the main caregivers and the participants about the quality of their relationships. The researcher also asked the participants if a limited amount of involvement of the main caregivers would be acceptable for them. Based on this initial screening, exactly three participants were identified (Remenyi, 2012; Hesse-Biber, 2017).

The researcher then discussed telephonically with both the main caregivers and the potential participants independently, the ethical requirements which are mentioned in appendix B and C (Richards, 2015). Thereafter, the researcher sent them both the informed consent forms to sign (see Appendices B and C). Each participant was requested to bring a 20-page flip-file with plastic sleeves to the sessions, in which to keep the art or the photos of the arts. This collection of art later served as a trail of artefacts. The researcher then requested each of the participants to bring along to the first session one song or poem (from the Internet or written by herself) that would best represent the ‘space’ that she was in at that time, and one song or poem that would best represent the ‘space’ she wished to be in (Hoffmann, 2016). The participants were asked to highlight the sentences in each song which resonated with them the most, such as “look towards the mountain tops”.

The researcher asked each participant for permission to involve her main caregiver by asking the main caregiver to contribute two reflections. One reflection at the beginning of the process on how he/she perceives his/her daughter’s depressive symptoms manifesting, and one reflection at the end of the process on whether or not he/she noticed any change in his/her daughter regarding inner strength, mood and behaviour (Patton, 2015).

Poems were used because writing is a powerful tool for expressing emotions (Degges-

White & Davis, 2011; Oaklander, 1988). Through creativity, one gets a chance to explore and express dreams, hopes, thoughts, desires, joy and pain, and to acknowledge one's intentions and desires that might have no chance to be fulfilled in reality (Oaklander, 1988; Hoffmann, 2016). Engaging with creativity facilitates tapping into the cognitive, as well as the non-cognitive aspects of the human mind (Olsen, 2012). The use of creativity also leads to the attachment of personal meanings and interpretations to the creative item, be it a poem, a song, an object or painting. The meaning and interpretations will be based on one's own background and history (Olsen, 2012). Therefore, in order for the participants to start engaging with their deep feelings, hopes and dreams, both the conscious ones and the unconscious ones, right from the beginning of the process, the researcher asked each participant to look for songs or poems that would best represent the 'space' that they are in now and the 'space' where they wish to be. By asking each participant to highlight the lines that resonated with her the most, the researcher encouraged them to attach their own personal meanings and interpretations to those works of art. Bringing about self-awareness is part of inner-strength building (Phillips & Frederick, 1995). An example for this can be viewed from Kelly's poem: "Worrying can be debilitating, it can be an enemy and a curse". This made Kelly realise how much she wants and needs to recover from her ongoing worrying.

4.6.2 Session 1. Gaining self-awareness through poetry, the genogram and the lifeline

Session 1 began with a discussion of the poems and the highlighted sentences. Each participant was asked what she thought needed to happen from within, in order to move from the unwanted 'space' to the wanted 'space'. The participants were asked to select the most important line for the second song/poem and to copy it onto the front cover of their flip-file. After a discussion about the poem, the researcher drew a genogram consisting of various interconnected shapes and lines from information provided by the participant, which captured the family constellation and dynamics (Gatfield, 2017). The next step was exploring the history and background of each participant. The history was jotted down on a 'lifeline' (Maree, 2007), in point-form, according to the chronological order of the participant's life, capturing both the meaningful events, as well as the emotions these events brought about. When the

lifeline had been completed, the repetitive themes of the emotions were summarised (adapted from Maree, 2007). Subsequently, the process of the sessions was explained to each participant (Hesse-Biber, 2017).

4.6.2.1 Objectives, session content, rationale and expected outcomes of the session

A. Objectives

The objectives for Session 1 were as follows:

- To bring about self-awareness in each participant of how she feels now and how she wishes to feel.
- To provide motivation for each participant to work towards achieving their desired space.
- To help the therapist and each participant understand what dynamics in the family may contribute to their current depression as evidenced in the genogram.
- To help the therapist and each participant understand what experiences from each participant's life contributed to the difficult emotions which keep the depression alive, and to motivate the participants to work through those experiences.

B. Session content

In this session, each participant read the poems/songs that she had brought. The genogram was created, the lifeline was drawn and elaborated upon, and the process of the upcoming sessions was discussed.

C. Rationale

The rationale behind the song/poem activity is the intention of activating the participant's subconscious, in order to bring about self-awareness. Songs and poems are part of creative expressive art. Art activates the right brain, which is closely connected to the limbic system (the mammalian brain), hence creativity brings about deep work, involving the subconscious (Degges-White & Davis, 2011). Moreover, discerning where a person wants to be, paves the way ahead for the client (Schwartz

& Gladding, 2011). Another advantage of this method is that by choosing a song about where one wishes to be, by highlighting the lines that resonate with the person the most and extracting the main line which symbolises where the person wishes to be, and at the end creating a front page from this, all contribute to giving motivation to the participant to work towards achieving this pleasant and desirable 'space' (Degges-White & Davis, 2011). The family genogram was created so that the researcher could understand the family dynamic and whether there was any genetic component or an environmental component contributing to the depression. It was also important for the participant to understand these contributing factors, in order to understand what was keeping her depression alive. The rationale of creating the lifeline is to assist the therapist to understand the structure of the participant's brain, as human history and human interactions bring about "experience-dependent plasticity". This means that the brain is structured and restructured through interactions with the social and natural environment which, in turn, shape the brain (Cozolino, 2006; Perry & Szalavitz, 2006). The lifeline can also assist the participant and the therapist to see clearly what events contributed to the different emotions which currently contribute to the depression.

The genogram is a creative diagram which has been used for many years by family therapists as a salient and informative tool (Gatfield, 2017). This tool captures the family constellation, structure and relationships on a single sheet of paper (Gatfield, 2017; Hanna & Brown, 2007; Leoncio, De Souza, Regina Pereira & Machado, 2017). The genogram focuses not only on the nuclear family, but also on transgenerational relationships, pathology and assets (Gatfield, 201; Leoncio et al., 2017). The use of circles, squares and lines turns the 'conversational genogram' into an art-based activity which promotes the externalisations of internal processes with the aid of visual explication (Gatfield, 2017). The genogram allows the therapist to understand the client in her context, and to have insight into the interactions and dynamics that may be playing a role in causing or maintaining the depressive symptoms. It should also bring about clarity to the client herself (Gatfield, 2017; Hanna & Brown, 2007).

Drawing a lifeline is an activity that assists clients to make sense of their lives, as well as allowing the therapist to get to know the blue print of the client's brain (Maree, 2007) due to the fact that the brain is shaped predominantly by past experiences (Perry & Szalavitz, 2017; Van der Kolk, 2014; Levine, 1997). The lifeline facilitates the

revelations and the unpacking of the client's life themes and patterns, bringing about insight and self-awareness (Maree, 2007). Therefore, the lifeline can aid in understanding which of the experiences contributed to the depressive symptoms (unless the source is fully genetic). This may empower the participant to work through those experiences in order to evolve emotionally and to realise that her symptoms may not be intrinsic but rather situational. From the lifeline, she may notice that her depressive symptoms evolved as a result of negative messages that she received from society about herself, which she may decide to reject and replace with more adaptive messages (Prochaska & Norcross, 2010).

The process of the sessions needs to be explained as part of ethical practice, so that each participant knows what to anticipate. This may also give the participant motivation to commit to complete the process (Hesse-Biber, 2017).

D. Expected outcome

Each participant should gain self-awareness about her current and desirable emotional state, as well as some degree of motivation to get out of the undesirable space. She should gain awareness of the family dynamics and how they are affecting her. She should also gain awareness in terms of her life history and how that has contributed to her current emotional state.

4.6.3 Session 2. The sand tray

In this session, each participant's current emotional situation was explored through the sand tray. She explored the space she was currently in and the space where she wished to be, as well as what needed to happen for her to get to her destination. The sand tray consisted of a box filled with sea sand with a bridge in the middle. The participant was given many different figurines which were divided into boxes. Each box had its own theme, namely, nature, animals, people, stones and shells, food, transportation, sea creatures, insects and lastly, a box with random items (Oaklander, 1988). In this session, the participant was asked to create a scene of her current life with all of its challenges, using the figurines, in the left-hand side of the box. On the right-hand side of the box, the participant was asked to create her future life, without all the challenges. The bridge lies between the two scenes. Then the participant was asked to find a figurine that could symbolise herself as her strongest self and to place

it in the challenging side of the sand tray in a spot which she believed was the space that she was in at that time. Then the participant was presented with the question - “What do you believe needs to happen from within (looking for an internal locus of control as people cannot control the environment) so that you can move away from the challenging, depression-provoking space to a more positive and happier space, namely, the space on the right?” (Feldman, 1985; Gunnison & Moore, 2003; Hoffmann, 2016).

4.6.3.1 Objectives, session content, rationale and expected outcomes of the session

A. Objectives

The objectives for Session 2 were as follows:

- To bring about awareness to the participant as to what was happening in her life, and how it was affecting her.
- To allow the participant to explore her emotions.
- To view clearly where she wished to be and how good it would be to get there.
- To empower the participant to take steps towards change.

B. Session content

In this session, each participant’s life was explored in the sand tray.

C. Rationale

Using the sand tray can facilitate bringing unconscious material into awareness. It is intended to transform the thoughts and the feelings of the participant into a tangible form, so that the participant can view them as a detached entity and be able to review them in a more objective manner and explore if she is satisfied with the current situation. On the left side, she will notice more clearly what the issues or situations are that are holding her back. This awareness brings about motivation for change, as well as clarifying both the desired journey and destination. Asking the participant what needed to happen from within to get to the ideal side, brings about the awareness and motivation that she can do something about her situation and that this “something” is

doable and achievable.

D. Expected outcome

The participant will have experienced a sense of clarity in terms of the issues that cause her to feel unsettled within her consciousness and subconscious. She will have experienced viewing the desired space in a tangible format. She should get motivation to work towards the desired space.

4.6.4 Session 3. Hypnosis: "Meeting your inner strength in a safe space"

In this session, the participant was introduced to hypnosis. It was explained to her that hypnosis is a natural state of the mind when dissociation occurs as in "day-dreaming". It was also explained to the participant that she would not lose control and that the up-coming hypnosis sessions that she would be experiencing were basically guided imagery, and therefore, she did not need to feel fearful. It was further explained that the aim of the hypnosis session was to strengthen her inner strength. During this hypnosis session, an "inner safe space" was created by the participant with the therapist's assistance. She also created her inner strength with playdough while under hypnosis. Following the hypnosis session, the participant got to watch a video clip from the Lion King which dealt with inner strength (as can be seen in appendix M).

4.6.4.1 Objectives, session content, rationale and expected outcomes of the session

A. Objectives

The objectives for Session 3 were as follows:

- To teach self-hypnosis to the participant so that when she needs to calm down or when she needs to receive affirmations or guidance from her inner strength, that she will have the tools to do so.
- To help the participant get in touch with her internal resources at any given moment when she has a need for it.
- To remind her about the beauty of her personality and about her achievements, in spite of all the difficulties, as an empowerment tool.

- To give her motivation to examine herself and to start to define herself from a correct point of view, rather than from the point of view of the people in her environment who communicated to her that she is not good enough. The motto is – “remember who you are.”

B. Session content

In this session, the participant experienced a hypnosis session about ‘meeting your inner strength in a safe space’. She was also asked to create her inner strength with playdough and lastly, she watched a video clip from The Lion King which carried a message that tied with the content of the hypnosis session.

C. Rationale

This hypnosis session was adapted from Phillips and Frederick (1995), who claimed that creating safety and stabilisation for a client is vital at the beginning of the process of therapy. This specific hypnosis session was used by ego state practitioners at the beginning of ego state work (Da Silva, 2009). Creating the inner strength while in hypnosis with playdough makes the concept of inner strength more tangible for the client (Oaklander, 1988).

Watching video clips is part of creative expressive art in therapy (Hoffmann, 2016). As mentioned above, any creative work functions within the limbic system and facilitates a deeper absorption of the message (Levine & Kline, 2008; Oaklander, 1988). The chosen video clip from The Lion King captures the idea of “remember who you are…you have forgotten who you are” which facilitates, encourages and motivates people to fulfil themselves and reach their goals, aspirations and passions in life (Hoffmann, 2016). People, who do not feel good enough or who are insecure, are often people who have forgotten who they are, they have lost touch with and forgotten about their inner strength. Hence this video clip could strengthen the message when delivered through the hypnosis session early in the session.

D. Expected outcome

The participant will know how to implement self-hypnosis. She will have experienced her inner strength as a resource, and learn how to use it when in need. She will experience herself as empowered rather than a victim, and gain awareness of the fact that maybe she has forgotten who she is due to certain insensitive people in her

environment or due to her personal challenges.

4.6.5 Session 4. Hypnosis: “If it’s to be, it’s up to me”

In this session, each participant experienced another hypnosis session aimed at inner-strength building. The aim of this hypnosis session was to instil in her an internal locus of control in terms of her agency to get better, and in terms of activating inner resources that can help her get better. Following the hypnosis session, “the cup activity” was carried out to consolidate and to make tangible what had been experienced. This entailed the participant being asked to make a list of activities, people or things she had been spending energy on during the preceding two months, as well as activities, people and things she wished to spend energy on. The items could be negative or positive. One of the items had to be “the critical voice” (Boholst, 2003; Prochaska & Norcross, 2010). An empty cup was allocated for each item. The participant had to fill up each cup with water, based on the amount of energy she spends on this person, activity, or thing which the cup represented. The participant then had to evaluate if she was satisfied with her situation. If she felt that too much energy was allocated to something that was unworthy of so much energy, she had to pour the water into a cup that represented a resource in her life, for which she did not spend enough energy.

This activity is based on existential therapy, ego state therapy and narrative therapy. Existential therapy maintains that people often loose contact with their “intentionality”, which is the foundation of people’s identity (Prochaska & Norcross, 2010, p. 108). In other words, people may have an idea of how to lead their lives, which is their intention and identity, however, they often fail to do so. The cup activity allows people to view the decisions through which they conduct their lives in a concrete manner, allowing them to realign with their true identity.

The theme of identity also features prominently in the theory of narrative therapy. Narrative therapy maintains that people create their own reality and identity based on the stories that they tell about their lives. It would be arrogant of the therapist to tell a person who they are and what they ought to be. Clients should feel free to author their own narrative (Prochaska & Norcross, 2010, p. 108). The insight that emerges from the cup activity also facilitates the client’s re-authoring or their own stories.

The question is, what would be the cause for people to fail to live their lives according to their identity? The answer can be found in ego state therapy which maintains that the personality is divided into many different parts (see section 3.5.2), (Emmerson, 2007; Frederick & McNeal, 1999; Phillips & Frederick, 1995; Watkins & Watkins, 1997). When a person struggles with an emotional challenge, with a psychological disorder, or with unwanted behaviour, it means that one or more of the maladaptive parts consumes too much energy, over and above what is ideal for that person. The maladaptive part of the personality always assumes that it is a resource and that it comes to help the bigger personality, the person that it is a part of, while in fact, it sabotages the person's growth (Emmerson, 2007; Phillips & Frederick, 1995; Watkins & Watkins, 1997). Ego state therapy brings awareness to the person and through the SARI framework, it assists the person to reclaim his/her power back, in accordance with their identity or core personality. The cup activity brings about an awareness of which maladaptive parts of the personality may be assigning too much energy to themselves, leaving other parts which are more resourceful, with not enough energy.

Finding one's identity and implementing the changes brings about inner strength strengthening. Lundman et al. (2010) maintains that inner strength is made of five components, three of which apply to the cup activity. The cup activity brings about a sense of coherence, which is aligning with one's identity. It also strengthens one's purpose in life and facilitates self-transcendence.

4.6.5.1 Objectives, session content, rationale and expected outcomes of the session

A. Objectives

The objectives for Session 4 were as follows:

- To bring about an awareness to the participant of the thoughts that throw out her emotional balance.
- To give the participant the tools to challenge the critical voice with the aid of her resourceful parts.
- To instil agency in the client to put in effort towards the change with "if it's to be, it's up to me".

- To make her realise that even if the way is hard, it will be worthwhile in the end.
- To bring about an awareness of how the participant is dividing her energy and what would be the preferable situation for her.
- To bring about motivation for change.

B. Session content

In this session, the participants experienced a hypnosis session for further inner-strength building. They were also engaged in an activity which is called “the cup activity”. This activity was developed by the researcher.

C. Rationale

The aim of this hypnosis session was to build inner strength from the point of view of paying attention to and amplifying the resourceful voices which come from inner wisdom and inner strength. These voices carry positive messages about the person. Messages about her strengths, assets and achievements, as opposed to the messages that stem from the “critical voice” which carries mistaken labels and beliefs about the person. These negative messages often stem from insensitive people within the environment (Prochaska & Norcross, 2010). As Prochaska and Norcross (2010, p. 462) put it “first we need to become conscious of how much of our story has been constructed from the dominant discourses in our families and societies”. This session was intended to empower the participant to focus on her many strengths and reject messages which bring about self-doubt (Bourne, 2015; Frederick & McNeal, 1999). The motto of the session was “if it’s to be, it’s up to me”, namely, it is the participant’s choice of whether she wishes to give energy to her critical voice which throws out her emotional balance or whether she prefers to give energy to more empowering messages that are more congruent with who she is.

The cup activity was targeted to bring about a tangible realisation and clarity (Gatfield, 2017) of how much energy the participant spends on listening to her critical voice. The activity also aimed to promote introspection around silencing the critical voice by arousing the question, “how long you are still planning to give power to this destructive voice” to “if it’s to be, it’s up to me”. This activity is based on the idea that art and creativity assist a person in externalising internal experiences and making them tangible for the person (Hoffmann, 2016).

D. Expected outcome

The participant will have been made aware of the thoughts that get her out of her window of tolerance, which is her emotional balance. She will have been made aware of how to uproot them and what messages to replace them with. She will have been made aware that a change is “up to her”, as well as where her emotional energy is channelled to as opposed to how she wishes to divide her energy. Seeing things clearly brings about motivation for change.

4.6.6 Session 5. Hypnosis: “Turning garbage into manure”

In this session, the participant experienced another hypnosis session. This hypnosis session was about a tree that garbage was continually thrown at. Its motto was, “making garbage into manure”. The activity that followed entailed painting or drawing the participant’s vision during the hypnosis session, as well as spelling out what the “garbage” consisted of and what the “manure” consisted of. The manure is the participant’s personal and internal growth that emanated as a result of processing the “garbage”, dealing with it and rising above it.

This activity is based on narrative therapy and ego state therapy. Narrative therapy maintains that if a person wishes to realign herself with her true identity she needs not turn “into someone else’s theory” but rather she needs to “turn to the next chapter” of her own story (Prochaska & Norcross, 2010, p. 461). Peoples’ stories usually capture the “dominant discourse” of their society and family, who have a powerful impact on how people view themselves. This may not be in alignment with people’s true identity. A person needs to remember that he/she is the only one who possesses the privilege to define who he or she really is (Prochaska & Norcross, 2010). The story of the tree is designed to impress this idea upon a person.

Ego state therapy maintains that it is possible to minimise the activity of the non-helpful parts, and to expand the activity of the resourceful parts in order for the personality as a whole to function in a more adaptive manner (Emmerson, 2007; Phillips & Frederick, 1995; Watkins & Watkins, 1997). The story of the tree captures two main ego states. The one is the insecure part that absorbs and believes incorrect and unhelpful messages about the person, stemming from the environment. The other is the inner strength that assists the person to be proactive about the unwanted messages, to

reject the incorrect messages while turning the global experience into manure. This idea follows along the lines of the notion found in Frederick and McNeal (1999), who maintain that they favour activities that empower ego strengthening as they value an approach to therapy that utilises the healing powers that exist within the person, as well as techniques that mobilise those powers. The hypnosis and activity of the tree and the manure empower people to take responsibility for their choices and to activate their own healing powers. This is done through facilitating a sense of coherence, building hardiness and encouraging self-transcendence which are all components of inner strength (Lundman et al., 2010).

4.6.6.1 Objectives, session content, rationale and expected outcomes of the session

A. Objectives

- To empower the participant to externalise further the negative messages about her that don't belong to her.
- To empower the participant to utilise her negative experiences for personal growth.

B. Session content

The session consisted of a hypnosis session about turning garbage into manure, as well as an activity of painting or drawing.

C. Rationale

After meeting the inner strength in a safe space in the first hypnosis session, and after amplifying the positive voices and tuning down the negative ones in the second hypnosis, this third hypnosis aimed at reinforcing getting rid of the maladaptive "labels" that came from the environment and using the challenges in life as "manure" in order to grow and evolve as a human being (Bourne, 2015). People with depression tend to focus on the negative things that take place in their lives. Depressed people need to be empowered in directing their thoughts to see the positive aspects of a negative situation (Bourne, 2015; Yapko, 2013).

Drawing the image elicited in hypnosis, helps to bring the message deeper into the unconscious, adding and enduring effect (Oaklander, 1988). Making the participant

write down the messages in her life which equal “garbage” brings about conscious awareness of some of the thoughts that bring her down. When people are aware of those negative thoughts, they can then challenge them. However, as long as thoughts stay in the unconscious, one cannot work with them and they could bring about an unfathomable depression (Simons, Man Kit, Beach, Cutrona & Philibert, 2017). People need to realise that when it comes to constructing the narrative of their lives, each person possesses the privileged position of constructing their own story (Bourne, 2015; German, 2013; Prochaska & Norcross, 2010). Writing down the “presents” the participant received from the “garbage” also allows for the message to be driven home in a deeper way (Oaklander, 1988).

D. Expected outcomes

The participant will have realised how she allows mistaken messages about her to influence her negatively, and how she has the power to decide which messages are helpful and which ones should be discarded. She will experience a shift in terms of viewing herself as a victim, as opposed to someone powerful who can even transfer garbage into manure, metaphorically speaking.

4.6.7 Session 6. “The tree of life”

This session was intended to be spread over one session, however, with all three participants it was spread over three sessions. This made the framework nine sessions long, although with only seven themes. Therefore, the researcher refers to these three sessions as one. During this session, the participants were engaged in the activity of “the tree of life” (German, 2013; Peterson & Goldberg, 2016; Randle-Phillips, Farquhar, & Thomas, 2016).

4.6.7.1 Objectives, session content, rationale and expected outcomes of the session:

A. Objectives

- To help the participant establish the assets and strengths within herself and the environment.
- To help the participant expand and re-author her life story in a way that will help her experience a preferred identity.
- To assist the participant in realising how many people in her life do believe in her and love her.
- To give the participants the chance to hear from other people about her assets and strengths.
- To make the participant realise that she also had happy experiences in her life, and not only the unfortunate ones.
- To give her motivation to continue in spite of the depression, by helping her realise her hopes and dreams.

B. Session content

During this session, “the tree of life” was created (German, 2013; Peterson & Goldberg, 2016; Randle-Phillips, Farquhar, & Thomas, 2016).

C. Rationale

The art of “the tree of life” is a strength-based intervention which is based on narrative therapy. It was developed by a South-African psychologist, Ncazelo Ncube, with the aid of three Australian narrative therapists in order to heal children from losses and trauma (German, 2013; Randle-Phillips, Farquhar, & Thomas, 2016). The researcher adapted the activity to suit the intervention. The tree of life captures the alternative story of the client’s life and assists a client to “experience a preferred identity” so that she can challenge her problems in life (German, 2013; Randle-Phillips et al., 2016, p. 302). Clients come to therapy with a very narrow story, or narrative about themselves, their environment and their lives, focusing on all the negatives and challenges while failing to see the strengths and assets within themselves, their environment and their lives (Prochaska & Norcross, 2010). The activity of the tree of life can fill the gaps

within the narrow narrative, to expand the story so that it is able to include positivity and hope (German, 2013). Each part of the tree serves as a different metaphor (German, 2013). In the original work, the roots symbolise a place where the person comes from, ancestry and the names of people who taught them the most in life. The ground symbolises the person's current place of living and the activities she does on a daily basis. The trunk represents skills and abilities. The branches symbolise hopes and dreams and wishes for the direction of her life. The leaves symbolise significant people in the person's life, including people who have passed away. The fruits are gifts the person has received, such as being cared for and being loved, and the flowers represent gifts that the person gives to others (Randle-Phillips, Farquhar, & Thomas, 2016).

The researcher adapted the meaning of the different parts of the tree as follows. The roots represent the parents and grandparents, which is where the client originated from, while the tree itself is the client. The flowers around the tree symbolize the special people in her life. Under each flower there is a name written of a significant person in the client's life. On the bark of the tree, there are many words which capture the client's assets and strengths. These words come from the "witnesses", namely, the people that are mentioned as flowers who, between the first session and the second session of the tree, were asked, to give a list of the client's assets and strengths (provided consent was granted by the client). The leaves capture the pleasant memories from the past, as well as hobbies that the client enjoys. Finally, the fruits capture one's hopes and dreams for the future.

To summarize, this activity focuses on the positive and on what propels the client forward in life. Previous research has shown improvement in children's self-esteem and self-concept using the tree of life activity (German, 2013).

D. Expected outcome

The participant will have experienced a sense of inner strength, as well as positivity about her life, her environment and her future.

4.6.8 Session 7. The concluding session

In this session, the participant experienced a short hypnosis session which focused

on inner strengthening, anchoring and grounding. During this session, the participant was asked to find a memory of an event when she felt strong, brave, empowered and grounded. She was then given a metaphor about a ship at sea that gets caught in a storm. The ship gets thrown from side to side, and the lack of stability threatens to overturn the ship. This could cause the ship to sink. The first action taken by the captain is to throw the anchor overboard in order to stabilise the ship. The participant was then asked to create an “anchor” by interlocking her fingers. It was suggested to her that she attach to this action the memory of her being strong and brave. The participant then received a post hypnotic suggestion that from that day onwards, should she need to feel strong again, she could not only think about her inner strength, but she could also perform an action with her body (interlocking her fingers) that would bring about the sensation of strength and empowerment.

The idea of using the body in therapy as an asset and as an aid to the therapeutic process is found prominently in the work of Van der Kolk (2014) and Levine (1997), who both believed that in order to assist the person to work through emotions and especially through trauma, it is necessary to involve the body in the treatment. Levine and Kline (2008), as well as Oaklander (1988), maintain that through the sensory experience, a child receives a stronger sense of self. The emotions of flight, fight and freeze exist within the brain stem. The brain stem is connected to the body and can only understand the body language. It is physiological activities that make an impression upon this brain (Levine, 1997; Levine & Kline, 2007; Levine & Kline, 2008). Therefore, the researcher who wished to install a sense of safety and strength within the participants used an activity that could impress this message upon the participant.

This activity included a post hypnotic suggestion. These types of suggestions have proven to be effective for the future behaviour of the client (Sehan, Harun, & Ahmad, 2016). Erickson often made use of this tool during his hypnosis sessions, realising its effectiveness. Erickson maintained that when combining a post hypnotic suggestion with a metaphor, the message seeps deeper into the unconscious. He also maintained that post hypnotic suggestion may stay dormant in the unconscious until the person is ready to act upon the suggestion (Battino & South, 2005).

The hypnosis was followed by two activities. In the first activity, the participant had to create her evolved inner strength with colourful clay which she could take home. She

was encouraged to put it in her room in a noticeable place.

Secondly, she engaged in free writing about her evolved inner strength. The researcher asked her the following questions as guidelines for her free writing: Did her inner strength's capacity grow to an extent that it could assist her even more in the present, and what did she still need from her inner strength in the present and the future? Her writing had to include statements that represented how her inner strength assisted her in the past.

4.6.8.1 Objectives, session content, rationale and expected outcomes of the session:

A. Objectives

- To prepare the participant for terminating therapy.
- To give the participant a useful tool which can help her feel safe later in life.
- To create a visual and tangible representation of her inner strength from which she may be able to derive strength.
- To bring about awareness in terms of the capacity of her inner strength, and how it could continue to help her in the future.

B. Session content

During this session, the participant experienced grounding and anchoring. She also created her own evolved inner strength with clay, as well as writing about her inner strength.

C. Rationale

Since this was the last session of the treatment plan, the researcher wanted to provide the participant with resources to use further on in her life. One was a practical, accessible and easy-to-use tool; the other was a tangible representation of her evolvement, and lastly, an insight into her capacity.

During the hypnosis session, the physical activity of interlocking the fingers was aimed at the activation of the brain stem. Hence, the message can penetrate into the subconscious and it could have a lasting effect (Van der Kolk, 2014; Levine, 1997).

Creating a new and evolved inner strength with clay could assist in deepening a self-awareness of her ability to grow her inner strength and of how far it has grown thus far, if at all. The purpose of taking home that feature is intended to serve as a reminder of her inner strength and of our sessions together.

This activity was based on the Gestalt theory that maintains that the treatment needs to take place in the here and now. In order to process an emotion, one needs to recreate it in the present, re-experience it and then work through it (Oaklander, 1988). The awareness of the here and now allows for the emergence of the most important issue that still requires work and processing to emerge, through which it can be resolved. However, clients discover that to remain in the here and now is a challenge. It is often simpler for them to resort to their familiar ways, which is the reason why they would need more encouragement and direction from the therapist (Prochaska & Norcross, 2010). The image of inner strength that the participant created is intended to serve as ongoing encouragement and as a reminder from the therapist, even in her absence. Gestalt theory also maintains that the pathology, and therefore, the healing exists not in the individual, but in the individual's phenomenological relationship with her environment. This means that the experience of narrowing the possibilities manifests as a pathological symptom. In the researcher's opinion, the client's consciousness of her evolved inner strength, facilitated by the presence of the clay framework, enables a broadening of her perceived scope of possibilities, widening the relational field in which the environment is experienced (Roubal, Francesetti, & Gecele, 2017).

Free writing about her inner strength may facilitate getting in touch with her inner strength and its role in her life. Since this is also a creative activity, the message penetrates deeper into the subconscious about the usefulness of her inner strength and the motivation to use it as often as possible (Degges-White & Davis, 2011; Oaklander, 1988).

D. Expected outcome

After this session, the participant will have been prepared to end the treatment process and to continue on her own with the tools that she has received. She will also be encouraged to refer back, from time to time, to her therapeutic file, in order to remind herself of the therapeutic process and her achievements in therapy. This would not

mean that she should not be receiving further therapy, but it will mean that she has completed the treatment process that this research study had to offer and that she should already be in a better space.

The abovementioned sessions created ample raw data. Thereafter, data analysis was implemented in order to search for themes and to make sense of the data.

4.7 Data analysis

Data analysis is the process in which order, structure and meaning is attached to the data that was collected (Richards, 2015). There are a few methods through which one can analyse qualitative data. One commonly used method is thematic analysis (Bryman, 2016) which was implemented in this study.

4.7.1 Process of data analysis

Qualitative analysis transforms raw data into findings (Patton, 2015). Although there is no specific formula one can follow, there is guidance available which makes each research unique (Patton, 2015). The process which this study followed is the one presented by Braun and Clarke (2006) and it is described below.

4.7.2 Method of data analysis

The difficulty of qualitative analysis is having to make sense of large amounts of data (Patton, 2015). This requires reducing the amount of incoming information, sifting the superfluous from the essential and communicating the essence of the data through the findings (Patton, 2015). This process is called thematic analysis. Braun and Clarke (2006) identified six phases of thematic analysis, namely, familiarizing oneself with the data, generating initial codes, searching for themes, reviewing the themes, defining and naming the themes, and lastly, producing the report (Braun & Clarke, 2006). All of these stages have one goal in mind, namely, answering the research question (Bryman, 2016; Patton, 2015; Richards, 2015).

4.7.2.1 Familiarising oneself with the data

Researchers who would like to form a clearer picture of their data, in order to establish a theory and to potentially elicit findings, should “first run through the data” (Bryman, 2016; Hesse-Biber, 2017:311; Merriam & Tisdell, 2015). The method is achieved through writing memos which is the beginning phase of data analysis (Bryman, 2016; Hesse-Biber, 2017; Merriam & Tisdell, 2015). When the researcher goes through the data for the first time, she needs to read and reread, highlight and make notes of potentially important pieces of information, such as patterns, as well as writing down any ideas that come to mind while reading the notes (Braun & Clarke, 2006; Hesse-Biber, 2017; Patton, 2015). She needs to pay attention to what ideas fit together or what seems to be problematic, as well as recording meaningful quotes appearing in the data. She may want to make use of diagrams to assist in thinking about ideas (Hesse-Biber, 2017). Ideas can be marked up for the sake of creating codes at a later phase (Braun & Clarke, 2006; Braun & Clarke, 2013).

4.7.2.2 Generating initial codes

Codes identify various aspects of the data (Braun & Clarke, 2006; Bryman, 2016; Merriam & Tisdell, 2015) and they attach meaning to parts of the text (Hesse-Biber, 2017; Richards, 2015). These parts can be one word, a few words or full paragraphs (Hesse-Biber, 2017). Coding involves both interpretations and analysis (Hesse-Biber, 2017). Coding the data is done by writing notes next to the text that is being analysed and by using different coloured pens to highlight potential patterns. One needs to code as many potential patterns or themes as possible as they may be useful later in the process (Braun & Clarke, 2006; Bryman, 2016; Braun & Clarke, 2013). There are three categories of codes one can look for. The first being descriptive codes which means assigning a label or a “tag” to the words. This assists in organising the data by topic (Hesse-Biber, 2017, p. 315; Patton, 2015; Richards, 2015). The second type is categorical codes which involves abstracting a group of codes to form a more general category of meaning, not merely a description (Hesse-Biber, 2017). The third category is analytical codes. This is the stage at which the researcher focuses on the personal experience of the research subject. This refers to the meaning that the participant conveys to the researcher that extends beyond description and categorical coding (Hesse-Biber, 2017).

4.7.2.3 Searching for themes

In qualitative research, the researcher has the flexibility to change the design or approach during the study. Although qualitative researches are predominantly inductive by nature, it would be acceptable to analyse the data using both approaches, the inductive and deductive approaches. Hence, before going through the data, the researcher may have established theories that she may want to check and look for in the data - this is a deductive approach. The pre-established themes facilitate focusing during data collection and assist in organising the material. The researcher may also be looking for themes that are repetitive and which seem to emerge from the existing data - this is an inductive approach (Braun & Clarke, 2006; Bryman, 2016; Merriam & Tisdell, 2015; Richards, 2015). It is common practice to start off data analysis in a qualitative research with the inductive approach, namely, searching for codes and themes that emerge, and then to use a more deductive approach by searching for more evidence to support the final themes. This complex process entails moving back and forth between inductive and deductive approaches until reaching a point of saturation (Merriam & Tisdell, 2015).

The phase of searching for themes begins after all data have been initially collected and coded. At this point, the researcher re-focuses on the analysis at the level of themes. This involves categorising the different codes into potential themes. Essentially, this means analysing the different codes and grouping them through abstraction, in order to create an overarching theme. Themes consists of sub-themes and main themes (Braun & Clarke, 2006; Bryman, 2016; Braun & Clarke, 2013; Merriam & Tisdell, 2015). An example of codes, from kelly's raw data, that turned into a theme is: "she (her mother) brought a lot of anxiety to my life" as well as "she still lies about my father" as well as similar statements, became a theme of "resentment towards mom".

4.7.2.4 Reviewing the themes

As the themes evolve, they may need to be refined, combined, separated or discarded (Braun & Clarke, 2006). During the process of eliciting themes, it will become clear that some candidate themes are not really themes due to a lack of supporting data. Some themes that initially appeared to have been two separate ones, at a closer look

they may actually be combined, while other themes may need to be separated (Braun & Clarke, 2006). Examples of different themes, from Luna's raw data, that were integrated into one are: "Appreciating gran as she was full of life, loved nature, appreciated everything", "Luna appreciated Ugogo as she was spiritual", "Wanting to have more people like them in her life". There themes became one, namely, "Luna enjoys close connections with meaningful people".

4.7.2.5 Defining and naming themes

This refers to the continual refining of each theme, bearing in mind the overall story which the themes tell, including the clear naming and defining of each theme. This is the stage at which the researcher needs to identify the 'essence' of what each theme conveys (Braun & Clarke, 2006:92; Braun & Clarke, 2013; Patton, 2015). The researcher needs to clarify not only the narrative of each theme, but also the broader 'story' which emerges from all the themes together (Braun & Clarke, 2006; Bryman, 2016; Braun & Clarke, 2013). It is also the stage at which the researcher needs to review the data extracts, and to ensure that the grouping of extracts into themes is accurate and practical to work with. In some instances, the researcher will need to identify whether or not a theme should be divided into sub-themes which can help to give structure to large complex themes (Braun & Clarke, 2006; Bryman, 2016). A way for the researcher to test if this phase has been accomplished, is to see if the theme can be described in a couple of sentences. If not, more refinement of the theme is needed. At this stage, the researcher should be in the position to ascribe accurate, concise names to each theme (Braun & Clarke, 2006; Braun & Clarke, 2013). An example for this process can be seen from Rivki's case where she spoke about her mother favouring the maid's daughter, her mother favours Rivkis brother and the grandmother favours the cousins. The overarching theme was that of rejection. Rejection leads to sadness. Sadness is one of the depressive symptoms.

4.7.2.6 Production of the report

Once the themes have been established and the final analysis carried out, it is time to write up the complicated story of the data in a report form. The report needs to be written in a way that convinces the reader of the contributions, validity and merit of the researcher's analysis (Braun & Clarke, 2006; Bryman, 2016; Hesse-Biber, 2017; Patton, 2015; Richards, 2015). When writing up the analysis, it is important to provide

a concise, coherent, non-repetitive, logical and interesting layout of the story emerging from the data. The report needs to provide sufficient evidence of the themes and it needs to be presenting an argument, with connection to the research question, as opposed to just describing the data (Braun & Clarke, 2006; Merriam & Tisdell, 2015).

In order to ensure that the findings that were elicited through the data analysis were valid and reliable, measures were taken by the researcher. These measures are mentioned below.

4.8 Research quality

In order to ensure that it is worthwhile to carry out a study, and that the results are authentic and hence, that it would be worthwhile to carry out the recommendations of the research, one needs to clarify that the study is valid and reliable. The validity of a research refers to whether the research is measuring what it is supposed to measure; the reliability of a study is established if the measure is repeatable and consistent, namely, that it can generate the same results over again, even if done through other researchers with a different group of people. In order to ensure the quality of this research, the researcher used a number of measures, namely, triangulation, credibility, transferability, dependability, confirmability and authenticity (Braun & Clarke, 2013; Lincoln & Guba, 1985).

4.8.1 Triangulation

Triangulation means the use of two or more sources of data in order to examine a particular phenomenon. Triangulating data strengthens the study and aims at getting as close to the 'truth' of the research object as possible (Braun & Clarke, 2013; Creswell, 2013b; Hesse-Biber, 2017; Patton, 2015; Remenyi, 2012; Yin, 2003). Triangulation increases the credibility and internal validity of a study as it makes use of comparing and cross-checking multiple sources of data that are collected at different times or at different places or from different people (Merriam & Tisdell, 2015).

Since each method of data collection has its limitations, using several methods and triangulating them is necessary to maximise trustworthiness (Patton, 2015). Some argue that using a few sources of data does not only aid trustworthiness, but it also facilitates the formation of a fuller and richer story (Braun & Clarke, 2013; Remenyi,

2012). All the data collection methods are aimed at answering the research question (Patton, 2015).

There are four basic types of triangulation. In this study, the researcher used one type which was the triangulation of the data sources. This means triangulations within and across different data sources which allow for comparing and cross-checking the consistency of the information that is being elicited at different times and through different data sources (Patton, 2015). In this study, the researcher used four types of data sources - audio recordings, observations, reflections and artefacts which were all aimed at answering the research question, namely, “How can ego state therapy and creative expressive art in therapy be integrated to facilitate inner strength building in adolescent girls with depressive symptoms?”

The interview facilitates the understanding of the client and her uniqueness, which is necessary in order to provide treatment. When the observations have been done, both the researcher and the main caregiver explore the effect of the sessions on the participant. The reflections written by the researcher, the mother/caregiver and each participant also aid in the evolvement of the client through interventions, and finally, the artefacts also assist in assessing the impact of the sessions and whether inner strength building indeed took place.

4.8.2 Credibility

Credibility refers to the findings being confirmed by the participants, that they indeed represent the participants’ experience (Treharne & Riggs, 2015). In this study, member checking took place, the participants read the material and signed that indeed it was all authentic and that it did represent their experience. Peer debriefing also took place, where the information of the research and its findings was shared with other scholars, and they communicated their recommendations.

4.8.3 Transferability

Transferability refers to the ability to generalise the findings to wider or different populations (Braun & Clarke, 2013). In this study, the participants’ responses were transcribed, as well as the analysis of the researcher, in order to provide evidence for the reader that the findings could be applicable to other settings (Treharne & Riggs,

2015).

4.8.4 Dependability

Dependability refers to the ability to replicate the findings through other researchers (Treharne & Riggs, 2015). In this study, the findings were consistent with the raw data that was collected, hence, it would be likely that if another researcher undertook to replicate the study, using the same strategies, the results will not change.

4.8.5 Confirmability

Confirmability refers to the findings being devoid of the researcher's bias, intentions, motivations or interests (Lincoln & Guba, 1985). In this research, the member check, the peer debriefing, the raw data with the researcher's interpretations and the triangulation, all served as measures against this concern.

4.8.6 Authenticity

Authenticity refers to the usefulness of the findings, or their transformative potential. In other words, will members of the community be empowered to make use of the findings of the research (Treharne & Riggs, 2015). In this study, after the peer check took place, it appeared that they are intending to make use of some ideas mentioned in this research.

The worthiness of a research should also be judged on the ethical considerations that were implemented in the research (Richards, 2015). In the next paragraph, some important ethical rules are mentioned.

4.9 Ethical consideration

Ethical considerations need to be considered from the conception of the project to the final report, and often even past the final report. This is due to the fact that a qualitative research is more likely to impact people's lives than the research that collects their data in an impersonal manner (Richards, 2015). Therefore, prior to carrying out this research, the researcher received ethical clearance from Faculty of Education Research Ethics Committee of the University of Johannesburg (Appendix A).

At the beginning of the process, the main care giver was contacted and the

requirements as well as the process was explained to him/her. Once they were satisfied with the information, they signed an informed consent (appendix C). in terms of the participants, each of them received as much information as was needed for her to make an informed decision about whether or not she would like to participate in the study, and she signed an informed consent form (Bryman, 2016; Hesse-Biber, 2017) (appendix B). The nature of her voluntary participation was discussed as well. Before beginning with the interview, each participant was made aware of the guaranteed confidentiality. Therefore, pseudonyms were used and definitive descriptions were avoided (Richards, 2015). They were also made aware of the eventual publication of the findings. Each participant was informed of her right to ask questions whenever she wished to do so. The researcher ensured that the participants were not subjected to any harm. This included physical harm, harm to the participants' development, or harm to their self-esteem and stress (Bryman, 2016). The researcher ensured that the participants felt comfortable to contact her, should they encounter any emotional distress, during the process. They were also given the option to continue with therapy after the process was completed.

4.10 Conclusion

In this chapter, research methodology has been discussed. The nature of qualitative research was explained together with its advantages. The research design, a case study design, was elaborated upon as well. Inductive and deductive approaches to research were discussed in reference to this research study. The criterion on which the participants were chosen, was stated. The procedure of the therapeutic sessions, that the participants participated in, was discussed at length. The sources for data collection was elaborated upon, as well as the method of analysis. Finally, ethical considerations were discussed. In the next chapter, the results and the interpretations of all three case studies will be discussed.

CHAPTER 5: RESULTS AND INTERPRETATIONS

5.1 Introduction

In this chapter, the outcome of this research study will be described and interpreted. The data that was collected through the interviews and the sessions will be analysed. The researcher's observations, as well as each participant's main caregiver's observations will be discussed. The reflections written by the participants, by the main caregivers and by the researcher will be discussed as well. Finally, the artefacts will be examined and analysed. The themes and sub-themes that emerged from each case will be elaborated upon.

The results will be discussed in accordance with the specific research objectives which focused on the facilitation of inner-strength building in adolescent girls with depressive symptoms through ego state therapy and creative, expressive art in therapy. The objectives also focused on the development of a framework which this analysis could assist with.

With case studies, the analysis is done in the same manner for all cases. However, the uniqueness of each case was preserved as different themes emerged (Braun & Clarke, 2006). After the case study was analyzed, a cross case study took place in order to compare and contrast the experiences of the participants through the process and the themes that emerged from the entire data. Three participants participated in this study. Pseudonyms were used to ensure confidentiality. The pseudonyms were chosen by the participants.

5.2 Interpreting and describing the case studies

As mentioned in section 4.7, the interpretation of the case studies was based on thematic analysis suggested by Braun and Clarke (2006). The codes were derived from the raw data which evolved into themes and sub-themes. There were also predetermined main themes which were utilised, that were derived from the research title, aim and question. Hence, data was analysed against two predetermined themes:

- The emotional status of the participants
- The inner strength status of the participant

Within these broad themes, the researcher further identified sub-themes specific to each participant through inductive thematic analysis.

The emotional status of the participants was explored by identifying depressive symptoms according to the DSM-V. These symptoms became sub-themes that helped to interpret the cases. The symptoms include emotions, attitudes, thoughts and physical symptoms that contribute to depression. This realm of **emotions** consists of sadness, emptiness, hopelessness, being teary or irritable, as well as feelings of worthlessness and guilt. Similarly, the realm of **attitudes** consists of diminished interest or pleasure in activities that were previously enjoyed. The realm of **thoughts** includes the reduced ability to think or concentrate, as well as indecisiveness. The realm of **physiology** includes physical symptoms, such as the loss or gain of weight, as well as hyper insomnia or insomnia, restlessness or slowness, as well as the lack of energy or fatigue (American Psychiatric Association, 2013). This main theme, namely, the emotional status of the participant, was used as a theoretical framework in order to explore each participant's unique experience, and the symptoms and effects of their depressive symptoms before, during and after the therapy process.

The inner strength status of the participants was the second pre-determined theme. The participants' inner strength was explored in accordance with Lundman et al.'s (2010) conceptualisation of inner strength in terms of resilience, sense of coherence, hardiness, purpose in life and self-transcendence.

5.2.1 Case study 1: Kelly

5.2.1.1 Background and demographic information

Kelly is a 16-year-old Jewish, semi-religious girl, who lives in the Northern Suburbs of Johannesburg. She attends a school which is predominantly Jewish. She is a good student and a high achiever who demands excellent marks for herself. She is also creative. Her father describes her as a person who is "good hearted, caring, considerate, loves her religion, loves her friends, enjoys music, creative, sporty, and she does everything 100 percent". Her father reported that she was born three weeks pre-mature, by a caesarean birth. She spent two weeks in ICU, and her parents were not with her most of the time she spent there. According to the father, while her current health is good, for many years she used to get sick intermittently "due to her mental

status". Kelly has two older brothers whom she was not close to for most of her life, but now they all seem to be trying to get closer. All her grandparents are alive. She is close to her paternal grandparents, but she is not in contact with her maternal grandparents. Her parents got divorced when she was four years of age. The parents currently live in different towns. Kelly is close to her father and she has been living with him, since the age of ten, when her mother "kicked her out of her house". Kelly is not on speaking terms with her mother. Kelly claims that her mother is selfish and unpredictable. According to Kelly and her father, the mother rejected and neglected Kelly from a young age. At her mother's place, the house helper used to abuse Kelly physically and emotionally. Up until the time of the divorce, the home felt like a "war-zone" to Kelly; it was saturated with conflict between her parents. After the divorce, Kelly experienced a lack of stability while living with her mother due to her family moving house quite a few times. There were times when they had to move in with other people.

At the age of six, when Kelly started primary school, she experienced severe separation anxiety. However, Kelly enjoyed being at school and she enjoyed the learning too. From the age of six and upwards, Kelly claims, that her mother used to scare her about all the challenges that were waiting for Kelly as she reached adolescence and adulthood. This caused Kelly extreme anxiety, fear and terror which she, currently, is still struggling with. At the age of ten, Kelly started developing symptoms of severe obsessive-compulsive disorder. She was unable to stop washing her hands; she used to take very long showers; and, she used to rub her feet on her carpet until they bled. From the time when the mother demanded that Kelly leave her house, Kelly's marks deteriorated and she stopped eating, maintaining that she was not hungry. Her overall motivation deteriorated. According to Kelly, her mother carried on traumatizing her and causing her pain, even after Kelly left to live with her father. This carried on until Kelly decided to cut all ties with her mother. Kelly has been challenged socially for many years. Currently, she is struggling with depression, high anxiety, obsessive compulsive disorder, intense anger, confidence issues, and social issues. Kelly has been using antidepressant medication since the age of 10.

When analysing Kelly's case, it became apparent that she started off our therapy sessions with severe depressive symptoms, some of which improved during the

process. During the interview, it was evident that Kelly exhibited most of the DSM-V criteria for depression, namely, sadness, irritability, emptiness, hopelessness, tearfulness, lack of motivation, decreased appetite, fatigue, feelings of worthlessness, difficulty concentrating and suicidal ideation. It also became apparent that she started the process with challenges with her inner strength, within all the constructs of her inner strength, namely, resilience, sense of coherence, hardiness, purpose in life and self-transcendence. These improved significantly through the process. The following analysis of Kelly's case will illustrate the abovementioned conclusions.

5.2.1.2 Session 1

Session 1 consisted of discussing the poems Kelly had written, and producing the genogram and the lifeline (see section 4.6.2 and Appendix D). When analysing the data emerging from these activities, it became apparent that Kelly used to struggle with symptoms of depression and limited inner strength. A few examples below will illustrate this. Her poems (she downloaded from the Internet), which capture the emotional space that she was currently in, and the emotional space in which she wished to be, represented excessive worry, fear and weakness, as well as a wish to get stronger. The first poem stated, "we live in a world that doesn't slow down, it's seems everyone is in a hurry which causes us lots of stress, lots of anxiety and an abundance of worry". According to this poem, she experiences worry stemming from all fronts. The poem presents the worry as a debilitating condition, as well as an enemy and a curse. She also expresses being debilitated by fear in the following sentence which she highlighted, "I have come to realise I am paralyzed by fear". Kelly seems to have the awareness that worrying does not help, as reflected in the following sentence which she highlighted, "worry never robs tomorrow of its sorrow, no matter what people might say, all it does is zap the joy and happiness from today". However, she seems to be stuck in this worried state without the ability to transcend it. She also seems to feel helpless and weak, "I'm falling like the autumn leaves". Trying to find purpose did not seem to help either as the second poem says, "I've tried to see a new path for my life to travel, but I get stuck in the first step and watch it all unravel". Her wish, which she highlighted, is that "I wish I was as strong as everyone believes". All the above quotes from her chosen poems represent diminished resilience, a sense of coherence, hardiness, purpose of life and self-transcendence.

When Kelly spoke about her relationships with her mother, grandparents and brothers, during the genogram activity, her eyes and voice saddened. There was heaviness in the room. She mentioned how over the years, she used to miss her brothers due to the lack of a relationship between them. When she spoke about her mother, there was anger in her voice. This activity served as evidence that relationships are of utmost importance to Kelly, and that the absence of meaningful relationships, with these close family members, contributed to her depression.

When examining Kelly's lifeline, it became apparent that she has experienced a weak sense of inner strength over many periods of her life. A few examples will be mentioned here. At the age of six, she struggled with separation anxiety. Kelly was scared to grow up as her mother created fear in Kelly about physical maturation. For a long period of time, Kelly struggled with severe obsessive-compulsive disorder which debilitated her and made her feel out of control. A friend's rejection resulted in major distress. When going on holiday to Cape Town, and seeing some of her school friends there, she experienced a high level of anxiety. All the above-mentioned examples express diminishments within all her inner strength's constructs.

Between the first and second session, Kelly wrote a reflection about her experience. From this reflection, it seemed that as a result of the first session, shifts were created within her thought patterns, in terms of self-awareness, hope, and the ability to detach her experiences from the self; viewing them, instead, as part of her life, not as her own actions. Sharing her story helped her feel a lot better and she valued the empathy received in the therapeutic context. Through the therapeutic session, she gained insight into her current emotional space and into the space she rather wished to be in. This created insight is a predetermined phase for change. Kelly also wrote,

> I am tired of feeling sad and out of control, I really hope to gain more self-confidence, self-worth, happiness, and to be able to let go of my anger, instead of blocking it out. I want to be happy the majority of the time instead of feeling useless, anxious, and depressed, I want to feel lively, awake and joy.

Between the first and second session, the researcher similarly documented the following in her process notes:

> Though Kelly had a smile on her face a lot of the time, her eyes were full of

sadness throughout the session. In her quiet way, she spoke about her life and her challenges. When she spoke about her mom, about their relationship, and especially about how her mom threw her out the house at the age of 10, there was a lot of pain in her voice. She was emotional when she spoke about certain events that she mentioned on the sad side of the lifeline. After seeing the finished product of the lifeline, she felt a sense of relief, when she realised where all her issues stemmed from. She left the session with a smile on her face and a sense of hope.

This means that her purpose of life and self-transcendence have started to shift positively.

From the process of the session, as well as from the reflections, it was evident that Kelly experienced depressive symptoms and diminished inner strength. However, a positive shift was noticeable even after the first session.

5.2.1.3 Session 2

The sand tray activity (see section 4.6.3) provided an opportunity for Kelly to examine and express her current experiences, challenges and emotions, as well as to exam the emotional space in which she wishes to be. When examining Kelly's challenging side of the sand tray (as can be seen in Appendix I), one can see a broken ship, about which she said, "I cannot control anything in my life, as if the ship collapsed". She also used a little bear sitting in a box in order to illustrate her loneliness and her lack of ability to talk to others**.** During this activity, Kelly said, "I've come to realize I'm paralyzed by fear because recently I have realised that I'm so scared of doing so many things that hold me back…I mean, I'm afraid to even talk to my friends, so I become the third wheel. And I don't really like that". Kelly also expressed her lack of confidence by saying, "I wish I was as strong as everyone believes. I wish I was more confident". She also feels that she cannot progress in life, as she said, "I get stuck on the first step". And even when she gets enough desire to implement change, she gets discouraged as she said, "So I've often tried to think, okay. I have this moment. I wanna get my life together, but it doesn't last long and I think what's the point? And after a little while, I just give up".

When the researcher asked Kelly "on a scale from zero to ten, how sad do you feel if

sadness is the highest?" She replied, "ten", and when she was asked "how much do you believe in yourself and how much confidence you have if a score of ten is high confidence?", she replied, "zero". Kelly is clearly struggling with depressive symptoms and with a challenged inner strength. From the sand tray activity, it became evident that all the inner strength constructs were low and required improvement.

However, from the positive side of the sand tray, she seemed to be gaining self-awareness, as well as motivation for change. Self-awareness contributes to inner strength building as Lundman et al. (2010, p. 253) explains, "*Purpose of life* or meaning in life, "measures the degree to which individuals experience life as meaningful and develop a sense of purposeful direction". The sand tray gives people a sense of direction and meaning in their lives. Lundman et al. (2010) also sees s*elf-transcendence* as achieving greater awareness of one's own values and integrating one's past and future in one's present moment. The sand-tray activity allows for people to realise their own value in terms of what they are capable of achieving. It also facilitates the integration of the past and future in the present moment, bringing about the awareness of the possible journey, depending on one's motivation.

From this activity, it became evident that creating the future, problem-free side for Kelly, brought about self-awareness and the realisation of her abilities and personal value, as well as a desire to implement change. A few examples from the future side of the sand tray, which point to self-growth are mentioned below. On the positive side, Kelly put a frog playing the flute which represented happiness, freedom and carefreeness. The man sitting on a chair and reading represented relaxation as opposed to "stressing about school life or social life". The dog represented "no grudges". Kelly said, **"**I guess that means that when I'm angry I hold grudges for a very long time, like, I'm still very angry with my mom for what she did two years ago, which was terrible. But I just want to be able to let go of it". Kelly would like to be able to control her anger. This was represented through a leopard who is "someone that controls their anger and doesn't want to always lash out". She seems to have an insight that the same situation could be viewed from different perspectives, hence it may bring about different attitudes as she said, "when it comes to the stones on the bad side, I felt as if I was stuck in a dark and a terrible place. And, I find that those stones (in the positive side) are very pretty colours, calm colours". The birds represented freedom

and peace. The peace also relates to accepting the past. Kelly added an angel to the positive side, maintaining that “lately, I’ve also felt as if I’m not as connected to G-D as I used to be and I want to be more connected”. Kelly was then asked to identify a figure which would represent her in her strongest state and she chose a tiger. She was asked to place it on the negative side. She was then asked to write down what are the “things that need to happen from within, that will allow for the tiger to move away from the negative side, cross the bridge and get to the other side”. Kelly wrote the following: “therapy”, “accepting myself and stop criticising myself”, “take everything as it comes”, “let go and let G-D”, and “exercise, every day for 20 minutes”. She was then asked when would she like to reach the positive side. After thinking about it, she replied, “as soon as possible”. This shows motivation for change. Hence, it became evident that the sand-tray activity assisted Kelly in creating shifts in terms of her inner strength and its capacity.

According to the researcher’s reflection, when Kelly was presented with the sand-tray activity, she was keen to tackle it. At first, she was quiet for a long time, focusing within herself. When she explained the sad side of the sand tray, her voice was filled with sadness. No inner strength was expressed, her energy was low and she spoke softly. There was a sense of despair that came through. While the sad side symbolised immobility, frozenness and sadness, the future side symbolised freedom and flow. When she explained the positive side, there was a smile on her face. The researcher got a sense that there is a part of her that believes that her aspirations can materialise.

In Kelly’s reflection on this activity, she expressed how it facilitated her self-awareness, “it helped me to put things into perspective”. She felt that it also helped her add meaning and sense to her confusing emotions. This means that her inner strength got stronger in terms of purpose of life, as well as self-transcendence.

From the process of the session, as well as from the reflections and the artefact, which was the sand tray, it was evident that Kelly was challenged with depressive symptoms and with diminished inner strength. However, both these categories seem to be shifting for the better as is evident from her emerging motivation for change, as well as from the self-awareness that was taking place.

5.2.1.4 Session 3

When Kelly came back for Session 3, she reported that during the week she was angry about her past and her present “feeling like punching someone”. She also felt sad and “up and down”, but “today I am feeling better" she reported. The session commenced with the hypnosis session aimed at “meeting your inner strength in a safe space” (see section 4.6.4 for a description of the interventions, as well as Appendix H). During the hypnosis, she was asked to create the image of her inner strength from clay. The image she created was that of herself. She imagined it to be white in colour. She felt it in her chest. When her inner strength was asked to suggest a solution to her most pressing problem, which at the time was her debilitating anxiety, it replied “I must take some time to enjoy whatever comes as it comes without stressing” (presence of self-transcendence). When the inner strength was asked to give Kelly an affirmation which she could carry with her for life to strengthen her, it replied: “You’ve gone through so much. I’m proud that you never gave in”. The hypnosis session seemed to have brought about growth within her inner strength as Kelly reported, “It made me feel powerful and strong” (indication of hardiness, resilience and a sense of coherence). After the hypnosis session, she watched the video clip of the Lion King (see Appendix M). This seemed to have facilitated growth within her self-esteem. When she was asked to identify the parts in the clip that resonated with her the most, she replied, “he has forgotten himself”. She felt that the clip helped her focus on her own self-growth as she said, “It gets me focussed on me. I’ve been so focussed on what everyone else should be instead of who I should be”. This serves as evidence for emerging self-transcendence as Kelly managed to stop the judgment towards her friends and instead, she started focusing on her self-growth.

After Session 3, the researcher reflected on the session and wrote that “Kelly came happily into the session, but her face and eyes looked somewhat red and she looked distressed. The hypnotic induction took place smoothly; she enjoyed the video clip and she left the session in a good mood.”

Between Session 3 and 4, Kelly wrote a reflection which is indicative of inner strength evolvement, as well as reduction in depressive symptoms: “I felt very relaxed and happy after the session. I also felt very relieved…it helped me think deeper into myself. I felt a little sense of hope and acceptance too”.

From the process of the session, as well as from the reflections and the artefact, it was evident that Kelly is still struggling with her moods and with a challenged inner strength. However, it is clear that the activity helped to strengthen her inner strength, as can be seen above. Her hardiness, resilience, sense of coherence and self-transcendence have all strengthened.

5.2.1.5 Session 4

When Kelly came into this session, she seemed happier, she had a smile on her face, her breathing was deeper, and her body did not seem as tight as it was previously. When asked how she had been in the past week, she replied, “feeling down now and then”. She reported the following, which was of concern to her, “I was talking to my father at the dinner table last night, about, like, after school, I’d love to go travel… although I’d really love to go, I don’t think I will, because I don’t have the confidence and I don’t think I’ll be able to take care of myself. Then I just started to cry and said to him that it’s hard growing up”. The fact that she reported “feeling down now and then” as opposed to her previous default position of “feeling up and down” could indicate a positive shift in mood. Her fear of traveling and of growing up indicates a challenge within her inner strength. It seems that her mother managed to instil deep fear in Kelly about the challenges of growing up, which will require time and therapy to undo.

In this session, she experienced another hypnosis session aimed at inner strength building. Kelly felt that this hypnosis gave her additional confidence and self-acceptance. After the hypnosis, the cup activity (see section 4.6.5 and Appendix H) took place. This activity made Kelly realise which aspects of her life she would like to channel her time and energy towards. This activity seemed to have expanded her inner strength through growing her purpose of life and self-transcendence, as Kelly commented in her reflection on the activity,

> I felt the session was very relaxing. I loved doing the cup exercise, seeing how much energy I am putting into different aspects of my life. I really felt it helped to put the water into different cups. It made me feel better to see what aspects of my life I want to put more effort into …

Kelly filled up the cup that represented her mother, to the top. She felt that she was

spending unnecessary energy on this aspect of her life, in terms of paying attention to the hurts and negative messages that came from her mother. Kelly, immediately, made a conscious decision to empty out that cup and rather share the water with cups that can be more useful for her, namely, pets, art and inner strength. Consequently, the “mother’s cup” got emptied out. Kelly seemed to be feeling relieved. The cup representing her brothers received about an eighth of the water. She felt it was unnecessary to give them any energy, hence she emptied it out into “healing my emotions”. The cup which represented “external looks” also needed alteration. Kelly said that it is full of negative self-image and now she wants it to be full of positive self-image. When she handled the cup representing the critical voice, she filled it up to the top. As she realised the amount of energy it was demanding of her, she emptied out the cup into another cup representing traveling and inner strength. Her motivation for implementing change is indicative of the fact that her depression is decreasing.

The table below illustrates Kelly’s cup activity. The measurements represent the extent to which she filled the cup up, namely, the amount of energy that she feels she is directing into this aspect of her life.

Table 5.1

The cup activity – Kelly

Where does my energy go	**How much of it**	**Where do I prefer it to go**
School-work	full	
Art	1/5	
Father	Almost full	
Pets	1/2	
Mother	full	Transferring into pets, art, inner strength
Brothers	1/8	Transferring into healing my emotions
Gym	1/2	
Healthy eating	1/2	
Travel	1/4	
Friends	1/2	
Critical voice and insecure part	full	Transferring into travelling and into inner strength
Inner wisdom and inner strength	1/8	
External looks	full	Staying full, was negative, now positive
Healing my emotions	1/2	

According to the researcher's reflection, Kelly enjoyed the hypnosis and the cup activity. It seemed as though she is gaining agency in her life. Her self-awareness brought about a sense of responsibility for her own life.

In Kelly's reflection about the session, she mentioned that the session was very relaxing and that she loved doing the cup activity. She maintained that the activity contributed to her insight and motivation to change things. This is indicative of

diminishing depression and an enhancement of her inner strength.

From the process of the session, as well as from the reflections and artefact, which was the cup activity, it was evident that Kelly's depressive symptoms were starting to diminish and her inner strength, although needing more work, was making progress in terms of purpose of life, as well as self-transcendence.

5.2.1.6 Session 5

The researcher noted that when Kelly came into this session, she was glowing, she projected a stronger presence and less sadness. It seems that her subconscious is internalising the therapeutic messages. Kelly was a lot more in flow with herself and with life. When asked how her week had been, she replied, "I am not sitting on my own anymore. I am sitting with some nice boys". This serves as evidence of the enhancement of her inner strength, in terms of resilience, sense of coherence, hardiness, as well as self-transcendence.

In this session, Kelly experienced a hypnosis session (see section 4.6.6 and Appendix H) aimed at assisting her to detach the maladaptive messages which she absorbed over the years into the self, from negative people in her environment, as well as to notice the positive, the personal growth and the gains that may have stemmed from those challenges. She was also asked to paint the tree which she visualised during the hypnosis session and illustrate the "garbage" in her life by painting it and writing on it the kind of negative messages that she absorbed (see section 4.6.6 and Appendix I). The messages she wrote were: "Not good enough", "not valuable enough", "too sensitive", "you are a bitch" and "not clever enough". She was also expected to illustrate the personal gains, for which she wrote: "able to empathise", "mature", "strong", "good listener", "good insight" and "smart". This self-awareness brings about hardiness. This session assisted her with realising more about who she really is and what messages do not belong to her. The intervention facilitated ego strengthening, in terms of resilience, hardiness and self-transcendence. This is evident from Kelly's reflection of the session: "I really loved the story of the tree, and how she (the tree) went from feeling worthless to making herself useful in which she ultimately achieved her goal. I really loved painting my tree…it sparked a light for me that I have lacked for a while".

According to the researcher's reflection, Kelly enjoyed both the hypnosis session and the creative work. She came across significantly stronger, happier and more grounded. The fact that she was already making positive shifts, made her feel more relaxed and joyful.

From the process of the session, as well as from the reflections and the artefact, which was the painting of the tree, it was evident that Kelly's depressive symptoms are starting to diminish and that her inner strength, although requiring more work, is making progress in terms of resilience, hardiness, as well as self-transcendence.

5.2.1.7 Session 6

In this session, the intervention consisted of "the tree of life" which expanded over three sessions (see section 4.6.7 and Appendix L). In the beginning of the session, Kelly indicated that, in general, she is feeling better. During the sessions, Kelly was happy and did not speak as softly as she had done in the first session. She was more settled and relaxed. She enjoyed doing the artwork of the tree and she invested effort in it. Kelly only created three roots. The roots represent the people one is descended from (there should be six roots, as in two sets of grand-parents and two parents, as explained in section 4.6.6). However, due to the fact that Kelly is in conflict with her mother and her mother's parents, she chose to leave them out. Kelly added 14 flowers. These represent the special people in her life, who become the witnesses to her strengths. She only agreed to ask five of them what they see in her as assets and strengths. Upon the replies, Kelly felt proud, as well as surprised. She did not expect people to see in her so many assets and strengths. The activity clearly improved her self-image and her inner self-value. The researcher also added assets and strengths which she saw in Kelly. When Kelly read the researcher's words, her eyes lit up. When she was asked if she was aware of the fact that people think so highly of her, with a smile she replied, "no". The many leaves on her tree symbolised her happy memories from the past. And the fruits symbolised her hopes and dreams for the future, which are: "to be in a job I love, to have a nice house, go to university, travel the world, be happy, to have meaningful relationships, to be able to take care of my father".

According to the researcher's reflection, Kelly is open to therapy and she is always keen to learn new techniques. During the session, Kelly was relaxed and in flow,

although she is in the middle of exams, which at this junction, caused most of her anxiety. Her face was glowing too. She enjoyed the art activity. She seemed to be absorbing the therapeutic messages. During the sessions she spoke freely and happily. She said, “things don’t bother me all that much anymore”. When we discussed her hopes and dreams, her face lit up. Focusing on the positive in the future, seemed to have given her a boost of energy and a reason to try heal from her challenging life.

Kelly’s reflections on the three sessions of ‘the tree of life’ serve as evidence of some clear shifts in her depressive symptoms which are diminishing, as well as in her inner strength which is expanding. In her reflection, she wrote,

> I haven’t been feeling down lately. I think I feel more confident with my friends. I am not so scared of them anymore. I can see that they are not really leaving me out, it was more my projection. I think things are going a lot smoother. For some reason, I wasn’t so stressed for my exam.

After the second session of ‘the tree of life’, she wrote that she had a problem with her group of friends. However, she got over it within a few hours as opposed to after a few days. She also said, “I have been feeling a lot better lately”. After the third session of ‘the tree of life’, she wrote, “the activity was very therapeutic. It was very interesting to see what people thought of me…which is not what I expected… it made me a lot more confident”. Amongst other things, she also wrote, “I have been able to speak to my friends a lot easier and even my friends noticed that I am not so judgmental and I have become more accepting. My friends find it easier to speak to me. I did get the burst of happiness where I just wanted to dance”. The fact that Kelly viewed the fear of her peers as her own projection and not as a reflection of them being a real threat to her serves as a sign that her depression is diminishing. Research indicates that depression is associated with negative interpretations of peoples’ intentions and behaviour and high sensitivity to minimal social threats (Jankowski et al., 2018).

From the process of the session, as well as from the reflections and the artefact of ‘the tree of life', it was evident that Kelly’s depressive symptoms are diminishing and her inner strength is making progress within all of its aspects, namely, within resilience, sense of coherence, hardiness, purpose in life and self-transcendence.

5.2.1.8 Session 7 The concluding session

In this session, Kelly experienced a short hypnosis session focused on anchoring and grounding (see section 4.6.8 and Appendix H). The activity in this session entailed creating her evolved inner strength from clay (see Appendix I), as well as free writing about her evolved inner strength. She enjoyed the hypnosis session and found it beneficial. The anchoring gave her a practical tool to use in life whenever she feels ungrounded. Her previous inner strength represented an image of herself when she feels strong and in control. Her current, evolved, inner strength is also an image of herself but stronger, as she said, "When I went up to the waterfall area (where she initially met with her inner strength), I still see a "me", but a happier me… that is saying 'I've come a long way and that it's okay', like putting its hand on my shoulder…". As an inner strength, Kelly created a white female image that had a smile on her face. In terms of examining the artefacts, it is difficult to compare the two images, as the first one was shaped by Kelly with closed eyes, in hypnosis.

When examining Kelly's free writing about her evolved inner strength, it became apparent that it is flourishing. A few sentences from the free writing are quoted here:

> …I do still have my moments when I feel worthless and uncomfortable and sad, but now the ball of light I had first seen is shining brighter. My inner strength (me) is touching my shoulders showing me how I have come such a long way. I barely ever get a sudden feeling of just crying.

The following is her inner strength talking to her:

> You have become closer to your friends and you find that you are smiling a lot more often…without you knowing it, your inner strength has been there for you. That is why you are less stressed, don't feel like crying and have trusted yourself when you had to learn for your history test. You have also, since you are happier, been slightly less judgmental…my inner strength is also helping me in communicating better.

The researcher reflected on the session and said that during this session, Kelly seemed relaxed and happier, she had a glow on her face. She seemed less angry. She enjoyed the hypnosis session and she was involved deeply in creating her inner

strength. Her insight that emerged and as she was writing about her inner strength, it was strengthening itself in its own right.

From the process of the session, as well as from the reflections and the artefact, it was evident that Kelly's depressive symptoms are diminishing markedly, and her inner strength is progressing within all of its aspects, namely, within resilience, sense of coherence, hardiness and self-transcendence.

5.2.1.9 The father's observations and reflections from before commencing the process and at the end of the intervention

Before the process began, her father had said the following about Kelly:

> Her approach to others is very judgmental… She sits alone at break…she won't move from her spot at school because it's her security…her mood is generally ok but she does hit a low three to four times a week…she does snap often…her anxiety is 90% due to school. She is scared to fail. She sets very high levels for herself. She needs more self-esteem. She will never ask something from someone unless I force her to. She does not think she is worthy. She doesn't know how her friends are lucky to have her as a friend, she is so loyal. She is unable to see people as grey only as black or white. If someone says something she doesn't like, she puts him in the 'black box'. She is unable to see the colour in life. At times, she is scared to explore new things. She lacks motivation. During transformation to adulthood, she was in tears the whole time…

After the intervention, the observable shifts in Kelly, according to the father's report, were significant. The father said that "now Kelly has a lot more contact with friends. Occasionally she reaches out. Her mood is not nearly as low as it used to be. She is more secure and less snappy. She can now deal better with her anger. The anxiety is… a lot less than what it was and she doesn't obsess about it. Her self-esteem is a lot better, she has quite a lot more self-confidence. The worthlessness is better; she isn't stuck any more in a negative space. Her thinking is still extreme; she still puts people in the "black box". She still lacks motivation but she is a lot happier".

It is evident from the father's report that her depressive symptoms decreased markedly in terms of sadness, irritability and self-value. Simultaneously, her inner strength

increased markedly in terms of resilience, sense of coherence, hardiness and self-transcendence, as she was able to reach out to friends. She was “less snappy”, her anger management has improved and she is “not stuck any more”.

5.2.1.10 Summary: Building Kelly’s inner strength through ego state therapy and creative expressive art in therapy

The outcome of the thematic analysis of data stemming from the therapeutic sessions, the researcher’s observations and her reflections, Kelly’s reflections, the father’s observation and reflections, and lastly, the artefacts, showed a marked change from the beginning to the conclusion of treatment. A reduction in Kelly’s depressive symptoms became apparent. At the end of the process, the researcher also asked Kelly to rate her depressive symptoms from before the commencement of therapy and at the end of the intervention on a scale from zero to ten, ten being severe symptoms and zero being no symptoms. According to Kelly, her sadness initially was at level seven and after treatment, at level four. Her lack of motivation and interest was at level nine, and now it is at level five. Her hypersomnia was severe, on level ten and has decreased to level five. She never had an issue with restlessness or slowness. Her energy is slightly better, the feelings of worthlessness, or the feelings of not being good enough used to be on level nine, and now they are on level four. Her ability to concentrate requires slight improvement and that was not impacted upon throughout the process. In other words, her concentration still requires slight improvement.

Regarding Kelly’s inner strength, all the data sources serve as evidence that her inner strength became stronger within all five components of the inner strength. At the end of the process, the researcher was interested to find out about the other themes that emerged from the data which were a challenge to Kelly. These themes are also an indication of the function of her inner strength. The researcher asked Kelly about her tendency to judge people, which according to Kelly, diminished from level nine to level five. Her anger did not shift (even though, according to the father, there was an improvement within this area). Her anxiety diminished from level ten to level six, and her feelings of rejection diminished from level ten to level five. All the above serve as evidence for a marked increase in her inner strength capacity.

The evidence appears to suggest that in Kelly’s case, the framework used for this

research did yield a positive outcome in building inner strength and reducing depressive symptoms.

5.2.2 Case Study 2: Luna

5.2.2.1 Background and demographic information

Luna is 14 years old, Christian, semi-religious girl, who lives in the Northern Suburbs of Johannesburg. She attends a small school which is predominantly Jewish. Luna has had a problem of school refusal since Grade 3 due to being severely bullied. The mother assumes another reason for the school refusal; she maintains that Luna is intelligent and hence, she finds school boring. When the mother was asked to describe Luna, she replied that Luna was creative, loved animals, struggled with anger management, depression, and with severe mood fluctuations. She also struggles with social interactions. However, she is always confident enough to speak to adults she doesn't know. The mother said, "At the garage nearby our house, everybody knows her and loves her". Luna's parents did not marry. Her father had six children from six different women. Luna is the youngest sibling. She has no relationship with any of the siblings. When the father heard that Luna's mother was pregnant, he left. He made it clear that he did not want another child. When Luna was one, four and thirteen years of age, the father came back for visits. According to Luna, these visits made her feel happy. Her father lives abroad. Unfortunately, there was no relationship between them up until a year ago, when Luna initiated contact. The relationship between Luna and her mother is ambivalent, on the one hand they are close and on the other hand, Luna feels anger towards her mother. The mother is a sickly person. Therefore, Luna feels as though she needs to assume responsibility for her mother's health. Luna also lives in fear that something may happen to the mother. This situation also seems to contribute to Luna's depression and anxiety.

Luna experienced two difficult losses in her life. At ten years of age, she lost her grandmother whom she was very close to, and at the age of fourteen, Luna lost her 'ugogo', who was the family's helper since before Luna was born. She was a 'second mother' to Luna (ugogo means grandmother in Zulu). Luna received no therapy for these losses and she has not recovered from them yet. From the age of four to thirteen, Luna was also bullied severely at school. The class formed a 'club' by the name 'the

Luna touch', which meant that any child who touches Luna is considered 'a nerd'. The children rejected her and kept their distance from her. This was very hurtful to Luna. Over the years, she developed severe anger issues, to the extent that when she was in Grade 6, she had to be admitted to a psychiatric hospital for three months, where she had felt 'caged'. The admission did not help and her anger issues still persist. Luna tends to instruct the class teachers and classmates as to what to do and as might be expected, she faces objections. Luna said that she has been struggling with 'a doll phobia' since someone told her that she (Luna) is possessed. The sight of dolls brings about intense anxiety. Currently, she has two good friends who are five years younger than her. Luna is now experiencing depressive symptoms, high anxiety, school refusal, anger issues, social issues, self-esteem issues, and a need to control. She has been taking anti-depressant medication since the age of eight or nine.

When analysing Luna's case, it became apparent that she started off with severe depressive symptoms, some of which eased up during the process. During the interview, it was evident that Luna exhibited most of the DSM-V criteria for depression, namely, sadness, irritability, hopelessness, tearfulness, lack of motivation, restlessness, worthlessness, difficulty concentrating, and thoughts about death. It also became apparent that she started the process with challenges with her inner strength, within all the contracts of the inner strength, namely, resilience, sense of coherence, hardiness, purpose in life and self-transcendence. These improved significantly through the process. The following analysis of Luna's case will illustrate the abovementioned conclusions.

5.2.2.2 Session 1

Session one consisted of poems she had written, the genogram and the lifeline (see section 4.6.2). When analysing the data emerging from these activities, it became apparent that Luna used to struggle with symptoms of depression and limited inner strength. A few examples below will illustrate this. Luna wrote the poems herself (sees Appendix D). Within them, she captured the emotional space that she was currently in, and the emotional space in which she wished to be. The poems represent excessive frustration about wanting solitude but being unable to achieve it. She wrote, "people always judging you, telling you what to do when all you want to do is be left alone". Her inability to cope with external demands, her feelings of being judged, and

the feelings of being overwhelmed suggest a lack of sense of coherence and hardiness. In the poem which represents the space she wishes to be in, she spoke about freedom “now I am free, free to do what I want”. During the session, she gained insight about being able to do both, fulfilling her responsibilities, as well as having time for herself. She liked the idea and asked to add this to her poem and she wrote, “after a while I found a compromise, a little bit of time with those that I love and some to do what I want”. From this point, it seems that her inner strength is starting to expand in terms of self-transcendence.

The genogram served as evidence of the conflict she feels towards her parents. She is close to her mother and simultaneously they often fight. This may be an indication of lack of resilience. As the characteristic of resilience would have helped her stay more in emotional balance. Regarding her relationship with her father, Luna seems to be blocking the anger and hurt that he caused her, as she said, “It’s like I’ve gotten over it”. The mother’s opinion about Luna’s loss of the father is, “I don’t think she’s been through it effectively. There is a lot of bereavement even with her father being away …”. This denial by Luna shows lack of hardiness.

The lifeline provided evidence of her two major losses which she has not yet recovered from. At times, she says that she does not want to go to school as a result of losing her grandmother which occurred a few years ago. The ongoing bullying and abuse from the school children seemed to have caused her to feel worthless, to struggle with her self-esteem, and to have major anger issues. She distinctly remembered the following incident: “…you’ll never believe that this happened, but twice this boy poured cooldrink all over me”. As a result of this, she said that she felt ‘not good enough’. Low self-esteem invites bullying and abuse, since people who seek power and control are attracted to people who seem weak to the bullies (Levine & Kline, 2014). This also is evidence of a lack of sense of coherence and hardiness. Luna’s low self-esteem manifested itself in different ways, one of them is the fact that her two main friends are five years younger than her. Her anger issues brought her into a psychiatric hospital. All the above indicate a challenge within her resilience, sense of coherence, hardiness, purpose in life and self-transcendence. However, her confidence that she shows in certain, non-threatening situations, as in talking to strangers, does indicate inner strength within the component of hardiness.

After the first session, the researcher reflected on the session and she noted the following: Luna came in with a happy and light spirit. When she was asked to share her poems, her eyes lit up. She was clearly very proud of her product. When she noticed my obvious surprise at the fact that she wrote them herself and also composed her own tune to them, her joy grew. She was restless during the session, especially when her mom joined us. She was happy to participate in the activities and was saddened when she spoke about her losses. Luna was a pleasure to work with. She was keen to share her life story even thought I was a stranger to her.

Between the first and second session, Luna wrote:

> …I liked how I was appreciated for my talents to sing and write songs and for my drawings…I didn't like all the dolls you have…I liked how kind you were to me and that you tried to help me feel comfortable. It was nice to know that I could count on you. I didn't really like how you wanted to know a lot about me, when like my song 'I want to be left alone', but I am still happy to help with your research. I am glad I can help.

This reflection serves as evidence of her high anxiety regarding dolls and being possessed, which may be a sign of lack of resilience, since she did not seem to have managed to recover from the message of the person who told her that she is possessed. Concurrently, her ability to express her feelings shows that she does possess a certain amount of resilience. The researcher is not clear if this resilience was facilitated by the researcher's attitude towards Luna or would she perhaps, have been able to express her uncomfortable feelings even without the unconditional acceptance that Luna felt.

From the process of the session, as well as from the reflections, it was evident that Luna experienced depressive symptoms and diminished inner strength, but that a positive shift was noticeable even during the first session in terms of finding a solution to the conflict of her commitments to help at home and do her schoolwork versus being free.

5.2.2.3 Session 2

Luna came into the second session shining. She brought along a few bottles of

perfume that she had created. She was glowing and proud, especially when hearing the researcher's positive reinforcements that it was "unbelievable". She was excited to engage with the sand-tray activity. But as soon as the researcher brought out some small dolls, she experienced terror. She raised her voice begging to remove them. The researcher asked her if she is afraid of dolls, she replied, yes, very much, and she explained her fear. The researcher then removed the dolls and reassured Luna that during the process of therapy her fear will diminish. A few of the significant aspects of the sand-tray activity are mentioned below (see section 4.6.3 and Appendix J).

In the 'problem saturated' side of the sand tray, Luna expressed the major losses in her life which were the loss of her grandmother and her ugogo. Luna represented these losses through an image of a skeleton. Since she has not yet recovered from these events, it may indicate a lack of resilience. She represented her fear of demons and her fear of being possessed through an image of a skull as she said, "when the person came, he said that… when I was feeling down or something, a demon used that chance to come in and corrupt me or something like that". Luna also has a fear of being forgotten which she represented through an open treasure box and inside it, there was a golden chain. Luna has a fear of death and dying which, she represented through a 'stop-sign'. Her fears may represent lack of hardiness which is defined as lack of personality characteristics that enable resistance to stressful events (Lundman et al., 2010).

When working on the 'problem free' side of the sand-tray, she illustrated herself being surrounded by all the people and animals that she loves and by things which make her happy, as she wishes to be in a happy place. She also put a crystal there about which she expressed the following: "I chose it so, like in life, you can be a spotted crystal and so strong and so beautiful… but also quite fragile…". Through her sand-tray, Luna received an insight about how to be strong on the one hand, yet fragile and soft on the other. When asked to find a figurine that would represent herself at her strongest, she chose a dog, claiming that she always feels strong amongst animals. When she was asked when she would like to reach the happy side, she replied 'as soon as possible'. This shows motivation for change. Then she was asked to write what she believes needs to happen from within, so that she could move from the sad space into the happy place. She wrote down the following points: "I need to calm down.

I need to help other people while helping myself. I need to show my emotions through creativity". These statements serve as evidence of self-agency, as well as self-efficacy which seem to be developing in Luna as her self-awareness is improving.

According to the researcher's reflection on the session, Luna created a creative looking sand- tray (as can be seen in Appendix J). To the same extent that the sad side encompassed despair, the happy side clearly symbolised inner strength, resilience and hope.

Luna's reflection shows the growth which she gained through the activity: "I loved the session, it really helped me to think more positively. It also helped me to think what I need to do to be happy…it was fun…I felt I could really explain myself through the sand".

From the process of the session as well as from the reflections and the artefact, it was evident that Luna experienced depressive symptoms and diminished inner strength. However, the insight that this activity elicited for her brought about motivation, as well as self-awareness which helped grow her inner strength.

5.2.2.4 Session 3

Luna came into the session happy. She was looking forward to the hypnosis session (see section 4.6.4 and Appendix H). She experienced the hypnosis in a vivid manner. It was as though she was living the experience. When asked to go into her safe space, and describe it, she replied, "it's a place where there are beautiful, shiny waters…I can see the beautiful golden beach that's around. I see my gran and I see something at the end of the lake". The inner strength that she chose was that of her "inner white merwolf". A "merwolf", she explained "is half a mermaid and half a wolf. I love wolves as night time is my favourite time… and mermaid (is because) I love the water; it makes me feel calm" (the merwolf can be seen in the Appendix J). She felt as though it was emerging strongly from her heart. Luna viewed it as being light-blue in colour. During the hypnosis, the researcher also provided a post hypnotic suggestion that would give her strength in the present and the future:

> *While calling your inner strength on a conscious level, on a subconscious level, you will be pleasantly surprised to find out how much more freedom you are*

going to have; how much more happiness you are going to feel. How your fears will reduce... and how you can make dreams come true… you'll be able to receive joy and celebrate the life of the people that loved you, and who still love you, even though they're not in your life anymore…

Later, during the hypnosis session, the researcher mentioned to Luna her strength in order to help her build her inner strength:

And now, I'd like to take this opportunity to thank your inner strength for being there for you through thick and thin, and for allowing you to become the special sunshine that you are: so loving, so warm, good, kind-hearted. A person who loves to help. A person who is so considerate. A person who is full of energy. A person who is so friendly, humble, insightful, sensitive and very creative. And in spite of your difficult life circumstances, you've become that person.

When her inner strength was asked to come and give a suggestion to Luna about how to cope with her biggest challenge, she replied, "water helps me to calm down. It involves my inner strength to be stronger". When the inner strength was asked to give Luna an affirmation that will assist her in life, she said, "It will be okay and everything will work out". This hypnosis session clearly helped Luna build her inner strength as she said in her reflection, "…it made me so happy…it feels like I can conquer the world".

At the end of the hypnosis session, she watched a video clip from the Lion King (see Appendix M). When asked to interpret it, she replied,

I feel like that from running from the loss of my ugogo and my gran. They have both passed on... and it's not like the fact that I need to fear it. I need to embrace it. I need to know that they will always be with me and I don't have to run from my problems any more….

This is an indication of resilience. She also added, "how the water glistened in the nights and the weather just changed. It shows that times can change, and it might hurt, but it's in the past. And you need to get over the past. You need to become better. To be a stronger self". This insight indicates of a growth within her purpose of life as she is revealing a sense of purposeful direction. The video clip seemed to have given Luna

insight and it facilitated the expansion of her inner strength also in terms of self-transcendence as she seems to be expanding her personal boundaries.

After the session, the researcher reported that Luna entered the office and as soon as she noticed a doll, she became frightened and ran past the doll into the therapy room. She was excited about the hypnosis session and settled into it immediately. She saw her images vividly. She expressed her sadness about missing ugogo and granny. The image of her inner strength came naturally and spontaneously. After the session, Luna asked the researcher to send her the photo of her wolf. She enjoyed the video clip and her face lit up when the researcher said that “perhaps she had forgotten who she is, just as Simba did…”

Luna’s reflection on the session was positive. It showed that her inner strength had strengthened markedly. Amongst other things she wrote: “the session was very relaxing, I loved the place…I was so happy in that place…I felt I could express myself there. I saw a whole new light to everything. I just wanted to stay there forever…knowing that I could go back there, made everything so much easier…

From the process of the session, as well as from the reflections and the artefact, it was evident that Luna’s depressive symptoms are starting to diminish and her inner strength, although requiring more work, is making progress in terms of all its constructs.

5.2.2.5 Session 4

Luna came into the session in a good mood. She reported that she is less angry. During this session she experienced another hypnosis session for inner strength building (see section 4.6.5 and Appendix H). Luna felt that this session gave her an abundance of strengthening. She was excited to involve herself with the cup activity.

The table below illustrates Luna’s responses to the cup activity. The measurements represent the extent to which she filled the cup up, namely, the extent of energy that is directed into this aspect of her life; and the places where she wants the energy to go to, representing the life aspects where she would like to redirect her energy.

Table 5.2

The cup activity – Luna

Where my energy goes:	**How much**	**Where would I like to channel it to:**
Reading	1/2	She would like to raise it to ¾
School-work	A drop	She would like to raise it to ½
Keeping calm	3/4	
Making perfumes	1/2	
Friends	3/4	
Mom	3/4	
Inner wisdom and inner strength	1/4	She raised it to half
Critical voice	A drop	channelled into schoolwork
Exercise	1/4	She would like to raise it to ½
Anger	1/6	Emptied out into friends
Anger towards dad	1/3	She channelled ½ of it into school attendance and ½ of it into schoolwork and it was left empty
Going to school	1/2	This was raised

As Luna was busy with the activity, she had the insight that for a more optimal life, she would like to create some changes. She would like to spend more energy on her reading. She wanted her school work to be raised from ‘a drop’ to ‘a half’. She also wishes to raise her inner strength and inner wisdom. She would like to grow the time she spends exercising. She also had the realisation of the extent that her anger depletes her of energy and that she could rather choose to reserve this energy for something more beneficial. At this point, she realised that there is also anger towards her father which she would rather channel towards her academic success. Her motivation for implementing change serves as an indication that her depression is decreasing. Her insight into what requires change in her life, in order for her to live more optimally, expands the construct of purpose of life which also means, meaning

in life. It also expands self-transcendence in terms of achieving greater awareness.

According to the researcher's reflection, Luna enjoyed the hypnosis session and the cup activity. She felt that the cup activity gave her insight. She left the session feeling a great sense of satisfaction.

Luna's reflection on the session serves as evidence of the marked improvement in her mood and inner strength. She said: "I now feel more confident, stronger, freer, calmer and less aggressive".

From the process of the session, as well as from the reflections and the artefact, it was evident that Luna's depressive symptoms are starting to diminish and her inner strength is improving markedly in terms of purpose of life and self-transcendence.

5.2.2.6 Session 5 "The garbage and the manure"

Luna came in excited as she was not expecting another hypnosis session. However, she did not show that she had an issue with this. In this session, Luna experienced a hypnosis session aimed at assisting her to detach the maladaptive messages which she has absorbed over the years into the self, from negative people in her environment, as well as for her to be able to notice the positive, the personal growth and the gains that may have stemmed from those challenges (see section 4.6.6 and Appendix H). Luna enjoyed painting her tree. She divided the tree into two halves. The poor looking half had the 'garbage' on it, and the revived half had the manure on it (see Appendix J). The 'garbage' consisted of the following: "not good enough", "not important", and "we don't want you as a friend". On the manure, which symbolises the growth, she wrote: "more sensitivity", "learnt how to control my emotions", "got more in touch with art and safe space" and "more clued up on how to defend myself". This session was empowering for Luna as it assisted her to detach harmful messages from the self that had been absorbed over many years into her core; messages that stemmed from the father's absence, as well as from years of bullying, exclusion and rejection.

According to the researcher's observation, this session was impactful for Luna. It seemed as though the penny had dropped. Realising that some harmful messages have no connection to who she is, helped her to relax. The researcher is assuming

that this work will not only help the depression, but the anger issues as well, as through this activity, the anger that resulted from the negative messages is channelled into more productive and practical gains (Nussbaum, 2016). This can be seen in Luna's reflection too. The gains which she noticed that she had received from her life experiences, were liberating for her and they expanded her purpose of life.

When Luna reflected on the session, she said, "I thought it was a very good story. It really helped me to understand that there is good in everything bad. I loved painting the tree. The session helped my anger. It helped me to find better ways to calm down. The sadness is better. If 'very happy' is ten out of ten, I am now on eight. In terms of self-esteem, it's been good. I feel more confident about myself".

From the process of the session, as well as from the reflections and the artefact, it was evident that Luna's depressive symptoms are diminishing and her inner strength is improving markedly in terms of hardiness, purpose of life and self-transcendence.

5.2.2.7 Session 6 "The tree of life"

In this session, the intervention consisted of "the tree of life" which expanded over three sessions (see section 4.6.7 and Appendix L). Luna enjoyed this activity. She created only three roots for her tree instead of six. The roots represented her mother, and maternal grandparents. She did not add her father and his parents due to the lack of connection. Luna added 17 flowers which represented the special people in her life. She was keen to send a message to all the people still alive, asking them about her assets and strength. People seemed to have been keen to reply to her message. Each of them sent a loving message back which incorporated Luna's assets in accordance with their views. Her mother sent the following message about Luna, saying,

> Luna is a confident person. She has a capacity to love with all her heart, not only family and friends but strangers too. She has love for animals, she is kind, caring, sympathetic, generous and affectionate. Luna sees the best in people. She loves to dance and sing. She loves to surprise people. She climbs trees. She has an amazing imagination and she is intelligent.

Upon seeing the replies, Luna felt proud, and she said,

> I loved all the nice complements, they make me feel happy. I did not know I had all these assets and strength and I did not know that people see this in me. It made me feel happy… in the past week, I noticed how many people love…and care for me…I felt more supported, knowing that everyone is there for me.

The leaves of the tree symbolised her happy memories, which were in abundance. With some of the memories which she mentioned, she and the researcher had a good laugh, about which she reflected, “it was fun to be reminded of all these lovely memories and it was fun getting to laugh with you”. She mentioned ten hopes and dreams for the future. She created a fruit for each one. Her dreams are: “a house full of dogs”, “to make people care more about animals”, to live in my dream house with my sisters (her best friends)”, “to have a family”, “to make sure that my mom is safe”, “to support the people I love”, “to open a pet shelter”, “to have a positive influence on society”, “to support my mom one day”, and “to live on a farm”.

The researcher’s three reflections about the activity of the tree were merged into one:

> When Luna came into the session, she wanted to share with me her stories and drawings that she had created. She was very upset to hear that we would be finished in two more sessions. Luna derived pleasure and enjoyment creating ‘the tree of life’. Her eyes lit up when I wrote the assets and strengths which I see in her. From time to time, she got distracted. She enjoyed writing the names of the people who love her. She decorated the extra special flowers. We laughed about all the funny past experiences. She was in a good mood and she said that she prefers this type of therapy to the ‘dark’ therapy where you just talk about your problems. She was so proud to share with me the responses from the witnesses. Her eyes were shining. There was excitement in her voice.

During these three sessions, it became apparent to the researcher that Luna’s core had strengthened. She was that much more grounded and showed more confidence and happiness.

Luna wrote three extensive and positive reflections about the three sessions of ‘the tree of life’. The following stood out: “the tree of life is a beautiful activity…best therapy session ever. I loved how, instead of being weepy and all depressed, we actually had some fun, and that was comforting for me (she is used to other kinds of therapy which

she did not enjoy). After we did ‘the tree of life’, I have been feeling better. I was really fine, nothing went wrong, I feel stronger sadness wasn’t around… Before the treatment my sadness was as high as nine out of ten, (if ten is severe sadness) now I am about a one… I can believe in myself more. It overall helped me to boost my self-confidence. I was less angry and I got into less fights with my mom. I learnt to calm down and to express my emotions but not physically…I can communicate better. I feel really good…it’s good to feel less alone”.

From the process of the session, as well as from the reflections and the artefact, it was evident that Luna’s depressive symptoms are diminishing significantly and her inner strength is expanding its capacity, in a visible way, in terms of its constructs.

5.2.2.8 Session 7 The concluding session

In this session, Luna experienced a short hypnosis session about anchoring and grounding (see section 4.6.8). The next activity entailed creating her evolved inner strength from clay. In this session, the intervention consisted of “the tree of life”, which expanded over three sessions (see Appendix J), as well as free writing about her evolved inner strength. Her previous image of inner strength was that of a white merwolf. Her current, evolved, inner strength is a merwolf too. However, the first image lay on the ground and the second image showed its power and its ability to be strong and to stand tall (as can be seen in Appendix J).

When examining Luna’s free writing about her evolved inner strength, it became apparent that it is flourishing. A few sentences from the free writing are quoted below: “When I was younger, my inner strength was faint. It wasn’t always strong when I needed it to be. But now…that I attended Dvori’s framework, I have felt it improve and become as strong as I need it to be for me…it helped me improve and better myself”.

After the session, the researcher expressed that during the session Luna enjoyed the short hypnosis. She experienced joy through making her new and evolved inner strength, as she felt that she gained an insight regarding her personal growth and evolvement.

From the process of the session, as well as from the reflections and the artefact, it was evident that Luna’s depressive symptoms are diminishing considerably and her inner

strength is making progress within all of its aspects, namely, within resilience, sense of coherence, hardiness and self-transcendence.

5.2.2.9 The mother's observations and reflections from before commencing the process and at the end of the intervention

Prior to the commencement of the process, Luna's mother wrote a comprehensive reflection about Luna's emotional status. Here is a summary of her words:

> Even though Luna is on medication, she is struggling with her depression, with severe mood fluctuations and anger bouts. She struggles with social interactions. She is either withdrawn or she acts out. She talks a lot in her sleep while mentioning 'granny'. She often feels misunderstood.

Here is the mother's reflection after the intervention:

"I noticed that she's a different child to what she was. She's much happier; she's out-going; you can see the happiness radiating from her. Whereas, usually, she'd just be in the garden and doing her thing. Now she plays happy games. I'm very happy with her progress".

She also mentioned that Luna's anger is "better but not 100%". A few days later, the mother sent a message saying:

> I read Luna's report. The teachers all went on about what a beautiful child she is, energetic, enthusiastic, happy… and it is not the kind of report that I am used to receiving. I think it's got everything to do with the therapy that she has been doing. I do believe that you have made the difference.

5.2.2.10 Summary: Building Luna's inner strength through ego state therapy and creative expressive art in therapy

The outcome of the thematic analysis of the data stemming from the sessions, the researcher's observations and reflections, Luna's reflections, the mother's observations and reflections, as well as from the artefacts, show a marked change between the beginning and at the end of the process. A reduction in Luna's depressive symptoms became apparent and her inner strength improved within all the five

constructs of it. When examining her depressive symptoms, it became evident that her sadness, feeling of hopelessness, her tearfulness, and her irritably have improved. Her motivation and her general diminished interest in activities she used to previously enjoy, and then stopped enjoying, improved too. She is still restless in her sleep, and she is still not motivated to get up in the morning to go to school. Her psychomotor restlessness has not changed. Her feelings of worthlessness have improved. She is still struggling with her concentration. Her suicidal ideation has now improved.

In terms of Luna's inner strength, her resilience has grown stronger, as she said, "I feel a lot freer and a lot more anger and aggression and stress has come out, it's like released itself". Luna seemed to feel that she possesses the resources required to meet her environmental demands to a large extent, as she said, "after a while I found a compromise, a little bit of time with those that I love and some to do what I want" (an indication of a sense of coherence). Her personality characteristics have become stronger, as she reported, "Now I know that I can do anything" (an indication of hardiness). Luna started to experience a sense of purposeful direction in terms of her future contributions to her surroundings, when she expressed her wishes, that she would like "to open a pet shelter" and "to have positive influence on society" (indication of purpose of life). She also gained meaning into her personal narrative as she expressed that her deceased grandfather, who passed away before she was born, wanted her in this world for a special reason (indication of purpose of life). She seemed to have gained a substantial amount of self-awareness, as she said the following about her losses, "It shows that times can change, and it might hurt, but it's in the past. And you need to get over the past, you need to become better, to be a stronger self" (an indication of self-transcendence). She also seemed to be expanding her personal boundaries, as she said: "I feel more confidence and stronger. Like, I feel I can conquer the world…" (an indication of self-transcendence). It can now be concluded that in Luna's case, the framework used for this research did yield a positive outcome in building inner strength and reducing depressive symptoms.

5.2.3 Case study 3: Rivki

5.2.3.1 Background and demographic information

Rivki is fourteen years of age, Jewish, a semi-religious girl, who lives in the Northern

Suburbs of Johannesburg. She attends a small school which is predominantly Jewish. She has attended three schools since Grade 1. The mother described her as a person who “has a heart of gold, artistic, friendly, people get drawn to her easily, kind, she has a strong personality, loving, soft spoken, sensitive and a framework child”. During the first 18 months of her life, she was hospitalised eight times. She also experienced a medical trauma. Currently she complains often about aches and pains.

Rivki’s parents were never married. As soon as the father heard that the mother was pregnant, he left. This event seems to be quite impactful in Rivki’s life, in terms of her feeling rejected. The father later came back and was prepared to resume his responsibilities as a parent. Since then, the parents have been living in different towns. As a child she used to spend her weekends with her father. But she was unhappy and she always used to cry to return to her mother. According to the mother, Rivki felt anxious at her father’s place as he used to move frequently and Rivki felt the lack of stability. Rivki feels close to her mother, although they fight. She does not feel very close to her father. Rivki has an older sister from her father’s side and a younger brother from her mother’s side. The family-helper’s child is part of the family and Rivki views her as a younger sister.

Rivki is challenged with dyslexia. Her Grade 1 teacher missed this challenge and related to Rivki with on-going criticism. This impacted Rivki’s emotional well-being negatively. Rivki was bullied at that school too, through the children mocking her and rejecting her. In Grade 2, Rivki moved to another school. At the end of Grade 6, when she decided to move to a special needs school, she suffered intense cyber bullying from her peers. They called her “stupid” for having to go to a remedial school. At the special needs school, according to Rivki, most of the children were struggling with depression. This caused Rivki to feel even more depressed, to the extent that she often used to go to the bathroom to cry. At the age of 13, she experienced rejection by her boyfriend. This event seemed to have impacted Rivki’s emotional wellbeing significantly.

5.2.3.2 Session 1

Session 1 consisted of poems Rivki had written, the genogram and the lifeline (see section 4.6.2 and Appendix D). When analysing the data emerging from these

activities, it became apparent that Rivki struggles with symptoms of depression and limited inner strength. A few examples below will illustrate this. Her poems, which captured the emotional space that she was currently in, and the emotional space in which she wished to be, represented sorrow, as well as guilt: “I am sorry I messed up yet again, but you got to understand I don’t intend on it”. She is also expressing feeling lost and disillusioned: “I am so lost right now, nothing really makes sense”. She feels persecuted: “I feel like they are out to get me” and she expresses a need to run away as a solution to the problem: “I am soon gonna run away and forget all the pain”. She wishes to protect her loved ones from worrying about her, hence she uses pretence as a defence: “I am faking my smile till the pain numbs away”. She expresses a need to be free and to be loved. The poems serve as evidence of her depression, as well as diminished inner strength.

From the genogram, it became apparent that Rivki feels rejected to some extent, by her meaningful others. Although it was apparent that this was painful to her, she used denial as a defence. She mentioned her father favouring her half-sister; her grandmother favouring the other cousins, and her mother favouring the younger half-brother, as well as the helper’s child. This does not mean that it is the reality, however, these were Rivki’s perceptions. The perceived rejection brought about sadness, and her denial evinces a struggle with her sense of coherence.

When examining Rivki’s lifeline, it became apparent that she has experienced a weak sense of inner strength over many periods of her life. A few examples are mentioned here. Rivki dealt with the cyber bullying in Grade 6 through withdrawal and self-harm. Rivki said the following about the bullying: “I just felt completely horrible. Like, I couldn’t handle it, to a point where I just felt like dying, that sort of thing”. The depression of her peers in Grade 7 caused her to despair and cry in the bathroom: “When I was twelve, when I went to (name of a school), I became friends with a lot of depressed people. And it just really hit rock bottom for me and it took me to a point where I’d actually lock myself in a bathroom and cry”. The rejection by her former boyfriend caused her major distress and insecurities. Although these all are natural responses, nevertheless, had her inner strength been stronger, she would have been able to overcome these challenges and they would have had less of an impact.

After the first session, the researcher documented the following: Rivki entered the

office in a good mood. For most of the session she had a smile on her face. She seemed to be emotionally ready for therapy. She gave the impression of a person who has good character traits and who is delightful to work with. Throughout the session, she used dissociation and blocked her emotions in order to deal with her unpleasant feelings. It was only after probing that she remembered the fact that her brother and the helper's daughter were the favourites and about her ongoing fighting with her mother.

In her reflection on the session, Rivki wrote:

> I felt very emotional after the session. I am not sure why. It felt good to get it all out. It brought me more peace to see where the anger is coming from. The happy side (of the lifeline) made me feel at peace, it reassured me. On a scale of zero to ten, if ten is very negative, at school I feel sad eight out of ten and at home, when I am lonely, it can be ten out of ten.

From the process of the session, as well as from the reflections, it was evident that Rivki experienced severe depressive symptoms and a diminished sense of inner strength.

5.2.3.3 Session 2

In the sand-tray activity, Rivki had an opportunity to examine and express her current experiences, challenges and emotions, as well as examining the emotional space where she would wish to be (See section 4.6.3 and Appendix K). When examining Rivki's challenging side of the sand-tray, one can see a tank, which represented "all the wars that are like fighting in my head". Rivki was referring to different parts of the personality that lack integration and that pull in different directions. She then received an insight, and she said: "This is all my feelings trapped". Another feature was a skull attached to a mirror, about which Rivki said: "This is when I look in the mirror. I don't want to see a monster, like, I see a monster, not me". She explained that this is due to the fact that she feels as though she is not a good person. The heart represented a broken heart and the broken ship represented lost battles, and she expressed this by saying, "just emotionally, everything is broken". In the centre, on the left side of the sand tray, she put a few snakes, with only their heads exposed. Those represented the "bad people that keep telling me that I'm not worth it and other things". The stop

sign represented the block that prevents her crossing over the bridge to reach the ideal side. The challenging side contained sadness, loneliness, feelings of being stuck, and brokenness. This is evincing that Rivki struggles with lack of resilience, a sense of coherence, hardiness, a purpose in life and self-transcendence.

The future, “problem free” side, was filled with joy, confidence, freedom, flow and self-growth. Following are some of the features that Rivki used: The mirror represented seeing her own reflection, and not that of a monster. She represented her self-growth through a cactus on top of which she placed flowers, and about which she said, “I want to grow as a person. I want to be better”. She represented her freedom through dolphins swimming, and being loved was represented through a frog holding a heart.

When she was asked to choose a figurine that would represent her at her strongest, she chose an angel. She placed it amongst the snakes, in the middle. When she was asked how long would she still like to be there for, she replied, “not long”. Then she was asked if she would like help to get to the other side and she replied positively. This is evidence of motivation for change. She was then asked what needs to happen so that she could get to the other side, which she thought about for a moment and then replied, “to focus on the good within”, “to exercise”, “to eat healthily” and to “keep away from toxic people”.

The researcher noted that throughout the session, Rivki projected a heavy energy, as is typical of depressed people. She tried to smile. She cooperated and showed sensitivity as always. She enjoyed the sand-tray activity, but her sand-tray was not very full as is typical of depressed people who experience a lack of energy.

Rivki’s reflection is evidence of a growing self-awareness, as well as self-agency to optimise her life by bringing about the required change. Rivki wrote: “Doing the sand-tray really made me feel aware and see what I need to do to help myself. I found it really helpful.”

From the process of the session, the reflections, as well as from the artefact, it was evident that Rivki experienced severe depressive symptoms and a diminished sense of inner strength. However, the insight that she received, which alluded to a growing self-awareness, her motivation for change, and the solutions she found in order to overcome her “stop-sign”, all serve as evidence of the evolvement of her sense of

coherence, hardiness, purpose in life and self-transcendence.

5.2.3.4 Session 3

When Rivki came into the session she looked somewhat better. She reported that, “In the past week, I was eight out of ten (feeling) down and normally I am ten out of ten. I am trying very hard…to be more emotionally upbeat. I wake up and say, ‘you are a good person’”. From this report, it is evident that her depressive symptoms are starting to diminish and that her inner strength in terms of resilience, hardiness and self-transcendence is evolving.

The session commenced with the hypnosis session aimed at “meeting your inner strength in a safe space” (see section 4.6.4). During the hypnosis, she was asked to create the image of her inner strength from clay. At first, she struggled with finding the image. Then she created a person, which she said was, maybe, the angel from the sand tray (see Appendix K). She felt that her inner strength resides in her chest. She imagined it to be black in colour. When her inner strength was asked to give Rivki a suggestion of how she could feel more confident and how to be able to look in the mirror and to see “the real me”, she replied, “to forgive myself”. When the inner strength was asked to give Rivki an affirmation which she could carry with her for life and strengthen her, she replied, “I am very strong”. After the session, she watched the video clip of the Lion King. She was not sure how to interpret it, however, she seemed to have enjoyed it and to have internalised the researcher’s interpretation (see Appendix M for the interpretation).

After the session, the researcher noted that Rivki enjoyed the hypnosis session, as well as the video clip and its interpretation. When the researcher said to her after the video clip “…and perhaps you have also forgotten who you are…”, her eyes lit up. She left the session in a good mood.

Between the third and fourth session, Rivki reported the following:

> The last session was good. It made me realise that I am not alone, even though I am alone at times (at home). And even when I am in a group and they are not talking to me, I am not alone as I have my inner strength with me. My sadness used to be ten out of ten and now it varies between four, three, five and six. I

am trying so hard to keep positive.

From the process of the session, as well as from the reflections and the artefact, it was evident that Rivki's depressive symptoms are diminishing and her inner strength is improving markedly in terms of resilience, hardiness and self-transcendence.

5.2.3.5 Session 4

Rivki came into the session saying,

> "I have been much better since our last session. I don't have to fake a smile as much anymore. Yesterday I was super high when I left school, I am not sure why. However, this morning I saw the money van (a trigger for her anxiety), and then I saw the teacher who shouted at me yesterday, and I got an anxiety attack".

In this session, Rivki experienced another hypnosis session aiming at inner strength building (see section 4.6.5 and Appendix H). Rivki felt that this hypnosis session facilitated additional strengthening in her. After the hypnosis, the cup activity took place which made Rivki realise which unwanted places she is channelling her energy into, as she said, "The cup activity made me understand where I am incorrectly placing my time and effort". Rivki felt that three cups received too much water, namely, three aspects of her life that received too much energy. This was the cup representing friends, the cup representing the critical voice and the cup representing her former boyfriend. She rather preferred to channel the extra energy into clothes, her schooling, her inner strength, her father, and into her most favourite hobby, photography.

The table below illustrates Rivki's cup activity. The measurements represent the extent to which she filled the cups up, namely, the extent of energy that is directed into this aspect of her life, and the places where she wants the energy to go, representing the life aspects where she would like to redirect her energy into.

Table 5.3

The cup activity – Rivki

Where my energy goes:	How much of it:	Where do I prefer it to go:
Healing myself	full	
School-work	1/3	
Mom	Semi full	
Sister	1/2	
Helper's daughter	1/2	
Father 1/3		
Physical health	1/2	
Music	full	
Photography	1/2	
Clothes	A drop	
Friends	1/2	Transformed into clothes and school and a 1/3 is left
Critical voice	1/8	Transformed into inner strength
Inner strength	2/3	
Former boyfriend	1/3	Transformed into father and photography

According to the researcher's reflection, Rivki entered the session glowing, and she projected a calmer energy in spite of the fact that she experienced a panic attack on that day. Although she did not create much change within the cup activity, she still found it to be of benefit to her.

In her reflection, Rivki mentioned that in the past week, a friend of hers felt sad. She suggested to him that he finds someone who loves him, "I am trying to help him be positive". This is evidence that Rivki is not only self-transcending, but she is starting to help others to self-transcend too. She also wrote that her self-esteem is improving significantly. She reported that in the past she was not able to leave the house without looking a certain way: "now I can go to school with my pjs". She reported that if good self-esteem is equal ten, she used to be on level four to five and now she is on level nine to ten. She also wrote: "I am working hard to be happy, and if someone wants to put me down, 'shame', that's my new mode".

From the process of the session, as well as from the reflections and the artefact, it was evident that Rivki's depressive symptoms are diminishing, the sadness is reducing, her motivation is growing, and her feelings of worthlessness are also diminishing. Simultaneously her inner strength is improving as can be seen from the fact that she is gaining self-awareness and self-agency in creating change in her life; she is letting go of the pretences and she could even assist a friend with his depression. This means that she is improving within all the inner strength constructs, namely, resilience, sense of coherence, hardiness, purpose in life and self-transcendence. With any emotional self-growth and evolvement, one can expect setbacks. The road to recovery is usually not just a smooth climb, there are progressions and regressions. However, when overall, there is a reality of growth and evolvement, one can determine that healing is taking place. From this session, it was evident that there was growth taking place, and concurrently, Rivki also experienced a setback during the week that is discussed below.

5.2.3.6 Session 5

When Rivki came into the session, she reported that she had started regressing in terms of her mood. In this session, Rivki experienced a hypnosis session aimed at assisting her to detach the maladaptive messages which she had absorbed over the years into the self, from negative people in her environment. The aim was also to help her notice the positive, the personal growth and the gains that may have stemmed from these challenges. She was also asked to paint the tree which she visualised during the hypnosis session and illustrate the "garbage" in her life by painting it and writing on it the kind of negative messages that she had absorbed (this can be viewed in Appendix K). The messages she wrote were: "not important enough", "a waste of air", "stupid", "unworthy of living", "unlovable", "useless", and "not good enough". For the personal gain and growth from the challenges, she wrote: "I learnt to believe in myself", "understanding other people's pain", "not to listen to all the negative messages", I learnt to forgive and give people a second chance", "I learnt to grow in a spiritual realm", "insight", "I learnt to let go of people who don't appreciate me", and "sensitivity towards other people's pain".

The researcher noted that Rivki enjoyed the hypnosis session, as well as the creative work of the tree. Rivki found the message emerging from the session as a new and

valuable insight. She was relieved to realise that she is the only person with the privilege to define herself and decide what messages to accept and what messages to reject. During the session, she appeared to be happy and relaxed.

In her reflection, Rivki mentioned that the session was very good and insightful. She felt that the session taught her how to reject toxic messages stemming from society.

From the process of the session, as well as from the reflections and the artefact, it was evident that Rivki is gaining valuable insight which is part of inner strength building in terms of self-transcendence. The session helped her build resilience, as her core was getting stronger through the realisation that some messages do not belong to her. She was also receiving direction which is part of the purpose of life. Although her mood regressed, she still showed motivation for change.

5.2.3.7 Session 6

Session 6, “the tree of life”, expanded over three sessions (the tree can be viewed in Appendix K). Rivki enjoyed making the tree. Her tree had six roots as she is at peace with her parents and grandparents. She added 22 flowers that correspond to 22 significant people in her life. She was happy to send the message to most of them, asking them to send through the assets and strengths which they can see in her. The replies were heart-warming and encouraging. Rivki had many positive memories and experiences from the past. This helped her realise that her life contained many positive aspects too. Remembering all those experiences brought light to her face. She then added five fruits. The fruits represent her hopes and dreams for the future. The hopes were “to finish school”, “to travel”, to be a photographer”, “to make a difference” and “to have a family”.

The researcher noted that Rivki was happy to make ‘the tree of life’. When she read the assets and strengths which the researcher saw in Rivki, her face was shining. When the researcher recommended that Rivki leave enough space on the trunk for the many strengths that would still be coming from her ‘witnesses’, she looked like she was filled with joy.

Between the fifth and sixth session Rivki reflected on her past week by saying,

> I was feeling good. I have my off days. If ten is the most happiness, I am now on nine…everything is going up, my happiness, my endorphins…I am not missing as much school. I am not getting angry as easily.

To the researcher's question of whether she believes that therapy helped with those issues, she replied, "Yes, I do". When she was asked with what exactly it had helped, she replied, "with my anger a lot. I am a very angry person. I get angry about little things, but its ok, because if you can handle your flaws, you can handle anything". When Rivki reflected about the activity of 'the tree of life', she wrote: "This work was really interesting. I found out a lot about myself through what people think that my strengths are". She seemed to have benefited a great deal from this activity.

From the process of the session, as well as from the reflections and the artefact, it was evident that Rivki's depressive symptoms are diminishing, and her inner strength is strengthening significantly, as can be seen from the fact that she is more capable to attend school, which is a sign of resilience; she is less angry, more confident and she is able to accept her flaws. These are all signs of stronger resilience, a sense of coherence, hardiness, a purpose in life and self-transcendence.

5.2.2.8 Session 7 The concluding session

Rivki entered the session with a glow on her face. She was relaxed. In this session, Rivki experienced a short hypnosis session about anchoring and grounding (see section 4.6.8). The next activity entailed creating her evolved inner strength from clay (see Appendix K), as well as free writing about her evolved inner strength. She enjoyed the hypnosis session and found it beneficial. The anchoring gave her a practical tool to use in life whenever she feels ungrounded. Her previous inner strength was that of a person, "perhaps the angel from the sand-tray" as she described it. Her current, evolved, inner strength is an image of herself: "She is kind of like me, but more confident". Rivki chose a bright yellow-coloured clay in order to create her inner strength (as can be seen in Appendix J).

When examining Rivki's free writing about her evolved inner strength, it became apparent that it is flourishing. Quotes from her free writing are as follows:

> My inner strength was always a girl but she seemed out of reach so I saw her

> as an angel, and through this process she has come closer and easier to be around and more accessible. Now I can see and reach her as though she was a person although she was me. I am a lot more confident because of it. It becomes easier to let go of toxic people. I fight a lot less with my mom and with everyone actually. I don't feel so insecure about the favouritism. All my insecurities died down as if it is almost gone. People are not a threat any more.

According to the researcher's reflection, Rivki enjoyed the activity. She seemed to be doing better emotionally. She explained that she is now happier to go to school and when she was asked what assisted this change, she replied, "I didn't like going to school as I was scared of the human species. Now I don't care what people think of me or say about me anymore. If you don't give them the power, they can't control you". Her mother sent a message on the day of this session saying, "I do find her a lot better".

In her reflection, Rivki wrote:

> I have been really good. I had one night when I had an emotional breakdown, when I didn't want to be alive. My (close) friend and I had a huge fight; it came to a point when he blocked me. My anger had died down a lot. My sadness is nearly gone, it's much better. My anxiety had cooled down.

From the process of the session, as well as from the reflections and the artefact, it was evident that Rivki's depressive symptoms are diminishing markedly. Her inner strength is strengthening significantly within all its constructs, namely, her resilience, a sense of coherence, hardiness, the purpose in life and self-transcendence have all been strengthened.

5.2.3.9 The mother's observations and reflections from before commencing the process and at the end of the intervention

Before the process of therapy commenced, Rivki's mother wrote the following: "I find Rivki to be very moody, one minute she is happy and then all of a sudden, she is angry and snappy…Rivki does not like to wake up in the morning for school…Rivki loves being with people and she makes friends easily…her eating habits are terrible, she eats a lot of sugar …and chocolates. When Rivki is with people she knows and likes,

she is very confident. I find her always to be tired".

After the process was completed, the mother reported: "A lot of change is there in terms of moodiness. She is not as difficult to be with…she is much happier and more approachable. She still gets irritated, and she still does not like to wake up. The eating is much better. She is not so tired anymore. She got an amazing report from school this term. She is not as negative and withdrawn. I have seen a lot of change in her. She is much better overall".

5.2.3.10 Summary: Building Rivki's inner strength through ego state therapy and creative expressive art in therapy

The outcome of the thematic analysis of data stemming from the sessions, the researcher's observations and reflections, Rivki's reflections, the mother's observations and reflections, and the artefacts show significantly different results between the beginning and the end of the process. A reduction in Rivki's depressive symptoms became apparent and her inner strength improved within all five constructs of inner strength.

When examining her depressive symptoms, her sadness diminished, and her motivation increased. Additionally, her eating habits as well as the quality of her sleep have improved, and at least, in part, as a result of this, she has a lot more energy. Her feelings of worthlessness have improved too.

Major positive shifts seemed to have taken place within Rivki's inner strength. As can be seen from the fact that Rivki is now more comfortable about attending school. Her anger issues have markedly diminished. Her insecurities are diminishing and her confidence is evolving as can be seen by the fact that she does not feel so insecure about the favouritism any more, people are not so threatening to her any longer, and she is prepared to face and accept her flaws.

It can now be concluded that in Rivki's case, the framework used for this research did yield a positive outcome in building inner strength and reducing depressive symptoms.

5.3 Cross-case analysis

In the previous part of this chapter, the three cases and their uniqueness were

discussed at length. In this part of this chapter, cross-case analysis, including the commonality and the disparity between the cases, will be discussed.

5.3.1 General commonalities and differences between the cases that may have contributed to the results

First, the participants shared similar backgrounds in many ways. It is significant to mention this as often one can expect a similar display of symptoms from similar cases (American Psychiatric Association, 2013). All three participants lived with a single parent from a young age. Kelly lived with her mother from the age of four, Luna and Rivki lived with their mothers from birth. All three felt rejection by one of the parents. Kelly felt rejected by her mother who asked her to leave the house when Kelly was ten years of age. Luna's father left when he heard that the mother was pregnant, and so did Rivki's father. In all three cases, this perceived rejection played a major role in their personal narrative and consequently, in their depression. Further, all three participants did not have a close relationship with their siblings, although they would like to feel closer to them. All three participants have at least one person in their lives that represents for them a "pillar of strength", a source of support and authentic love. In summary, all participants felt rejected by the one parent and did not have a relationship with their siblings, both of which seemed to have exacerbated their depression. They all felt supported and loved by the one parent which appeared to have assisted the therapeutic process.

Second, there were certain symptoms shared by the three participants, other than the depressive symptoms and diminished inner strength. They were all challenged with major anger issues, major anxiety issues, as well as an experience of rejection stemming from one of their parents. Furthermore, they all experienced severe and impactful experiences of rejection from classmates, in addition to feelings of loneliness, low self-esteem, social challenges, erratic mood swings, snappiness, fear, in general, as well as a fear of being judged. All three participants' school work was impacted upon by their lack of motivation. In summary, other than depression, the participants dealt with many other emotional challenges, some of which could have stemmed from depression and some of which could have exacerbated their depression.

Third, there were also similarities in terms of the inner strength which the participants created. All three participants chose an inner strength that represented themselves. Moreover, with all three participants, the evolved image was similar to the original one, however, it represented more stability, confidence, power and control.

Fourth, personality characteristics are also a pre-determined factor for the success of therapy (Dennhag, Ybrandt, & Sundström, 2017; Egan, 2007). In terms of the participants' personalities, all three participants possess a good value system, high moral behaviour and conduct, they all believe in being real, true and loyal friends. All three participants care very deeply about their main caregiver. They are all warm people, deep thinkers and insightful; they have a strong need to make a difference in this world. All participants showed a need for freedom and for change, as well as the motivation to bring about change.

On the other hand, there were some differences between the participants in terms of the symptoms they manifested. Kelly was the only one who was challenged with being judgmental, as well as with having a severe obsessive-compulsive disorder, which was more prominent in the past. Luna was the only one whose friends were five years younger than her. She was also the only one struggling with a need for power and control, as well as with bereavement issues. Only Luna and Rivki used denial as a defence mechanism and were inclined to be reluctant to attend school. Finally, Rivki was the only one who is challenged with a sensory disorder, dyslexia and psychosomatic complaints.

5.3.2 Participants' experience of the depressive symptoms prior and upon completion of the intervention

There were also some commonalities and differences between the participants regarding their depressive symptoms as is illustrated below in Table 5.4.

Table 5.4

The participants' depressive symptoms before treatment

Participant	Age of onset	Sadness/ irritability	Diminished interest	Increased or decreased appetite	Insomnia/hypersomnia
Kelly	10	yes	yes	Decreased appetite (in the past)	yes
Luna	8	yes	yes	no	no
Rivki	11	yes	yes	Consuming too much sugar	insomnia

Participant	Restlessness/ slowness	Fatigue	Feelings of worthlessness	Difficulty with concentration	Thoughts about death
Kelly	no	yes	yes	yes	yes
Luna	yes	no	yes	yes	yes
Rivki	yes	yes	yes	yes	yes

As can be seen from Table 5.4 above, all three participants struggled with sadness, irritability, diminished interest, feelings of worthlessness, lack of concentration, and thoughts about death. However, not all of them struggled with eating, sleeping, restlessness, and fatigue issues. Upon completion of the process, Kelly's mood improved, as well as her motivation, her quality of sleep, her energy levels, and her feelings of worthiness. Kelly also does not entertain thoughts about death any more. Luna's depressive symptoms improved in terms of sadness, having more motivation, feeling worthy, as well as not having suicidal ideation any more. Rivki's depressive symptoms improved in terms of mood, motivation, bad eating habits, insomnia, low energy, and feeling worthy.

5.5.3 Participants' experience of inner strength through the course of the intervention

In terms of the inner strength constructs, all three participants struggled with diminished resilience, sense of coherence, hardiness, purpose in life and self-transcendence. Depressed people often struggle with a sense of diminished inner strength (Brann et al., 2012; Phillips & Frederick, 1995; Yapko 2006). This is why it is important to start with inner strength building (Alladin, 2013; Da Silva, 2009; Forgash & Knipe, 2012; Fredrick & McNeal, 1999; Phillips & Frederick, 1995). As the sessions progressed, so did their inner strength. Simultaneously, the depressive symptoms started to diminish.

5.3.4 Shifts within the participants' depressive symptoms and inner strength during the treatment

Table 5.5 below illustrates the growth and evolvement of all participants so that comparison can be made.

Table 5.5

Shifts within the participants' depressive symptoms and inner strength during treatment

Names and session no.	Depressive symptoms	Inner strength
Kelly 1	Severe symptoms	diminished
Luna 1	Severe symptoms	diminished
Rivki 1	Severe symptoms	diminished
Kelly 2	A slight improvement	A slight improvement
Luna 2	Still struggling	A slight improvement
Rivki 2	Severe symptoms	A slight improvement
Kelly 3	A slight improvement	A slight improvement
Luna 3	A slight improvement	Starting to improve
Rivki 3	A slight improvement	Marked improvement
Kelly 4	More improvement	improving
Luna 4	More improvement	Marked improvement
Rivki 4	Marked improvement	Marked improvement
Kelly 5	More improvement	More improvement
Luna 5	More improvement	Marked improvement
Rivki 5	regression	improving
Kelly 6	More improvement	Marked improvement
Luna 6	Marked improvement	Marked improvement
Rivki 6	Improving	Marked improvement
Kelly 7	Marked improvement	Marked improvement
Luna 7	Marked improvement	Marked improvement
Rivki 7	Marked improvement	Marked improvement

As is evident from Table 5.5 above, Rivki's improvement was slightly more delayed

than Kelly's and Luna's improvements. This is to be expected as clients' progress at a different pace in therapy (Prochaska & Norcross, 2010). However, upon completion of the process, the outcome was significantly positive in regard to all three participants.

5.4 The evaluation of the intervention

The results of the cross-case analysis indicate that treating depressive symptoms through a combination of ego state therapy together with creative expressive art in therapy, using the specific framework proposed in this study, provided a practical and effective treatment framework for these participants.

The framework proved itself to be effective in the treatment of depression and in building inner strength. In addition, material emerging from the rich data, across the data sources, indicates an abundance of additional benefits and gains for the participants, that resulted from the use of this framework. The researcher proposes that these areas may be included within the wide umbrella terminology of "inner strength" building. The material below is based on statements made by the participants.

In terms of self-awareness, considerable shifts took place within the level of insight of the participants. Their self-awareness grew in terms of how they feel, think and behave (Prochaska & Norcross, 2010). The participants gained insight into the interpretations of the sources of their feelings. While previously these feelings caused them to self-blame, now they felt relieved to see the cause for those uncomfortable feelings. The participants started noticing their thought patterns, which assisted them to channel their thoughts towards more positive directions (Kevereski, Dimovska, & Ristevski, 2016). They also gained insight into their personal growth that was taking place through the process. Their insight into the positives in their lives that emerged from the lifeline, allowed for peace and reassurance to come through (Guse & Fourie, 2013; Short, Erickson, & Erickson-Klein, 2006). The sand tray facilitated the insight of what the participants need to do in order to help themselves. Another insight that emerged is that there can be failures on the way to healing. The participants also gained an insight into the fact that therapy "can be fun".

In terms of feeling stronger and more grounded, the participants felt that the process helped them to feel stronger and more grounded. They felt that they gained better

tools to calm down and the ability to self-regulate. They can now cope better with exams as there is a close correlation between depression and exam stress (Ciobanu et al., 2018; Kevereski, Dimovska, & Ristevski, 2016). The process facilitated them learning about and experiencing the existence of their "inner safe space". They felt that now they can worry less about other people's opinions of them. They learnt how to externalise toxic messages stemming from toxic people in their environment (Prochaska & Norcross, 2010). They experienced more self-acceptance. They also gained the realisation that people in their environment cherish and appreciate them. They are experiencing less fear of people and they made a conscious decision not to hand out power to people, to avoid being controlled.

In terms of mobilisation and the utilisation of internal resources, the participants learnt how to mobilise and utilise their own resources (Fredrick & McNeal, 1999; 1993). They realised that for many human predicaments, solutions exist from within (Fredrick & McNeal, 1999). This was evident from the suggestions and the affirmations of their inner strength. They also learnt that they can utilise their resources in a way that would suit their purpose in life, as they witnessed through the cup activity. The participants realised that they can also utilise their positive memories to feel better. And that they can also think about the people who are special to them in order to be more grounded. The correlation between the recollection of positive memories and the ability to affect regulation has been proven through research. Positive memories work as a reparative strategy by bringing about positive emotions and negating negative ones (Vanderlind, Stanton, Weinbrecht, Velkoff & Joormann, 2017). They realised that they can use their assets and strengths to feel stronger and better within themselves, and that they could mobilise and amplify those abilities in order to live a more optimal life (Short, Erickson, & Erickson-Klein, 2006). They also learnt that they could utilise their hopes and dreams as a guide, as motivations and goals to live and work towards (Baker, 2017). They learnt "to see the good in the bad", they learnt about self-agency and about taking responsibility for their own lives. One of the results of their improved self-agency was the fact that they all improved regarding their schoolwork as research shows the correlation between depression and school performance (Stefanek, Strohmeier & Yanagida, 2017).

In terms of their social interactions, this process helped them improve in this area as

well. They learnt to be less judgmental, to possess better communication skills, and to be able to verbally express their emotions. They learnt to avoid feeling lonely and to be more outgoing. They became more pleasant to be around and more approachable. They are now less withdrawn and can even assist a friend to feel better. In general, their interpersonal interactions improved with the easing of their depression (Springer, Rubin & Beevers, 2011).

In terms of their moods, they became less snappy and less angry, with diminished mood-swings. They are no longer “stuck in a negative space”. They are more energetic and more enthusiastic. They feel as though “a light was sparked in them”.

Against the backdrop of the abovementioned material, it can be concluded that the treatment framework used for this research, the objective of which was to develop and describe a framework which aims at facilitating inner strength building in adolescent girls with depressive symptoms, was beneficial for the participants. Therefore, it is worth proposing guidelines for the implementation of this framework, which is this research’s second objective. This will be discussed in Chapter 6.

5.5 Concluding summary

In the first part of this chapter, each case study was discussed and interpreted in terms of the themes and sub-themes that emerged from the case. All data sources were discussed and interpreted, session by session. Thereafter, conclusions were drawn for each individual case, in terms of each of the participant’s depressive symptoms and her inner strength. In the second part of this chapter, cross-case analysis took place, where the cases were compared and contrasted in terms of the results. In the third part of this chapter, the evaluation of the intervention was elaborated upon. In the next chapter, the summary of this research, conclusions, limitations and recommendations will be discussed.

CHAPTER 6: SUMMARY, CONCLUSIONS, GUIDELINES, LIMITATIONS, RECOMMENDATIONS AND CONTRIBUTIONS

6.1 Introduction

In the world of research, there seems to be a limited number of evaluative studies regarding the application of Ericksonian and ego state approaches to build inner strength through hypnosis. As discussed in Chapter 1, although inner strength is vital for the therapeutic process, it has not yet received enough scientific attention. Therefore, this study, which focused on the facilitation of inner strength building in adolescent girls with depressive symptoms, attempted to contribute to closing the gap in the existing literature.

This chapter will include a concluding summary of the previous chapters as well as guidelines for the use of a proposed framework for building inner strength in adolescent girls with depressive symptoms. The guidelines will be made for therapists as well as for teachers and consolers, as some of the activities can be done with educationalists, even if they are not therapists. Possible limitations of the study as well as recommendations for further research will be elaborated upon. Finally, the contributions of the study will be discussed.

6.2 Summary and conclusions

Depression is a mental disorder that has become an epidemic in the 21st century (Akhtar, 2012; Amini et al., 2018; Opie, O'Neil, Jacka, Pizzinga, & Itsiopoulos, 2018; Ranney et al., 2018; Singh et al., 2018; Van Grieken, Van Tricht, Koeter, Van den Brink, & Schene, 2018). Adolescence is an age which is prone to depression (Duarte, Pinto-Gouveia & Rodrigues, 2015; Nisar, 2018). Adolescents are at a crucial phase of identity formation as failing to achieve identity formation results in their not being ready to enter the challenges of adulthood (Erikson & Erikson,1990). It is, therefore, essential to address symptoms of depression early, in young people's lives.

Although commonly used modalities for the treatment of depression do exist, they each have their limitations (Emmerson, 2007). The researcher chose one less researched (Da Silva & Fritz, 2012) modality of treatment in this research study, which is ego state therapy (Watkins & Watkins, 1997) as it does not contain the limitations

of the other modalities (Emmerson, 2007). Ego state therapy is based on the premise that the global personality is composed of separate parts, “a divided self” rather than a homogeneous whole (Emmerson, 2007; Hartman, 1995; Da Silva & Fritz, 2012; Phillips & Frederick, 1995, p. 1). Ego state therapy offers a “causal solution” and not merely a coping strategy, because it uses the unwanted symptom to find the causal disturbance (Da Silva & Fritz, 2012; Emmerson 2007, p. 195).

Ego state therapy suggests using the **SARI** model as a treatment plan, which consists of four phases, namely, **S**afety and stabilization, **A**ccessing the trauma and related resources, **R**esolving traumatic experiences and re-stabilization, and personality **I**ntegration (Phillips & Frederick, 1995; Phillips, 2008). Based on this model, and in combination with the Ericksonian approach to treatment, which emphasizes the principle of utilising the client’s assets and strengths (Zeig, 1992), the researcher created a framework that expands upon phase one of the SARI model. The researcher combined to the ego state model and the Ericksonian approach, the method of creative expressive art in therapy, in order to create a new framework that is an expansion of phase one of the SARI model (Phillips & Frederick 1995; Phillips, 2008).

To this end, the emerging research question was: “How can ego state therapy and creative expressive art in therapy be integrated to facilitate inner strength building in adolescent girls with depressive symptoms?”

The objectives of this research were twofold: To develop and describe a framework which aims at facilitating inner strength building in adolescent girls with depressive symptoms, as well as to propose guidelines for the implementation of this framework.

In order to answer the research question and achieve the objectives, the researcher used a qualitative research approach with a multiple case study design. Three adolescent females, between 14-16 years, took part in the study. A framework of seven sessions (which in the end spread over nine sessions), aiming at inner strength building, was created and implemented.

Based on the implementation of this framework and the analysis of the data and the outcomes, the proposed framework appeared to achieve its purpose which was to be a framework for the treatment of depressive symptoms in adolescent girls. This framework has been developed, consolidated and described in this study (presented

in 6.3). Accordingly, the suggested framework is presented below, deviating slightly from the original framework put forward in Chapter 4.

6.3 A proposed framework for addressing depressive symptoms through facilitating inner strength

Figure 6.1. The proposed framework for addressing depressive symptoms

through facilitating inner strength

A summary of the framework (presented in figure 1.6) together with the recommended changes, are discussed below.

Session 1 included the poems which the participants wrote and brought to the session. The poems representing the “space that they are in now” and the “space where they wish to be”. The genogram, which encompasses the family constellation and dynamics was drawn and discussed. The participant’s lifeline was elaborated upon and the process of the following sessions was explained. This session may need to be expanded into two sessions, in order to allow the client to process the material at their own needed pace.

In *Session 2*, the participant’s life story, the current one and the future one was created in the sand tray. In S*ession 3,* hypnosis about “meeting your inner strength in a safe place” was introduced. The participants also created an image of their inner strength from clay and lastly, they watched a video clip that helped them to integrate the message of the hypnosis session.

In S*ession 4,* the participants experienced another hypnosis session that aimed at negating toxic messages stemming from their “critical voice”, and focusing on messages stemming from their ego states of inner strength and inner wisdom parts, which communicate their assets and strengths to them. Following the hypnosis session, the “cup activity” took place, which reinforced the idea that they have the choice of where to channel their energy in their lives.

In S*ession 5,* they experienced another hypnosis session titled “turning garbage into manure”. The aim was to empower the participants to reject harmful messages stemming from the environment and to utilize life challenges as “manure”, namely, as growth. Following the hypnosis session, they engaged in creative expressive art work of painting the tree. The negative messages were written on the “garbage”, and the gains and areas of growth were written on the “manure”. In the following session, S*ession 6* (which spread over three therapeutic sessions), the participants created “the tree of life”. The tree captured the “alternative story of the participants’ lives and focused on the positive aspects. The tree consisted of the special people in their lives, the participants’ assets and strengths, their pleasant memories from the past, and their

hopes and dreams for the future. This intervention deviated from the original framework as Session 6 required three sessions. The aims of the session could not be done in one single session. This was due to the fact that in the first session of this activity, the focus was on the flowers, and between the first and second session of this activity, the participants were expected to contact the meaningful people in their lives, "their flowers", in order to receive information about themselves, in terms of their assets and strength. During the second session of this activity, the researcher assisted the participants to internalize these messages. The participants then added their assets and strengths to the tree. The third session of this activity, focused on the leaves, which represented the pleasant memories from the past, as well as on the fruits which represented their hopes and dreams. Three sessions not only assisted technically in terms of time, but they also assisted the participants to realize and integrate all the positivity which exists within themselves, as well as within their environment. The added sessions allowed them to process all the positive memories which are healing in their own right (Vanderlind et al., 2017). Lastly, *Session 7* consisted of a short hypnosis session aimed at giving the participants another tool that would help them ground themselves in times of need. Following this activity, the participants created their evolved inner strength from clay, and engaged in free writing about their evolved inner strength.

The material, namely the five sources of data, the audio recordings, the observations (which were documented in the researcher's reflections), the reflections, the documents and the artefacts were analyzed based on thematic analysis (Braun and Clarke, 2006). The two main themes that were examined were the presence of inner strength and depressive symptoms. The researcher explored whether the proposed process assisted with building inner strength and with decreasing the depressive symptoms. Depression was examined according to nine symptoms (see section 2.2.2) (American Psychiatric Association, 2013), and inner strength was explored according to five constructs (see section 3.2.2), (Lundman et al., 2010).

The findings in terms of the participants' inner strength were as follows: When examining the inner strength constructs, all three participants struggled with diminished resilience, sense of coherence, hardiness, purpose in life and self-transcendence (see figure 3.1). As the sessions progressed, so did their inner

strength. Ultimately, all three participants improved within all five constructs of inner strength.

The findings in terms of the depressive symptoms were as follows: Before the commencement of the process, Kelly, participant number one, struggled with depressed and irritable mood, lack of motivation, insomnia, fatigue, feelings of worthlessness, difficulty concentrating, and thoughts about death. Upon completion of the process, improvement was evident within a number of the abovementioned symptoms, namely, her mood improved, as well as her motivation. Her quality of sleep and her energy levels improved, as well as her feelings of worthiness. Furthermore, Kelly no longer entertains thoughts about death.

Before the commencement of the process, Luna, participant number two, struggled with depressed and irritable mood, lack of motivation, restlessness, feelings of worthlessness, difficulty concentrating, and thoughts about death. Upon completion of the process, improvement was evident with her depressed and irritable mood, her motivation, her feelings of worthlessness, as well as diminished thoughts about death.

Before the commencement of the process, Rivki, participant number three, struggled with depressed and irritable mood, lack of motivation, challenges with her eating, insomnia, restlessness, fatigue, feelings of worthlessness, difficulty with concentration, and thoughts about death. Upon completion of the process, improvement was evident with her depressed and irritable mood and her motivation. She managed to improve her bad eating habits. Her insomnia improved, as well as her low energy, and her feelings of worthlessness.

It was evident throughout the process that the participants' inner strength was strengthening and enhancing, and that the depressive symptoms were diminishing. Accordingly, the researcher deems it essential to provide guidelines for implementing this framework.

6.4 Guidelines for the use of the framework for clinical practice and for other educational settings

The following points will serve as guidelines for the implementation of the framework.

- When working with people with depression, the therapist needs to establish how the prominent depressive symptoms manifest, according to the DSM-V (American Psychiatric Association, 2013). During and after the treatment, the therapist needs to check to what extent these symptoms have diminished. The intervention strategy should also be tailored in accordance with these symptoms. A goal-oriented therapy assists both the therapist and the client to track the level and pace of the evolvements (Egan, 2014; Law & Cooper, 2018).

- Based on the Ericksonian principle of utilization, when working with depression, rather than over-focusing on the challenges that are a part of the client's life, or dwelling upon the deficits within the client, the therapist should ideally try to build upon existing assets and strengths that exist within the client's environment and circumstances, as well as within the client herself (Egan, 2014). This should assist the client to shift from a "problem saturated story" to a story of strength, triumph, self-love, containment, groundedness, and hope.

- It is advisable to incorporate the framework proposed in this study with all the steps of the SARI model. This means that phase one of the SARI model, **s**afety and stabilization, should be incorporated into this study's framework. The rest of the phases can then follow as usual.

- When working with depression, clinicians can expect ongoing improvements and set-backs for a period of time until the client's situation balances out. The client needs to be prepared for this journey and expect these typical symptoms. When getting to a point of better equilibrium and emotional stability, the client will still experience, from time to time, leaving a space of balance, however, this should not occur often, and she will be able to bounce back quicker than before each time this happens.

- Parts of the framework proposed in this study could also be suitable for implementation in other educational settings such as schools and youth movements. Activities, such as creating the child's inner strength from clay, the "cup activity", painting the tree with the "garbage and the manure", and writing negative messages on the "garbage" and their growth on the "manure", creating 'the tree of life", as well as free writing about their inner strength, could all be done by teachers and lay counselors.

- Since this process, based on the evidence, appears to be beneficial in the treatment of depression, it is suggested that the same framework could be explored to treat other psychological and emotional challenges such as anger, anxiety, and social problems.
- The framework proposed in this chapter could be used as a measure of prevention, and not only as a treatment plan. Assisting children in growing their inner strength creates a stronger core which can act as a buffer for future challenges (Frederick & McNeal, 1999). The activities chosen for this study are all aimed at ego strengthening.
- Ideally, this framework should be implemented as one session per week, so that the client has a chance to process and internalize all she learns in the session. However, should there be time constraints, implementing this framework into a more concentrated format will also be beneficial.
- The framework can be implemented on a one-on-one basis or in groups. Groups, ideally, should be kept small and intimate. This would facilitate the children receiving support from each other. Larger groups may also benefit if sufficient personnel and facilities are available to enable the process.
- When applying this framework with clients, it is advisable to ask them to bring along a flip-file (a file with plastic pockets) in order to keep or preserve the work or the photos of the work that has been accomplished together. These would include the poems, a photo of the sand tray, a photo of the original inner strength, a photo of the cup activity, a photo of the tree with the “garbage and the manure”, a photo of “the tree of life”, a photo of the evolved inner strength, as well as the free writing. For the front page of the file, the client is asked to identify the most meaningful line of the poem which represents her “future space”. This is then written or placed on the front page in a creative manner. This will serve as an inclusive artefact or a reference item that the clients can refer back to should they need additional strengthening. Alternatively, the client can create a large-sized collage that can include the abovementioned artefacts. They should ideally keep it in a place that is readily visible.

- This framework should be implemented in the suggested order of sessions, as there is logic to the chosen order.
- It is advisable, before the start of the process, to involve the parents in the process so that they can be supportive of it.
- Particularly when working with adolescents, therapy should be varied with different activities. The activities should be interesting to them, without demanding excessive conversation. For those adolescents who enjoy creativity, art activities should be incorporated. For those adolescents who appreciate guided imagery and the relaxation of hypnosis session, hypnosis sessions can be incorporated.
- Should it be the case that while implementing the recommended framework, no noticeable evolvement or change is made by the client, especially after five sessions, the clinician needs to explore medical and systemic issues which may contribute to the symptoms.
- Other activities can be added to the framework, either as a "task" that can be done at home, or as additional sessions. For example, one can ask a child to create a collage at home about: "this is who I am, this is who I am not" or "these are my talents, these are my personality strengths", or "these are the main players of my personality parts", or "this is what I like, this is what I don't like". These kinds of activities facilitate self-awareness and self-growth. For those who enjoy dancing, they could be tasked with finding a song about inner strength and creating matching movements. A group could be asked to create a show about inner strength. Those who enjoy creative writing could create a story about their inner strength. Matching the tasks to the child's strengths is part of the utilization principle.
- It is the researcher's recommendation that clients receive and take home the artwork done during the sessions.

Although the results of this study are promising, as with all research studies, there are limitations to the study which need to be considered.

6.5 Limitations of this study

The main limitation of this study was the small number of participants. This can create a challenge when trying to implement the findings to the rest of the adolescents in the world who are struggling with depression. However, the three cases used for this research did reach a point of saturation within the case study, as well as when the cross-case analysis was executed. Another limitation of this study was the fact that there were no male participants, thus research is needed to explore the usefulness of this framework for adolescent boys. In terms of cultural differences, although one participant is Christian and the other two are Jewish, they are all semi-religious, and they all live in the same area, attending schools that are predominantly Jewish. This may have influenced the therapeutic process to some extent. The issue of trustworthiness may become questionable when a therapist simultaneously functions as a researcher as she may be emotionally involved with the material and she may have a bias towards achieving certain results. However, following the guidelines and steps of data collections and data analysis, together with keeping a trail of evidence, as well as including a peer check and a participants' check, should minimize this concern (Scholl, 2017; Yin, 2003).

6.6 Recommendations for further research

The following recommendations are made for further research:

- Further research should be executed in order to determine if this framework is as beneficial for girls who are not creative by nature, as lack of congruence between the chosen therapeutic method and the client's needs or personality can affect the treatments results negatively.
- Further research of implementing this framework should also be done with other age groups, such as children and adults, as well as with groups as opposed to just individuals.
- More investigation should be done utilizing this framework with two groups of adolescent boys, where one group enjoys creativity while the other group does not.

- Quantitative research would be beneficial by using this framework with a large number of adolescent girls from different cultures, as this research focused on three participants whose cultures were similar.
- It would be worthwhile to execute a longitudinal study on the long-term effects of the implementation of this framework.
- It is recommended that further research is executed to extend this framework to treat other emotional or psychological problems, such as anger management, social challenges, anxiety, feelings of shame or guilt, problems with jealousy, feelings of victimization, a need for power and control, laziness, addictions, and trauma.

6.7 Contributions of the study

This study provided a framework for the treatment of depression through inner strength building, using ego state therapy, as well as creative expressive art in therapy. There is a limited number of evaluated studies available regarding the application of the Ericksonian and ego state approaches to inner strength building. In addition, as far as the researcher is aware, there is a limited number of evaluated studies using ego strengthening techniques in general. There also does not seem to be an available study that focuses on inner strength building for the treatment of depressive symptoms, using ego state therapy with the Ericksonian approach. Hence, this study has made an important contribution in closing an existing gap in the available literature on hypnosis, ego state therapy and art in therapy. Other related contributions of this research study are mentioned below:

- This study contributed to the application of theory to practice. The framework presents practical ideas and tools for practitioners of how to use the utilization approach in combination with ego state therapy while using as tools, hypnotherapy and creative expressive art in therapy. Often people are not clear of Erickson's intention when speaking about the principle of utilization, as there are no guidelines provided by him, only anecdotes. This framework makes the utilization theory more tangible.
- This framework provides practitioners with a framework to treat depression, within a short-term period, from an asset-based approach as opposed to a pathological point of view.

- This research contributed to an expansion of the SARI model, adding a few extra sessions to phase one. This, according to the researcher may enrich the SARI model.
- This framework suggests some original ideas of how to use creativity in building inner strength, namely, the use of poems, the specific use of the sand tray, the video clip of The Lion King, the cup activity, the different manner in which “the tree of life” was used, the anchor method, as well as creating the inner strength from clay. These are all innovated ideas which can assist the therapist.
- The researcher created three hypnotherapy sessions. Hence, this provided tools and knowledge for other practitioners to implement hypnotherapy for inner strength building.

6.8 Concluding comments

Depression is a wide-spread, debilitating psychological condition, which has become an epidemic in the 21st century. For many sufferers, it is a life-long condition. Many attend years of therapy while obtaining minimum relief. However, depression can be helped and improve. Emotional balance and equilibrium can be achieved. This research study proposes a treatment framework which consists of nine to ten sessions of inner strength building in order to reduce depressive symptoms. The participants certainly showed how their depressive symptoms diminished. They all improved within the realms of sadness, irritably, motivation, and feelings of worthlessness. There were also individual improvements within other symptoms. The participants’ inner strength grew and evolved. Their resilience, sense of coherence, hardiness, purpose in life, and self-transcendence have all improved. It can, therefore, be concluded that this treatment plan, or framework, is effective for improving depression, and that it should be used by other clinicians.

6.9 The researcher’s reflections on the process

The framework of treatment discussed and elaborated on in this research study is, in fact, a part of a larger treatment framework that the researcher created for the treatment of depression, anxiety, anger, self-esteem, and trauma. The researcher has used her expanded framework with hundreds of clients, with a high rate of success. The researcher decided to use this framework, in a more narrowed-down form, in a

scientific setting, in order to explore its usefulness, and in order to provide guidelines for its use for other therapists. The process of the original framework includes four sections, namely, activities for self-awareness, activities for inner strength building, ego state therapy, and practical guidance. The framework chosen for this research is extracted mainly from the second section, which consisted of activities for inner strength building. For this research, the researcher initially planned to use seven sessions, but she was doubtful whether seven sessions would be sufficient to show the clear evolvement of the participants in terms of depression and inner strength. At the first session with each participant, the researcher noted the extent to which they were broken, and her doubts increased about whether she would be able to show that evolvement took place in such a short time. The seven sessions grew into nine as the researcher realized how much the participants were enjoying “the tree of life” activity, and she felt that it would not be wise to shorten the required process. However, even nine sessions were not quite sufficient enough to achieve the aim of the research. The researcher was surprised to witness the on-going evolvement of the participants, which became evident from the data that was collected through the sessions.

The process was positive for all who were involved, including the researcher. Instead of the participants dwelling in a “dark place” for an extended period of time, the process entailed enjoyable activities. The participants found this method to be interesting and “fun”. The researcher enjoyed seeing the participants deriving pleasure from the process. Reading the participant’s reflections was particularly rewarding, and especially so when reading the parents’ reflections. Watching the participants’ happiness grow, as well as their inner calmness, was satisfying. It was a joyous experience to witness and to be part of the steady growth and recovery in the participants’ journey. The researcher now feels confident to propose this framework to other therapists, with the hope that the use of this framework will bring healing to many adolescent depression sufferers.

REFERENCES

Aarons, Z., Levin, P., & Taub-Da Costa, A. (2012). *Recognising postnatal depression: A handbook for mothers*. Johannesburg: Penguin.

Abel, A., Hayes, A. M., Henley, W., & Kuyken, W. (2016). Sudden gains in cognitive-therapy for treatment-resistant depression: Processes of change. *Journal of Consulting and Clinical Psychology, 84*(8), 726-737. doi:10.1037/ccp0000101

Abela, J. R. Z., Fishman, M. B., Cohen, J. R., & Young, J. F. (2012). Personality predispositions to depression in children of affectively-ill parents: The buffering role of self-esteem. *Journal of Clinical Child and Adolescent Psychology, 41*(4), 391-401. doi:10.1080/15374416.2012.654463

Agerup, T., Lydersen, S., Wallander, J., & Sund, A. M. (2015). Associations between parental attachment and course of depression between adolescence and young adulthood. *Child Psychiatry and Human Development, 46*(4), 632-642. doi:10.1007/s10578-014-0506-y

Akhouri, K., & Akhouri, D. (2018). Impact of parent-child relationship on educational aspiration and self-esteem of adolescent boys and girls. *Indian Journal of Health & Wellbeing, 9*(1), 43-49.

Akhtar, M. (2012). *Positive psychology for overcoming depression: Self-help strategies for happiness, inner strength and well-being*. London, UK: Watkins Publishing.

Aldahadha, B. (2018). The effectiveness of self-hypnosis training in reducing depression and insomnia. *Psychiatry Psychotherapy & Clinical Psychology, 9*(1), 30-39.

Alladin, A. (2013). Healing the wounded self: Combining hypnotherapy with ego state therapy. *American Journal of Clinical Hypnosis, 56*(1), 3-22. doi:10.1080/00029157.2013.796282

Allen, R. P., & Allen, R. P. (2004). *Scripts and strategies in hypnotherapy: The complete works.* Carmarthen, Wales, UK: Crown House Publishing.

Amini, P., Ghaleiha, A., Zarean, E., Sadeghifar, M., Ghaffari, M. E., Taslim, Z., & YadzIl-Ravandi, S. (2018). Modelling the frequency of depression using Holt-

Winters exponential smoothing method. *Journal of Clinical and Diagnostic Research, 12*(10), 1-4. doi:10.7860/JCDR/2018/35765.12085

Andrade, H. G. (2000). Using rubrics to promote thinking and learning. *Educational Leadership, 57*(5), 13-19.

Annesi, J. J. (2004). Relationship between self-efficacy and changes in rated tension and depression for 9-to 12-yr.-old children enrolled in a 12-wk. after-school physical activity program. *Perceptual and Motor Skills, 99*(1), 191-194.

Auslander, W., Sterzing, P., Threlfall, J., Gerke, D., & Edmond, T. (2016). Childhood abuse and aggression in adolescent girls involved in child welfare: The role of depression and posttraumatic stress. *Journal of Child & Adolescent Trauma, 9*(4), 359-368. doi:10.1007/s40653-016-0090-3

Baker, W. (2017). Aspirations: The moral of the story. *British Journal of Sociology of Education, 38*(8), 1203-1216. doi:10.1080/01425692.2016.1254540

Baker, Z. G., Krieger, H., & LeRoy, A. S. (2016). Fear of missing out: Relationships with depression, mindfulness, and physical symptoms. *Translational Issues in Psychological Science, 2*(3), 275-282. doi:10.1037/tps0000075

Barabasz, A. F., Barabasz, M., & Watkins, J. G. (2012). Single-session manualized ego state therapy (EST) for combat stress injury, PTSD, and ASD, Part 2: The procedure. *International Journal of Clinical & Experimental Hypnosis, 60*(3), 370-381. doi:10.1080/00207144.2012.675300

Barabasz, A., Barabasz, M., Christensen, C., French, B., & Watkins, J. G. (2013). Efficacy of single-session abreactive ego state therapy for combat stress injury, PTSD, and ASD. *International Journal of Clinical and Experimental Hypnosis, 61*(1), 1-19.

Barbieri, J. L. (2008). The URGES approach: Urge reduction by growing ego strength (URGES) for trauma/addiction treatment using alternate bilateral stimulation, hypnotherapy, ego state therapy and energy psychology. *Sexual Addiction & Compulsivity, 15*(2), 116-138. doi:10.1080/10720160802035584

Barlett, C. P., & Fennel, M. (2018). Examining the relation between parental ignorance and youths' cyberbullying perpetration. *Psychology of Popular Media Culture, 7*(4), 547-560. doi:10.1037/ppm0000139

Basile, S. (2017). Movie-therapy: Sex-addiction and nymphomaniac by Lars Von Trier. *Journal of Sexual Medicine, 14*(5), e317. doi:10.1016/j.jsxm.2017.04.519

Bastos, A. G., Trentini, C. M., & Guimaraes, L. S. P. (2015). The efficacy of long-term psychodynamic psychotherapy, fluoxetine and their combination in the outpatient treatment of depression. *Psychotherapy Research, 25*(5), 612-624. doi:10.1080/10503307.2014.935519

Battino, R., & South, T. L. (2005). *Ericksonian approaches: A comprehensive manual*. Carmarthen, Wales, UK: Crown House Publishing.

Bazargan, Y., & Pakdaman, S. (2016). The effectiveness of art therapy in reducing internalizing and externalizing problems of female adolescents. *Archives of Iranian Medicine (AIM), 19*(1), 37-42.

Beatson, J., & Taryan, S. (2003). Predisposition to depression: The role of attachment. *Australian and New Zealand Journal of Psychiatry, 37*(2), 219-225. doi:10.1046/j.1440-1614.2003.01126.x

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond (2nd ed.).* New York, NY: The Guildford Press.

Bergeron, J. A. (1990). Outcomes of short-term individual therapy for elderly clients experiencing reactive depression in a skilled nursing facility (M.S.W.). Available from ProQuest Dissertations & Theses Global. (303936622). Retrieved 27.08.2018.

Bernecker, S. L., Constantino, M. J., Atkinson, L. R., Bagby, R. M., Ravitz, P., & McBride, C. (2016). Attachment style as a moderating influence on the efficacy of cognitive-behavioral and interpersonal psychotherapy for depression: A failure to replicate. *Psychotherapy, 53*(1), 22-33. doi:10.1037/pst0000036

Birmaher, B. (2004). *New hope for children and teens with bipolar disorder: Your friendly, authoritative guide to the latest in traditional and complementary solutions*. New York, NY: Harmony Books.

Bishwajit, G., O'Leary, D. P., Ghosh, S., Sanni, Y., Shangfeng, T., & Zhanchun, F. (2017). Association between depression and fruit and vegetable consumption among adults in South Asia. *BMC Psychiatry, 17*, 1-9. doi:10.1186/s12888-017-1198-1

Blease, C. R. (2015). Too many friends, too few likes? Evolutionary psychology and 'Facebook depression'. *Review of General Psychology, 19*(1), 1-13. doi:10.1037/gpr0000030

Bloch, D. (2013). Healing from depression naturally: 52 proven ways to elevate your mood and live free from depression and anxiety. Brandfort, ON: Pallas Communications.

Blomdahl, C., Guregård, S., Rusner, M., & Wijk, H. (2018). A manual-based phenomenological art therapy for individuals diagnosed with moderate to severe depression (PATd): A randomized controlled study. *Psychiatric Rehabilitation Journal, 41*(3), 169-182. doi:10.1037/prj0000300

Bohman, B., Santi, A., & Andersson, G. (2017). Cognitive behavioral therapy in practice: Therapist perceptions of techniques, outcome measures, practitioner qualifications, and relation to research. *Cognitive Behaviour Therapy, 46*(5), 391-403. doi:10.1080/16506073.2016.1263971

Boholst, F. A. (2003). Effects of transactional analysis group therapy on ego states and ego state perception. *Transactional Analysis Journal, 33*(3), 254-261.

Boman, E., Gustafson, Y., Häggblom, A., Santamäki Fischer, R., & Nygren, B. (2015). Inner strength - associated with reduced prevalence of depression among older women. *Aging & Mental Health, 19*(12), 1-6. 1078-1083. doi:10.1080/13607863.2014.977775

Botha, F. B., & Dozois, D. J. A. (2015). The influence of emphasizing psychological causes of depression on public stigma. *Canadian Journal of Behavioural*

Science / Revue canadienne des sciences du comportement, 47(4), 313-320. doi:10.1037/a0039611

Bourne, E. J. (2015). *The anxiety and phobia workbook* (6th ed.). Oakland, CA: New Harbinger Publications.

Brann, L., Owens, J., & Williamson, A. (Eds.). (2012). *The handbook of contemporary clinical hypnosis: Theory and practice.* Chichester, UK: Wiley-Blackwell.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London, UK: Sage.

Braverman, E. R. (2005). *The edge effect: Achieve total health and longevity with the balanced brain advantage*. New York, NY: Sterling Publishing Company, Inc.

Briks, A. (2007). Art therapy with adolescents: Vehicle to engagement and transformation. *Canadian Art Therapy Association Journal, 20*(1), 2-15.

Brogan, K., & Greenblatt, J. (2016). *Integrative therapies for depression: Redefining models for assessment, treatment and prevention*. Boca Raton, FL: CRC Press.

Brown, P. (1991). *The hypnotic brain: Hypnotherapy and social communication.* New Haven, CT: Yale University Press.

Bryman, A. (2016). *Social research methods* (International Edition). Oxford, UK: Oxford University Press.

Calnan, R. D. (1977). Hypnotherapeutic ego strengthening. *Australian Journal of Clinical Hypnosis, 5*, 105-118.

Cavanagh, A., Wilson, C. J., Caputi, P., & Kavanagh, D. J. (2016). Symptom endorsement in men versus women with a diagnosis of depression: A differential item functioning approach. *International Journal of Social*

Psychiatry, 62(6), 549-559. doi:10.1177/0020764016653980

Chin, J. T., Hayes, R., Orchard, L., Smith, C., Sutton, N., & Walters, K. (2017). Art and music therapy with adopted children under five. *International Journal of Birth & Parent Education (IJBPE), 5*(2), 11-14.

Chow, T. S., & Wan, H. Y. (2017 December). Is there any 'Facebook depression'? Exploring the moderating roles of neuroticism, Facebook social comparison and envy. *Personality and Individual Differences*, *119,* 277-282. Doi ://doi.org/ 10.1016/j.paid.2017.07.032

Cingel, D. P., & Olsen, M. K. (2018 April). Getting over the hump: Examining curvilinear relationships between adolescent self-esteem and Facebook use. *Journal of Broadcasting and Electronic Media, 62*(2), 215-231.

Ciobanu, T., Brodard, F., Antonietti, J.-P., Genoud, P. A., & Brandner, C. (2018). Screening negative affectivity in young adults: Validation and psychometric evaluation of the French version of the depression anxiety stress scales. *Canadian Journal of Behavioural Science / Revue Canadienne des Sciences Du Comportement, 50*(4), 238-247. doi:10.1037/cbs0000110

Clark, H. A. (2008). *Depression and narrative: Telling the dark*. Albany, NY: SUNY Press.

Cozolino, L. (2014). *The neuroscience of human relationships: Attachment and the developing social brain* (2nd ed.)*.* Norton Series on Interpersonal Neurobiology. New York, NY: WW Norton & Company.

Craven, M. A., & Bland, R. (2013). Depression in primary care: Current and future challenges. *Canadian Journal of Psychiatry, 58*(8), 442-448.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative,*

and mixed methods approaches. Thousand Oaks, CA: Sage Publications, Inc.

Curry, J. F., Wells, K. C., Lochman, J. E., Craighead, W. E., & Nagy, P. D. (2001). Group and family cognitive behavior therapy for adolescent depression and substance abuse: A case study. *Cognitive and Behavioral Practice, 8*(4), 367-376.

Curtis, A. C. (2015). Defining adolescence. *Journal of Adolescent and Family Health, 7*(2), 2.

Da Silva, J. S. S. (2010). The experiences of educational psychologists utilizing ego state therapy with adolescents presenting with dissociation. M.Ed. Thesis. University of Johannesburg, Johannesburg. Retrieved from http://hdl.handle.net/10210/4948

Da Silva, J., & Fritz, E. (2012). The experiences of educational psychologists who utilise ego state therapy to address dissociation in adolescents. *South African Journal of Psychology, 42*(2), 169-181.

Dagirmanjian, S., Eron, J., & Lund, T. (2007). Narrative solutions: An integration of self and systems perspectives in motivating change. *Journal of Psychotherapy Integration, 17*(1), 70-92. doi:10.1037/1053-0479.17.1.70

Darewych, O. (2015). The effectiveness of art psychotherapy on self-esteem, self-concept, and depression in children with glaucoma. *Canadian Art Therapy Association Journal, 22*(2), 2-17. doi.org/10.1016/j.adolescence.2013.10.008

Dean, J., & Keshavan, M. (2017). The neurobiology of depression: An integrated view. *Asian Journal of Psychiatry, 27*(1), 101-111.

Degges-White, S., & Davis, N. L. (2011). Integrating the expressive arts into counseling practice: Theory-based interventions (1st ed.). New York, NY: Springer.

DelMonte, M. (2012). Mindfulness and awareness: Constructivist, psychodynamic and eastern perspectives. *International Journal of Mental Health and Addiction, 10*(3), 311-329. doi:10.1007/s11469-011-9368-8

Dennhag, I., Ybrandt, H., & Sundström, A. (2017). The relationship between clients' personality traits, working alliance and therapy outcome in a training context. *Current Issues in Personality Psychology, 5*(2), 132-142. doi:10.5114/CIPP.2017.65244

Devi, G. (2012). *A calm brain: Unlocking your natural relaxation system.* New York, NY: Penquin Publishing Group.

Dewan, M. J., Steenbarger, B. N., & Greenberg, R. P. (2017). *The art and science of brief psychotherapies: A practitioner's guide*. Washington, DC: American Psychiatric Publishing.

Dhai, A., & McQuoid-Mason, D. J. (2010). *Bioethics, human rights and health law: Principles and practice.* Cape Town, SA: Juta.

Dopheide, J. A. (2006). Recognizing and treating depression in children and adolescents. *American Journal of Health-System Pharmacy, 63*(3), 233-243.

Driessen, E., Van Henricus, L., Peen, J., Don, F. J., Kool, S., Westra, D., . . . Dekker, J. J. (2015). Therapist-rated outcomes in a randomized clinical trial comparing cognitive behavioral therapy and psychodynamic therapy for major depression. *Journal of Affective Disorders, 170*(0), 112-118. DOI: 10.1016/j.jad.2014.08.023

Driessen, E., Van, H. L., Peen, J., Don, F. J., Kool, S., Westra, D., . . . Dekker, J. J. (2015). Therapist-rated outcomes in a randomized clinical trial comparing cognitive behavioral therapy and psychodynamic therapy for major depression. *Journal of Affective Disorders, 170*, 112-118.

Driessen, E., Van, H. L., Peen, J., Don, F. J., Twisk, J. W. R., Cuijpers, P., & Dekker, J. J. M. (2017). Cognitive-behavioral versus psychodynamic therapy for major depression: Secondary outcomes of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 85*(7), 653-663. doi:10.1037/ccp0000207; 10.1037/ccp0000207.supp

Drouet, N., & Chedeau, G. (2017 February). Hypnopraxia, a new hypnotic technique for hypnoanesthesia. *Journal of Clinical Anesthesia, 37*, 14-16.

Drouin, M., Ross, J., & Tobin, E. (2015). Sexting: A new, digital vehicle for intimate partner aggression? *Computers in Human Behavior, 50,* 197-204. doi://doi.org/10.1016/j.chb.2015.04.001

Duarte, C., Pinto-Gouveia, J., & Rodrigues, T. (2015). Being bullied and feeling ashamed: Implications for eating psychopathology and depression in adolescent girls. *Journal of Adolescence, 44*, 259-268.

Duberstein, P. R., Ward, E. A., Chaudron, L. H., He, H., Toth, S. L., Wang, W., . . . Talbot, N. L. (2018). Effectiveness of interpersonal psychotherapy-trauma for depressed women with childhood abuse histories. *Journal of Consulting and Clinical Psychology, 86*(10), 868-878.

Egan, G. (2014). *The skilled helper: A problem-management and opportunity-development approach to helping* (10th ed.). Australia: Brooks/Cole, Cengage Learning.

Emmerson, G. (1999). What lies within: Ego states and other internal personifications. *Australian Journal of Clinical Hypnotherapy and Hypnosis, 20*(1), 13.

Emmerson, G. (2003). *Ego state therapy*. Carmarthen, Wales, U.K.: Crown House Publishing.

Emmerson, G. (2006). *Advanced skills and interventions in therapeutic counseling*. Carmarthen, Wales, U.K.: Crown House Publishing.

Emmerson, G. (2007). *Ego state therapy.* Carmarthen, Wales, U.K.: Crown House Publishing.

Emmerson, G. (2017). Hypnosis defined: A resource therapy perspective. *Australian Journal of Clinical & Experimental Hypnosis, 42*, 34-40.

Emmerson, G. J., & Farmer, K. (1996). Ego state therapy and menstrual migraine. *The Australian Journal of Clinical Hypnotherapy and Hypnosis, 17*, 7-14.

Emmerson, G. J. (1999). What lies within: Ego state and other internal

personifications. *The Australian Journal of Clinical Hypnotherapy and Hypnosis, 20*, 13-22.

Erickson, M. H., & Rosen, S. (1982). *My voice will go with you: The teaching tales of Milton H. Erickson, M.D.* New York, NY: W.W. Norton & Company.

Erickson, M. H, Rossi, E. L, & Rossi, S. I. (1976). *Hypnotic realities: The induction of clinical hypnosis and forms of indirect suggestion.* New York, NY: Irvington.

Erikson, E. H., & Erikson, J. M. (1990). *The life cycle completed* (2nd ed.). New York, NY: W.W. Norton & Company.

Feldhahn, S. (2013). *For women only in the workplace: What you need to know about how men think at work*. Colorado Springs, CO: Multnomah.

Feldman, J. B. (1985). The work of Milton Erickson: A multisystem model of eclectic therapy. *Psychotherapy: Theory, Research, Practice, Training, 22*(2), 154-162. doi:10.1037/h0085488

Forgash, C., & Copeley, M. (Eds.). (2007). *Healing the heart of trauma and dissociation with EMDR and Ego State Therapy.* New York, NY: Springer Publishing Company.

Forgash, C., & Knipe, J. (2012). Integrating EMDR and ego state treatment for clients with trauma disorders. *Journal of EMDR Practice and Research, 6*(3), 120-128. doi:10.1891/1933-3196.6.3.120

Fourie, G. (2009). An integrated Ericksonian and ego state intervention for the treatment of survivors of childhood sexual abuse. D.Litt. et Phil. Thesis. University of Johannesburg, Johannesburg. Retrieved from http://hdl.handle.net/10210/4146

Franklin, M. (1992). Art therapy and self-esteem. *Art Therapy, 9*(2), 78-84.

Frederick, C. (1996). With a little help from our friends: Ego states as resources for ego-strengthening. Paper presented at the *Annual Meeting of the American Society of Clinical Hypnosis,* Orlando, FL.

Frederick, C., & Kim, S. (1993). Heidi and the little girl: The creation of helpful ego states for the management of performance anxiety. *Hypnos, 20*, 49-58.

Frederick, C., & McNeal, S. (1993). From strength to strength: “Inner strength” with immature ego states. *American Journal of Clinical Hypnosis, 35*(4), 250-256.

Frederick, C., & McNeal, S. (1999). Inner strengths: Contemporary ego-strengthening in hypnotic and non-hypnotic psychotherapy. *New York: Lawrence Erlebaum and Associates.*

Frederick, C., & McNeal, S. A. (2013). *Inner strengths: Contemporary psychotherapy and hypnosis for ego-strengthening.* Mahwah, New Jersey: Lawrence Erlbaum Associates.

Free, M. L. (2007). *Cognitive therapy in groups: Guidelines and resources for practice* (2nd ed.). New York, NY: John Wiley & Sons.

Frischholz, E. J. (2013). Antidepressant medications, placebo, and the use of hypnosis in the treatment of depression. *American Journal of Clinical Hypnosis, 55*(3), 209-214.

Gask, L. (2013). Educating family physicians to recognize and manage depression: Where are we now? *Canadian Journal of Psychiatry, 58*(8), 449-455.

Gatfield, E. (2017). Augmenting Bowen family of origin work: Using the genogram and therapeutic art-based activity. *Australian & New Zealand Journal of Family Therapy, 38*(2), 272-282. doi:10.1002/anzf.1216

German, M. (2013). Developing our cultural strengths: Using the 'tree of life' strength-based, narrative therapy intervention in schools, to enhance self-esteem, cultural understanding and to challenge racism*. Educational and Child Psychology, 30*(4), 75-99.

Goldstone, D. (2017). Cognitive-behavioural therapy versus psychodynamic psychotherapy for the treatment of depression: A critical review of evidence and current issues. *South African Journal of Psychology, 47*(1), 84-96. doi:10.1177/0081246316653860

Gonzalez-Ramirez, E., Carrillo-Montoya, T., Garca-Vega, M. L., Hart, C. E., Zavala-Norzagaray, A., & Ley-Quinez, C. P. (2017). Effectiveness of hypnosis therapy and Gestalt therapy as depression treatments. *Clinica Y Salud, 28*(1), 33-37. doi:10.1016/j.clysa.2016.11.001

Gray, P. (2011). The decline of play and the rise of psychopathology in children and adolescents. *American Journal of Play, 3*(4), 443-463.

Green, E. J., & Drewes, A. A. (Eds.). (2013). *Integrating expressive arts and play therapy with children and adolescents.* Somerset, NJ, USA: John Wiley & Sons.

Green, J. P., Laurence, J., & Lynn, S. J. (2014). Hypnosis and psychotherapy: From mesmer to mindfulness. *Psychology of Consciousness: Theory, Research, and Practice, 1*(2), 199-212. doi:10.1037/cns0000015

Greenberg, G. (2010). *Manufacturing depression: The secret history of a modern disease*. London, UK: Bloomsbury.

Gruber, H., & Oepen, R. (2018). Emotion regulation strategies and effects in art-making: A narrative synthesis. *Journal of Clinical Anesthesia, 37*, 14-16

Guest, G., Namey, E. E., & Mitchell, M. L. (2013). *Collecting qualitative data: A field manual for applied research*. Los Angeles, CA: Sage.

Gunnison, H., & Moore, S. (2003). Hypnocounseling: Carl Rogers and Milton Erickson / Hypnocounseling: Carl Rogers und Milton Erickson / Hipnocounseling: Carl Rogers y Milton Erickson. *Person-Centered & Experiential Psychotherapies, 2*(3), 204-218. doi:10.1080/14779757.2003.9688312

Guse, T. (2014). Increasing psychological well-being through hypnosis. In G. Fava & C. Ruini (Eds.), *Increasing psychological well-being in clinical and educational settings.* (pp. 91-102). Dordrecht: Springer.

Guse, T., & Fourie, G. (2013). Facilitating psychological well-being through hypnotherapeutic interventions. *Well-being research in South Africa,* (pp.539-

555). New York, NY: Springer Science + Business Media.

Guse, T., Wissing, M., & Hartman, W. (2006). The effect of a prenatal hypnotherapeutic programme on postnatal maternal psychological well-being. *Journal of Reproductive & Infant Psychology, 24*(2), 163-177.

Habib, F., & Khan, S. (2016). Attributional style and academic achievement among senior secondary school students. *Indian Journal of Health & Wellbeing, 7*(6), 632-635.

Habibi, M., Mokhtar, S. M., Ghanbari, N., Nooripour, R., & Motabi, E. (2016). Marital maladjustment and depression in women: Mediating role of self-repression. *Romanian Journal of Experimental Applied Psychology, 7*(2), 10-27. doi:10.15303/rjeap.2016.v7i2.a2

Hageman, J. H., & Frederick, C. (2013). Phenomenological and evidence based research in ego state therapy: Recognized and unrecognized successes and future directions. *American Journal of Clinical Hypnosis, 56*(1), 66-85. doi:10.1080/00029157.2013.796283

Halappa, N., Thirthalli, J., Varambally, S., Rao, M., Christopher, R., & Nanjundaiah, G. (2018a). Improvement in neurocognitive functions and serum brain-derived neurotrophic factor levels in patients with depression treated with antidepressants and yoga. *Indian Journal of Psychiatry, 60*(1), 32-37. doi:10.4103/psychiatry.IndianJPsychiatry_154_17

Hanna, S. M., & Brown, J. H. (2007). *The practice of family therapy: Key elements across models* (4th ed.). Australia: Thomson/Brooks/Cole.

Hartman, W. (1995). *Ego state therapy with sexually traumatized children*. Pretoria: Kagiso Tertiary.

Hartman, W. (2002). Ego state therapy - then and now: Towards a naturalistic utilization approach. *Hypnos: Swedish Journal of Hypnosis in Psychotherapy and Psychosomatic Medicine, 29*(2), 52-58.

Hartwig, E. K., & Bennett, M. M. (2017a). Four approaches to using sandtray in play

therapy supervision. *International Journal of Play Therapy, 26*(4), 230-238. doi:10.1037/pla0000050

Hassouneh, D., Nguyen, T., Chen, Z., & McNeff, E. (2013). Healing pathways: A program for women with physical disabilities and depression. *Rehabilitation Research & Practice,* Article ID 649875,1-15. doi:10.1155/2013/649875

Havens, R. (2003). *The Wisdom of Milton H. Erickson: The Complete Volume.* Williston, VT: Crown House Publishing.

Hayes, B. K., Stephens, R. G., Ngo, J., & Dunn, J. C. (2018). The dimensionality of reasoning: Inductive and deductive inference can be explained by a single process. *Journal of Experimental Psychology: Learning, Memory, and Cognition, 44*(9). doi:10.1037/xlm0000527; 10.1037/xlm0000527.supp (Supplemental)

Hayes, L. A. (2018). Mobile and temporary: Women and workplace precarity in Appalachian Kentucky. *Journal of Appalachian Studies, 24*(1), 26-44.

Herber, T. J. (2006). *The effects of hypnotic ego strengthening on self-esteem.* Washington, DC: Washington State University, College of Education.

Hesse-Biber, S. N. (2017). *The practice of qualitative research: Engaging students in the research process* (3rd ed.). Los Angeles, CA: Sage.

Higenbottam, W. (2004). In her image: A study in art therapy with adolescent females. *Canadian Art Therapy Association Journal, 17*(1), 10-16. doi:10.1080/08322473.2004.11432256

Hilgard, E. R. (1991). A neodissociation interpretation of hypnosis. In S. J. Lynn & J. W. Rhue (Eds.), *The Guilford clinical and experimental hypnosis series. Theories of hypnosis: Current models and perspectives,* 83-104. New York, NY: Guilford Press.

Hilgard, E. R., & Hilgard, J. R. (1994). *Hypnosis in the relief of pain* (Rev ed.). Levittown, PA: Brunner/Mazel Inc.

Hoffmann, B. (2016). The role of expressive therapies in therapeutic interactions; art

therapy - explanation of the concept. *Trakia Journal of Sciences, 14*(3), 197-202. doi:10.15547/tjs.2016.03.001

Holford, P. (2010a). *The feel good factor: 10 proven ways to boost your mood and feel happy and motivated*. London, UK: Hachette UK. Digital.

Holford, P. (2010b). *Optimum nutrition for the mind*. London, UK: Piatkus Books.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). Chichester, UK: Wiley-Blackwell.

Holopainen, D., & Emmerson, G. J. (2002). Ego state therapy and the treatment of depression. *Australian Journal of Clinical Hypnotherapy and Hypnosis, 23*(2), 89-100.

Horowitz, L. M., & Strack, S. (Eds.). (2010). *Handbook of Interpersonal Psychology: Theory, Research, Assessment, and Therapeutic Interventions*. Chichester, UK: Wiley. Retrieved from http://uj.lib.overdrive.com/ContentDetails.htm?ID=FEC86CE3-80B6-4CCB-BE0C-88E3FC733BDF

HPCSA. (2011). Professional board of psychology: Ethical code of professional conduct. Retrieved from https://www.hpcsa.co.za/PBPsychology/Guidelines

Huberty, T. J. R. (2012). *Anxiety and depression in children and adolescents: Assessment, intervention, and prevention*. New York, NY: Springer-Verlag.

Hunter, C. R. (2010). *The art of hypnotherapy: Part II of "diversified client- centered hypnosis" (based on the teachings of Charles Tebbetts),* (4th ed.). Bancyfelin, Wales, UK: Crown House.

Hypnotism. (2017). *Columbia Electronic Encyclopedia, 6th Edition.* New York, NY: Columbia University Press.

Ibtesam, R. (2017). On teenage 'sexting' and the law. *The Mitchell Hamline Journal of Public Law & Policy, 37*(1), 245-277.

In-Albon, T., Meyer, A. H., Metzke, C. W., & Steinhausen, H.-C., Meyer, A. H., &

Metzke, C. W. (2017). A cross-lag panel analysis of low self-esteem as a predictor of adolescent internalizing symptoms in a prospective longitudinal study. *Child Psychiatry & Human Development, 48*(3), 411-422. doi:10.1007/s10578-016-0668-x

Isacsson, G., & Rich, C. (2014). Antidepressant drugs and the risk of suicide in children and adolescents. *Pediatric Drugs, 16*(2), 115-122. doi:10.1007/s40272-013-0061-1

Jacob, J., & De Guzman, R. G. (2015). Development of taking in the good based-bibliotherapy intervention program in the female adolescent depression treatment. *Indian Journal of Positive Psychology, 6*(4), 331-339.

Jankowski, K. F., Batres, J., Scott, H., Smyda, G., Pfeifer, J. H., & Quevedo, K. (2018). Feeling left out: Depressed adolescents may atypically recruit emotional salience and regulation networks during social exclusion. *Social Cognitive & Affective Neuroscience, 13*(8), 863-876. doi:10.1093/scan/nsy055

Jensen, M. P., Adachi, T., Tom-Pires, C., Lee, J., Osman, Z. J., & Mir, J. (2015). Mechanisms of hypnosis: Toward the development of a biopsychosocial model. *International Journal of Clinical and Experimental Hypnosis, 63*(1), 34-75.

Jesudas, H., Kamble, S. V., & Duggi, D. B. (2014). Optimism, home environment and depression of urban and rural school children. *Indian Journal of Health & Wellbeing, 5*(6), 676-680.

Jorgensen, D., White, G. E., Sekikawa, A., & Gianaros, P. (2018 June). Higher dietary inflammation is associated with increased odds of depression independent of Framingham risk score in the National Health and Nutrition Examination Survey. *Nutrition Research, 54,* 23-32. doi: 10.1016/j.nutres.2018.03.004.

Joshi, R. (2015). Depression, anxiety and social support among working and non-working women. *Indian Journal of Health & Wellbeing, 6*(9), 900-904.

Kapikiran, S., & Acun-Kapikiran, N. (2016). Optimism and psychological resilience in

relation to depressive symptoms in university students: Examining the mediating role of self-esteem. *Educational Sciences: Theory and Practice, 16*(6), 2087-2110.

Kellis, E. (2010-2011). Clinical hypnosis and cognitive-behaviour therapy in the treatment of a young woman with anxiety, depression, self-esteem issues. *Australian Journal of Clinical & Experimental Hypnosis, 38(2) / 39*(1), 155-165.

Kevereski, L., Dimovska, M. K., & Ristevski, D. (2016). The influence of the emotional intelligence in protection of the mental health in conditions of a psychosocial stress. *International Journal of Cognitive Research in Science, Engineering & Education (IJCRSEE), 4*(1), 17-21. doi:10.5937/IJCRSEE1601017K

Khawam, E. A., Laurencic, G., & Malone, D.A. Jr. (2006). Side effects of antidepressants: An overview. *Cleveland Clinic Journal of Medicine, 73*(4), 351-353, 356-361.

Kikhavani, S., & Taghinejad, H. (2015). Personality factor as a predictor of depression score among depressed and CHD patients. *Journal of Clinical & Diagnostic Research, 9*(10), 4-7. doi:10.7860/JCDR/2015/14337.6668

Kilicaslan, E. E., Esen, A. T., Kasal, M. I., Ozelci, E., Boysan, M., & Gulec, M. (2017 December). Childhood trauma, depression, and sleep quality and their association with psychotic symptoms and suicidality in schizophrenia*. Psychiatry Research, 258,* 557-564. doi: 10.1016/j.psychres.2017.08.08

Kirsch, I., & Lynn, S. J. (1998). Social-cognitive alternatives to dissociation theories of hypnotic involuntariness. *Review of General Psychology, 2*(1), 66-80. doi:10.1037/1089-2680.2.1.66

Kleintjes, S., Flisher, A. J., Fick, M., Railoun, A., Lund, C., Molteno, C., & Robertson, B. A. (2006). The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa: Original article. *South African Psychiatry Review, 9*(3), 157-160.

Kongkasuwan, R., Voraakhom, K., Pisolayabutra, P., Maneechai, P., Boonin, J., & Kuptniratsaikul, V. (2016). Creative art therapy to enhance rehabilitation for stroke patients: A randomized controlled trial. *Clinical Rehabilitation, 30*(10), 1016-1023. doi:10.1177/0269215515607072

Kraines, M., Krug, C., & Wells, T. (2017). Decision justification theory in depression: Regret and self-blame. *Cognitive Therapy & Research, 41*(4), 556-561. doi:10.1007/s10608-017-9836-y

Kumara, H., & Kumar, V. (2016). Impact of cognitive behavior therapy on anxiety and depression in adolescent students. *Journal of Psychosocial Research, 11*(1), 77-85.

Kushner, S. C., Bagby, R. M., & Harkness, K. L. (2017). Stress generation in adolescence: Contributions from Five-Factor Model (FFM) personality traits and childhood maltreatment. *Personality Disorders: Theory, Research, and Treatment, 8*(2), 150-161. doi:10.1037/per0000194

Kuyken, W., Watkins, E., & Beck, A. T. (2005). Cognitive-behavior therapy for mood disorders. In G. O. Gabbard, J. S. Beck, & J. Holmes, (Eds.), *Oxford textbook of psychotherapy*,111-126. New York, NY: Oxford University Press.

Lankton, S. R. (Ed.). (1989). *Ericksonian hypnosis: Application, preparation and research: Ericksonian Monographs No. 5.* New York, NY: Brunner/Mazel.

Law, D., & Cooper, M. (2018). What do you want to change? *Therapy Today, 29*(1), 28-32.

Lawrence, H. R., Nangle, D. W., Schwartz-Mette, R. A., & Erdley, C. A. (2017). Medication for child and adolescent depression: Questions, answers, clarifications, and caveats. *Practice Innovations, 2*(1), 39-53. doi:10.1037/pri0000042

Lebowitz, E., & Reber, C. (2012). The union of the expressive arts and dialectical behaviour therapy with adolescents presenting with traits of borderline personality disorder in a residential setting. *Journal of Applied Arts and Health, 2*(3), 335-346.

Lebowitz, M. S., Ahn, W., & Nolen-Hoeksema, S. (2013). Fixable or fate? Perceptions of the biology of depression. *Journal of Consulting and Clinical Psychology, 81*(3), 518-527. doi:10.1037/a0031730; 10.1037/a0031730.supp (Supplemental)

Leedy, P. D., & Ormrod, J. E. (2014). *Practical research: Planning and design* (10th ed.). Harlow, Essex, UK: Pearson Education.

Leibovich, L., & Zilcha-Mano, S. (2017). Integration and clinical demonstration of active ingredients of short-term psychodynamic therapy for depression. *Journal of Psychotherapy Integration, 27*(1), 93-106. doi:10.1037/int0000043

Lemke, W. (2007). Fostering internal cooperation through the use of imagery in the treatment of dissociative identity disorder. *Journal of Trauma & Dissociation, 8*(4), 53-68. doi:10.1300/J229v08n04_04

Leoncio, E. T., de Souza, S., R. P., & Machado, J. L. M. (2017). Degradation of parental bonding and violence against children: The use of family genogram in the pediatric clinic. *Revista Paulista De Pediatria, 35*(2), 185-190. doi:10.1590/1984-0462/;2017;35;2;00009

Levenson, J. C., Shensa, A., Sidani, J. E., Colditz, J. B., & Primack, B. A. (2016 April). The association between social media use and sleep disturbance among young adults. *Preventive Medicine, 85*, 36-41. doi://doi.org/10.1016/j.ypmed.2016.01.001

Levin, P. (2015). Ego States and Emotional Development in Adolescence. *Transactional Analysis Journal, 45*(3), 228-237. doi:10.1177/0362153715599990

Levin, P., Aarons, Z., & Taub-Da Costa, A. (2012). *Recognising postnatal depression: A handbook for mothers*. Johannesburg, SA: Penguin Books.

Levine, P. A. (1997). *Waking the tTiger: Healing tTrauma: The iInnate cCapacity to tTransform oOverwhelming eExperiences.* Berkeley, CA: North Atlantic Books.

Levine, P. A., & Kline, M. (2007). *Trauma tThrough a cChild's eEyes: Awakening the oOrdinary mMiracle of hHealing: Infancy through aAdolescence.* Berkeley, CA: North Atlantic Books.

Levine, P. A., & Kline, M. (2008). *Trauma-proofing yYour k Kids: A pParents' gGuide for iInstilling cConfidence, jJoy and rResilience.* Berkeley, CA: North Atlantic Books.

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suarez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board Task Force Report. *American Psychologist, 73*(1), 26-46. doi:10.1037/amp0000151

Liebmann, M. (2004). *Art Therapy for Groups: A handbook of themes and exercises*. Hove, East Sussex: Brunner-Routledge.

Lim, C., Rice, E., & Rhoades, H. (2016). Depressive symptoms and their association with adverse environmental factors and substance use in runaway and homeless youths. *Journal of Research on Adolescence, 26*(3), 403-417. doi:10.1111/jora.12200

Lin, L. y., Sidani, J. E., Shensa, A., Radovic, A., Miller, E., Colditz, J. B., . . . Primack, B. A. (2016). Association between social media use and depression among U.S. young adults. *Depression and Anxiety, 33*(4), 323-331. doi:10.1002/da.22466

Lincoln, Y. S., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Little, K., Olsson, C. A., Youssef, G. J., Whittle, S., Simmons, J. G., Ycel, M., . . . Allen, N. B. (2015). Linking the serotonin transporter gene, family environments, hippocampal volume and depression onset: A prospective imaging gene environment analysis. *Journal of Abnormal Psychology, 124*(4), 834-849. doi:10.1037/abn0000101; 10.1037/abn0000101.supp (Supplemental)

Louw, D. A., Van Ede, D. M., & Louw, A. E. (1998). *Human development* (2nd ed.).

Pretoria, SA: Kagiso Tertiary.

Lundman, B., Aléx, L., Jonsén, E., Norberg, A., Nygren, B., Fischer, R. S., & Strandberg, G. (2010). Inner strength - A theoretical analysis of salutogenic concepts. *International Journal of Nursing Studies, 47*(2), 251-260. doi:10.1016/j.ijnurstu.2009.05.020

Marcia, J., & Josselson, R. (2013). Eriksonian personality research and its implications for psychotherapy. *Journal of Personality, 81*(6), 617-629. doi:10.1111/jopy.12014

Maree, J. G., Ebersöhn, L., & de Villiers, D. A. (2012). Combining Ericksonian and sandplay approaches to therapy with children who manifest depression as a developmental barrier. *Journal of Psychology in Africa, 22*(2), 221-226. doi:10.1080/14330237.2012.10820520

Maree, K. (2007a). *First steps in research*. Pretoria, SA: Van Schaik Publishers.

Maree, K. (2007b). *Shaping the story: A guide to facilitating narrative career counselling*. Pretoria, SA: Van Schaik Publishers.

McClelland, S. I. (2017). Vulnerable listening: Possibilities and challenges of doing qualitative research. *Qualitative Psychology, 4*(3), 338-352. doi:10.1037/qup0000068

McNeal, S., & Frederick, C. (1993). Inner strength and other techniques for ego strengthening. *American Journal of Clinical Hypnosis, 35*(3), 170-178.

McNeal, S., & Frederick, C. (1996 March). Inner love: Projective/evocative ego-strengthening of ego states with inner resources of unconditional love. Paper presented at the *Annual Meeting of the American Society of Clinical Hypnosis, Orlando, FL.*

McNiff, S. (1998). *Art-based research*. London, UK: Jessica Kingsley Publishers.

Merriam, S. B. (1990). *Qualitative research and case study applications in education* (Rev & exp ed.). San Francisco, CA: Jossey-Bass.

Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Jossey-Bass.

Michael, M. (2012). Reply to Dr. Sand. In M. A. Holowchak (Ed.), *Radical claims in Freudian psychoanalysis: Point/Counterpoint,* 97-101. New York, NY: Jason Aronson.

Midgley, N., Reynolds, S., Kelvin, R., Loades, M., Calderon, A., Martin, P., . . . O'Keeffe, S. (2018). Therapists' techniques in the treatment of adolescent depression. *Journal of Psychotherapy Integration, 28*(4), 413-428. doi:10.1037/int0000119

Milan, S., & Carlone, C. (2018). A two-way street: Mothers' and adolescent daughters' depression and PTSD symptoms jointly predict dyadic behaviors. *Journal of Family Psychology, 32*(7), 1097-1108. doi:10.1037/fam0000467; 10.1037/fam0000467.supp (Supplemental)

Milling, L. S., & Randazzo, E. S. (2016). Enhancing sports performance with hypnosis: An ode for Tiger Woods. *Psychology of Consciousness: Theory, Research, and Practice, 3*(1), 45-60. doi:10.1037/cns0000055

Minev, M. (2018). Self-esteem and depression in adolescents. *Trakia Journal of Sciences, 16*(2), 119-127. doi:10.15547/tjs.2018.02.008

Moe, A., Hellzen, O., Ekker, K., & Enmarker, I. (2012). Inner strength in relation to perceived physical and mental health among the oldest old people with chronic illness. *Aging & Mental Health, 17*(2), 189-196. doi:10.1080/13607863.2012.717257

Moilanen, K. L., Padilla-Walker, L., & Blaacker, D. R. (2018). Dimensions of short-term and long-term self-regulation in adolescence: Associations with maternal and paternal parenting and parent-child relationship quality. *Journal of Youth & Adolescence, 47*(7), 1409-1426. doi:10.1007/s10964-018-0825-6

Moksnes, U. K., Bradley Eilertsen, M.-E., & Lazarewicz, M. (2016). The association between stress, self-esteem and depressive symptoms in adolescents. *Scandinavian Journal of Psychology, 57*(1), 22-29.

doi:10.1111/sjop.12269

Moksnes, U. K., Løhre, A., Lillefjell, M., Byrne, D. G., & Haugan, G. (2016). The association between school stress, life satisfaction and depressive symptoms in adolescents: Life satisfaction as a potential mediator. *Social Indicators Research, 125*(1), 339-357.

Moosa, A., Koorankot, J. K. N., & Nigesh, K. (2017). Solution focused art therapy among refugee children. *Indian Journal of Health & Wellbeing, 8*(8), 811-816.

Morton, P., & Frederick, C. (1997). Intrapsychic transitional space: A resource for integration in hypnotherapy. *Hypnos, 24*, 32-41.

Moscovici, L., & Kotler, M. (2009). A multistage chronobiologic intervention for the treatment of depression: A pilot study. *Journal of Affective Disorders, 116*(3), 201-207. doi://doi.org/10.1016/j.jad.2009.01.015

Murphy, J. A., Sarris, J., & Byrne, G. J. (2017). A review of the conceptualisation and risk factors associated with treatment-resistant depression. *Depression Research & Treatment,* 1-10. doi:10.1155/2017/4176825

Murshed, F., & Zhang, Y. (2016). Thinking orientation and preference for research methodology. *Journal of Consumer Marketing, 33*(6), 437-446.

Nair, M., Paul, M. K., & John, R. (2004). Prevalence of depression among adolescents. *The Indian Journal of Pediatrics, 71*(6), 523-524.

Neuman, W. L. (2006). *Social research methods: Qualitative and quantitative approaches* (6th ed.). Boston, Mass.; London: Allyn and Bacon.

Newsham, G., Drouin, M., & McDaniel, B. T. (2018). Problematic phone use, depression, and technology interference among mothers. *Psychology of Popular Media Culture.* doi:10.1037/ppm0000220

Nisar, A. W. (2018). Depression, optimism-pessimism attitude and psychological well-being in adolescent boys and girls. *Indian Journal of Health & Wellbeing, 9*(5), 714-716.

Nussbaum, M. C. (2016). *Anger and forgiveness: Resentment, generosity, justice*. New York, NY: Oxford University Press.

O'Sullivan, D. J., O'Sullivan, M. E., O'Connell, B. D., O'Reilly, K., & Sarma, K. M. (2018). Attributional style and depressive symptoms in a male prison sample. *PLoS ONE, 13*(2), 1-14. doi:10.1371/journal.pone.0190394

Oaklander, V. (1988). *Windows to our children: A Gestalt therapy approach to children and adolescents*. Highland, N.Y.: The Gestalt Journal Press.

O'Hanlon, W. (1987). Taproots: Underlying principles of Milton Erickson's therapy and hypnosis. New York, NY: W.W. Norton.

O'Keeffe, G. S., Clarke-Pearson, K., & Council on Communications and Media. (2011). The impact of social media on children, adolescents, and families. *Pediatrics, 127*(4), 800-804. doi:10.1542/peds.2011-0054 [doi]

Olorunju, S. B., Akpa, O. M., & Afolabi, R. F. (2018). Modelling the factor structure of the child depression inventory in a population of apparently healthy adolescents in Nigeria. *PLoS ONE, 13*(3), 1-14. doi:10.1371/journal.pone.0193699

Olsen, W. K. (2012). *Data collection: Key debates and methods in social research*. Thousand Oaks, CA: Sage.

Opie, R. S., O'Neil, A., Jacka, F. N., Pizzinga, J., & Itsiopoulos, C. (2018). A modified Mediterranean dietary intervention for adults with major depression: Dietary protocol and feasibility data from the SMILES trial. *Nutritional Neuroscience, 21*(7), 487-501. doi:10.1080/1028415X.2017.1312841

O'Reilly, K. (2008). *Key concepts in ethnography.* Thousand Oaks, CA: Sage.

Otani, A. (1989). Integrating Milton H. Erickson's hypnotherapeutic techniques into general counseling and psychotherapy. *Journal of Counseling & Development, 68*(2), 203-207.

Padilla Paredes, P., & Calvete Zumalde, E. (2015). A test of the vulnerability-stress model with brooding and reflection to explain depressive symptoms in

adolescence. *Journal of Youth & Adolescence, 44*(4), 860-869. doi:10.1007/s10964-014-0148-1

Parks, A. N. (2015). *Exploring mathematics through play in the early childhood classroom*. New York, NY: Teachers College Press.

Parris, B. A. (2017). The role of frontal executive functions in hypnosis and hypnotic suggestibility. *Psychology of Consciousness: Theory, Research, and Practice, 4*(2), 211-229. doi:10.1037/cns0000106

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *The Lancet, 369*(9569), 1302-1313. doi:10.1016/S0140-6736(07)60368-7

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: Sage.

Pechenik, J. (2001). Treatment of mild depression in female employees: A program design (Psy.D.). Available from ProQuest Dissertations & Theses Full Text. (304781945). Retrived 08.11.2017.

Perloe, A., Esposito-Smythers, C., Curby, T. W, & Renshaw, K. D. (2014). Concurrent trajectories of change in adolescent and maternal depressive symptoms in the TORDIA study. *Journal of Youth & Adolescence, 43*(4), 612-628. doi:10.1007/s10964-013-9999-0

Perry, B. D., & Szalavitz, M. (2017). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook - What traumatized children can teach us about loss, love, and healing.* (Revised and Updated Edition). New York, NY: Basic Books.

Petersen, J. J., Hartig, J., Paulitsch, M. A., Pagitz, M., Mergenthal, K., Rauck, S., . . . Gensichen, J. (2018). Classes of depression symptom trajectories in patients with major depression receiving a collaborative care intervention. *PLoS ONE, 13*(9), 1-13. doi:10.1371/journal.pone.0202245

Peterson, N. L., & Goldberg, R. M. (2016). Creating relationship trees with grieving

clients: An experiential approach to grief counseling. *Journal of Creativity in Mental Health, 11*(2), 198-212. doi:10.1080/15401383.2016.1181597

Phillips, M. (2004). Joan of Arc meets Mary Poppins: Maternal re-nurturing approaches with male patients in ego state therapy. *American Journal of Clinical Hypnosis, 47*(1), 3-12.

Phillips, M. (2008). Combining hypnosis with EMDR and ego state therapy for ego strengthening. In C. Forgash and M. Copeley (Eds.), *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy,* 91-120. New York, NY: Springer.

Phillips, M., & Frederick, C. (1995). Healing the divided self: Clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions. New York, NY: WW Norton & Company.

Polit, D. F., & Beck, C. T. (2010). Essentials of nursing research: Appraising evidence for nursing practice (7th ed.). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Poole, J. C., Dobson, K. S., & Pusch, D. (2017). Childhood adversity and adult depression: The protective role of psychological resilience. *Child Abuse & Neglect, 64*, 89-100. doi:10.1016/j.chiabu.2016.12.012

Portnoff, L., McClintock, C., Lau, E., Choi, S., & Miller, L. (2017). Spirituality cuts in half the relative risk for depression: Findings from the United States, China, and India. *Spirituality in Clinical Practice, 4*(1), 22-31. doi:10.1037/scp0000127

Prochaska, J. O., & Norcross, J. C. (2010). *Systems of psychotherapy: A transtheoretical analysis* (7th ed.). Belmont, CA: Brooks/Cole. Cengage Learning.

Pu, J., Zhou, X., Liu, L., Zhang, Y., Yang, L., Yuan, S.,…& Xie, P. (2017). Efficacy and acceptability of interpersonal psychotherapy for depression in adolescents: A meta-analysis of randomized controlled trials. *Psychiatric Research, 253,* 226-232. doi://doi.org/10.1016/j.psychres.2017.03.023

Puri, A., & Sharma, R. (2016). Internet usage, depression, social isolation and loneliness amongst adolescents. *Indian Journal of Health & Wellbeing, 7*(10), 996-1003.

Quach, A. S., Epstein, N. B., Riley, P. J., Falconier, M. K., & Fang, X. (2015). Effects of parental warmth and academic pressure on anxiety and depression symptoms in Chinese adolescents. *Journal of Child & Family Studies, 24*(1), 106-116. doi:10.1007/s10826-013-9818-y

Radovancevic, L. (2009). Doprinos pionira hipnoterapije - Ddr. Franza Aantona Mmesmera U povijesti psihoterapije i medicine. *Acta Medico-Historica Adriatica, 7*(1), 49-60.

Rahmani, M., Saeed, B. B., & Aghili, M. (2016). Integrating effect of art and music therapy on depression in adolescents. *Journal of Educational Sciences & Psychology, 6*(2), 78-87.

Ramsey-Wade, C., & Devine, E. (2018). Is poetry therapy an appropriate intervention for clients recovering from anorexia? A critical review of the literature and client report. *British Journal of Guidance & Counselling, 46*(3), 282-292. doi:10.1080/03069885.2017.1379595

Randle-Phillips, C., Farquhar, S., & Thomas, S. (2016). Adapting and evaluating a tree of life group for women with learning disabilities. *British Journal of Learning Disabilities, 44*(4), 301-308. doi:10.1111/bld.12166

Ranney, M. L., Pittman, S. K., Dunsiger, S., Guthrie, K. M., Spirito, A., Boyer, E. W., & Cunningham, R. M. (2018). Emergency department text messaging for adolescent violence and depression prevention: A pilot randomized controlled trial. *Psychological Services, 15*(4), 419-428. doi:10.1037/ser0000193

Reck, M. I. (2017). Theoretical and phenomenological considerations for Gestalt therapy research. *Gestalt Journal of Australia & New Zealand, 13*(2), 17-28.

Reinecke, M. A., & Davison, M. R. (2006). *Depression: A practitioner's guide to comparative treatments.* New York, NY: Springer.

Reiser, M. F. (1994). Review of Freud's The interpretation of dreams. *Dreaming, 4*(1), 67-70. doi:10.1037/h0094396

Reyes-Portillo, J., McGlinchey, E. L., Yanes-Lukin, P. K., Turner, J. B., & Mufson, L. (2017). Mediators of interpersonal psychotherapy for depressed adolescents on outcomes in Latinos: The role of peer and family interpersonal functioning. *Journal of Latina/O Psychology, 5*(4), 248-260. doi:10.1037/lat0000096

Rheker, J., Winkler, A., Doering, B., & Rief, W. (2017). Learning to experience side effects after antidepressant intake - results from a randomized, controlled, double-blind study. *Psychopharmacology, 234*(3), 329-338. doi:10.1007/s00213-016-4466-8

Rhew, I. C., Fleming, C. B., Van der Stoep, A., Nicodimos, S., Zheng, C., & McCauley, E. (2017). Examination of cumulative effects of early adolescent depression on cannabis and alcohol use disorder in late adolescence in a community-based cohort. *Addiction, 112*(11), 1952-1960. doi:10.1111/add.13907

Ribeiro, A., Ribeiro, J. P., & von Doellinger, O. (2018). Depression and psychodynamic psychotherapy. *Revista Brasileira De Psiquiatria, 40*(1), 105-109. doi:10.1590/1516-4446-2016-2107

Richards, L. (2015). *Handling qualitative data: A practical guide* (3rd ed.). Los Angeles, CA: Sage.

Ritchie, J. (2014). *Qualitative research practice: A guide for social science students and researchers* (2nd ed.). Los Angeles, CA: Sage.

Roberts, M. (2016). Abbe faria (1756-1819): From lucid sleep to hypnosis. *American Journal of Psychiatry, 173*(5), 459-460. doi:10.1176/appi.ajp.2016.16010035

Robertson, D. (2009). The discovery of Hypnosis - Braid's lost manuscript, "On hypnotism" (1860): A brief communication. *International Journal of Clinical & Experimental Hypnosis, 57*(2), 127-132. doi:10.1080/00207140802665344

Rogers, S. D., & White, S. L. (2017). Experiential reframing: A promising new treatment for psychosocial and existential trauma. *Practice Innovations, 2*(1), 27-38. doi:10.1037/pri0000040

Roghanchi, M., Mohamad, A. R., Mey, S. C., Momeni, K. M., & Golmohamadian, M. (2013). The effect of integrating rational emotive behavior therapy and art therapy on self-esteem and resilience. *The Arts in Psychotherapy, 40*(2), 179-184. doi://0-dx.doi.org.ujlink.uj.ac.za/10.1016/j.aip.2012.12.006

Ronald, H. (2003). *The wisdom of Milton H. Erickson*. Carmarthen, Wales, UK: Crown House Publishing.

Rossi, E. L. (2007). *The breakout heuristic: The new neuroscience of mirror neurons, consciousness, and creativity in human relationships.* Phoenix, AZ: Milton H. Erickson Foundation Press.

Rossi, E. L., Ryan, M. O., & Sharp, F. A. (Eds.). (1983). *Healing in hypnosis: The seminars, workshops, and lectures of Milton H. Erickson, Volume 1*. New York, NY: Irvington.

Roubal, J., Francesetti, G., & Gecele, M. (2017). Aesthetic diagnosis in Gestalt therapy. *Behavioral Sciences, (2076-328X), 7*(4), 1-13. doi:10.3390/bs7040070

Rueger, S. Y., Malecki, C. K., Pyun, Y., Aycock, C., & Coyle, S. (2016). A meta-analytic review of the association between perceived social support and depression in childhood and adolescence. *Psychological Bulletin, 142*(10), 1017-1067. doi:10.1037/bul0000058

Rusu, L. (2017). 1 in 5 young people lose sleep over social media. Retrieved from https://www.techtimes.com/articles/193098/20170118/1-in-5-young-people-regularly-loses-sleep-over-social-media-study.htm

Sadeeqa, S., Mustafa, T., & Latif, S. (2018). Polycystic ovarian syndrome-related depression in adolescent girls: A review. *Journal of Pharmacy & Bioallied Sciences, 10*(2), 55-59. doi:10.4103/jpbs.JPBS_1_18

Saltis, J. (2016). Three session mindful self-hypnosis training for analgesia in a severely depressed client. *Australian Journal of Clinical & Experimental Hypnosis, 41*(2), 136-150.

Sarris, J., Gadsden, S., & Schweitzer, I. (2014). Naturopathic medicine for treating self-reported depression and anxiety: An observational pilot study of naturalistic practice. *Advances in Integrative Medicine, 1*(2), 87-92. doi://doi.org/10.1016/j.aimed.2013.06.001

Satre, D. D., Leibowitz, A., Sterling, S. A., Lu, Y., Travis, A., & Weisner, C. (2016). A randomized clinical trial of motivational interviewing to reduce alcohol and drug use among patients with depression. *Journal of Consulting & Clinical Psychology, 84*(7), 571-579. doi:10.1037/ccp0000096

Scharf, M., Mayseless, O., & Rousseau, S. (2016). When somatization is not the only thing you suffer from: Examining comorbid syndromes using latent profile analysis, parenting practices and adolescent functioning. *Psychiatry Research, 244*, 10-18. doi:10.1016/j.psychres.2016.07.015

Schmidt, S. J., & Hernandez, A. (2007). The developmental needs meeting strategy: Eight case studies. *Traumatology, 13*(1), 27-48. doi:10.1177/1534765607299913

Scholl, M. B. (2017). Recommendations for writing case study articles for publication in the Journal of College Counseling. *Journal of College Counseling, 20*(1), 81-93. doi:10.1002/jocc.12060

Schumann, L., Boivin, M., Paquin, S., Lacourse, E., Brendgen, M., Vitaro, F., . .& Booij, L. (2017). Persistence and innovation effects in genetic and environmental factors in negative emotionality during infancy: A twin study. *PLoS ONE, 12*(4), 1-16. doi:10.1371/journal.pone.0176601

Schwartz, J., & Gladding, R. (2011). *You are not your brain: The 4-step solution for changing bad habits, ending unhealthy thinking, and taking control of your life*. New York, NY: AveryPenguin.

Sehan, Z., Harun, M., & Ahmad, I. (2017). The effects of light trance and post-

hypnotic suggestions towards the university students' reading comprehension improvement. *Sleep & Hypnosis, 19*(4), 78-82. doi:10.5350/Sleep.Hypn.2016.18.0125

Selkie, E. M., Kota, R., Chan, Y., & Moreno, M. (2015). Cyberbullying, depression, and problem alcohol use in female college students: A multisite study. *CyberPsychology, Behavior & Social Networking, 18*(2), 79-86. doi:10.1089/cyber.2014.0371

Seubert, A. (2018). Becoming known: A relational model utilizing Gestalt and ego state-assisted EMDR in treating eating disorders. *Journal of EMDR Practice & Research, 12*(2), 71-85. doi:10.1891/1933-3196.12.2.71

Sharma, S., & Agarwala, S. (2013). Contribution of self-esteem and collective self-esteem in predicting depression. *Psychological Thought, 6*(1), 117-123.

Short, D., Erickson, B. A., & Erickson-Klein, R. (2006). *Hope and resiliency: Understanding the psychotherapeutic strategies of Milton H. Erickson, MD*. Carmarthen, Wales, UK: Crown House Publishing.

Silk, J. S., Siegle, G. J., Lee, K. H., Nelson, E. E., Stroud, L. R., & Dahl, R. E. (2014). Increased neural response to peer rejection associated with adolescent depression and pubertal development. *Social Cognitive and Affective Neuroscience, 9*(11), 1798-1807. doi:10.1093/scan/nst175

Simons, A. D., Padesky, C. A., Montemarano, J., Lewis, C. C., Murakami, J., Lamb, K., . . . Beck, A. T. (2010). Training and dissemination of cognitive behavior therapy for depression in adults: A preliminary examination of therapist competence and client outcomes. *Journal of Consulting and Clinical Psychology, 78*(5), 751-756. doi:10.1037/a0020569

Simons, R. L., Man Kit Lei, Beach, S. R. H., Cutrona, C. E., & Philibert, R. A. (2017). Methylation of the oxytocin receptor gene mediates the effect of adversity on negative schemas and depression. *Development & Psychopathology, 29*(3), 725-736. doi:10.1017/S0954579416000420

Singh, M., Sharma, P., Raj, D., Sharma, S., Kaushal, A., & Raina, S. K. (2018).

Leisure time physical activity and risk of developing depression among the youth of Kangra District, Himachal Pradesh, India. *Indian Journal of Psychological Medicine, 40*(5), 426-432. doi:10.4103/IJPSYM.IJPSYM_85_18

Springer, D. W., Rubin, A., & Beevers, C. G. (2011). *Treatment of depression in adolescents and adults: Clinician's guide to evidence-based practice*. Hoboken, NJ: John Wiley & Sons.

Stanbury, P. (2012). Reflections of mesmerism in literature. *Anaesthesia & Intensive Care, 40*, 10-17.

Stander, M. P., Bergh, M., Miller-Janson, H., De Beer, J. C., & Korb, F. A. (2016). Depression in the South African workplace. *South African Journal of Psychiatry, 22*(1), 1-2. doi:10.4102/sajpsychiatry.v22i1.814

Stark, A., Kaduszkiewicz, H., Stein, J., Maier, W., Heser, K., Weyerer, S., . . . & Bock, J.O. (2018). A qualitative study on older primary care patients' perspectives on depression and its treatments - potential barriers to and opportunities for managing depression. *BMC Family Practice, 19*, 1-10. doi:10.1186/s12875-017-0684-3

Stefanek, E., Strohmeier, D., & Yanagida, T. (2017). Depression in groups of bullies and victims: Evidence for the differential importance of peer status, reciprocal friends, school liking, academic self-efficacy, school motivation and academic achievement. *International Journal of Developmental Science, 11*(1), 31-43. doi:10.3233/DEV-160214

Stepakoff, S. (2009). From destruction to creation, from silence to speech: Poetry therapy principles and practices for working with suicide grief. *The Arts in Psychotherapy*, *36* (2), 105-113. DOI: 10.1016/j.aip.2009.01.007

Stephens, R. G., Dunn, J. C., & Hayes, B. K. (2018). Are there two processes in reasoning? The dimensionality of inductive and deductive inferences. *Psychological Review, 125*(2), 218-244. doi:10.1037/rev0000088; 10.1037/rev0000088.supp (Supplemental)

Stets, J. E., & Burke, P. J. (2014). Self-esteem and identities. *Sociological*

Perspectives, 57(4), 409-433. doi:10.1177/0731121414536141

Stikkelbroek, Y., Bodden, D. H. M., Dekovic, M., & van Baar, A. L. (2013). Effectiveness and cost effectiveness of cognitive behavioral therapy (CBT) in clinically depressed adolescents: Individual CBT versus treatment as usual (TAU). *BMC Psychiatry, 13*(1), 3141-20. doi:10.1186/1471-244X-13-314

Stikkelbroek, Y., Bodden, D. H. M., Kleinjan, M., Reijnders, M., & van Baar, A. L. (2016). Adolescent depression and negative life events, the mediating role of cognitive emotion regulation. *PLoS ONE, 11*(8), 1-16. doi:10.1371/journal.pone.0161062

Strader-Garcia, S. (2012). The impact of an expressive arts group therapy process on anxiety and self-esteem for highly sensitive adolescents. Institute of Transpersonal Psychology, ProQuest Dissertations Publishing. 3557626. Retrieved 28.07.2018.

Studer, L. H., & Aylwin, A. S. (2005). Pedophilia: The problem with diagnosis and limitations of CBT in treatment. *Medical Hypotheses, 67*(4), 774-781.

Swift, S. (2016). Metastatic cancer and hypnosis. *Australian Journal of Clinical & Experimental Hypnosis, 41*(2), 193-200.

Temple, J. R., Le, V. D., van den Berg, P., Ling, Y., Paul, J. A., & Temple, B. W. (2014). Brief report: Teen sexting and psychosocial health. *Journal of Adolescence, 37*(1), 33-36.

Tomlinson, M., Grimsrud, A. T., Stein, D. J., Williams, D. R., & Myer, L. (2009). The epidemiology of major depression in South Africa: Results from the South African stress and health study. *SAMJ: South African Medical Journal, 99*(5), 3678-373.

Tran, S. N. (2005). Short term, time limited cognitive behavioral therapy of major depression with Vietnamese refugee women: An analysis of three cases (Psy.D.). Available from ProQuest Dissertations & Theses Full Text. (305372870). Retrieved 24.08.2017

Treharne, G. J., & Riggs, D. W. (2014). Ensuring quality in qualitative research. In P. Bohleder, & A. C. Lyons (Eds), *Qualitative Research in Clinical and Health Psychology*, (pp. 57-73). Basingstoke, UK: Palgrave MacMillan.

Trotter, E. L. (2008). Impact of pre-treatment perfectionism on therapeutic alliance and outcome in the short-term treatment of depression (M.A.). Available from ProQuest Dissertations & Theses Full Text. (304363624). Retrieved 19.02.2018.

Undheim, A. M., & Sund, A. M. (2005). School factors and the emergence of depressive symptoms among young Norwegian adolescents. *European Child & Adolescent Psychiatry, 14*(8), 446-453. doi:10.1007/s00787-005-0496-1

Untas, A., Chauveau, P., Dupr-Goudable, C., Kolko, A., Lakdja, F., & Cazenave, N. (2013). The effects of hypnosis on anxiety, depression, fatigue, and sleepiness in people undergoing hemodialysis: A clinical report. *International Journal of Clinical & Experimental Hypnosis, 61*(4), 475-483.

Van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Viking/Penquin.

Van Grieken, R. A., van Tricht, M. J., Koeter, M. W. J., van den Brink, d. W B., & Schene, A. H. (2018). The use and helpfulness of self-management strategies for depression: The experiences of patients. *PLoS ONE, 13*(10), 1-12. doi:10.1371/journal.pone.0206262

Van Lith, T., Quintero, A., Pizzutto, E., & Grzywacz, J. G. (2018). “Vamos a la escuelita arte terapia”: An art therapy protocol for promoting resilience with Latino farm worker children. *Journal of Infant, Child & Adolescent Psychotherapy, 17*(3), 213-228. doi:10.1080/15289168.2018.1490068

Van Ouytsel, J., Van Gool, E., Ponnet, K., & Walrave, M. (2014). Brief report: The association between adolescents' characteristics and engagement in sexting. *Journal of Adolescence, 37*(8), 1387-1391. doi:10.1016/j.adolescence.2014.10.004

Van Westrhenen, N., & Fritz, E. (2014). Creative arts therapy as treatment for child

trauma: An overview. *The Arts in Psychotherapy*, 41(5). doi://doi.org/10.1016/j.aip.2014.10.004

Vanderlind, W., Stanton, C., Weinbrecht, A., Velkoff, E., & Joormann, J. (2017). Remembering the good ole days: Fear of positive emotion relates to affect repair using positive memories. *Cognitive Therapy & Research, 41*(3), 362-368. doi:10.1007/s10608-016-9775-z

Vrshek-Schallhorn, S., Stroud, C. B., Mineka, S., Zinbarg, R. E., Adam, E. K., Redei, E. E., Hammen, C., & Craske, M. G. (2015). Additive genetic risk from five serotonin system polymorphisms interacts with interpersonal stress to predict depression. *Journal of Abnormal Psychology, 124*(4), 776-790. doi:10.1037/abn0000098

Walrave, M., Ponnet, K., Vanderhoven, E., Haers, J., & Segaert, B. (Eds.). (2016). *Youth 2.0: Social media and adolescence.* Switzerland: Springer International Publishing.

Watkins, H. H. (1990). Suggestions for raising self-esteem. In D.C. Hammond (Ed.), *Handbook of Hypnotic Suggestions and Metaphors,* 127-130. New York, NY: W.W. Norton & Company.

Watkins, H. H. (1993). Ego state therapy: An overview. *American Journal of Clinical Hypnosis, 35*(4), 232-240.

Watkins, J. G. (1992). *The practice of clinical hypnosis: Vol. II, Hypnotherapeutic techniques.* New York, NY: Irvington Publishing.

Watkins, J. G. (2009). Hypnosis: Seventy years of amazement, and still don't know what it is! *American Journal of Clinical Hypnosis, 52*(2), 133-145.

Watkins, J. G., & Watkins, H. H. (1990). Ego state transferences in the hypnoanalytic treatment of dissociative reactions. In M. L. Fass & D. Brown (Eds.), *Creative Mastery in Hypnosis and Hypnoanalysis. A Festschrift for Erika Fromm*, 255-261. Hillsdale, NJ: Lawrence Erlbaum.

Watkins, J. G., & Watkins, H. H. (1990). *Ego states: Theory and therapy*. New York,

NY: W.W. Norton & Company.

Watkins, J. G., & Watkins, H. H. (1997). *Ego states: Theory and therapy.* New York: W.W. Norton & Company.

Waxman, D. (1990). Trancework - an introduction to the practice of clinical hypnosis (2nd ed.). - Yapko, M.D. *British Journal of Psychiatry, 157*(5), 950-951.

Wehrenberg, M. (2011). *The 10 best-ever depression management techniques: Understanding how your brain makes you depressed & what you can do to change it.* New York, NY: W.W. Norton & Company.

Weinstein, A., Maayan, G., & Weinstein, Y. (2015). A study on the relationship between compulsive exercise, depression and anxiety. *Journal of Behavioral Addictions, 4*(4), 315-318. doi:10.1556/2006.4.2015.034

Wijnhoven, L., Creemers, D., Vermulst, A., Scholte, R., & Engels, R. (2014). Randomized controlled trial testing the effectiveness of a depression prevention program ('op volle kracht') among adolescent girls with elevated depressive symptoms. *Journal of Abnormal Child Psychology, 42*(2), 217-228. doi:10.1007/s10802-013-9773-5

Willis, N., Mavhu, W., Wogrin, C., Mutsinze, A., & Kagee, A. (2018). Understanding the experience and manifestation of depression in adolescents living with HIV in Harare, Zimbabwe. *PLoS ONE, 13*(1), 1-11. doi:10.1371/journal.pone.0190423

Wilson-Barnardo, J. (2006). Therapeutic factors in short-term group psychotherapy for depression (D.Clin.Psych.). Available from ProQuest Dissertations & Theses Full Text. (304916679). Retrieved 04.03.2018.

Wolinska, W., Pawlak, I. E., & Mroczek, B. (2016). Analysis of insomnia in those over 60 year of age. *Family Medicine & Primary Care Review, 18*(4), 482-485. doi:10.5114/fmpcr.2016.63707

Wollants, G. (2012). *Gestalt therapy: Therapy of the situation*. Los Angeles, CA: SAGE.

Wong, M., Zhang, J., Wing, Y., & Lau, E. (2017). Sleep-related daytime consequences mediated the neuroticism-depression link. *Sleep & Biological Rhythms, 15*(1), 21-30. doi:10.1007/s41105-016-0074-6

Woods, H. C., & Scott, H. (2016). #Sleepyteens: Social media use in adolescence is associated with poor sleep quality, anxiety, depression and low self-esteem. *Journal of Adolescence, 51*, 41-49. doi: 10.1016/j.adolescence.2016.05.008.

Wright, J. H., Thase, M. E., & Beck, A. T. (2014). Cognitive-behavior therapy. In R. E. Hales, S. C. Yudofsky, L. W. Roberts, (Eds.), *The American Psychiatric Publishing Textbook of Psychiatry* (6th ed.), 1119-1160. Arlington, VA, US: American Psychiatric Publishing, Inc.

Yaghoubi Asgarabad, E., Ahangi, A., Feizi, M., Sarmasti, E., & Sharifnezhad, A. (2018). The effectiveness of detached mindfulness techniques - oriented poetry therapy on cognitive attentional syndrome. *The Arts in Psychotherapy*, *61*, 33-37.doi://0-doi-org.ujlink.uj.ac.za/10.1016/j.aip.2018.09.002

Yapko, M. D. (2003). *Trancework: An introduction to the practice of clinical hypnosis*. New York, NY: Brunner-Routledge.

Yapko, M. D. (2006a). (Ed.). *Hypnosis and treating depression: Applications in clinical practice*. New York, NY: Routledge.

Yapko, M. D. (2006b). Treating depression systemically: A guest commentary*. Journal of Systemic Therapies.* Fall.

Yapko, M. D. (2011). An interview with Michael D. Yapko. *Contemporary Hypnosis & Integrative Therapy, 28*(1), 77-97.

Yapko, M. D. (2012). *Trancework: An introduction to the practice of clinical hypnosis* (4th ed.). New York, NY: Routledge.

Yapko, M. D. (2013). *Treating depression with hypnosis: Integrating cognitive-behavioral and strategic approaches*. New York, NY: Routledge.

Yapko, M. D. (2014). *Essentials of hypnosis* (2nd ed.). New York, NY*:* Routledge.

Yapko, M. D. (2017a). Hypnosis in the treatment of depression: An overdue approach for encouraging skilful mood management. *Australian Journal of Clinical & Experimental Hypnosis, 42*, 59-70.

Yapko, M. D. (2017b). Hypnotically catalyzing experiential learning across treatments for depression: Actions can speak louder than moods. *Australian Journal of Clinical & Experimental Hypnosis, 42*, 42-58.

Yazici, E., Ulus, F., Selvitop, R., Yazici, A. B., & Aydin, N. (2013). 1449 – A novel approach of watching movies and conducting therapy for psychiatric inpatients. *European Psychiatry, 28,* Supplement 1*.* https://doi.org/10.1016/S0924-9338(13)76479-4

Yeates, L. B. (2014). Hartland's legacy (I): The ego strengthening procedure. *Australian Journal of Clinical Hypnotherapy and Hypnosis, 36* (1), 4-18.

Yeatts, P. E., Martin, S. B., & Petrie, T. A. (2017). Physical fitness as a moderator of neuroticism and depression in adolescent boys and girls. *Personality & Individual Differences, 114*, 30-35. doi:10.1016/j.paid.2017.03.040

Yin, R. K. (2003). *Case study research: Design and methods*. Thousand Oaks, CA: Sage.

Yin, R. K. (2012). *Applications of case study research* (3rd ed.). Los Angeles, CA: Sage.

Yin, R. K. (2016). *Qualitative research from start to finish, second edition*. New York, NY: The Guilford Press.

Zeig, J. K. (1992). The virtues of our faults: A key concept of Ericksonian therapy. Paper presented at *The Evolution of Psychotherapy: The Second Conference,* 252-266. New York: Brunner/Mazel.

Zeig, J. K. (2013). *Teaching seminar with Milton H. Erickson*. New York, NY: Routledge.

Zeig, J. K., & Gilligan, S. G. (1990). *Brief therapy: Myths, methods and metaphors*. New York, NY: Brunner/Mazel.

Zhou, X., Qin, B., Del Giovane, C., Pan, J., Gentile, S., Liu, Y., Lan, X., Yu. J., & Xie, P. (2015a). Efficacy and tolerability of antidepressants in the treatment of adolescents and young adults with depression and substance use disorders: A systematic review and meta-analysis. *Addiction, 110*(1), 38-48. doi:10.1111/add.12698

Zugec, L. Showcasing I-O psychology in South Africa. *TIP: The Industrial-Organizational Psychologist, 52*(4), 36-42.

APPENDIX A: ETHICS CLEARANCE CERTIFICATE

FW: Ethics matters

From: Robinson, David
Sent: 30 July 2018 03:04 PM
To: Dunbar Krige, Helen <helenk@uj.ac.za>
Subject: Ethics matters

Dear Helen

The Committee approved the following:

D. Blumenau Ethical clearance number **Sem 1 2018-017**.

Regards,

David R

www.uj.ac.za

Dr David Robinson
Department of Education and Curriculum Studies
Faculty of Education
Tel +27 11 559 2585

APPENDIX B: INFORMED CONSENT FORM FOR PARTICIPATION IN RESEARCH

FACULTY OF EDUCATION

DEPARTMENT EDUCATIONAL PSYCHOLOGY

LETTER OF CONSENT FOR PARTICIPANTS

Date

Hi _____ (name of participant)

My name is Dvori Blumenau, I am an educational psychologist in private practice and doctoral research student at the University of Johannesburg. I would like to invite you to participate in my research study to find out how can ego state therapy and creative expressive art in therapy be integrated to facilitate inner strength building in adolescent girls with depressive symptoms? The process will involve about 7 sessions, once a week.

It is important that you only take part in this inquiry because you wish to. It is also important that you know that you can stop at any time without any negative consequences. It will be possible to have more sessions after the process is finished if necessary.

The data collection methods will include audio recordings of the sessions which will be used to assist me in transcribing the sessions. We will be taking photographs of all your creative work. You will be asked to write up a half page reflection after each session. Your gradient parent (mom or dad) will be asked to write up her/his impression of you before and after the sessions. She /he will also be asked to come

in with you during our first session for a period of time to help us with some of your history and background story.

The recording of our conversations, as well as the visual recordings, will only be available to me and my supervisor and will be stored in a safe and locked space. Recorded material to be shared with other individuals will only be done with your written permission with the knowledge that your identity will be protected.

Your participation will be valuable for many therapists who would like to help adolescents with depressive symptoms. You are contributing to the building of a unique program for this purpose. In the process, your identity will be protected by the use of a name chosen by you for the purposes of the inquiry. The findings of the inquiry may also be presented at conferences, as well as appear in books or articles, where your chosen name will be used. Feedback of the findings will be shared with you at the end of the research project. If you have any questions concerning the research project, you are welcome to contact me on 07 824 3460. Alternatively, you can call my supervisor, Dr Helen Dunbar-Krige on 011-5592273.

Yours sincerely

Dvori Blumenau Prof Tharina Guse and Dr Helen Dunbar-Krige

Researcher Supervisors

By signing below, you are acknowledging that you have read and understood the above description of the proposed research project and give your permission to take part in this inquiry as well as to include your audio recording in the material. However, nothing will be published without your consent.

_____ _____ _____

Signature of participant **Printed name** **Date**

APPENDIX C: INFORMED CONSENT FORM FOR PARTICIPANTS' PARENT

Dvori Blumenau

Educational Psychologist and psychotherapist

MA Hons. (Unisa) ▪ MED. Ed PSych (UJ)

International Ego state therapist and hypnotherapist (MEISA)

PS 0114987 PR 0860030424684

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E-Mail: dvoriblum@gmail.com

9 Kenilworth Sydenham Jhb

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I_____

Parent of_____ (name of participant)

Is giving permission for my daughter to participate in this research study, conducted by the psychologist, D.Blumenau.

Sig.

Date_____

APPENDIX D: THE GIRLS' POEMS

Kelly's "current space"

Worrying is pointless: Jim Yerman

We live in a world that doesn't slow down, it seems everyone's in a hurry
Which causes us lots of stress, lots of anxiety, and an abundance of worry.

We worry about money, our health, our children, we worry about being late
We worry about getting older, about our jobs and gaining weight.

I imagine amidst all this hustle, all this hapless hurrying
There are even people out there who worry about worrying!

Worrying can be debilitating, it can be an enemy and a curse
And everyone knows telling someone not to worry only makes it worse.

So what do we do for our worriers, what can we tell them that would suffice?
How 'bout if we scour the internet and offer them other people's advice.

For there is something everyone knows whether you're 7 or 92
If you find it on the internet then, by G_d, it has to be true.

Ok all of you worriers, and you know who you are.
Here's sage advice from the internet to add to your repertoire.

Don't worry be happy is good advice we should never disavow
When you worry ask yourself this question, will this matter a year from now?

Worry doesn't help with any future tribulation
At best it is a misuse of one's imagination.

Worry never robs tomorrow of its sorrow, no matter what people might say
All it does is zap the joy and happiness from today.

And a big mistake we can make in life when all is said and done
Would be not acting because we're worried about actually making one.

How many of gather bundles if sticks, think of all the time we've lost
As we use those sticks to build bridges which we'll likely never cross.

Yes if we think about it how much of our lives have to this point been blurred
By all the misfortunes we've had, that never actually occurred?

By the looks of all the people giving advice it seems that worrying has grown
If nothing else, isn't it nice to know that as a worrier you're not alone?

Does any of this help? Some of you may say yes others of you will doubt it
Did I just plagiarize a bunch of people? I shall not worry about it.

Because it won't change the outcome, no matter how I worry of complain
And there ain't no use puttin' up my umbrella … that is, until it rains.

Kelly's "future space"

Stuck between chance and circumstance, in a hell of my own making.
Can you see into my eyes, beyond the smile I'm faking.
Shrouded by the darkness and all that I hold dear,
I have come to realize I'm paralyzed by fear.

I really wish I was as strong as everyone believes.
Instead, I feel I'm falling like the Autumn leaves.
I've tried to see a new path for my life to travel.
But I get stuck on the first step and watch it all unravel.
I feel that I'm being selfish, in this big wide world of pain.
And I often wonder, if my heart, will ever feel again.

I look towards the mountain tops,
And think of all the many stops
I've made along the way.
Some days are worse than others, as I'm sure we all can say.
I lost sight of what's important, somewhere along the way.

In you, I've found a touchstone and I hope that you will stay,
Be my friend and guide my heart, to find its strength again

Jennifer Rothgordt

Luma's "current space"

Times can be tough
When you don't get your way
People always bugging you
When all you want is to be left alone …
To be left alone with your thoughts …
I wish that I could just be left alone …

To be left alone …
Oh h oh
To be left alone …
Oh oh oh
I just wanna be left alone

People always judging you
Telling you what to do
When all you wanna do is be left alone
I when I was younger
I always loved attention
But now that I'm older all I want is to be left alone

To be left alone …
Oh oh oh
To be left alone …
Oh oh oh
I just wanna be left alone.

Luma's "future space"
"Free to be me"

Once long ago
I was never left alone
But now I am free
Free to do what I want

Who is free
I am free
Who is free
I am free
Freeeeeeee
Tooooooooo
Doooooooooo
What I want
Freeeeeeee
Tooooooooo
Doooooooooo
What I want

Verse 1

After
A while
I found
A compromise
A little bit of time
With those that I love
And some
To.do.what.I want.

(repeat verse 1)

Rivki's "current space"

"I'm Sorry"

I'm sorry I messed up yet again
But you gotta understand I don't intend on it
I'm so lost right now
Nothing really makes sense
It feels like they out to get me but I know deep down it's gonna be okay because one day someday soon I'm gonna run away and forget the pain
I know you won't understand but it's who I am faking my smile till the pain numbs away

Rivki's "future space"

All I really want is to be free feel loved and trusted
I know it's hard to believe but I feel most loved when I'm listening to my music It's my only hope
I want to feel like that all the time without my music

APPENDIX E: KELLY'S TRANSCRIBED SESSIONS (SESSIONS ONE AND TWO)

This appendix was taken out for confidentiality purposes.

APPENDIX F: LUNA'S TRANSCRIBED SESSIONS (SESSIONS ONE AND TWO)

This appendix was taken out for confidentiality purposes.

APPENDIX G: RIVKI'S TRANSCRIBED SESSIONS (SESSIONS ONE AND TWO)

This appendix was taken out for confidentiality purposes.

APPENDIX H: THE HYPNOSIS SESSIONS

Through the description of the cases below, the positive evolvement of the participants becomes evident. In order to clarify how the process helped the evolvements, one needs to understand what took place through the sessions. Hence the hypnosis sessions will be mentioned. Although all participants experienced the same hypnosis sessions, the researcher used as an example the sessions that were done with Kelly. Therefore, the letter K for Kelly and the letter R for the researcher.

Hypnosis session 1: meeting your inner strength in a safe space

Induction that followed the relaxation:

"You may want to imagine yourself standing in a beautiful lake. Its waters are warm, as this lake is being fed by hot springs. The waters are covering you up to your knees. Now, we know that hot springs are full of minerals. Hence, hey have the power to relax us. And now these minerals are travelling up your body, relaxing each and every limb. That's right. Very good. You're looking around and you can see the beautiful, breath-taking views. There is three hundred and sixty degrees of just nature all around you. You can see beautiful mountains, interesting rock formation, colourful vegetations, deep blue skies, birds which are passing by, butterflies flying around. You can see some waterfalls in the background. You can hear the birds tweeting, the grass-hoppers and the wind blowing softly. There's a waterfall behind you. You can hear its waters coming down. And, when you take a deep breath, you bring into yourself the beautiful smells of the place: fresh, fresh healing smells. The temperature around you is perfect. You then decide to go and immerse yourself beneath the waterfall because you know that this waterfall is also being fed by hot springs. So, you go beneath and you notice how this waterfall is covering you; how it's waters are making you feel so calm. At first you notice how these waters are penetrating your brain, washing away all the negative

messages, all the negative thoughts, all the negative beliefs, all the negative labels that stuck into your brain, thanks to some insensitive people in your environment. Replacing them with correct affirmations and beliefs, which are congruent with who you are. Notice how these waters are coming down, and they're now relaxing the back of your head. And then, you notice them on your face, relaxing each and every muscle in your face, and even your eyes, and your ears, and your nose and your cheeks and your chin and your mouth are all letting go. Notice how this beautiful waterfall is busy relaxing your neck and shoulders, softening your neck and shoulders and moving all the heavy weight that's sitting there. Reminding you of the theme of "Let go, and let G_D". That's right. Notice how this waterfall is coming down and is busy relaxing your arms; your hands, your fingers. Notice how this waterfall is coming down your back, your upper back, your middle back, your lower back, your entire back is getting nice and loose and limp that's right. Notice how this water is coming down and they are busy relaxing your chest, and your lungs, and thereby they are reminding you to take some good deep breaths throughout your life, at every opportunity that you remember about the breathing, because breathing is going to help you with anxiety, with anger and with rebalancing. Notice how these waters are coming down. They are busy penetrating your digestive tract, your gut, so that your gut learns to be relaxed and to digest your food nicely and properly. Unlike the way we digest our food when we're all stressed out. Notice how these beautiful waters are coming down and are busy relaxing your waist and your hips. Loosening up your waist and hips. They are busy relaxing your thighs. And as from the knees down, you are anyway inside the waters. Feeling nice and relaxed".

The hypnosis itself

And now, I'd like to invite you, to go on a beautiful journey that will lead you into a very beautiful, special place. An **'inner safe space'** that exists within the very depth of your being. A place where you always wish to be in, a place of your dreams. In this special place you will meet a very special part of yourself, a part that I will be referring to as your **'inner strength'**. And, in order to get there, you are going to need to go down

ten stairs. If going downstairs is okay for you, please can you give me a nod of the head. Thank you. You are now standing at the top of your staircase. And I'm not quite sure what your staircase looks like within your own eyes. I am not sure if it has a Victorian style or a modern style. I am not sure if your staircase is made out of marble, wood, metal or maybe it is carpeted. I am not sure if there is a rail next to your staircase or not. That's all up to you. And, with each and every step that you're going to take down, allow yourself to become as comfortable as you wish to become ... and as happy as you wish to become….

So, let's go down to stair nine … down to eight … down to seven … down to six … You may be feeling more relaxed. Your body may be feeling heavier. Down to five … four … three... two … one. Careful. It's your last step and off you go.

And now you're standing in front of a very beautiful gate. When you open the gate, you have arrived at the most beautiful place of all. And I'm not quite sure, Kay, if you are by the sea-side or by some mountains and waterfalls. Or by a beautiful garden. Or in a forest or field or in your own bedroom, or perhaps you are at a holy site. Wherever you wish to be, that's okay. So, I wonder which is your safe space? You can answer me if you want to.

K: I am at a waterfall.

R: Ok, beautiful. You are walking around, you are looking at the beautiful waters coming down; the lake beneath them, the rocks all around, the greenery. You can smell the beautiful fresh smell of the place. You can hear the waters coming down and the birds tweeting. And as you are walking around there, you see something or somebody that's coming closer and closer to you. And when you look at it carefully, you notice that this is actually a part of yourself. A part of yourself that I will be referring to as your inner strength part. This, Kelly, is a part of yourself that has probably been

there since the moment of your birth. Even though, at times, it may have been difficult for you to feel it. That part is with you now. It's that part of yourself that has allowed you to survive and to overcome many obstacles in the past. Things like disappointments; hurts; sadness; shortcomings and problems. Things like, a challenging relationship with a mom and a gran. Things like stress from school. Things like social challenges and other problems, just as it helps you now to overcome obstacles wherever you face them today. So, maybe, Kelly, you would like to take a few moments of your inner time, to get in touch with that part of yourself. And you can notice what images or feelings; what thoughts; what bodily sensations are associated with being in touch with your inner strength part.

I am soon going to hand to you a piece of play-dough with which you can create for me the image of your inner strength. I will be giving you a few examples to see what your inner strength looks like within your own eyes. You can either use my one of my examples, or you can make up your own. When you've done creating it, you can just hand it to me. So, as you're sensing the playdough, its temperature; its texture, I am going to give you a few examples. If, for instance, you could have seen your inner strength part, it might be an image of yourself looking strong and in control. It could be a family member; or a friend that you associate with being strong and in control. It might even be someone that has passed away already. It could be a religious figure; a friendly animal; or even a ball of light. Or, alternatively, your inner strength might be something that you feel, such as a warm or tingly feeling in the body. It could be something from nature, like a tree, a rock, the sun. It could be a character from Walt Disney.

So, take a few moments of your inner time now, Kelly, to find out who or what your inner strength is for you. Or, what form or symbol it takes. And when those images, or thoughts, or feelings or bodily sensations are clear to you, you can just create for me your inner strength.

R: And so, what is your inner strength for you?

K: Myself

R: And I wonder where, in your body, do you feel this inner strength coming through the most? Do you feel it the strongest coming from your heart; your chest; your face; your hands; your legs?

K: From my chest.

R: Okay.

You can now put your two hands on your chest, and you can sense your inner strength Notice how it's getting deeper, taking roots, notice how it is spreading. And I wonder what colour is your inner strength through your inner eyes?

K: White.

R: Notice this whiteness. It is spreading; it is getting deeper, and it is there with you all the time.

So, from today onwards, Kay, should you, in future, wish to get in touch with your inner strength part, all you have to do, is to touch your heart just like you're doing now. People are not going to know what you are doing. They may be thinking that you are just scratching there. And you can do so at any time that you need to call upon your inner strength and its power. Whether it is before an exam; whether it is before encountering a person that you are nervous to encounter; whether it is before you are to fulfil a mission that you are not comfortable to fulfil.

All that you'll need to do is to consciously call your inner strength part, by thinking about it, or, even better, by touching your heart and, immediately you'll get in contact with your inner strength again. However, as you consciously call upon your inner strength by thinking about it, on an unconscious level, you will be pleasantly surprised how much more confidence you're going to have. How much less sadness you're going to experience. How much more inner peace you're going to have. How much less anger you will experience.

This is going to help you move faster from the side of the sand-tray that expresses the

loneliness, the sadness, the anger, the brokenness and the snakes which are in your life, as well as the fear from the school and the schoolwork. Your inner strength will help you overcome all of these challenges. Being in touch with your inner strength is going to get you faster to the 'other side', to a space where you can experience that freedom that you want, the carefree happiness that you wish to experience, without feeling any stress from society and school. (the followings are images from her sand tray) To be like that guy that fishes fish, who just enjoys his life. You will be able to be like those loyal dogs that don't judge and don't have resentment. You will able to experience true happiness. And you'll be able to connect better with the Creator of the world, just like you said you wish to do. And you'll be able to realize that you can fulfil your dreams. You have enough power inside you to help you do so.

The more you're going to practise these self-hypnosis techniques that I've just taught you, the more you're going to be able to get in touch with your inner strength and the more automatically it be will be there for you, to help you. And the more you'll realise your true strength.

I'd like now to ask your inner strength to come and whisper in your ear a solution to your anxiety problem, that you so wish to overcome. And when it's done doing so, you can give me a nod of the head. Thank you.

Are you prepared to share?

K: To enjoy whatever comes as it comes without stressing.

R: Nice one. Thank you.

I'd like now to take the opportunity to thank your inner strength for being there for you through thick and thin, and for allowing you to become the special teenager that you are today, the spiritual person that you are, the deep, insightful, sincere person that you are. A person who doesn't want to judge; who doesn't want to be angry, who wants to be connected to her G_D, who likes to spoil other people with her money. You are also a person who likes to focus on her work and do what is meant to be done. A

person who is goal-orientated so much so that you can even lift heavy weights and a person who is so persistent. Instead of allowing your life to make you bitter, your inner strength had allowed you to become the special girl that you are today.

I would like now to ask your inner strength, one last thing. If your inner strength could come and give you one affirmation that you can carry with you through life and get strength from. Something like: 'well done. I'm so proud of you' or 'there is no-one like you', or 'look what you have achieved' or 'look where you've come from and where you are now'. Anything like that. And if you're prepared to share it, please will you say it loud.

K: 'You've gone through so much. I'm proud that you never gave in'.

R: Nice. Beautiful. Beautiful.

I'd like now, to ask your inner strength to go where it is necessary for it to go and continue being there for you, Kelly, for the days and weeks and years to come.

And now, I'd like to ask of you to leave your beautiful space, knowing that you can go back there any time you wish, as it exists within the very depth of your being.

And now, you're going to go up the stairs again. Step one, two, three and four – feeling stronger and more rejuvenated; knowing that you can do it. You can achieve your goals. Step five, six, seven, eight. Feeling stronger, knowing that your dreams will come true. You are a fighter, and you will do it. Step nine and ten. Back in the here and now. And when you are ready, you can open up your eyes. But, please don't talk because the next step is coming now.

Hypnosis session 2: “If it’s to be it’s up to me”

This section was taken out

Hypnosis session 3

This section was taken out

Hypnosis session 4

“In the past, Kelly, when ships went into the sea, the at times got trapped in a storm. The wind would try to tipple them over from side to side. The ship and the travellers were in danger. The first thing that the captain had to do, was to through the anchor in the water, to stabilise the ship. In life we are the ship, we are on a journey, at times strong winds come and they threaten to push us over. Now we too possess an anchor. Try Kelly to interlock your fingers together so that your palms touch each other, that’s right…can you please tell me of an event in your life that made you feel strong and proud?

K: “Yes when I passed my exams with flying colours”.

R: “Ok. Good, focus on that for me and on the feelings and sessions it brings…have you got it?

K: “Yes”

R: “Now insert that empowering memory between your palms… Good”

From today on, should you feel like you need some grounding, strength and safety, all you would have to do is to create your anchor, put inside your memory of strength and you will be pleasantly surprised how much more strength you are going to have, how much more stability you will feel and that you will be able to believe in yourself that you can cope”.

APPENDIX I: KELLY'S ART

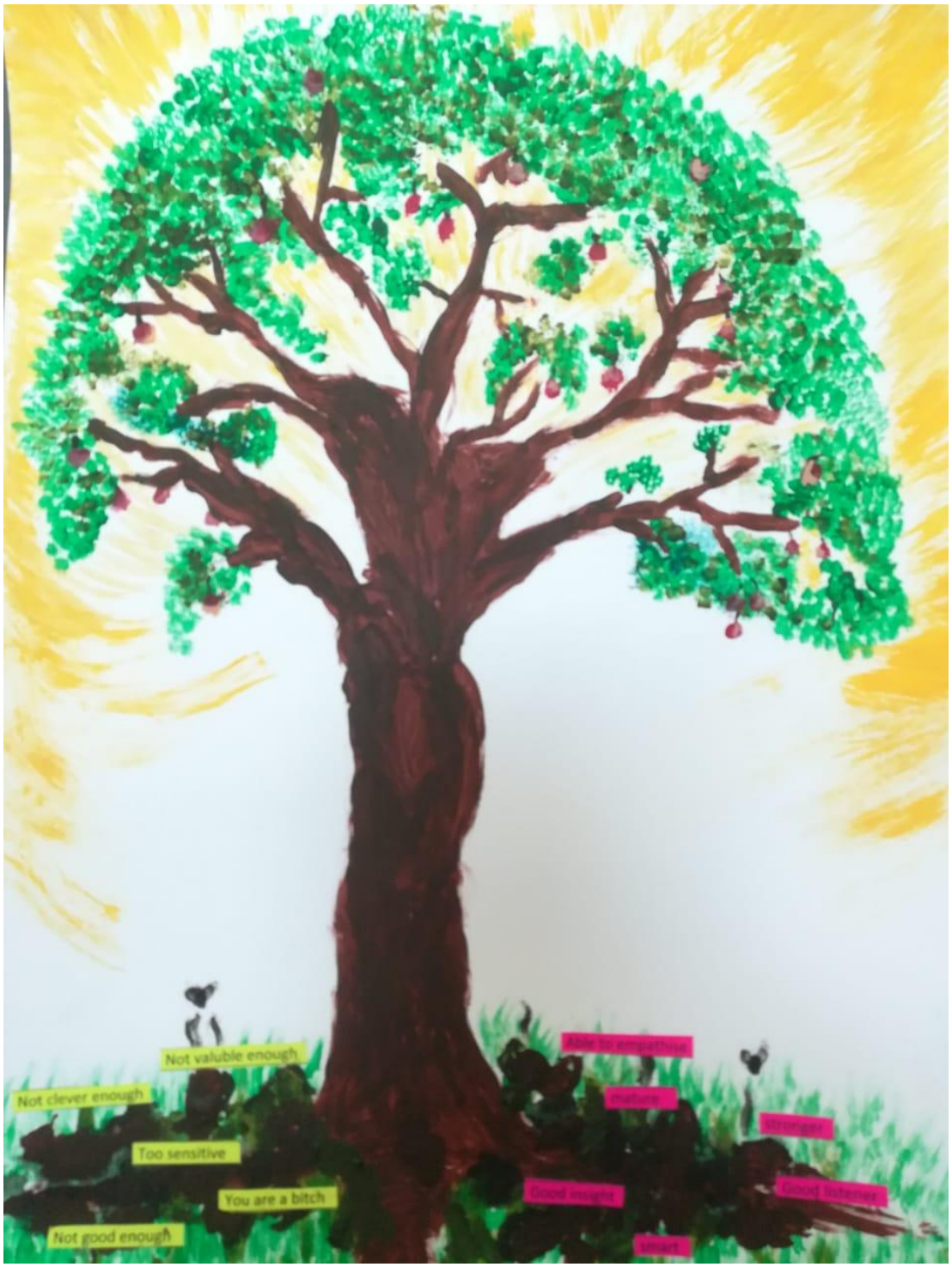
Kelly's sand tray

Kelly’s initial inner strength

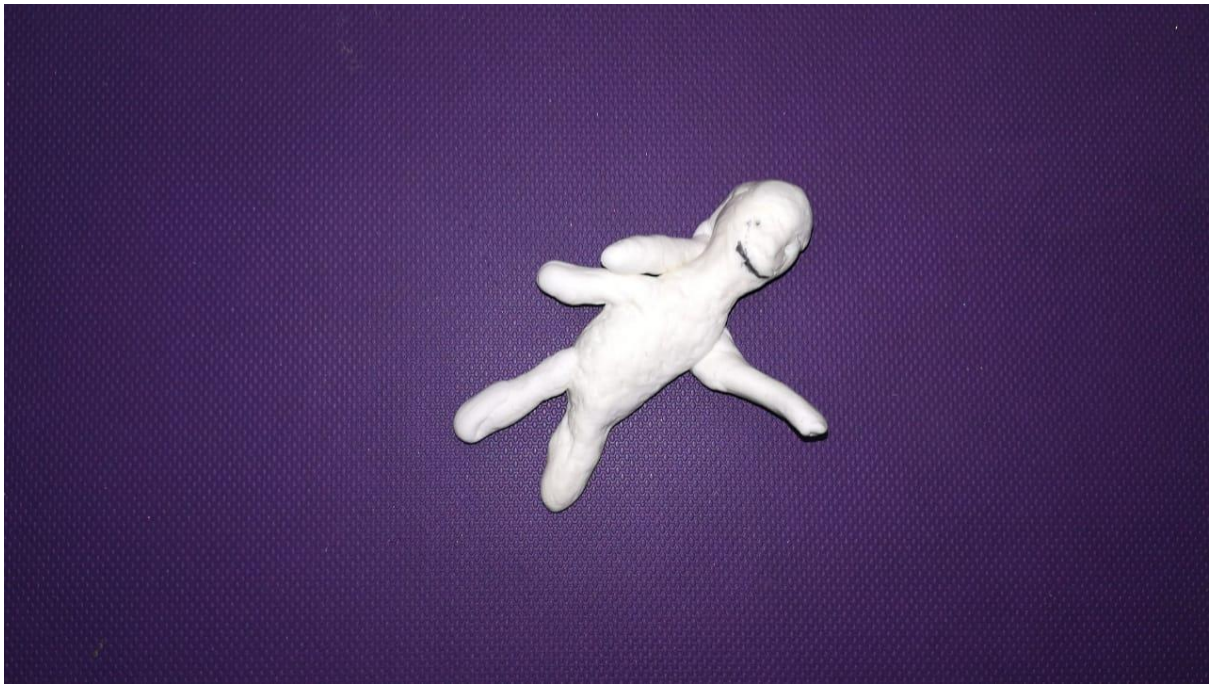
Kelly’s cup activity

Only one “cup activity” was inserted as the other two look the same from far.

Kelly's tree with the "Garbage and Manure"



Kelly's evolved Inner Strength



APPENDIX J: LUNA'S ART

Luna's Sand Tray

The initial Inner Strength

Luna's tree of "Garbage and Manure"

Luna’s evolved Inner Strength

APPENDIX K: RIVKI'S ART

Rivki's sand tray

Rivki's initial Inner Strength

Rivki's tree "The Garbage and Manure"

Rivki’s evolved Inner Strength

APPENDIX L: THE TREE OF LIFE

(done by another client for confidentiality purposes, as their hand-writing appears on the art)

APPENDIX M: THE LION KING VIDEO CLIP AND ITS INTERPRETATION

This video clip was extracted from the movie Lion King, is connected to the hypnosis session as it presents “Simba” the young lion in a state of despair. He then receives guidance from “Rafiki” the monkey who, to the researcher, represents Simba’s inner wisdom. Rafiki takes Simba to a place where he is exposed to Mufasa’s (his deceased father) energy, manifesting as a reflection in the water. To the researcher’s subjective understanding, the father represents Simba’s inner strength. The father encourages and pushes his son, in spite of Simba’s insecurities and feelings of guilt, to go and become a part of the “circle of life” by fulfilling his role and taking on the reign. This is a mission that only he, Simba could accomplish. It is interesting to note that both Simba’s “inner wisdom” and “inner strength” used the same words when rebuking him by saying: “you have forgotten who you are!”. And perhaps, you (name of client) also, somewhere along the way have forgotten who you are?