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## **Cinematherapy as a Clinical Intervention: Theoretical Rationale and Empirical Credibility**

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**CINEMATHERAPY AS A CLINICAL INTERVENTION:  
THEORETICAL RATIONALE AND EMPIRICAL CREDIBILITY**

CINEMATHERAPY AS A CLINICAL INTERVENTION:  
THEORETICAL RATIONALE AND EMPIRICAL CREDIBILITY

A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy in Counselor Education

By

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## ABSTRACT

Two problems must be addressed before cinematherapy can advance as a credible therapeutic intervention: (a) a solid theoretical rationale must exist supporting its use in mental health counseling, and (b) quantifiable data must exist promoting its treatment efficacy, and these data need to extend to various clinical populations representing a range of mental health conditions. This study intends to address both problems by critiquing the theoretical and experimental literature on cinematherapy and measuring the relative effectiveness of a structured, nondirective cinematherapy intervention at improving the hope and optimism of an adult diagnosed with Major Depression.

One person ( $N = 1$ ) was randomly selected from a group of depressed clients participating in a five-week cinematherapy intervention in which themes of hope and positivism were highlighted during the showing of the movie *The Lord of the Rings: The Fellowship of the Ring* (Osbourne & Jackson, 2001). Using a single-subject interrupted time-series design (Glass, 1997) the subject completed the Beck Hopelessness Scale (BHS; Beck & Steer, 1993) and an adapted sentence completion task for 11 weeks in order to assess the effect that the cinematherapy intervention had on the subject's perception toward the future (hope) and general disposition toward life (optimism). Data obtained during the treatment period were compared with non-treatment data obtained three weeks before and three weeks after the cinematherapy intervention. Results suggest that a theoretical rationale does exist for the use of films in counseling, and that a structured, nondirective group cinematherapy intervention is statistically and clinically effective at improving hope, and clinically effective at improving optimism. Implications for the practice of cinematherapy are discussed.

This dissertation is approved for  
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I would first like to acknowledge my wife for her support and encouragement as I completed my doctoral education. Without her motivation I would be still writing this paper today (I owe you so many back-rubs). So, how about eight more years, my love? Then, forever!

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Finally, a personal acknowledgment is due to God, because resiliency is not innate, and to myself...

## DEDICATION

This dissertation is dedicated to my daughter; Morgan McKenzie Powell, whom my wife and I recently brought into this world. Her arrival was the best thing that ever happened to us.

Baby, I love you so much and cannot imagine existing without you. You are so wonderful, and changed my life. I am a better person because of you, and am looking forward to watching you grow and develop into a wonderful woman like your mother. May God bless you all the days of your life.



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## CHAPTER ONE: THE PROBLEM

Cinematherapy is growing in recognition, but its clinical utility and therapeutic effectiveness has been called into question (Portadin, 2006). These reservations exist because cinematherapy maintains a weak foundation, theoretically and empirically.

First and foremost, no clear theoretical rationale exists that supports using motion pictures in a creative therapeutic manner to facilitate insight and change (Portadin, 2006). The only clear principal seems to be cinematherapy's general intent: (a) assign a client a movie that portrays his or her life, (b) help the client identify with the characters and gain understanding into the problem, and (c) learn from the character's mistakes and/or good decisions, and acquire strategies that encourage resolution of the problem (Berg-Cross, Jennings, & Baruch, 1990; Dermer & Hutchings, 2000; Foster, 2001; Sharp, Smith, & Cole, 2002; Wedding & Niemiec, 2003). Why cinematherapy works and how it works remains uncertain.

Second, a limited amount of empirical data exists supporting the use of cinematherapy. Most of the literature is anecdotal or qualitative in nature (e.g., Bierman, Krieger, & Leifer, 2003; Christie & McGrath, 1987; Hesley, 2001; Peske & West, 1999; Suarez, 2003), while only three are experimental (Adams & McGuire, 1986; Jurich & Collins, 1996; Powell, Newgent, & Lee, 2006). This scarcity of empirically-supported data is problematic, because recent social and legislative appeals suggest that professionals in the counseling community employ experimentally-validated methods and interventions in their work as a way to ensure professional accountability and best practices (Mental Health America, 2006; Wendt, 2006). At this time, cinematherapy's empirical support is too limited to be considered experimentally-validated.

Last, it is difficult to convince stakeholders of the therapeutic usefulness of creative interventions with poor empirical credibility. In fact, federal subsidiaries (e.g., Medicaid) and health maintenance organizations (HMOs) restrict the presence and payment of services where creative therapeutic tools like cinematherapy are practiced (Levant, 2005). As a result, counselors are left to defend their craft. As is the case with cinematherapy, the defense consists of no clear theoretical rationale and limited experimental data supporting its use. Therefore, a challenge exists for counselors to add credibility to the practice of cinematherapy.

#### Statement of the Problem

Taking into account the theoretical and empirical limitations of cinematherapy, it is clear why the clinical value of the intervention would be contested. Until an apparent theoretical rationale is established and additional experimental data is collected on different samples experiencing various mental health related conditions, cinematherapy will not advance as a credible therapeutic intervention in an empirically-driven society (Levant, 2005; Mental Health America, 2006).

#### Significance of the Study

This study intends to accomplish two fundamental goals in order to support the use of cinematherapy in counseling: (a) to provide a clear theoretical rationale for the use of film and popular movies in counseling to generate insight and change, and (b) to provide additional experimental data that supports cinematherapy as a viable therapeutic intervention, namely, by measuring its clinical effectiveness with an adult diagnosed with Major Depression.

## Assumptions Underlying the Study

Several underlying assumptions exist for this study. First, it is assumed that the impact that a cinematherapy intervention can have on an individual's mental health and behavior is measurable. Second, it is assumed that the participant engaging in the investigation is representative of individuals struggling with Major Depression, and that the responses provided by this person on the selected self-report measurements are an accurate indication of her level of hopelessness and optimism each week. Finally, it is assumed that the variance accounted for during statistical analyses is due to the cinematherapy intervention and not other confounding effects.

## Research Questions

- RQ1: Does a clear theoretical rationale exist for the use of film in counseling?
- RQ2: Is a structured, nondirective cinematherapy intervention effective at decreasing the hopelessness of an adult diagnosed with Major Depression?
- RQ3: Is a structured, nondirective cinematherapy intervention effective at improving the optimism of an adult diagnosed with Major Depression?

## Delimitations

Several delimitations exist within this study. First, the subject of this study is delimited to a 58-year-old adult patient diagnosed with Major Depression. Second, data collection instruments are delimited to self-report measurements. Thus, results rely solely on the subject's level of candor and disclosure at the time responses were given to items on each instrument. Third, the cinematherapy intervention is delimited to a three-hour movie applied within five group therapy sessions. Likewise, measurements are delimited to investigating the effect of a cinematherapy intervention for three weeks pre-treatment, five weeks during treatment, and three weeks post-treatment. Last, this study is delimited

to examining the impact of a cinematherapy intervention without additional psychotherapeutic interventions (e.g., individual or family counseling).

### Definitions and Operational Terms

For the purposes of this study, the following definitions and operational terms will apply:

1. *Cinematherapy* is a creative therapeutic intervention in which a trained professional prescribes a client the task of watching a movie and uses the characters and themes as metaphors to promote self-exploration and change (Berg-Cross et al., 1990; Sharp et al., 2002). For purposes of this study, cinematherapy was applied by dividing the film *Lord of the Rings: The Fellowship of the Ring* (Osbourne & Jackson, 2001) into five 45-minute segments and showing each segment across five structured, nondirective group therapy sessions where themes of hope and optimism are highlighted.
2. *Clinically significant decline* is a 25% decrease in a particular variable across time between a control and treatment group, or in a before vs. after study (Long, 2005). For purposes of this study, a clinically significant decline means that there is a 25% decrease in the level of hopelessness from pre- to post-treatment as measured by the Beck Hopelessness Scale (Beck & Steer, 1993).
3. *Clinically significant improvement* is a 25% increase in a particular variable across time between a control and treatment group, or in a before vs. after study (Long, 2005). For purposes of this study, a clinically significant improvement means that there is a 25% increase in the level of optimism from pre- to post-treatment as measured by an adapted sentence completion task.



4. *Credible therapeutic intervention* means that a treatment or technique has been shown through empirical support to be an effective clinical intervention for the remediation of mental health symptoms. For purposes of this study, a clinically significant improvement will support cinematherapy as a credible therapeutic intervention.
5. *Hopelessness* is defined as a negative view toward the short and long-term future. Adhering to Scotland's (1969) conception of hopelessness, Beck and Steer (1993) report that hopeless individuals are pessimistic, and perceive: (a) that nothing will turn out right for them, (b) that they will never succeed at what they attempt to do, (c) that their important goals can never be obtained, and (d) that their worst problems will never be solved. For purposes of this study, hopelessness is measured by the Beck Hopelessness Scale, with scores of 0 to 3 representing minimal hopelessness, scores of 4 to 8 representing mild hopelessness, scores of 9 to 14 representing moderate hopelessness, and scores of 15 to 20 representing severe hopelessness.
6. *Major Depression* is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) as a mental illness in which an individual experiences a depressive episode or loss of pleasure/interest in nearly all activities for at least two weeks, in addition to four of the following seven symptoms: (a) significant weight loss or gain, or decrease in appetite nearly every day, (b) insomnia or hypersomnia nearly every day, (c) psychomotor agitation or retardation nearly every day, (d) fatigue or loss of energy nearly every day, (e) feelings of worthlessness or excessive or

inappropriate guilt nearly every day, (f) diminished ability to think or concentrate, or indecisiveness, nearly every day, and (g) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. For purposes of this study, the person randomly selected to participate in this study has a clinical diagnosis of 296.33 Major Depression, Recurrent, Moderate with a History of Psychotic Features.

7. *Optimism* is a general disposition to expect the best in all things (WordNet, 2006). For purposes of this study, optimism is measured as an overall attitude toward life by an adapted sentence completion task.

#### Summary

The amount of experimental data on the effectiveness of cinematherapy is limited (Adams & McGuire, 1986; Jurich & Collins, 1996; Powell et al., 2006). As a result, empiricists such as Portadin (2006) have questioned whether counselors should be using this technique as a mental health intervention in their daily practices. This argument stems from the reality that most of the literature on cinematherapy is anecdotal or theoretical (e.g., Hesley, 2001; Peske & West, 1999; Suarez, 2003). Therefore, in order for cinematherapy to advance as a credible therapeutic intervention, additional experimental investigations measuring the effect of cinematherapy on various clinical populations representing a range of mental health conditions are needed. This study intends to investigate the use of cinematherapy by measuring the effect this intervention would have on the level of hope and optimism within an adult diagnosed with Major Depression following a five-week structured, nondirective group cinematherapy program.

## CHAPTER TWO: CRITIQUE OF THE LITERATURE

Evidence-based practices are becoming commonplace in counseling due to a recent societal petition for the helping professions to be accountable for the interventions they employ in the remediation of mental health disorders (Mental Health America, 2006; Wendt, 2006). This appeal is driven by federally funded programs (e.g., Medicaid) and health maintenance organizations (HMOs) that recommend experimentally supported explanations to validate therapeutic practices in order to receive payment (Levant, 2005). Consequently, methods and interventions that have long been used in counseling are getting scrutinized to ensure that they have an empirical foundation.

Likewise, newer interventions such as cinematherapy are criticized in the same fashion when the introductory literature fails to produce enough solid experimental evidence to support their use in clinical practice. For example, Portadin (2006) recently questioned the credibility of cinematherapy given that a limited amount of data exists verifying its therapeutic effectiveness. After a review of the literature, he stated:

The critical analysis of the [cinematherapy] literature led me to conclude that there is a lack of a rationale to support the use of film, a lack of a reasonable independent theory to support the use of film, an absence of outcome research to support the use of film, and an abundance of personal opinion that in and of itself is not enough to support the use of film as a new therapeutic practice (p. 140).

Portadin continued by suggesting to readers how they might go about enhancing the practice of cinematherapy, namely, by providing a solid theoretical rationale and more empirical data through experimental research designs.

### Method of Systematic Review

This study intended to address Portadin's (2006) concerns by first examining the literature on cinematherapy in order to determine if a solid theoretical rationale exists

regarding why and how cinematherapy works, and then critiquing its experimental history. To accomplish this, a comprehensive review was conducted in June 2007, January 2008, and later in June 2008 using the following databases: Ebsco Academic Search Premier, PsychINFO, ProQuest Direct, and WorldCat. The following keywords were used: “cinema,” “film,” “movie,” “motion picture,” “counseling,” “psychology,” “therapy,” “psychotherapy,” and “cinematherapy.” Each source was examined in an attempt to address Portadin’s concerns and ultimately support the premise that: (a) there is a clear rationale and reasonable independent theory to support the use of film in counseling, (b) there does exist some outcome research to support the use of film in counseling, and (c) although the abundance of personal opinion may not be enough, these opinions are based on years of clinical experience and case studies evidencing the effectiveness of film in counseling, which may be a more appropriate place to start when supporting the use of a newer intervention such as cinematherapy.

### General Background

The following sections include the early existence of films and therapy, movie-work throughout the 20<sup>th</sup> century, and current trends and special programs that document the use of cinematherapy for therapeutic gains.

#### *The Genesis of Movie-Work*

The use of motion pictures as an adjunct to psychotherapy began in the early 20<sup>th</sup> century with the advancement and availability of multi-media technology to the general population. Although the actual genesis of movie-work is unknown, a survey by Katz (1946) examining the application of films in psychotherapy revealed counselors at St. Elizabeth’s Hospital in Washington, D.C. were using movies for therapeutic gains some

20 years prior to his investigation. In fact, letters from personnel working at this facility and such places as the Naval Department, the Department of Veteran Affairs, and several other military psychiatric hospitals revealed that films were not only being used for therapeutic gains, but for their entertainment value and for educational, vocational, and inspirational purposes.

Among all the various gains obtained from early movie-work, Katz (1947) reported that “perhaps the most dramatic development along therapeutic lines was the use of motion pictures in connection with group psychotherapy” (p. 43). He theorized that movies were typically shown in group settings because of the reality that films afforded counselors the opportunity to affect several clients on an emotional level, simultaneously. This “mass audience” (Moreno, 1945, p. 7) was rather attractive to counselors who worked in settings such as military hospitals where several clients were available at one time (Rome, 1945). Perhaps the best example of the early application of motion pictures in group therapy is the Naval Department’s creation of several films that were successfully used to assist soldiers in understanding the incidence and effects of poor mental hygiene in the military (Katz, 1947; Rome, 1945). Some of the films included *Combat Fatigue: Irritability* (MacMullan, 1946), which portrays a seaman developing symptoms of depression after his crew’s ship is torpedoed; *Assignment Home* (MacMullan, 1947) which reveals some of the strains that neuropsychiatric patients face when returning to their jobs and school following a psychological discharge; and *An Introduction to Combat Fatigue* (MacMullan, 1945) which educated soldiers on the importance of identifying symptoms of traumatic stress. Films such as these were often used by Katz (1945; 1947; Rubin & Katz, 1946a; 1946b) during his own movie-work.

### *Movie-work in the Middle of the Century*

Motion pictures continued to be a useful tool with military personnel throughout the 20<sup>th</sup> century, but more importantly they were also becoming acceptable in general psychiatric facilities (Whitmyre, 1958). Although there is little literature documenting this use, a few examples do exist. For instance, Berman (1946) reported using 16mm motion pictures as entertainment in order to reward patients that exhibited tidy and compliant behaviors in both their individual and community rooms. Initially, he intended that patients who did not get rewarded would ultimately hear about the films and make the necessary changes in order to qualify. However, after several showings with the compliant group, Berman began to notice something entirely new. The movie viewings were helping patients on more than a behavioral level. They were helping emotionally. In fact, Berman noted that most patients became calmer than normal during the showings, they were more attentive and socially engaging with one another after the showings, and even referenced the films during therapy sessions by discussing how they identified with the characters and their problems. As a result, he removed the participation restrictions and allowed other patients to join the group, including those that were considered disturbed and unruly in order to see if the films would have the same effect on them. In the end, Berman observed that most patients were exhibiting progress in hygiene and compliance over time.

Similar observations were made by other counselors at this time. For example, Prados (1951) showed motion pictures to residents of a treatment facility for anxiety and psychosomatic disorders in order to instill insight about the physiological effects of fear. He found that patients were not only more educated about their conditions following the

viewing, but also less resistant to disclose personal material during therapy when focusing on the pictorial images rather than themselves. Likewise, Tucker, Lewis, Martin, and Over (1957) noted a broad range of behavior reactions following showings. Using closed-circuit television, they observed that patients who rarely communicated with anyone would have long conversations with the characters viewed on the television. In addition, patients were seen modeling social behaviors demonstrated on the screen by imitating the performers, and others would show signs of anticipation, excitement, and general activity when particular programs of interest were due to air.

Interestingly, Berman (1946), Prados (1951), and Tucker et al. (1957) all chose group therapy as the therapeutic modality for these movie interventions. In addition, their clients were psychiatric patients receiving some form of residential treatment. It was not until later in the 20<sup>th</sup> century that movie-work began to expand to include other therapeutic approaches and modalities.

#### *Movie-work at the End of the Century*

Just as the practice of cinematherapy was about to surge during a time of technological advancements that make employing cinematherapy more feasible, a few researchers had demonstrated how the use of popular movies could be an effective tool with youth for reducing resistance and generating therapeutic discussions. Unlike the approaches used by earlier counselors (Berman, 1946; Katz, 1947; Prados, 1951, Rome, 1945; Tucker et al., 1957), these documented interventions did not use a group modality to reach their clients, nor were the clients acute psychiatric patients. Rather, they were maladjusted youth receiving outpatient services.

The first documented case study in which movies were used with non-psychiatric patients was by Duncan, Beck, and Granum (1986). They used the movie *Ordinary People* (Schwary & Redford, 1980) to help teenage girls prepare for reentry into their homes and communities following group-home living. Shortly thereafter Christie and McGrath (1987) documented how they used the film *The Never Ending Story* (Eichinger, Geissler, & Peterson, 1984) to assist an 11-year-old boy with grief, adjustment, and an eventual adoption following his mother's suicide. Later, they documented using *The Karate Kid* (Weintraub, Louis, & Avildsen, 1984) to assist a juvenile with learning self-control and discipline (Christie & McGrath, 1989).

It was not until the landmark Berg-Cross et al. (1990) report, which coined movie-work as "cinematherapy," that the formal clinical practice of assigning popular movies to individuals experiencing general mental health disorders surged (p. 135). Cinematherapy became popular at this time, in part, because of the reality that Berg-Cross et al. were the first to develop and define the concept of movie-work so innovatively. In fact, by giving cinematherapy its conceptual name and operational definition, the intervention became universally recognized and accepted. Furthermore, Berg-Cross et al. were the first to tie the application of cinematherapy to that of another creative intervention; bibliotherapy, which has several decades worth of documented success (Wedding & Niemiec, 2003). Bibliotherapy involves the prescription of books to clients, which produces therapeutic gains similar to those of the prescription of movies (Manisses Communications Group, 1996). By connecting cinematherapy to bibliotherapy, counselors felt that they had a solid foundation from which to similarly use movies for therapeutic reasons.



It should be noted, however, that several mistakenly assume that Berg-Cross et al. (1990) were the first to use films in therapy, because of their landmark article and their assertion that cinematherapy owes its beginnings to that of Carl Menniger and his development of bibliotherapy in the 1930s (Hesley, 2001). However, just as Carl Menniger was not the first to use books as a therapeutic tool (Salup & Salup, 1978), Berg-Cross et al. were not the first to use movies in therapy (Katz, 1947). This mistake is understandable, however, since these studies (Berg-Cross et al.; Christie & McGrath, 1987, 1989; Duncan et al., 1986) are the only ones actually documented in the literature. It would not be surprising if a current survey conducted similar to that of Katz (1946) revealed that movie-work was more common at this time than the literature suggests. Nonetheless, according to a survey conducted by Lampropoulos, Kazantzis, and Deane (2004), the practice of cinematherapy continued growing. Among the 827 licensed psychologists that they surveyed, 67% reported using movies to promote treatment gains and 88% reported effective outcomes as a result.

#### *Current Trends in Cinematherapy*

Although there remains a paucity of literature documenting cinematherapy's various procedures and therapeutic properties, the literature has increased since the Berg-Cross et al. (1990) report. Unlike their early predecessors (Berman, 1946; Katz, 1947; Prados, 1951, Rome, 1945; Tucker et al., 1957), current mental health professionals appear to use motion pictures in a structured manner with specific populations for particular therapeutic gains. For example, Hesley (2000) explained how movies could be a vital brief intervention for encouraging positive psychological growth in an era of managed care. Dermer and Hutchings (2000) compiled a list of films that are effective

when conducting family cinematherapy. Bierman et al. (2003) suggested a number of films for use with adolescent girls in residential treatment. Suarez (2003) focused on using films in Christian counseling, and Peake and Steep (2004) recommend a list of movies that assists a practitioner in counseling the older couple.

This literature is not only limited to peer-reviewed journals, however. Several other resources are devoted to the practice of cinematherapy, including six general textbooks on the intervention (Hesley & Hesley, 2001; Solomon, 1995, 2001; Teague, 2000; Ulus, 2003; Wolz, 2005), three texts covering the incidence of psychopathology in the movies (Gabbard & Gabbard, 1999; Robinson, 2003; Wedding, Boyd, & Niemiec, 2005), one book on how cinema can help a counselor understand human development (Peake, 2004), two other texts on using cinema to transform lives and facilitate spiritual growth (Grace, 2005; Sinetar, 1993), and one website instructing helping professionals in appropriate movie selection (Wolz, 2002). Similarly, perhaps due to its growing popularity, cinematherapy has found its way into mainstream society due to such self-help gurus as Peske and West (1999) and their “popcorn cinematherapy” (Wolz, B., personal communication, January 24, 2008).

Furthermore, programs have been established to bring cinematherapy to those that otherwise could not normally benefit from it. In particular, individuals who receive long-term inpatient medical care or hospice are now able to enjoy the therapeutic effects of film in their hospital rooms. One such program; *MediCinema*, is a charity that brings “big screen therapy” to numerous patients in “purpose-built state-of-the-art cinemas” (Hill, 2006, p. 6). *Starlight* is another program dedicated to brightening the lives of terminally ill children via movies and other forms of entertainment, which aims to distract children

from the fear, pain and isolation they can feel as a result of their illness (Starlight Children's Foundation, 2005).

### *Movie-work Outside of Counseling*

Coincidentally, it is important to note that films and motion pictures are being used outside of the counseling and psychology community in a seemingly therapeutic way to produce professional gains. This includes such fields as medicine, law, and business for such purposes as instruction, healing, persuasion, and cognitive reconstruction. None, however, have used popular media and films for professional gains as much as education. Several examples exist, including: (a) Kelly's (1998) use of silent pictures to teach complex syntax to adult deaf readers, (b) Watson and Van Etten's (1977) use of films to teach and change attitudes about the incidence of childhood disabilities and the subsequent financial needs of special education programs, (c) Nugent and Shaunessy's (2003) use of motion pictures to train in-service teachers and graduate students about the needs and characteristics of the gifted, (d) Raingruber's (2003) application of films with advanced practicing nurses to enhance empathy and aesthetic behavior when working with patients, (e) Madan-Bahel's (2005) use of film clips to generate discussion and teach important concepts in a sexual health program, and (f) Stinchfield's (2006) use of movies to teach systems thinking.

### Theoretical Rationale

#### *How Cinematherapy Works*

Cinematherapy is more than simply watching a movie (Dermer & Hutchings, 2000; Foster, 2001). First, practitioners guide clients on how to view a prescribed film through a therapeutic lens so that they will metaphorically project themselves into the

assigned movie as though they were an actor experiencing the action on an emotional and cognitive level (Wedding & Niemiec, 2003). Next, during the viewing, it is theoretically intended that clients “identify with movie characters who face similar difficulties, find support and acceptance for their condition, deepen their emotional states, achieve catharsis, increase their awareness of the problem, get information, find solutions through vicarious learning, and prepare for action” (Lampropoulos & Spengler, 2005, p. 50). Then, following the viewing, it is anticipated that clients will ideally work through any significant psychological stressors with the counselor by processing how the material in the movie relates to their own personal lives (Sharp, Smith, & Cole, 2002).

The previous description of cinematherapy is one general procedure. According to Powell (2007), several other methods exist for the practitioner interested in using movies as an adjunct within psychotherapy. In fact, Powell is the first researcher to identify the various procedures one can employ when conducting a cinematherapy intervention. These approaches include how to apply cinematherapy in a nondirective or directive manner, in a structured or unstructured manner, and how the intervention can intend to teach, heal, persuade, generate insight, or restructure irrational beliefs. The following sub-sections rely heavily on Powell’s work at developing a framework regarding the various applications of a cinematherapy intervention. The applications are based on formal training and almost a decade of experience in providing cinematherapy, critical reviews of a number of documented cinematherapy case reports, and interviews with several leading cinematherapists.

*Nondirective vs. directive cinematherapy.* Kottler and Brown (2000) explain that directiveness involves one’s ability to influence individuals in such a way that they are

motivated to make positive changes. For example, practitioners using directive orientations may take initiative, set limits, structure sessions, offer suggestions, and assert their expert position so that positive therapeutic gains are possible (Powell & Newgent, 2008). Nondirective practitioners, on the other hand, prefer that the client take charge and direct the therapeutic movement. In regards to cinematherapy, practitioners can apply a cinematherapy intervention using either a directive or nondirective approach (Powell, 2007).

When using a nondirective delivery method, the practitioner only processes with the client the metaphors found within the film (e.g., characters, plot, dilemmas) and refrains from connecting the information to the client's life. Rather, it is intended that the client will make that connection on his or her own, and bring whatever he/she choose to the table for discussion. A directive practitioner, on the other hand, helps facilitate that connection by pointing out with the client similarities between both the movie and his/her own life (Powell, 2007).

*Structured vs. unstructured cinematherapy.* According to Kerr (1986), structured counseling sessions are those in which the counselor presents or decides ahead of time what topics and issues need to be discussed. Essentially, structured counselors have an agenda, or use particular techniques for the purpose of obtaining a particular outcome.

Structured cinematherapy sessions are similar. The cinematherapist using this approach intends for clients to process particular parts of a movie, because he/she believes that those specific clips will have the most powerful therapeutic properties for a given client (Powell, 2007). For example, this style would suggest that clients who have relationship troubles should be cognizant of relationship themes in a movie and be

prepared to discuss them afterward. In contrast, an unstructured cinematherapist will let the client decide which clips were most important, and process whatever the client feels like discussing, whether it involves relationship issues or not.

*Integrative delivery methods.* Another functional thing about cinematherapy is the fact that a counselor can combine the previous delivery methods to fit with their personal approach to therapy. For example, an individual can provide an *Unstructured Nondirective* method, meaning a counselor would refrain from having an agenda or informing the clients about particular themes and refrain from directing the clients during the viewing about how the material resembles their own lives. Other examples would be: (a) an *Unstructured Directive* method, which involves letting clients choose what clips were most important, but helping them connect how the material might metaphorically relate to their own lives, (b) a *Structured Nondirective* method, which means the counselor informs the clients about what themes are most important to watch for, but letting them connect the material to their own lives, and (c) a *Structured Directive* method, which means that a counselor picks the themes and helps direct the connection of cinematic material to the clients' lives (Powell, 2007).

*The psychoeducation approach.* Although the term cinematherapy was not coined until 1990 by Berg-Cross et al., films have been used by the U.S. military since the early 20<sup>th</sup> century to educate soldiers about the detection, prevention, and treatment of mental illnesses (Katz, 1946). Short films and documentaries were used specifically to help veterans identify any potential symptoms they might be experiencing and how it was crucial for them to seek subsequent help. This approach continues to exist, for example, if a practitioner assigns a movie such as *Stepmom* (Roberts, Sarandon, Porter, & Columbus,

1998) to a family in order to help educate them about the potential difficulties of divorce and blended families (Powell, 2007).

*The healing approach.* There are several documented cases of military and state hospitals using films to treat mental illnesses in veterans and residential patients (Katz, 1946). Some of the treatments were found to have a negative effect, particularly, in cases where staff showed veterans with Post Traumatic Stress Disorder extremely graphic and violent war scenes. The theory was that exposure to war and violence on the screen would help desensitize patients to their own war trauma. It actually helped perpetuate anxieties instead, especially when no debriefing occurred following the viewing of each film. Other cases, however, document movies used in a positive and humorous way to relax patients and distract them from their ailments or trauma. Today, a counselor may use this approach in the same manner when asking a client to view an entertaining movie as a momentary escape from his or her stress/grief (Powell, 2007).

*The insight approach.* Similar to the psychoeducation approach, the insight approach intends for clients to obtain new information about a particular issue. However, insight is more than just information. It implies action, and that a client has new understandings about a problem and potential solutions (Carlson, Watts, & Maniaci, 2006). Thus, the insight approach intends for a client to gain clarity into a problem and obtain new possibilities in order to apply action and change. A cinematherapist would use this approach, for example, in order to teach kids how to handle a dispute with friends by asking them to watch characters in a popular movie use both healthy and unhealthy dispute resolution strategies. Then, the children would be asked to compare their own

conflict resolution skills to those demonstrated on the screen before developing a plan of action to solve their own peer conflict (Powell, 2007).

*The persuasive approach.* Movies are a powerful medium (Hebert & Neumeister, 2001) that can “persuade in multiple ways on multiple levels” (Gass & Seiter, 2003, p. 320). One way, according to Gass and Seiter, is by promoting Western values and popular culture within and outside the United States, by modeling appropriate and inappropriate social behaviors, and by fostering stereotypes. Another way is as propaganda to change peoples' minds and propel political and cultural shifts (Severin & Tankard, 1997). A third way, which is most salient and congruent with cinematherapy, is the fact that movies can persuade by promoting viewer identification. Gass and Seiter illustrate this concept, by stating:

Sometimes the story of the character overlaps with the viewer's own experience, causing the viewer to identify with the character in the film. [For example] many older veterans who saw action in World War II found it easy to identify with the characters in the movie *Saving Private Ryan*. Like Matt Damon's character, Private Ryan, they too had survived the war, but lost good friends in battle. In many ways, the film's story was also their story. In this way, movies establish a common bond with viewers (p. 322).

Gass and Seiter continue by suggesting that viewer identification can occur even if the viewer's experience does not directly overlap with the characters' lives. In fact, they suggest that even though no-one has met an extraterrestrial, individuals can still identify with the movie *E.T.* (Spielberg, Kennedy, Mathison, Spielberg, & Randall, 1982), because most people know what it is like to say good-bye to someone close to them.

In the case of counseling, films can be used as persuasion to restructure irrational beliefs, open minds, and assist clients to view a particular issue in new ways (Powell, 2007). Examples might be changing beliefs regarding gender roles and racial



discrimination, or simply helping children appreciate and respect the role of their teachers. An example given by Powell includes having children watch an episode in *Boy Meets World* (Kelly & Trainer, 1993) in which the main character complains to his instructor that teachers have it easy while students have it rough. In the episode, the teacher decides to bet the student otherwise by letting the student assume the role of a teacher for a week. As one might expect, the student-teacher has a difficult time getting control of his class, and soon realizes how difficult it is for his teacher to educate a classroom full of disruptive students. Ultimately, he has a new found appreciation for educators.

*The prescriptive technique.* The prescriptive technique, which evolved from that of bibliotherapy and is still used today in outpatient and school settings, is most often associated with cinematherapy (Sharp et al., 2002). Similar to a self-help approach proposed by Norcross (2006), this technique involves assigning clients the task of watching particular movies outside of the counseling session as homework, while a review of the material and movie content gets processed at a later session. An example by Powell (2007) is having a family of a gifted child view at home the movie *Searching for Bobby Fischer* (Horberg & Zaillian, 1993) and asking them to notice how abnormal the main character felt as a result of his gifted abilities, how pressured he was by his father to succeed and be the best chess prodigy in history, and the ultimate consequences of both.

*The guided viewing technique.* Coined by mental health professionals working in a residential facility, “guided viewing” is an in-vivo approach (Hebert & Neumeister, 2001). Rather than asking clients to view a film on their own as homework, both the practitioner and the client watch the movie or particular film clips together so that the

practitioner can assist the client with therapeutic growth at the moment the potential growth can occur. An example would be having a group of teenagers watch *The Breakfast Club* (Hughes, Tanen, & Hughes, 1985) during a group session in order to help them work through problems with peer pressure, learn self-acceptance, and resolve any interpersonal conflicts that might arise between the group members. Plus, as important issues come up during the viewing, a counselor can address them before the therapeutic effect and emotional atmosphere is lost.

#### *Cinematherapy Guidelines*

It is important to realize that not all films make suitable interventions. Similar to how early 20<sup>th</sup> century Navy films that depicted violent and graphic war scenes intensified trauma symptoms in war veterans (Katz, 1946), some popular films may actually have a negative effect on clients. Thus, not all clients will benefit from a cinematherapy intervention (Powell, 2007). Due to potential harm, it is imperative that a counselor first understand the appropriate guidelines when choosing and prescribing a movie before attempting to conduct cinematherapy.

Dermer and Hutchings (2000) outlined several steps that need to be considered prior to the use of a cinematherapy intervention in family therapy. These guidelines involve four phases: (a) an Assessment phase, (b) a Preparation phase, (c) an Implementation phase, and (d) a Processing phase. Powell (2007) adapted the guidelines to fit the general adult and child clinical population, and a thorough explanation of each phase can be found in Appendix D.

### *Why Cinematherapy Works*

Maratos (2006) defines power as the catalyst that brings about change. In cinematherapy, the therapeutic power is the focus on metaphors. Metaphors are “a figure of speech in which a word or phrase literally denoting one kind of object or idea is used in place of another to suggest a likeness or analogy between them” (Merriam-Webster’s Online Dictionary, 2008). A straightforward example might be the statement, “The soldier was as a lion in battle” (Inkson & Amundson, 2002, p. 99). The metaphor in this example is the connection between the soldier’s behavior and character in the midst of a war with that of a strong and courageous lion. Hence, in cinematherapy, metaphors found in films suggest a likeness between the characters and behaviors on the screen with that of a client and his or her lifestyle.

Metaphors can be a powerful source for change and an indispensable tool in therapy (Aten, 2004; Bailey, 2003; Sims, 2003), particularly because they are a nonthreatening way to explore one’s lifestyle and develop insight (Breen, 2005). Metaphors can indirectly foster open dialogue about personal matters that clients tend to avoid when feeling uncomfortable (Nadeau, 2006; Wedding & Niemiec, 2003), and make difficult concepts easier to understand (Rattray, 2004). By employing metaphors, counselors can use circuitous language to facilitate growth and cognitive restructuring in a creative and noninvasive manner (Sharp et al., 2002), so that “positive therapeutic movement may be accomplished” (Tyson, Foster, & Jones, 2000, p. 35). Furthermore, metaphors can provide a less threatening platform for confronting difficult material, which can be particularly useful for clients that are resistant, in denial, or have limited

insight. According to Oaklander (1997), it is sometimes easier to respond to a metaphor than to real life.

Gafner and Benson (2003) portray metaphors, metaphorically, as bridges by which changes in thinking and feeling can occur in therapy. However, according to Heston and Kottman (1997):

For a therapeutic metaphor to work, the counselor must find a balance between the obscure and the obvious. The parallels between the client's situation, relationships, self-perception, and those of the protagonist of the metaphor must be clear enough so that the client can make the "bridge of personal connection." However, the parallels need to be indirect enough so that the client is less likely to be resistant to the perspective presented by the metaphor than he or she would be if the counselor had directly conveyed information, suggestions, or interpretations about the client's life (p. 94).

This approach is key in such interventions as cinematherapy, because similar to those in stories, myths, and fables (Hesley & Hesley, 2001), a film's metaphors can captivate the imagination and indirectly suggest new possibilities toward healing, no matter the age of the viewer (Marvasti, 1997). Indeed, Noctor (2006) reports that metaphors have been found useful with children by helping them make sense of seemingly difficult emotions and real-world experiences, and Burns (2005) acknowledges that adolescents are influenced by metaphors, too.

The fact that metaphors are influential is perhaps a good reason why youth are constantly inundated with persuasive images from such mediums as popular movies, commercial advertisements, TV, and music videos (Severin & Tankard, 1997). Gass and Seiter (2003) state, "Images have the power to move us in ways that words can't" (p. 310). In regards to film, Hebert and Neumeister (2001) purport that movies are a "powerful medium in contemporary society" (p. 225). In fact, Hollywood films are the biggest cultural export for America (Hey, 2001). Films are highly persuasive, and have an

inherent ability to induce strong affective/cognitive movements in the viewer through the power of metaphor (Calisch, 2001). As a result, Gass and Seiter (2003) report that cinema is classified as a type of social persuasion, particularly, visual persuasion, which can be a powerful avenue for influencing individuals intentionally or unintentionally.

### Research Critique

Although a clear rationale has been established regarding the use of film as metaphor to induce therapeutic gains, in addition to documentation of a number of case studies evidencing its effectiveness over the years, Portadin (2006) pointed out that no experimental data exist that empirically supports the use of cinematherapy. Actually there are three articles that document the therapeutic effect of a cinematherapy intervention, and interestingly the articles span the past three decades and were published exactly ten years apart (Adams & McGuire, 1986; Jurich & Collins, 1996; Powell et al., 2006).

#### *The Effects of Humor on Pain and Affect*

Adams and McGuire (1986) measured the effect that viewing humorous movies would have on the pain and affect of elderly residents living in a long-term care facility. Although a number of residents participated in the treatment, only 13 people were used for statistical analysis. This consisted of two groups; a humorous treatment group ( $n = 7$ ) and a nonhumorous treatment group ( $n = 6$ ). Residents were asked to view popular movies of their generation in 30-minute segments for three straight days over the course of six weeks. Self-report measures were taken each week on the perceived level of chronic pain and level of affect balance (feelings toward life) experienced by the participants, in addition to observations of the amount of nonscheduled pain medications given by staff nurses. Baseline scores were taken two weeks prior to the study, and it was

hypothesized that the humorous treatment group would report statistically less pain and greater affect balance than the nonhumorous treatment group.

Results from self-reports on level of experienced pain indicated that residents in both groups felt less pain following the viewing of the movies. Examination of medical charts confirmed that every member of the humorous treatment group required less nonscheduled medications. However, the nonhumorous treatment group had mixed data. Some residents, although using less nonscheduled pain medications, continued to use significantly more than the humorous treatment group participants. Results from self-reports on affect balance revealed no statistically significant between-group differences at pretest (Mann-Whitney  $U = 20.5$ ,  $p = .94$ ), but the groups had statistically significant within-group differences at posttest ( $p = .04$ ) and statistically significant between-group differences at posttest ( $U = 14.0$ ,  $p = .08$ ).

Residents in this study were psychologically dependent on pain medications and had little optimism toward life at pretest, but following the study they all reported increases in affect balance and less need for nonscheduled pain medications by viewing popular movies of their generation. This finding is crucial information, because the results suggest that individuals can receive therapeutic gains just by viewing enjoyable films. Unfortunately, Adams and McGuire (1986) did not detail if additional therapies that are part of the residents' normal daily routine (e.g., occupational or physical therapy) were used in addition to the movie-work. If the residents participated in other therapies, then the internal validity of this study is threatened, because it is possible that the combination of therapies was the ultimate factor that contributed to the decrease in pain

and increase in affect balance. Nonetheless, the study still empirically supports the use of films in therapy.

### *The Effect of Popular Film on Self-Esteem*

Jurich and Collins (1996) measured the effect that viewing popular teenage movies would have on the level of total self-concept of adolescents participating in a 4-H program. Forty teenagers participated in the study (25 females and 15 males; 31 Caucasian and 9 Hispanic), which consisted of viewing one popular teenage film each week for six weeks, with an hour and a half long group discussion following each weekly showing. The Tennessee Self-Concept Scale was given to each participant at pre/post treatment, which is a 100-item, five-point Likert scale instrument measuring respondents on ten subscales: Total Self-Concept, Self-Criticism, Identity, Self-Satisfaction, Behavior, Physical Self, Moral-Ethical Self, Personal Self, Family Self, and Social Self.

Jurich and Collins (1996) hypothesized that the viewing of popular films depicting typical teenage behavior/experiences would be a valuable aid for generating open discussion and self-disclosure, which would ultimately improve participant overall self-concept. Using a paired *t* test, results indicated that the adolescents statistically improved from pre to post-test on Total Self-Concept ( $t = 7.53, p < .001$ ), Self-Satisfaction ( $t = 11.84, p < .001$ ), Family Self ( $t = 9.47, p < .001$ ), and Social Self ( $t = 11.40, p < .001$ ). No other subscales were statistically significant.

Participants in this study reported increases in several areas that affect overall self-concept by viewing and discussing popular movies that depicted and illuminated their typical lives and daily experiences. Although the intervention was not labeled as cinematherapy, per se, the movie-work provided by Jurich and Collins (1996) illustrates a

useful cinematherapy intervention. Essentially, the teens reported psychological gains via movie-work. This information is crucial, too, because similar to the Adams and McGuire (1986) report, the results suggest that individuals can improve from the viewing and discussing of popular movies that relate to one's personal life. The only limitations from this study were that: (a) the participants were not compared to a control group consisting of peers that did not receive the treatment, (b) participants were well-adjusted teenagers who did not get compared to maladjusted youth, and (c) follow-up measures were not taken to assess how long the effect would last post-treatment.

#### *The Effect of Cinematherapy on the Self-Esteem of SED Youth*

The Jurich and Collins (1996) report was influential in the experimental work of Powell et al., (2006), because these authors were also interested in the effects of popular movies on self-esteem. However, Powell et al. investigated to what degree a cinematherapy intervention coupled with group therapy could affect teenagers who were diagnosed as seriously emotionally disturbed (SED).

Using 16 adolescents enrolled in a six-week coping skills group (8 male and 8 female; 12 Caucasian and 4 Non-Caucasian), Powell et al. (2006) randomly placed each youth into one of three groups. Group 1 received the six-week coping skills treatment with an additional cinematherapy intervention during the first three weeks, which consisted of watching segments of the film *Fat Albert* (Cosby & Zwick, 2004) in each session and referring to the movie during the final three weeks; Group 2 received the six-week coping skills treatment without the cinematherapy intervention; and Group 3 received the six-week coping skills treatment with an additional cinematherapy intervention, but only during the final three weeks of the study, which limited this



group's ability to refer to the movie as Group 1 could do. Each participant completed a brief 10-item self-esteem scale at pre-test, post-test, and one-week follow-up. It was hypothesized that Group 1 would report statistically significant differences in state self-esteem than Group 2 and Group 3. Results indicated that no statistically significant differences existed between the three groups at pre-test, post-test, or one-week follow-up. However, meaningful information was found within the groups.

First, Group 1 almost obtained statistically significant improvement in self-esteem from pre-test to one-week follow-up,  $F(1, 5) = 4.23, p = .095, \eta^2 = .46$ , however, the sample size ( $N = 16$ ) was too small for the selected alpha level of .05. Consequently an alpha of .10, which would have been appropriate for this sample size, would have generated significant results. Sample size and a-priori alpha level are major limitations to this study.

Secondly, analyses for item 1 and item 2 of the self-esteem instrument revealed statistically significant effects for the trials,  $F(2, 10) = 5.38, p = .026, \eta^2 = .52$  and  $F(2, 10) = 6.43, p = .016, \eta^2 = .563$ , respectively, while contrasts showed that the pretest means on item 1 and item 2 revealed statistically significant differences to the 1-week follow-ups,  $F(1, 5) = 7.50, p = .041, \eta^2 = .60$  and  $F(1, 5) = 15.00, p = .012, \eta^2 = .75$ , respectively. This finding suggested that the cinematherapy intervention had a significant impact on specific areas of self-esteem, rather than overall self-esteem. A more comprehensive instrument such as the one used in the Jurich and Collins (1996) report would have been effective at measuring these specific areas.

Finally, within-group differences did not exist on any level for Group 2 and Group 3, while the former group's mean scores from pre-test to one-week follow-up

actually declined. This finding indicates that the coping skills treatment had little effect on the participants, whereas those individuals who had promising results benefited from the cinematherapy intervention.

Similar to the results obtained from the Adams and McGuire (1986) and Jurich and Collins (1996) studies, the information obtained from the Powell et al. (2006) study supports the claim that cinematherapy can be an effective therapeutic intervention. Although these three articles are the only experimental studies documenting empirical support for the approach, they are a great start in this age of empiricism. Plus, they are supported by a number of case reports that were reviewed in the general background section of this chapter. In fact, it will be argued in the next section that it is more appropriate to have a number of case studies before individuals attempt to gather experimental data on the effectiveness of an intervention, especially in the case of a fairly new intervention such as cinematherapy.

#### Research Agenda

Portadin (2006) proposed that it is best practice to only employ interventions that have enough empirical data supporting its use and validating its effectiveness. Subsequently, he explained that cinematherapy needed additional experimental data, because too much of its support came from personal anecdotes and case studies. Although he is correct in contending that an abundance of personal opinion may not be enough to support its use, it could be argued that these opinions are based on years of clinical experience and case studies evidencing the effectiveness of film in counseling, which may be a more appropriate place to start when supporting the use of a newer intervention such as cinematherapy.

Arguing against the use of cinematherapy may be just as presumptuous as Portadin (2006) would claim it is arguing for it. For example, considering its short lifespan, it seems imprudent to expect that such a young therapeutic tool would be clinically tested, replicated, and validated so quickly that the psychological community would support its use without hesitation. Plus, even if an intervention had several years of empirically-validated support, “Empirically-supported interventions do not guarantee success. The intervention must be validated locally through a direct demonstration of behavior change on part of the [person] in question” (Persampieri, Gortmaker, Daly, Sheridan, & McCurdy, 2006, p. 33). In other words, individual factors still play a large part in whether an empirically-validated intervention or treatment works. These factors could be from either the counselor or client (e.g., personality characteristics and one’s motivation to change).

Subsequently, formal research into the effectiveness of cinematherapy has been limited to case analyses and theoretical reports, because these designs were at the time more methodologically appropriate. According to Raudenbush (2005), qualitative research is a good place to start when little is actually known about a particular phenomenon. Qualitative data provide depth and meaning about a construct (Hatch, 2002), which is essential in the case of a newer therapeutic intervention such as cinematherapy. In fact, one could argue that the data obtained from early qualitative research into the dynamics of cinematherapy have actually strengthened modern investigations, first by establishing and defining its framework, and then by developing a theoretical rationale for its use. Operational definitions and theoretical underpinnings are the foundation of sound experimental research (Heppner, Kivlighan, & Wampold, 1999).

Therefore, empirical studies into the effectiveness of cinematherapy actually benefit from such pioneering data collected via personal anecdotes, case studies, and field observations.

Nonetheless, cinematherapy continues to be questioned as a legitimate therapeutic intervention. Therefore, additional empirical studies that measure its effect on a variety of clinical populations with a range of mental health conditions are needed to improve its therapeutic credibility.

#### Review of the Literature on the Instruments

To add credibility to the practice of cinematherapy, this study examined the impact of an intervention on an adult diagnosed with Major Depression. Particularly, it investigated the effect that a structure, nondirective group cinematherapy intervention had on this adult's level of hopelessness and optimism. Two instruments were used to measure these constructs. The first is the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, & Trexler, 1974). The second is a sentence completion task adapted from the Sentence Completion Series (SCS; Brown & Unger, 1992). This section reviews the literature on these instruments in order to support their use for this study.

#### *Review of the Beck Hopelessness Scale*

The BHS (Beck et al., 1974) is the most widely used and psychometrically sound scale for measuring hopelessness (Aish & Wasserman, 2001; Duberstein, Conner, Conwell, & Cox, 2001; Szanto, Reynolds, Conwell, Begley, & Houck, 1998). In fact, using the PsychINFO database and the keywords *Beck Hopelessness Scale* and *depress\**, over 300 articles of interest were generated evidencing this statement.

Based on this search, it turns out that the BHS (Beck et al., 1974) has been used to assess hope in various populations. This includes gay men (Purvis, 2008), women with HIV/Aids (Meacham, 1997), at-risk college students (Weber, Metha, & Nelsen, 1997), bereaved spouses of hospice patients (Atkinson, 1996), nonclinical adolescents (Moilanen, 1995), and individuals with drug abuse (Steer, Iguchi, & Platt, 1994). However, according to Beck and Steer (1993), the BHS is most successful as a measure of hope with the clinically depressed population (Beck & Steer, 1993). Especially when needing to screen for suicidal risks, because hopelessness, depression, and suicide ideation are all strong correlates (McMillan, Gilbody, Beresford, & Neilly, 2007; Oquendo, Giner, Friedman, Tardiff, Leon, & Marzuk, 2008; Webber et al., 1997).

Similar to the purpose of this study, it turns out that a few researchers have recently used the BHS (Beck et al., 1974) for measuring depressive symptomology following exposure to creative therapies. For example, Choi (2008) found by using the BHS that music therapy was an effective tool for improving hope in depressed individuals. Alladin (2007) used the BHS to discover that hypnotherapy coupled with cognitive-behavior therapy was more effective with depressed adults than cognitive-behavioral therapy alone, and Vlach (2007) found that expressive writing techniques did not improve hope in adults 18 years and older. Interestingly, all three articles attempted to empirically-support these creative interventions just as this study intends to do with cinematherapy.

#### *Review of the Sentence Completion Task*

A sentence completion task is a projective measure that requires respondents to complete unfinished sentences (e.g., *I want to...*; *My future is...*) in order to uncover

subjective thoughts and feelings that may not be expressed overtly to a test examiner (Gibb & Wales, 1990). Clinically, it is believed that the responses will delve into a client's subconscious and help a counselor safely explore whether any emotional turmoil may be contributing to his or her current level of functioning (Rogers, Bishop, & Lane, 2003). For purposes of this study, items were adapted from the Sentence Completion Series (SCS; Brown & Unger, 1992) in order to subjectively explore a participant's level of optimism, or general disposition toward life.

No literature exists regarding particular uses of the SCS in clinical research, however, sentence completions in general are common (Holaday, Smith, & Sherry, 2000). In fact, Holaday et al. reports that sentence completions are one of the most widely used forms of personality testing, and are often used in personality research. In a review of 15 popular sentence completion tests and a survey of members of the Society of Personality Assessment, Holaday et al. discovered that sentence completions were used in a number of ways with children and adults in both clinical and nonclinical settings. These included for establishing rapport, to obtain detailed quotes for treatment planning, for problem identification, to measure change over time, to assess written expression skills, and for general research purposes.

### Summary

Portadin (2006) recently questioned whether cinematherapy maintained a solid independent theory supporting its use, and whether there was enough experimental data to empirically-validate its treatment efficacy. The purpose of this chapter was to address his concerns by reviewing cinematherapy's theoretical literature and critiquing its scarce

experimental research history. It was determined that more empirical studies are necessary to improve the credibility of cinematherapy.

## CHAPTER THREE: METHODOLOGY

This chapter details this study's attempt to provide additional experimental data to support cinematherapy as a viable therapeutic intervention, namely, by measuring its clinical effectiveness with an adult diagnosed with Major Depression. The following topics are discussed: the research design, data collection procedures, participant, instruments, audio-visual aid, variable list, derivation of general and specific research hypotheses, statistical treatment, and limitations.

### Research Design

This study employs a single-subject quasi-experimental design referred to as an interrupted time-series design (Heppner et al., 1999). The defining characteristics of this design involves a researcher collecting multiple observations over time in order to monitor trends or changes in how a particular construct presents itself. For purposes of this study, the design is depicted as a single-subject A-B-A time-series design, with the letters A-B-A referring to the levels of treatment (McGraw-Hill Company, 2006): (A) self-report measurements were taken for three-weeks pre-treatment in order to establish a baseline, (B) the group cinematherapy intervention was introduced and additional measurements were taken for five weeks, and (A) another three weeks of measurements were taken for post-treatment analyses. This is also referred to by the McGraw-Hill Company (2006) as a reversal design, because a researcher removes the intervention following the treatment period to assess post-treatment changes. Removal is vital, because it is important to know whether participants' scores on a dependent variable stay the same without the intervention, or if they decline or move toward original baseline observations.



Several advantages exist when using a single-subject time-series design. First, single-subject designs “present a flexible and viable scientific methodology useful for counseling research and practice, regardless of theoretical orientation” (Lundervold & Belwood, 2000, p. 94). Namely, single-subject designs are sensitive to the demands of everyday practice (e.g., participant availability and time frames), and evaluate the process of a particular intervention as it is delivered, as opposed to just the outcome of the intervention on the participant. Plus with participants serving as their own control, which improves equivalence and strengthens validity, these designs can be a good start for new interventions that will rely on more stringent measures later during replication research aimed at improving the intervention’s generalizability (Sharply, 2007).

Second, this design provides researchers with a “flexible, yet systematic and intensive, way of introducing an experimental intervention and then ‘visually’ or graphically evaluating the subsequent impact (immediate or delayed, abrupt or gradual) of that intervention on some designated behavior or performance” (Levin & Wampold, 1999, p. 59). Similarly, by paying particular attention to the patterns on the graph and how the scores from multiple observations change over time, a researcher can pinpoint the precise moment or moments that the participant experiences change on a specific construct, and appropriate judgments can be made about an intervention’s effectiveness. According to Glass (1997), if the graph shows an abrupt shift in the dependent variable at the time an intervention was introduced, then this intervention is said to be the direct cause of any changes in the participant.

Third, a time-series study can provide stronger evidence for or against the effectiveness of a particular intervention, because change is viewed within a particular

context over time rather than solely at one particular instance (Kirk, 1995). Therefore, outcomes obtained from a time-series design can be more meaningful than data obtained from one-shot observations that occur in pre/post experimental designs that do not employ repeated-measures analyses (Newman, Newman, Brown, & McNeely, 2006). For example, a researcher that employs a one-shot pre/post design can report that change occurred post-treatment, but a time-series design will afford the researcher data on exactly when change occurred and how it looked throughout the course of the study. In fact, there are a variety of graphic illustrations of how time-series effects are depicted and described in Glass (1997).

Last, a time-series design is useful for assisting a researcher in accounting for threats to internal validity (Heppner et al., 1999). By viewing data over time, a researcher can identify potential maturational or historical confounds occurring prior to or during treatment commencement. These confounds are identified on a graph as abrupt shifts, which cannot be attributed to the effects of an intervention (Glass, 1997). Whereas in a one-shot pre/post design such threats are theoretically controlled for (although complete assurance to their control is never guaranteed and graphic scrutiny unavailable), confounds are exposable in a time-series design. Thus, a researcher can adjust for them during statistical analysis, if necessary, and essentially strengthen the overall power and test of effect (Glass, 1997).

## Procedures

### *Sampling Procedures*

One person ( $n = 1$ ) was randomly selected to participate in this study from a group of depressed clients ( $N = 8$ ) taking part in a structured, nondirective group

cinematherapy intervention. The participant was chosen using a simple selection procedure in which all group participants were given a single digit identification number, which was written on a strip of paper and placed into a hat. One number was then randomly pulled from the hat and the corresponding participant was given the opportunity to review the research proposal and sign the informed consent form before deciding to participate in this study (Appendix A).

### *Participant Background*

Jane Doe is the pseudonym of the 59-year-old, Caucasian female randomly selected to participate in this study. She was referred for group cinematherapy by her primary therapist to assist with depressive symptom reduction (hopelessness). Jane was diagnosed in 2008 by her psychiatrist with 296.23 Major Depression, Recurrent with a History of Psychotic Features.

Jane has been married for 35 years and has one son who lives in a town about one-hour away. Her husband is an accountant, and she works in his office doing filing and data processing. Prior to her first self-reported depressive episode in 2004, she worked as a receptionist for various companies. However, she started working with her husband so he could monitor her throughout the day because of severe symptoms, including suicidal ideation, failure to engage in positive social interactions, and paranoia/auditory hallucinations. Her current severity is moderate.

*Mental Status Exam.* Jane is a married, elderly woman with a thin build and curly brown hair who appears her stated age. She is casually and comfortably dressed, and no deficits in personal hygiene are noted. She is oriented to person, time, place and situation. She displays no signs of impaired reality testing, and appears to be of average

intelligence. Her immediate and remote memory appears intact. Her voice tone is soft, but her speech is comprehensible and does not appear to be pressured. Her thoughts seem to follow logical patterns, and she denies experiencing any hallucinations. There is no overt evidence of delusional processes. Her affect appears congruent to mood, which is reported as “hopeless.” No problems are reported with regard to appetite or weight. There is evidence of past and present suicidal ideation, but no evidence of a plan or intent for self-harm.

### *Instruments*

To assess the participant’s level of hope and optimism, two instruments were used. These include the Beck Hopelessness Scale (BHS; Beck & Steer, 1993) and a sentence completion task adapted from the Sentence Completion Series (SCS; Brown & Unger, 1992).

*Beck Hopelessness Scale.* The BHS (Beck, Weissman, Lester, & Trexler, 1974) is a unidimensional measure of pessimism or one’s negative view of the future, and chosen for this study due to its administration ease, brief properties, and readability. Originally designed for the depressed population, Beck and Steer (1993) report that the BHS “has a particular utility as an indirect indicator of suicidal risk in depressed examinees or individuals who have made suicide attempts” (p. 3). It has, however, also been used to measure the hopelessness of normal adult populations, and with adolescents as young as 13 years old (Johnson & McCutcheon, 1981; Topol & Reznikoff, 1982).

A 20-item measure, the BHS use a true/false rating scale with endorsed items = 1 and non-endorsed items = 0. Scores for all items are tabulated, and total scores of 0 to 3 indicating minimal hopelessness, scores of 4 to 8 indicating mild hopelessness, scores of

9 to 14 indicating moderate hopelessness, and scores of 15 to 20 indicating severe hopelessness. To decrease the likelihood of a response set, nine of the items are reverse keyed.

Items for the BHS were originally collected from two sources: (a) from Heimberg's (1961) test of attitudes about the future, and (b) from a pool of pessimistic statements collected from psychiatric patients who had described hopeless cognitions. The remaining statements were reviewed by several counselors until 20 items were found to have expert judge validity. In addition, several reliability and validity indices for various psychiatric populations have been collected over the years. For purposes of this study, five normative samples are of particular interest. These include data on 201 patients identified as Suicide Ideators, 499 patients identified as Suicide Attempters, 72 patients diagnosed with Single-Episode Major Depression, 134 patients diagnosed with Recurrent-Episode Major Depression, and 177 patients diagnosed with Dysthymic Disorder (Beck & Steer, 1993).

First, Kuder-Richardson (KR-20) reliabilities were calculated for each normative sample. Reliabilities were .92, .93, .92, .92, and .87, respectively. Second, concurrent validity was established for each depressed sample by examining correlations of the BHS with the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Correlations were .56, .56, and .64, respectively, and all were significant at the  $p < .001$  level. Finally, the predictive value of the BHS was studied by examining the eventual suicides among 165 of the patients in the suicidal subgroups. In a 5 to 10 years follow-up, and among the 11 patients who eventually committed suicide, 10 had initial BHS scores of nine or higher. When mean BHS scores between the suicide and non-

suicide groups were analyzed, results indicate that a significant difference between both groups existed  $t(163) = 2.33, p < .05$  (Beck & Steer, 1993).

*Sentence completion task.* A sentence completion task was used to help identify the participant's level of perceived optimism. The participant completed a modified seven-item version of the Sentence Completion Series (SCS; Brown & Unger, 1992) and three supplemental sentence completion items.

The SCS was developed to help counselors identify particular themes underlying an individual's concerns or areas of distress. The series consists of eight different self-report forms containing 50 content valid items each (e.g., My life as an adult...). The different versions include: adult, adolescent, family, work, marriage, parenting, illness, and aging. Only seven items were adapted from the SCS-Adult form, because these items were more likely to uncover themes of optimism due to their word content. Three additional items were added to those adapted from the SCS in order to directly assess the participant's view of the future, upcoming plans, and wishes. Cronbach's Alpha for the 10-item adapted sentence completion task is .93, while inter-rater reliability is .60.

#### *Audio-Visual Aid*

The motion picture *Lord of the Rings: The Fellowship of the Ring* (Osbourne & Jackson, 2001) was selected to be the audio-visual aid for this study. The choice to use this film is due to its themes of hope and recovery (Sandoz, 2006), but more particularly because of its portrayal of the main character; Frodo Baggins, struggling to overcome his limitations and discouragement, which prevent him from succeeding at his journey to save his world. In fact this "difficult journey" is a key metaphor for the study, because similar to that of the character Frodo, depressed individuals experience hopelessness and

discouragement as they attempt to overcome the mental health limitations that prevent them from experiencing optimal functioning and success in the world. It was intended that the participant would identify with this metaphor and gain hope from Frodo's determination to succeed and never give up, even when things seem impossible.

### *Group Therapy Procedures*

There were five group sessions during the treatment phase, which occurred during week four through eight of this study. During session one (week four), the first segment of the movie was shown to introduce the characters and build character identification. Similarly, trust building and introductions were covered with the group members in order to establish a group identity.

During session two (week five), another segment of the movie was shown, which portrayed the rising action and tragedy. The members began identifying with problem areas in the character's lives, and personal limitations and defeating behaviors were discussed by the group members.

During session three (week six), the climax of the movie was shown. The group began discussing in great detail how they identified with the characters' task to overcome misfortune, and the need to commit to the journey toward better health.

During week four (week seven), the group watched another segment in which the characters go from hopeful to doubtful because of the many obstacles they encounter on their journey. The group began identifying with these feelings of hopelessness, feelings of failure, and feelings of giving up.

Finally, the group watched the final segment of the movie during week eight, which is a cliff-hanger (ends without a conclusion). The group is left: (a) deciding how

the characters are going to cope with their misfortunes in order to finish the journey, (b) inferring whether or not the characters are going to eventually end up successful, and (c) encouraging one another to keep fighting their hopelessness and desires to give up in order to continue the journey toward mental health.

*Data Collection Procedures*

The participant completed both instruments every week on the same day and at the same time during each period of the study (see Table 3.1). During the treatment period, instruments were completed following each weekly viewing. During nontreatment weeks, the participant was asked to come to the researcher’s office at the same time and day to complete the instruments. Data were collected and kept with the researcher upon each weekly completion and analyzed at the end of the 11 weeks.

Table 3.1

*Time-Series Procedure*

	Phase of Study		
	Pre-treatment	Treatment	Post-treatment
Week	1, 2, 3	4, 5, 6, 7, 8	9, 10, 11

*Note.* Hopelessness and optimism scores were taken at the same time each week during the three phases.

Before statistical treatment could be applied to data collected from the sentence completion task, however, the participant’s qualitative statements were converted to quantitative data. Two clinical psychologists reviewed the participant’s sentence completions for the entire 11 weeks and rated each item’s corresponding response as either optimistic, slightly pessimistic, or pessimistic (optimistic = 2, slightly pessimistic =



1, pessimistic = 0). Scores from both psychologists' weekly ratings were then averaged, which resulted in a numerical score for each weekly sentence completion task.

#### Variable List

The following variables were used during analysis in order to determine the level of impact that a five-week structured, nondirective group cinematherapy intervention has on the hope and optimism of an adult diagnosed with Major Depression. Scores are raw scores.

##### *Beck Hopelessness Scale*

Minimal hopelessness	0 to 3
Mild hopelessness	4 to 8
Moderate hopelessness	9 to 14
Severe hopelessness	15 to 20

##### *Sentence Completion Task*

Minimal optimism	0 to 3
Mild optimism	4 to 8
Moderate optimism	9 to 14
Significant optimism	15 to 20

#### Derivation of General and Specific Research Hypotheses

It has been explained that two fundamental goals need to be achieved in order to support the use of cinematherapy in psychotherapy. The first goal intends to establish a solid theoretical rationale for the use of cinematherapy as an adjunctive tool within psychotherapy. To accomplish this, a research question (RQ1) was developed, "Does a

clear theoretical rationale exist for the use of film in counseling?” From this question, a general and specific research hypothesis was generated:

GRH1: A clear theoretical rationale does exist for using films in counseling.

SRH1: There will be a clear theoretical rationale for using films in counseling as measured by a thorough review of the cinematherapy literature.

These hypotheses will be tested by critically examining the theoretical, qualitative, and experimental literature on cinematherapy and identifying common themes that support its therapeutic use.

The second goal of this study requires an experimental research endeavor in order for it to be achieved, which intends to establish empirical data that supports cinematherapy as a viable therapeutic intervention with various populations experiencing a variety of mental health related conditions. Although a number of studies would need to be conducted to completely fulfill this goal, this study aims to contribute to this endeavor by examining how a cinematherapy intervention can improve the hope and optimism of an adult diagnosed with Major Depression. Therefore, two research questions (RQ2 and RQ3) were developed to accomplish goal number two.

RQ2 asks, “Is a structured, nondirective cinematherapy intervention effective at decreasing the hopelessness of an adult diagnosed with Major Depression?” From this question, a general hypothesis and three specific hypotheses were generated:

GRH2: Cinematherapy will be an effective therapeutic intervention for decreasing the hopelessness of an adult diagnosed with Major Depression.

SRH2.1: There will be a statistically and/or clinically significant decline in the level of hopelessness for an adult diagnosed with Major Depression as measured by the Beck Hopelessness Scale following a five-week structured, nondirective cinematherapy group when compared to a three-week pre-treatment baseline period.

SRH2.2: There will be a statistically and/or clinically significant decline in the level of hopelessness for an adult diagnosed with Major Depression as measured by the Beck Hopelessness Scale for three weeks post-treatment when compared to the three-week pre-treatment period.

SRH2.3: There will continue to be a statistically and/or clinically significant decline in the level of hopelessness for an adult diagnosed with Major Depression as measured by the Beck Hopelessness Scale for three weeks post-treatment when compared to the five-week treatment period.

These hypotheses will be tested using an interrupted time-series analysis via the statistical program ITSACORR. This program was developed by Crosbie (1993) and is to be used with brief single-subject time-series data, or data with few serial observations. An alpha level of .05 will be used for each test of statistical significance, while clinical significance will be assessed via a Percent Improvement Analysis (PIA) and by calculating an effect size via a Standard Means Difference formula ( $SMD_{all}$ ). Long (2005) suggests using the PIA to determine clinical significance for any before/after studies to compare the degree of change prior to and following the introduction of a variable. The convention according to Long is that a 25% improvement represents a clinically significant difference. The choice to use the  $SMD_{all}$  is based on the single-subject work of Olive and Smith (2005). They analyzed a set of single-subject, time-series data using several recommended effect size calculations and compared the results. The  $SMD_{all}$  was recommended due to the fact that it used mean performance data from both baseline and intervention phases, as opposed to the final three observations from each phase, and it was simple to calculate and produced a  $d$  value that was easily understood by most researchers who use Cohen's  $d$  to calculate effect size.

RQ3 asks, “Is a structured, nondirective cinematherapy intervention effective at improving the optimism of an adult diagnosed with Major Depression?” From these questions, general and specific research hypotheses were generated:

- GRH3: Cinematherapy will be an effective therapeutic intervention for improving the optimism of an adult diagnosed with Major Depression.
- SRH3.1: There will be a statistically and/or clinically significant improvement in the level of optimism for an adult diagnosed with Major Depression as measured by an adapted sentence completion task following a five-week structured, nondirective cinematherapy group when compared to a three-week pre-treatment baseline period.
- SRH3.2: There will be a statistically and/or clinically significant improvement in the level of optimism for an adult diagnosed with Major Depression as measured by adapted sentence completion task for three weeks post-treatment when compared to the three-week pre-treatment period.
- SRH3.3: There will continue to be a statistically and/or clinically significant improvement in the level of optimism for an adult diagnosed with Major Depression as measured by an adapted sentence completion task for three weeks post-treatment when compared to the five-week treatment period.

Similarly, these hypotheses will be tested using an interrupted time-series analysis via the statistical program ITSACORR. An alpha level of .05 will be used for each test of statistical significance, while clinical significance will be assessed via a Percent Improvement Analysis (Long, 2005) and a Standard Means Difference ( $SMD_{all}$ ) formula (Olive & Smith, 2005).

#### Statistical Treatment

To investigate the statistically and clinically significant effect that a structured, nondirective group cinematherapy intervention would have on an adult diagnosed with 296.23 Major Depression, Moderate, interrupted time-series analyses via ITSACORR (Crosbie, 1993) were used to compare data on the participant’s level of hopelessness and

optimism obtained three weeks pre-treatment, during the five-week cinematherapy intervention, and three weeks post-treatment. ITSACORR is a popular program for analyzing this type of data, because of its ability to discover trends in a small series of numbers such as the daily responses of a subject (Southerly, 2006).

ITSACORR was chosen over graphic eye-balling and repeated-measures analyses, because according to Crosbie, “Assessing change with short time-series data is difficult, because visual inference is unreliable with such data and current statistical procedures cannot control Type 1 error, because they underestimate positive autocorrelation” (p. 966). Autocorrelation refers to the fact that observations obtained in a time-series are “correlated with their own past and future observations” (Jenson, Clark, Kircher, & Kristjansson, 2007, p. 485), which can ultimately affect within-phase variability. If not accounted for initially, Jenson et al. assert that autocorrelation can lead to underestimated intervention effects.

Therefore, Crosbie’s ITSACORR “yields an overall *F*-test that uses an estimated adjustment to control for autocorrelation, and yields a *t*-test for the change in the *y*-intercept between the baseline and treatment conditions as well as a *t*-test for the change in slope between the conditions” (Stage & Quiroz, 1997, p. 343). Callow and Waters (2005) explain that of the three statistical outputs produced by ITSACORR, the omnibus *F* value is analyzed first in order to assess the overall explained variance for the *y*-intercept and slope parameters. If significant, change has occurred in the dependent variable between the baseline and treatment phases in either intercept or slope, and then post-hoc *t* tests can be analyzed to assess how much change actually occurred between the *y*-intercepts (analyzes whether a significant change occurred between last data-point

in phase one with the first data-point in phase two) and slopes (examines the trend of the data, which determines if there was a significant increase or decrease in the values of the dependent variable). If significant changes exist in either  $y$ -intercept or slope, effect sizes can be calculated with confidence (Jenson, Clark, Kircher, & Kristjansson, 2007). For purposes of this study, the  $F$ -test will determine if a significant change occurred between the participant's level of hopelessness or optimism from baseline to treatment, for example, and whether this change occurred at the point the cinematherapy intervention was introduced (change in  $y$ -intercept) or over the five weeks in general (change in slope).

It should be noted that although a useful program for analyzing brief single-subject time-series data (Crosbie, 1993), ITSACORR has been criticized by Huitema (2004) for having flaws. Namely, the program "yields conservative estimates of intervention effects" (Jenson et al., 2007, p. 488). However, conservative estimates are perhaps appropriate and responsible with single-subject data, which Jenson et al. suggests. In fact, Jenson et al. quotes Crosbie (1999), whom said years earlier, "ITSACORR is a much more conservative method than visual inspection...which ensures that only strong effects survive" (p. 107).

#### Limitations

There are several limitations with this study. First, only one adult diagnosed with 296.23 Major Depression, Moderate is participating in this study. Therefore, the data are not generalizable. Second, results are limited to the type of delivery method used, which was a structured nondirective group cinematherapy intervention that lasts for five weeks and uses only one film. Last, the participant did not attend regular individual counseling sessions in addition to the group cinematherapy intervention. Therefore, the

generalizability of results is limited to participants that receive group cinematherapy without counseling.

### Summary

A single-subject time-series design has several advantages over traditional true experimental pre/post designs. Primarily because multiple observations over time help monitor trends or changes in how a particular construct presents itself, which will afford the researcher data on exactly when change occurred and how it looked throughout the course of the study. One-shot observations in a pre/post design only tell that change actually occurred, but says nothing about how and when. This study intends to use the single-subject time-series design to measure the weekly effect that a cinematherapy intervention has on an adult diagnosed with 296.23 Major Depression, Moderate.

## CHAPTER FOUR: RESULTS

It was proposed that two fundamental goals need to be achieved in order to support the use of cinematherapy in psychotherapy. First, a solid theoretical rationale needs to exist that guides counselors in the appropriate use of a cinematherapy intervention as an adjunctive tool within psychotherapy. Second, additional empirical data needs to exist that supports cinematherapy as a viable therapeutic intervention with various populations experiencing a variety of mental health related condition. This chapter will describe the results of this study's attempt to accomplish both goals.

### Evidence of a Theoretical Rationale

To accomplish the first goal of this study, a research question was developed:

RQ1: Does a clear theoretical rationale exist for the use of film in counseling?

From this question, a general and specific research hypothesis was generated:

GRH1: A clear theoretical rationale does exist for using films in counseling.

SRH1: There will be a clear theoretical rationale for using films in counseling as measured by a thorough review of the cinematherapy literature.

These hypotheses were tested by critically reviewing the theoretical, qualitative, and experimental literature on cinematherapy, and identifying common themes that support its therapeutic use.

*Results of Specific Research Hypothesis 1.* Results from the literature review conducted in Chapter Two suggest that a clear theoretical rationale exists. In fact, this chapter included a historical review of movie-work throughout the 20<sup>th</sup> century, a discussion on the application and theoretical nature of metaphors in counseling, and a critique of three experimentally-validating studies on the effects of a cinematherapy



intervention with various samples (Adams & McGuire, 1986; Jurich & Collins, 1996; Powell et al., 2006). Based on this review and conclusions, SRH1 was accepted.

#### Evidence for Therapeutic Credibility

The second goal of this study cannot be accomplished in a single investigation, because of the need for a participant sample that comprises of a number of individuals representing various mental health conditions. Therefore, this research endeavor intended to contribute to the overall accomplishment of goal two by examining whether cinematherapy is effective at decreasing the hopelessness and increasing the optimism of an adult diagnosed with Major Depression.

#### *Evidence for Decreasing Hopelessness*

The first research question is concerned with the effect that a cinematherapy intervention would have on an individual's level of hopelessness:

RQ2: Is a structured, nondirective cinematherapy intervention effective at decreasing the hopelessness of an adult diagnosed with Major Depression?

From this question, a general hypothesis and specific research hypotheses were generated:

GRH2: Cinematherapy will be an effective therapeutic intervention for decreasing the hopelessness of an adult diagnosed with Major Depression.

SRH2.1: There will be a statistically and/or clinically significant decline in the level of hopelessness for an adult diagnosed with Major Depression as measured by the Beck Hopelessness Scale following a five-week structured, nondirective cinematherapy group when compared to a three-week pre-treatment baseline period.

SRH2.2: There will be a statistically and/or clinically significant decline in the level of hopelessness for an adult diagnosed with Major Depression as measured by the Beck Hopelessness Scale for three weeks post-treatment when compared to the three-week pre-treatment period.

SRH2.3: There will continue to be a statistically and/or clinically significant decline in the level of hopelessness for an adult diagnosed with Major Depression as measured by the Beck Hopelessness Scale for three weeks post-treatment when compared to the five-week treatment period.

The hypotheses for analyzing statistical significance were tested using Crosbie's (1993) ITSACORR program at an alpha level of .05. The hypotheses for analyzing clinical significance; effect size and the 25% decrease in hopelessness between phases, were tested using a Standard Means Difference ( $SMD_{all}$ ) formula (Olive & Smith, 2005) and a Percent Improvement Analysis (Long, 2005).

*Results of Specific Research Hypothesis 2.1.* Results indicate that there was a statistically significant change in the participant's level of hopelessness from the baseline to treatment phase,  $F(2, 3) = 13.61, p = .031$ ; a change that was not statistically significant for intercept,  $t(3) = -.52, p = .64$ , but was statistically significant for slope,  $t(3) = -4.05, p = .027$ . Tests of clinical significance reveal a large effect,  $SMD_{all} = 6.37$ , and a 48% improvement in level of hopelessness from baseline ( $M = 17.67, SD = 1.33$ ) to treatment phase ( $M = 9.2, SD = 5.7$ ; see Table 4.1).

Table 4.1

*Summary of Means and Standard Deviations*

Variable	Phase of Treatment		
	Baseline (M ± SD)	Treatment (M ± SD)	Post (M ± SD)
Hopelessness	17.67 ± 1.33	9.2 ± 5.7**	11.33 ± 1.33*
Optimism	2.33 ± 1.08	14.7 ± 3.08*	8.67 ± 4.33*

*Note.* \* Clinically significant difference from baseline. \*\*Clinically and statistically significant difference from baseline.

Visual inspection of the graphed raw data in Figure 4.1 supports the indication of a statistically and clinically significant decrease in hopelessness between phases.

Therefore, SRH2.1 was accepted in relation to statistical and clinical significance.

*Results of Specific Research Hypothesis 2.2.* Results indicate that there was not a statistically significant change in the participant's level of hopelessness from the baseline to post-treatment phase,  $F(2, 1) = 2.80, p = .389$ . As a result, tests of change in intercept and slope were not calculated. Tests of clinical significance, however, reveal a large effect,  $SMD_{all} = 4.77$ , and a 36% improvement in level of hopelessness from baseline ( $M = 17.67, SD = 1.33$ ) to post-treatment phase ( $M = 11.33, SD = 1.33$ ; see Table 1). Visual inspection of the graphed raw data in Figure 4.1 supports the indication of a clinically significant decrease in hopelessness between phases. Therefore, SRH2.2 was accepted for clinical significance, but rejected for statistical significance.

*Results of Specific Research Hypothesis 2.3.* Results indicate that there was not a statistically significant change in the participant's level of hopelessness from the treatment to post-treatment phase,  $F(3, 2) = 2.07, p = .273$ . As a result, tests of change in intercept and slope were not calculated. Tests of clinical significance, however, reveal a small negative effect,  $SMD_{all} = -.37$ , and a 23% increase in hopelessness from treatment ( $M = 9.2, SD = 5.7$ ) to post-treatment ( $M = 11.33, SD = 1.33$ ; see Table 1). Visual inspection of the graphed raw data in Figure 4.1 supports the indication of a nonsignificant decrease in hopelessness between both phases. Therefore, SRH2.3 was rejected due to the fact that the participant's level of hopelessness became worse upon removal of the intervention.

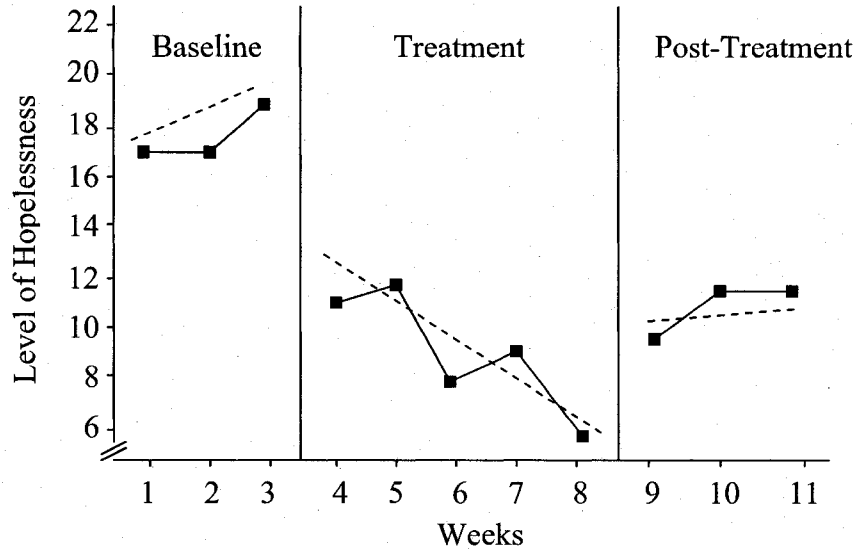


Figure 4.1. Level of hopelessness between the baseline, treatment, and post-treatment phases.

#### *Evidence for Improving Optimism*

The second research question involves the effect that a cinematherapy intervention would have on an individual's level of optimism:

RQ3: Is a structured, nondirective cinematherapy intervention effective at improving the optimism of an adult diagnosed with Major Depression?

The hypotheses for question two are as follows:

GRH3: Cinematherapy will be an effective therapeutic intervention for improving the optimism of an adult diagnosed with Major Depression.

SRH3.1: There will be a statistically and/or clinically significant improvement in the level of optimism for an adult diagnosed with Major Depression as measured by an adapted sentence completion task following a five-week structured, nondirective cinematherapy group when compared to a three-week pre-treatment baseline period.

SRH3.2: There will be a statistically and/or clinically significant improvement in the level of optimism for an adult diagnosed with Major Depression as measured by adapted sentence completion task for three weeks post-treatment when compared to the three-week pre-treatment period.

SRH3.3: There will continue to be a statistically and/or clinically significant improvement in the level of optimism for an adult diagnosed with Major Depression as measured by an adapted sentence completion task

for three weeks post-treatment when compared to the five-week treatment period.

The hypotheses for analyzing statistical significance were tested using Crosbie's (1993) ITSACORR program at an alpha level of .05. The hypotheses for analyzing clinical significance; effect size and the 25% increase in optimism between phases, were tested using a Standard Means Difference ( $SMD_{all}$ ) formula (Olive & Smith, 2005) and a Percent Improvement Analysis (Long, 2005).

*Results of Specific Research Hypothesis 3.1.* Results indicate that the participant's level of optimism from the baseline to treatment phase was not statistically significant,  $F(3, 2) = 8.39, p = .059$ . As a result, tests of change in intercept and slope were not calculated. Tests of clinical significance, however, reveal a very large effect,  $SMD_{all} = 11.45$ , and a 531% improvement in level of optimism from baseline ( $M = 2.33, SD = 1.08$ ) to treatment ( $M = 14.7, SD = 3.08$ ; see Table 1). Visual inspection of the graphed raw data in Figure 4.2 supports the indication of a clinical improvement in optimism between phases. Therefore, SRH3.1 was accepted for clinical significance, but rejected for statistical significance.

*Results of Specific Research Hypothesis 3.2.* Results indicate that the participant's level of optimism from the baseline to post-treatment phase was not statistically significant,  $F(2, 1) = 57.03, p = .093$ . As a result, tests of change in intercept and slope were not calculated. Tests of clinical significance, however, reveal a very large effect,  $SMD_{all} = 5.87$ , and a 272% improvement in level of optimism from baseline ( $M = 2.33, SD = 1.08$ ) to post-treatment ( $M = 8.67, SD = 4.33$ ; see Table 1). Visual inspection of the graphed raw data in Figure 4.2 supports the indication of a clinical improvement in

optimism between phases. Therefore, SRH3.2 was accepted for clinical significance, but rejected for statistical significance.

*Results of Specific Research Hypothesis 3.3.* Results indicate that there was not a statistically significant change in the participant's level of optimism from the treatment to post-treatment phase,  $F(3, 2) = 1.66, p = .32$ . As a result, tests of change in intercept and slope were not calculated. Tests of clinical significance, however, reveal a large negative effect,  $SMD_{all} = -1.96$ , and a 41% decrease in the level of optimism from treatment ( $M = 14.7, SD = 3.08$ ) to post-treatment phase ( $M = 8.67, SD = 4.33$ ; see Table 1). Visual inspection of the graphed raw data in Figure 4.2 supports the indication of a nonsignificant decrease in optimism between phases. Therefore, SRH3.3 was rejected due to the fact that the participant's level of optimism decreased upon removal of the intervention.

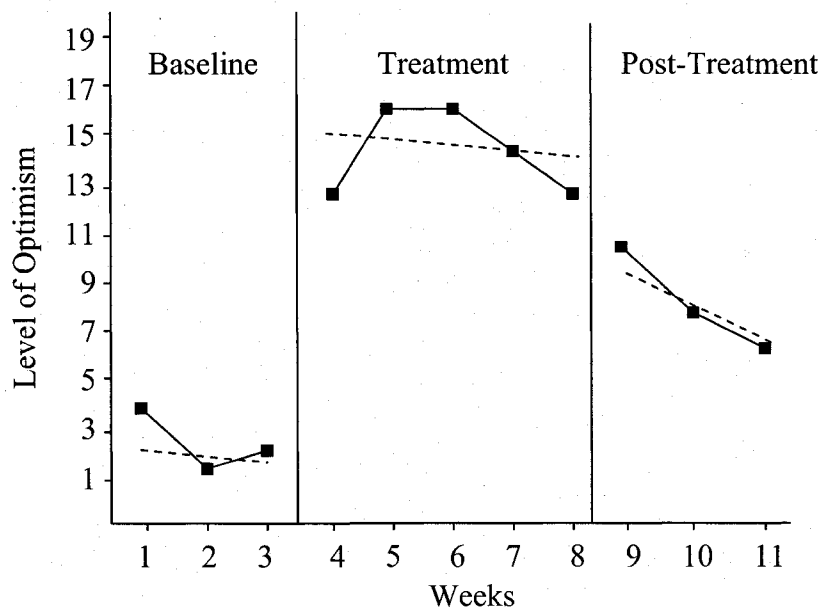


Figure 4.2. Level of optimism between the baseline, treatment, and post-treatment phases.

## Summary

Several research hypotheses were developed in order to test whether a theoretical rationale for using cinematherapy exists, and to what extent an intervention would have on the hopelessness and optimism of an adult diagnosed with 296.23 Major Depression, Moderate. Results indicate that a clear theory does exist, and that a structured, nondirective group cinematherapy was statistically and clinically effective at improving one's level of hopelessness, and clinically effective at improving optimism.

## CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND IMPLICATIONS

The purpose of this chapter is to provide a brief reminder about the purpose of this study and to summarize the results. In addition, this chapter discusses the conclusions and implications of these results for the counseling profession, and makes suggestions for further research. Limitations of this study are also discussed.

### Summary of the Study

The following sections restate the problem and goals of this study, and summarize the specific research hypotheses. They also discuss the procedures used to test them.

#### *Statement of the Problem and Goals*

The practice of cinematherapy has been scrutinized lately due to uncertainty regarding its theoretical foundation and limited empirical support (Portadin, 2006). Therefore, this study intended to accomplish two fundamental goals in order to advance the practice of cinematherapy. The first goal was to establish a clear theoretical rationale regarding the creative use of films as a therapeutic intervention in counseling. The second goal was to provide additional experimental credibility to the approach by examining how a cinematherapy intervention can be effective at improving the hope and optimism of an adult diagnosed with Major Depression.

#### *Statement of the Procedures*

Two general procedures were used to accomplish the goals of this study. The first procedure tested the first goal and involved a thorough review of cinematherapy's theoretical and experimental literature. This review was conducted in order to examine if a clear rationale existed regarding the creative use of films as a therapeutic intervention in counseling. The second procedure tested the second goal by asking one adult female who



was participating in a five-week group cinematherapy intervention to complete measures of hope and optimism each week, including three weeks prior to the intervention and three weeks following the intervention. This was conducted in order to test if statistical and clinical improvements existed in her views toward the future and her general disposition toward life after receiving a cinematherapy intervention.

#### *Specific Research Hypotheses*

Several specific research hypotheses were generated prior to this study's attempt to accomplish its goals. First, in regards to goal one, it was hypothesized that there would be a clear theoretical rationale for the creative use of films in counseling as measured by a thorough review of the cinematherapy literature. This hypothesis was tested via a critical review of the theoretical and experimental literature on cinematherapy, and by identifying common themes that support its creative therapeutic use.

Second, in regards to goal two, it was hypothesized that the adult female randomly selected for this study would experience a statistically and/or clinically significant decrease in hopelessness and increase in optimism when comparing her three-week pre-treatment scores to her five-week treatment scores and three-week post-treatment scores. In addition, it was hypothesized that this statistically and/or clinically significant decrease in hopelessness and increase in optimism would continue from treatment to post-treatment. These hypotheses were statistically tested using Crosbie's (1993) ITSACORR program at an alpha level of .05, and clinically tested using a Percent Improvement Analysis (Long, 2005) and a Standard Means Difference ( $SMD_{all}$ ) formula (Olive & Smith, 2005).

## Discussion and Conclusions

This section summarizes the results of each hypothesis test. In addition, conclusions for each test are discussed.

### *Evidence for a Theoretical Rationale*

A thorough examination of the cinematherapy literature was conducted in order to determine if a clear theoretical rationale existed for using films in counseling. The impetus for this endeavor came from the work of Portadin (2006) who found that most of the literature promoting the use of films in counseling was anecdotal, and other than the similarities that cinematherapy has with that of bibliotherapy, most researchers failed to report in their work the theoretical principles guiding their use of films as therapeutic interventions in the first place. As a result, Portadin called for additional theoretical justification prior to movie-work becoming more commonplace in counseling.

To examine whether this rationale existed, information was obtained by reviewing the historical use of films in therapy, the various approaches when applying a cinematherapy intervention, how a film's metaphors are used to evoke insight and encourage change, and the therapeutic impact that cinematherapy has empirically had on various individuals and groups. It was concluded that there is a clear rationale and reasonable independent theory to support the use of film in counseling, because of the praxis developed by Powell (2007) which explains how a counselor can use the metaphors inherently found in films in a nondirective, directive, structured, and/or unstructured format to educate, heal, and persuade clientele as therapeutically necessary. Furthermore, the review concluded that although the amount of empirical support is scarce and the theoretical foundation weak, there does exist some outcome research to

support the use of film in counseling, and that even the abundance of anecdotal and qualitative research on the effectiveness of film in counseling is based on years of clinical experience and outcomes observations, which may be a more appropriate place to start when supporting the use of a newer intervention such as cinematherapy.

#### *Evidence for Therapeutic Credibility*

One adult female diagnosed with Major Depression participated in a structured, nondirective group cinematherapy intervention for five-weeks. Her level of hopelessness was measured via the Beck Hopelessness Scale (BHS; Beck et al., 1974) and her level of optimism was measured via an adapted sentence completed task. These measurements were taken for three weeks prior to the group cinematherapy intervention, during the five-week group cinematherapy intervention, and for three weeks following the group cinematherapy intervention. Scores for the pre-treatment period were compared to treatment and post-treatment scores to assess the amount of change that occurred once the intervention was introduced. Treatment and post-treatment scores were compared to assess whether the intervention continued to have an impact for three weeks once removed.

*Changes in hopelessness.* A statistically and clinically significant change in hopelessness occurred between the pre-treatment and treatment phases. Namely, in regards to the slope (general direction of the scores), suggesting that the cinematherapy intervention had an impact over time. Changes in intercept were not statistically significant, meaning that the last pre-treatment score was not statistically different than the first treatment score, but the impact was meaningful. This suggests that the cinematherapy intervention had an immediate impact on the participant's level of

hopelessness once introduced, which was clinically significant. This claim is supported by the statistically significant difference that existed between both phases over time.

Although there was a statistically significant difference between the pre-treatment and treatment scores, there was not a statistically significant difference between the pre-treatment and post-treatment scores. This is because the participant's level of hopelessness slightly increased following the removal of the intervention, meaning that the positive effect experienced during the group cinematherapy intervention did not continue as expected post-treatment. In fact, a comparison of scores between the treatment and post-treatment phase reveals a non-statistically significant difference, and a negative clinical difference. It is promising to note, however, that the increase in hopelessness following the removal of the intervention was not so large that one should be concerned. This is because the difference between the pre-treatment scores and the post-treatment scores are still clinically significant, meaning that the cinematherapy intervention continued to have an impact on the participant's level of hopelessness for three weeks after the group sessions ended. As a result of these data analyses, it was concluded that a structured, nondirective group cinematherapy intervention is effective at improving the hopelessness of an adult diagnosed with Major Depression.

*Changes in optimism.* Differences in the participant's level of optimism between the pre-treatment and treatment phases was not statistically significant. Although not significant, a large clinically significant difference did exist, meaning that the cinematherapy intervention did have a therapeutic impact. Subsequently, it can be purported that if the measurements taken during the pre-treatment or treatment phases were just slightly more different, or if more observations were taken and eventually

compared, then statistical differences would have been found because these comparisons approached statistical significance.

Similar to the results found between the pre-treatment and treatment phases, the scores between the pre-treatment and post-treatment phases approached statistical significance and had a large clinical effect. Again, these findings suggest that the cinematherapy intervention had a therapeutic effect, however the impact was not as great post-treatment. This indicates that the participant's level of optimism decreased once the intervention was removed, which is supported by the negative effect that exists between the scores obtained during the treatment and post-treatment phases. However, similar to data on hopelessness, the change at post-treatment was not so large to cause concern because the difference between pre-treatment and post-treatment scores are still clinically significant. As a result of these data analyses, it was concluded that a structured, nondirective group cinematherapy intervention is effective at improving the optimism of an adult diagnosed with Major Depression.

### Implications

These findings are important for the future of cinematherapy and for the counseling profession in general. First, since the existence of a solid theoretical rationale for cinematherapy is supported, counselors who choose to incorporate films in their practice can be assured that there is a solid framework and praxis available to guide them when selecting a film and when delivering a particular cinematherapy method or approach. Second, in regards to recent questions about the efficacy of cinematherapy (Portadin, 2006), these findings will provide empirical evidences regarding how and why films can be applied in a therapeutic manner to effectively treat psychological symptoms,

ultimately supporting one's decision to apply a cinematherapy intervention as part of a client's treatment plan. Third, additional research is now available that empirically supports cinematherapy as an experimentally-tested counseling technique. In addition to the other three experimental studies (Adams & McGuire, 1986; Jurich & Collins, 1996; Powell et al., 2006), this study contributes to the call by social entities that helping professionals be accountable for the interventions they employ in the remediation of mental health disorders (Mental Health America, 2006; Wendt, 2006). Last, clinicians seeking additional therapeutic interventions for the treatment of depressive symptoms should be encouraged by the findings of this study. Particularly, that a structured, nondirective group cinematherapy intervention can be effective at decreasing the hopelessness and increasing the optimism of an adult female diagnosed with moderate levels of Major Depression.

#### Limitations and Suggestions for Further Research

Although the results from this study are promising for the future of cinematherapy and the counseling profession in general, limitations do exist. For example, the participant randomly selected for this study was a 59-year-old female diagnosed with Major Depression, Moderate. Data were not collected on the other members participating in the group cinematherapy intervention, which consisted of other women and men, with some being of a younger age and having less severe levels of depression. Therefore, the results of this study are limited to this one participant. It is suggested that this study be expanded and data from other members be gathered and compared with one another.

Another limitation is that the only intervention employed was a structured, nondirective group cinematherapy intervention. The participant under investigation did

not participate in any other services (e.g., individual therapy or case management) or cinematherapy approach/method. Therefore, it is suggested that further research investigate the effect of a cinematherapy intervention coupled with other services to assess the impact that such collaborative efforts can have on an individual, and whether an approach such as the unstructured, directive method can have similar effects. For example, using the time-series study outlined in this study, a researcher could incorporate individual therapy following the three-week post-treatment phase to assess the differences in hopelessness and optimism between a person or group who receives cinematherapy alone and a person or group who receives individual therapy, too (ABAC design).

Finally, it is recommended that researchers take the previous suggestions and investigate the impact of a cinematherapy intervention on a number of other individuals experiencing a variety of other psychological impairments besides depressive symptoms. Therefore, the therapeutic credibility of cinematherapy will be strengthened, and more evidence will exist regarding for whom and for what ailments a cinematherapy intervention can help treat.

### Summary

The two goals of this study: (a) establish a theoretical rationale for the use of films, and (b) provide additional experimental data to support the use of film, were accomplished. A thorough review of the literature concluded that the framework and praxis underlying the use of films is theoretically solid, and a structured, nondirective group cinematherapy intervention was found to be an effective intervention over time for an adult female diagnosed with Major Depression, Moderate. However, the data are not

generalizable due to the use of only one participant. Further research is needed to compare the impact of cinematherapy on other individuals representing the same depressive disorder, in addition to other psychological problems. However, data from this study are meaningful, because they suggest that cinematherapy is effective and can be a useful tool for therapeutic gains.



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## APPENDICES

**APPENDIX A**  
**INFORMED CONSENT FORM**

## Informed Consent

- Title:** Cinematherapy as a Therapeutic Intervention: Theoretical Rationale and Empirical Credibility
- Investigators:** Michael Lee Powell, Doctoral Student
- Supervisor:** Rebecca A. Newgent, Ph.D., Dissertation Chair
- Contact Info:** Michael Lee Powell and Rebecca A. Newgent, Ph.D.  
University of Arkansas  
College of Education and Health Professions  
Counselor Education Program  
136 Graduate Education Building  
Fayetteville, AR 72701  
(479) 575-3509  
mlpowel@uark.edu and rnewgent@uark.edu
- Purpose:** To provide support for the use of film as a viable therapeutic technique for increasing the hope and optimism of adults with Major Depression.
- Procedures:** You will be randomly selected from a group of adults preparing to participate in a five-week cinematherapy group and asked to complete two psychological instruments that measure hope and optimism each week for a total of nine-weeks. You will be asked to complete these instruments for three weeks before the group begins, for five weeks during group, and for three weeks after the group ends. No other requirements will be made of you.
- Risk/Benefit:** There are no anticipated risks to participating in this study.  
The benefit will be a \$50.00 gift card to Wal-Mart if you agree to the procedures and complete participation requirements outlined in the procedures section of this consent form.
- Participation:** Participation in this study is strictly voluntary. You can choose to withdrawal at any time without repercussion, however, payment of the \$50.00 gift card will not be rendered unless you complete the study and all procedural requirements.
- Confidential:** As a client of Western Arkansas Counseling and Guidance Center, each person has assigned to them a five-digit number for anonymity purposes. The researcher in this study will abide by this established confidentiality system, and will remove all identifiers on the testing instruments prior to the scoring procedures and data analysis process. In addition, your name and information will be kept confidential to the extent allowed by law and University policy, and scores/data will be held in the strictest of

confidence following completion of the study (e.g., filed away in a locked cabinet).

**Compliance:** The University's Institutional Review Board (IRB) reviews research projects to ensure that all procedures comply appropriately with the standards and ethics established for your youth's protection. If for any reason you feel that this project violated your rights as a participant, then you may contact the University's Compliance Coordinator at any time with your concerns.

Contact: Iroshi (Ro) Windwalker, CIP  
Compliance Coordinator  
Ozar 118  
Fayetteville, AR 72701  
(479) 575-3845

**Consent:** I, (print) \_\_\_\_\_, have read the purpose, procedure, risk/benefits, participation, confidentiality, and withdraw sections of this consent form, and have had all questions regarding this project answered by the researchers. I believe that I understand what is involved, and freely agree to participate in the study.

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Participant (print) (sign) Date

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Researcher (print) (sign) Date

**APPENDIX B**  
**INSTITUTIONAL REVIEW BOARD APPROVAL**





UNIVERSITY of ARKANSAS

1871

120 Ozark Hall • Fayetteville, Arkansas 72701 • (479) 575-2208 • (479) 575-3846 (FAX)  
Email: irb@uark.edu

**Research Support and Sponsored Programs  
Institutional Review Board**

April 29, 2008

MEMORANDUM

TO: Michael Lee Powell  
Rebecca Newgent

FROM: Ro Windwalker  
IRB Coordinator

RE: New Protocol Approval

IRB Protocol #: 08-04-491

Protocol Title: *Cinematherapy as a Therapeutic Intervention: Theoretical Rationale and Empirical Credibility*

Review Type:  EXEMPT  EXPEDITED  FULL IRB

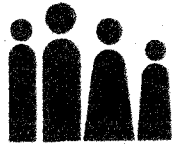
Approved Project Period: Start Date: 04/28/2008 Expiration Date: 04/21/2009

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Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. This form is available from the IRB Coordinator or on the Compliance website <http://www.uark.edu/admin/rsspinfo/compliance/human-subjects/index.html>. As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times. If you wish to make any modifications in the approved protocol, you must seek approval prior to implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 120 Ozark Hall, 5-2208, or irb@uark.edu.

**APPENDIX C**  
**AGENCY PERMISSION LETTER**



**WESTERN ARKANSAS  
COUNSELING AND GUIDANCE CENTER**

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March 7, 2008

Mitch Durham, Ph.D.  
Vice-President/Chief Clinical Officer  
Western Arkansas Counseling and Guidance Center  
3111 S. 70<sup>th</sup>  
Fort Smith, AR 72917

RE: Permission to do research

To Whom It May Concern:

Michael Powell has approached me about using clients and assessments/data from our agency in order to complete his dissertation on the efficacy of cinematherapy. Please accept this letter as my written permission for him to have such privileges.

Sincerely,

A handwritten signature in black ink, appearing to read "Mitch Durham".

Mitch Durham, Ph.D.  
VP/CCO

**APPENDIX D**  
**CINEMATHERAPY GUIDELINES**

## Cinematherapy Guidelines

### *Phase One: Assessment*

1. What problem will this intervention address?
  - ◆ Why would this client benefit from a cinematherapy intervention?
  - ◆ What would this client get out of it?
  - ◆ Can the intervention be tied back to the client's treatment plan?
2. Determine the client's abilities and curiosities (i.e., interests, activities, and attention span).
  - ◆ What type of film would benefit him/her: movie, documentary, or instructional?
  - ◆ What type of genre would he/she prefer: comedy, drama, or science fiction?
  - ◆ How attentive will the client be, or how long of a film clip can he/she stand?
3. Consider developmental issues (i.e., mental capacity and emotional development).
  - ◆ Will the client understand how to use the film as metaphor for his/her own life?
  - ◆ Does he/she have the mental ability to participate in processing the content?
  - ◆ Does he/she recognize the difference between fantasy and reality?
4. Determine cultural sensitivities (i.e. ethnicity, socioeconomic status, and gender).
  - ◆ Will the film be offensive, or be distracting from the purpose of the assignment?
5. Based on these criteria, obtain a list of potentially beneficial films, and choose the best suited.

### *Phase Two: Preparation*

1. Watch the chosen film alone.
  - ◆ Always watch a film before assigning it. You want to know where the important parts are in order to processing them afterward.
  - ◆ Most movies may have inappropriate scenes (i.e., language or sexual content). You can address these by fast-forwarding, or leaving such scenes out if necessary, or informing the client ahead of time.
2. Obtain consent.
  - ◆ Obtain consent (preferably written) from guardian to use a film with a child.
  - ◆ Each family has a different view on what is appropriate for their child to view. Don't assume a teenager has consent for PG-13.
  - ◆ Cover with the client the title of the movie, plot, benefits in therapy, and potential negative aspects (i.e., language or strong emotional issues).
3. Decide viewing format.
  - ◆ Will the client follow through with the assignment?
  - ◆ When, where, and with whom should the film be viewed?

- ◆ Would viewing the film with the client be more beneficial?
  - ◆ Do you need the entire film or specific scenes only?
  - ◆ Would breaking the film up into parts and viewing it over time be better?
  - ◆ Are there other clients that could use this intervention? If so, then group cinematherapy might be a better option.
4. Provide clients with a solid rationale for this intervention.
- ◆ Certain clients do better when they go into a cinematherapy experience knowing what to look for, especially those with poor insight or inattentive issues.
  - ◆ Explaining the benefits of the intervention helps ensure that the client will actually participate or complete the assignment.

*Phase Three: Implementation*

1. Assign the film.
  - ◆ Are the instructions clear?
  - ◆ Does the client need to know what to look for?
  - ◆ Would a worksheet be useful, which helps keep the client stay on task?
2. Schedule a session at a later date in order to process the viewing.

*Phase Four: Processing the Experience*

1. Discuss client's overall impression of the movie.
  - ◆ People enjoy talking about the content of a movie. This is helpful in the beginning, because it gets them talking about the character's feelings and perceptions. Talking in this way will help bridge forthcoming therapeutic questions about their own feelings and perceptions.
2. Explore perceptions and thoughts about how the movie may or may not relate to the client's own life.
  - ◆ In group cinematherapy, worksheets with open-ended questions are useful during this phase, especially when they are paired up with one another.
3. Generate ideas about how this information can help the client think, feel, or behave differently.

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*Note.* These guidelines were adapted from the following article in order to make them appropriate for the general clinical population: Dermer, S. B., & Hutchings, J. B. (2000). Utilizing movies in family therapy: Applications for individuals, couples, and families. *American Journal of Family Therapy*, 28, 163-180.

