

The Role of Response Art in the Case of an Adolescent Survivor of Developmental Trauma

Rebecca Beers Miller, New York City, NY

Abstract

This article presents the art therapist's engagement in responsive art making as an effective approach in working with an adolescent survivor of developmental trauma. Through a case study illustration, the art therapist's response art was effective in two main areas. First, in-session response art helped facilitate treatment goals in accordance with van der Kolk's (2005) conceptualization of Developmental Trauma Disorder. Second, systematic exploration of counter-transference issues through post-session art led to inner change in the therapist that coincided with change occurring in the client's behavior and approach to art making. Consequently, the client transferred defensive, acting-out behaviors from the context of the relationship into the art products themselves, thereby mastering artistic processes while moving towards expression of previously masked emotions connected with her trauma.

Introduction

This article discusses art therapy treatment with Shantelle (pseudonym), a 13-year-old girl attending a day treatment program for adolescent girls with severe emotional and behavioral problems. Shantelle's volatile behavior and unconscious engagement in traumatic reenactments in the milieu and sessions made her a particularly challenging client. Such behaviors, combined with a complex array of comorbid psychiatric diagnoses and learning disorders, were strongly suggestive of long-lasting effects of complex trauma during the most important developmental years of her childhood.

My use of response art was critical to making progress in treatment with Shantelle. In-session response art served as a non-verbal means of communicating with her through the mirroring and modeling of empathic attunement, thereby aiding in the building of mastery, competence, and ego strength. Shantelle gradually came to trust and rely on the safety of our relationship and the art therapy holding environment. As a result, she was increasingly able to use art in therapy as a means to connect with parts of herself that she had typically defended against by employing aggressive and regressive behaviors. Post-session response

art proved invaluable as a means of processing counter-transference reactions as they arose, enabling me to better witness and contain Shantelle's projections without becoming involved counterproductively, thus setting the stage for important shifts to occur in treatment.

Literature Review

Adolescent Theory: Acting Out in Treatment

In their article, "Acting out and its role in the treatment of adolescents," Amini and Burke (1979) defined acting out as an "organized activity" representing a "reenactment and reliving of the traumatic (and non-traumatic) past, rather than simply meaning misbehaving" (p. 250). They emphasized that while acting out is to some extent a normal part of all adolescence, it becomes exaggerated and pathological in those who experienced early deprivation, trauma, or pathological object relationships.

Amini and Burke acknowledged the challenge that this manner of relating poses to the therapist, commenting on the tendency of inexperienced clinicians to perceive the acting out of adolescents as an impediment to treatment: "The therapist is in danger of saying in effect, 'Give up this manner of relating, so that I can treat your core problem,' which overlooks the fact that this...*is* the core problem" (p. 249). Thus, treatment should consist of helping the adolescent find new adaptive ways of object relating before he or she can be expected to give up the familiar pattern of acting out. For the therapist, this means confronting the difficult task of trying to understand the meaning of the acting out without being pulled into it unknowingly.

Art therapist Bruce Moon (1998) recommended looking at the acting out behaviors of adolescents as performance art events. "When one thinks of the teenager's behaviors as being scenes from a drama one is freed to observe and reflect upon the meaning of the performance without becoming counter-therapeutically caught up in the drama itself" (p. 89). Mishine (1986) advised clinicians to keep in mind that the average adolescent in therapy is not a willing participant from the outset, but is usually there at the insistence of parents, schools, or courts. As the young person seeks to separate from family in the search for self-identity, he or she "is commonly loath to enter into a relationship and attachment with a new adult" (p. 326). Thus, the establishment of therapeutic rapport with the adolescent client is typically challenging for any therapist.

Editor's note: Rebecca Beers Miller, MA, CCLS, is an art therapist at Linden Hill, a residential treatment facility for adolescents with the Jewish Board of Family and Children's Services. Correspondence concerning this article may be addressed to rebeccabeersmiller@gmail.com.

Complex Childhood Trauma: 'Developmental Trauma Disorder'

In a recent article, "Developmental Trauma Disorder," van der Kolk (2005) argued that the posttraumatic stress disorder (PTSD) syndrome does not accurately capture the manifestation of symptoms and behaviors exhibited in relation to chronic complex trauma beginning in childhood. He defined "complex trauma" as "the experience of multiple, chronic and prolonged developmentally adverse traumatic events, most often of an interpersonal nature and early-life onset" (p. 402). This includes the experience of war; community violence; sexual, physical or emotional abuse; and educational neglect.

Whereas isolated trauma tends to lead to PTSD symptoms, prolonged maltreatment can interfere at a more fundamental level with cognitive and neurobiological development of the brain. Consequently, children tend to be given a range of comorbid diagnoses, as if they bear no relation to the PTSD symptoms. In response, van der Kolk (2005) conceptualized a new diagnosis for children with complex trauma histories called Developmental Trauma Disorder and outlined the proposed diagnosis by four criteria: (a) multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma, such as threats to bodily integrity, emotional abuse, or abandonment (a subjective experience that results in feelings such as rage, defeat or shame); (b) triggered pattern of repeated dysregulation in response to trauma cues, which concerns affective, somatic, behavioral, cognitive, relational, and self-attribution changes that do not return to baseline in the presence of cues and are not reduced in intensity by conscious awareness; (c) persistently altered attributions and expectancies, including negative self-attribution, loss of expectancy of protection by others, and inevitability of future victimization; and (d) functional impairment in the areas of family, education, peer relationships, vocation, and legality.

As van der Kolk (2005) observed, traumatized people tend to become fixated at the emotional and cognitive level at which they were traumatized. Thus, severe learning problems are often a natural consequence among chronically traumatized children. In an environment lacking predictability and continuity, abused children commonly experience difficulties categorizing experience, which is critical in developing evaluative and imaginative skills. Because the chronically aroused child is likely to misinterpret novel sensory information as traumatic or ignore it altogether, she is unable to evaluate what is relevant and what is not, making the integration of abstract concepts problematic. This tends to lead to visual perceptual problems and problems comprehending complex visual-spatial patterns, which leads to problems in reading and writing (Dopart, 1983).

According to van der Kolk (2005), treatment for children, adolescents, and adults who have experienced chronic childhood trauma must focus on three core areas. These are (a) establishing safety and competence, (b) dealing with traumatic reenactments, and (c) integration and mastery of the body and mind. Safety and competence is emphasized

as an important means in helping the individual learn to react differently within the context of a space and/or relationship that is predictable and safe. Engagement in activities that give the individual pleasure and mastery are highly encouraged. Through symbolic expression in creative play, individuals are able to gain the necessary distance from themselves and the events of their lives in order to be able to imagine different outcomes. Dealing with traumatic reenactments means examining, negotiating, and hopefully resolving reenactments. But first and foremost, it means recognizing that they are not an obstacle to treatment but are a critical aspect of treatment itself. Finally, integration and mastery can be achieved through the promotion of experiences that encourage relaxation, exploration of surroundings, feelings of empowerment and being in charge, and solving problems.

Countertransference and Art Therapy: The Role of Responsive Art

Within the art therapy literature, the role and utilization of countertransference in treatment has been discussed extensively (Agell et al., 1981; Allen, 1988; Klorer, 1993; Riley, 1999; Robins, 1988; Rubin, 1984; Wadeson, 1987; Wolf, 1985). Whether approached with great caution or embraced as a tool to be used within treatment, the prominence of such phenomena is undeniable, particularly in work with adolescents. Riley (1999) wrote that countertransference is a label "given to a human condition common to all relationships, in and out of therapy. How to turn these feelings and memories into a support for our adolescent clients is the goal that must be kept in mind" (p. 236). From this perspective, a number of art therapists have written about the process of making their own art either in collaboration with their clients in session (Haeseler, 1989; Moon, 1998) or as a means of processing countertransference post-session (Fish, 1989; Lavery, 1994; Marano-Geiser, Ramseyer, & Wadeson, 1990).

Fish (1989) and Lavery (1994) discussed using post-session imagery as a means of visually exploring countertransference issues that were unclear or as a means of self-soothing. Marano-Geiser, Ramseyer, and Wadeson (1990) delineated their reasons for creating post-session imagery to include processing of strong feelings, increasing empathy, and identifying and separating their own identifications and feelings of victimization from that of the client's treatment issues and needs.

Among those who work artistically alongside their clients, Haeseler's (1989) reasons for creating her own artwork in sessions included modeling a positive example, hastening the formation of the therapeutic alliance, and mirroring. Lachman-Chapin's (1979) self-psychology approach to art therapy also discussed the importance of mirroring, explaining that mirroring occurs effectively when the art therapist works in parallel with the client using her own art as a kind of "mirroring response." This allows the client to first borrow and then eventually build ego-strength from the example set forth through the empathic response of the therapist.



Figure 1



Figure 2

Method

Setting and Art Therapy Approach

The setting for the following case study was a day treatment program located in a large metropolitan area, which served emotionally disturbed adolescent girls ages 12 to 20. In conjunction with school services, the program provided a full-day therapeutic milieu including individual and group verbal therapy, art therapy, and family counseling. This case study focuses specifically on the first 4 months of individual art therapy sessions with Shantelle. Sessions were held on a weekly basis and lasted approximately 45 minutes. During this 4-month period, Shantelle attended 12 of 15 scheduled sessions. With the exception of the initial art therapy assessment, sessions were conducted in a non-directive, client-centered manner.

Response Art

For the purpose of this study, the term “response art” is conceptualized broadly. It refers to the therapist’s manipulation and use of art materials in response to the client in-session or as a means of processing feelings and reactions post-session.

In-session response art generally took one of the following four forms: (a) using art materials to mirror the client’s process as a form of empathic validation, (b) modeling specific methods and technical aspects of working with materials or creating a form, (c) modeling an overall general attitude and manner of connecting with and utilizing art materials, and (d) creating art images and symbols as a way of communicating with the client.

Post-session response art was employed primarily as a means of facilitating the exploration of countertransference. Accordingly, it was valued as an immediate outlet for the release of emotions, frustrations or identifications that were stirred up or projected onto me during the course of a session so that a more in-depth exploration of counter-

transference could then occur. In order to maximize its potential as a tool for learning and self-inquiry, response imagery was created after every session, whether I felt the need or not. I imposed a time limitation of approximately 30-45 minutes in order to parallel the time frame of client sessions. Moreover, I believed that such a limitation would help instill making response art as a regular part of my routine, considering the reality of having multiple responsibilities within the treatment setting. The approach to creating was generally spontaneous and without forethought, including spontaneity in choice of materials and theme of image/object ultimately created. After 30-45 minutes, the image or object was put aside without reflection or interpretative efforts at that time. Several days later, both individually and in supervision, I began the process of looking, reflecting, and otherwise trying to understand what I had created in response to my work with Shantelle.

Case Study

Client Description

Shantelle was a 13-year-old African-American girl with a history of severe emotional and behavioral difficulties. She was short, heavy-set, and had large brown eyes, though she rarely made direct eye contact with anyone. At the outset of treatment, Shantelle’s behavior within the milieu was especially explosive. She frequently antagonized other students, caused disruptions in the classroom and was oppositional with staff. When I went to get her for sessions, more often than not she could be found in the hallway or the “time out” room, as she tended to walk out without permission or be removed by staff because of her behavioral outbursts. In the hallways she often was observed touching and bumping up against others in an aggressive and attention-seeking manner, indicating a lack of appropriate relatedness and interpersonal boundaries. Though quite verbal, she was not particularly effective when communicating with others, and was referred for

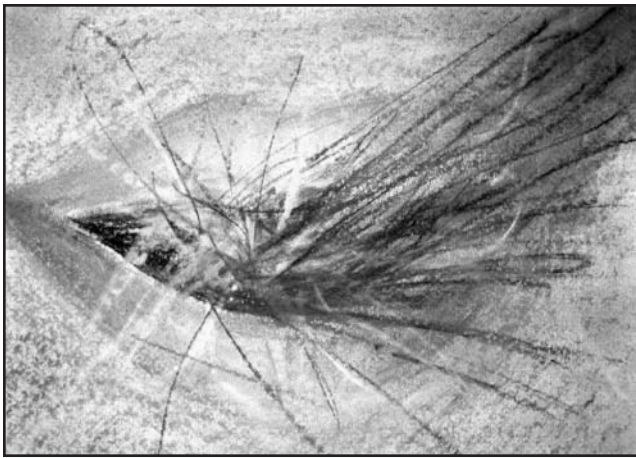


Figure 3

individual art therapy sessions. Shantelle was aware that not every student received art therapy services, and so perhaps her interest and excitement to begin art therapy treatment was in large part due to the individualized attention she knew she would receive.

Art Therapy Sessions

Phase I: Aggression, Regression, Roles, and Reenactments

Throughout the 4-month period of art therapy treatment described in this paper, Shantelle worked almost exclusively with clay. In the first phase of treatment (Sessions 1-5), she used the medium primarily to release regressive and aggressive impulses. Through mirroring, I validated Shantelle's expression and containment in the medium of her feelings and behaviors while also helping her to regulate regressive urges through the provision of clear structure and boundaries. For example, when Shantelle discovered the regressive properties of the clay slip, desiring to repeatedly immerse her hands in the slip bucket, I encouraged her to make handprints on a sheet of paper as a means of containing and practicing self-regulation for her regressive urge.

Shantelle invested little in the few rough and fragile objects she created during this phase of treatment as these objects were clearly secondary to her exploratory process (Figures 1 and 2). She created these forms quickly towards the end of each session as though she needed them simply to serve as the final and enduring punctuation to her play. It seemed as though they spoke, "I was here. I exist." These works contained defensive, stereotypic symbols (hearts, face caricatures, celebrity names) that appeared to lack genuine connection to her life. Not surprisingly, she was careless in her handling and treatment of these works. As both ceramic pieces were containers, the theme of containment seemed clearly connected to her persistent testing of boundaries and roles. Her behavior in these first sessions frequently sought to provoke me to play the role of aggressor in what appeared an attempt to reenact abusive and familiar patterns of relating with others. This occurred in our very first session when

Shantelle intentionally punctured a hole in the bottom of a cup filled with water to provoke my reaction, and persisted during the next several sessions with a variety of further malicious, yet subtle behaviors.

My exploration of countertransference through post-session response art was critical to understanding these reenactments. Following our third session, during which I witnessed Shantelle's violent method of applying glaze to her heart container using stabbing motions, I created Figure 3. I chose drawing materials, wanting nothing to do with clay due to the repulsive associations it held for me in that moment. Working quickly and frenetically, the image that emerged was a giant, open mouth, spewing a mess of black and white lines. While looking at the piece several days later, I could not help wondering if the drawing, a sort of "part-object," conveyed my dislike for Shantelle. The lines seemed to approximate her frequently hostile and inarticulate verbalizations that I felt the medium had only barely been able to contain. My self-reflective ego worried that this made me a "bad therapist" or otherwise indicated inability to handle what she was implicitly asking me to witness and contain. Supervision helped in processing these feelings more fully, bringing into greater awareness the complexities of Shantelle's object relationships that she sought to reenact through our relationship.

Ultimately, art making in response to Shantelle enabled me to more clearly separate feelings that were relevant to her treatment and those that triggered my own personal identifications. Remaining firm, consistent, and caring became my motto, and the reenactments lessened as Shantelle saw that she could trust in the relationship and art therapy holding environment. My own post-session response art then took a different tone, shifting away from part-objects to more of a cohesive whole. While creating Figure 4, I found myself swirling vine charcoal on a piece of paper until a face emerged. Adding peach, pink, and white, I emphasized the roundness of the cheeks over and over. Later, when looking at this piece, the words "big baby" kept coming to mind, perhaps reflecting the growing empathy that I began to feel towards Shantelle as I pondered her vulnerability.

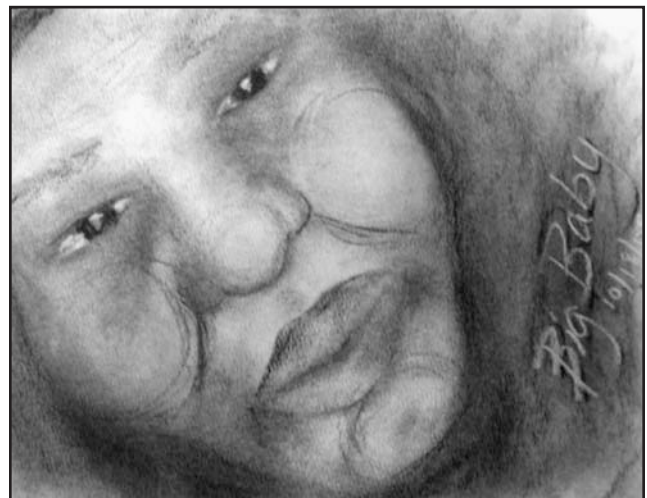


Figure 4

Concurrently, Shantelle's work also shifted towards more developed expression. The technicality involved in making her first coil pot required my role to shift to that of teacher, or "art expert," which I allowed by modeling the creation of my own coil pot. For the first time, Shantelle showed considerable investment in her work as well as the desire to gain artistic expertise. Furthermore, because Shantelle's behavior required me to continually reinforce firm boundaries, she gradually showed responsiveness to the protection this seemed to afford. She moved physically closer to me while working, seeking to copy and incorporate my process. In one particular session, she became interpersonally intimate with me, disclosing her experience related to the recent death of her great-grandmother.

In response to that session, I created Figure 5. For the first time in creating post-session response art, I felt the desire to stay with Shantelle's medium of choice. Previously my tendency was to rid the environment of the clay that had been worked so regressively and aggressively, instead choosing for myself a medium that allowed more control. However, my decision to finally work with clay reflected increased confidence and a shift in my own thinking. Despite my desire to avoid too much reflection during the actual creative process, I admit that I could not effectively distance myself from what had occurred moments before with Shantelle. Apart from the loss of her great-grandmother, her detached manner of disclosure made apparent the more longstanding loss of her ability to freely and authentically express herself related to her deepest emotions. As I worked, the cave became smooth on the inside and jagged on the outside. Reflecting the sadness I felt, the image of a girl huddled in the depths of the cave came to me and I formed a small figure accordingly.

In reflecting on the piece at a later time, I pondered the significance of the cave as an environment. Was it a dark and scary place or a place of refuge and safety? Or did the unfamiliarity of this potential "refuge" make it scary in and of itself? For me, the cave suggested a state of ambiguity, a place of uncertainty. It seemed to me the cave signified the treatment relationship itself that we had entered into together, with all of its uncertainties and hopes, and I saw the huddled figure both as a representation of Shantelle and myself.

Phase II: Approach and Avoidance

Because of risks taken at the end of Phase I, Shantelle's ambivalence played out more strongly in the second phase (Sessions 6-10) of treatment. Shantelle refused all but two of these sessions. This paralleled increased volatile behavior within the milieu in the aftermath of the death of her great-grandmother and the perceived threat of loss of familiar object relationships resulting from gains made in treatment. In other words, this newly developing way of relating with me seemed to challenge her familiar way of relating with an abusive caregiver and therefore was perceived as a threat to the attachment she had with that individual. My responsive art making was critical in understanding my countertransference to Shantelle's pattern of approach and

avoidance. Post-session art making (and art making during our regularly scheduled time when Shantelle refused to attend a session) made me aware of my feelings of disappointment related to the gains I felt had been made in treatment. As a result, I became conscious of my own desire to pull away as a protective response to Shantelle's unpredictable behavior.

Yet another shift occurred in treatment towards the end of Phase II when Shantelle unexpectedly came across my clay sculpture of a girl in a cave (Figure 5). In a spontaneous moment of therapist transparency, I disclosed my motivations for the piece. When Shantelle asked who had made the piece, I responded that I had after the session in which she had told me about the death of her great-grandmother. I honestly stated that what she had previously shared had made me feel deep emotions and so I decided to express those feelings through art. She immediately declared an intention to make a similar sculpture, suggesting an inner desire to connect through imagery with the intensity of her own emotions. Shantelle began focused work on this endeavor at the end of Phase II with the full expectation that I would work alongside her to model the process.

Phase III: Working it Out in the Art

Shantelle began and completed the intense emotional journey symbolized by the "cave and girl" sculpture (Figure 6) in this next phase (Sessions 11-15) of our work together. Shantelle was focused and dedicated to completing this work, despite its connection with strong emotional content that she typically had defended against through acting out behaviors. Whereas previously she had acted out ambivalence within the context of our relationship, in Phase III she was able to use the art as the container for that ambivalence. Shantelle alternated between the strong emotional content of the sculpture and a structured, benign bead-making process. This allowed her necessary respite from the emotional and at times overwhelming nature of the content and process; for Shantelle, there was a high level of interpersonal intimacy inherent in the process because of having to rely and trust in me as the "art expert."

In Phase III of treatment, Shantelle exhibited occasional reversion to the regressive behavior seen regularly in Phase I. By allowing this regression for a time and then directing her towards a means of containing it (making handprints), Shantelle practiced self-regulation and was able to continue focusing on the creative process. I assisted her when needed, while also encouraging her to do certain things independently that I knew she had mastered, conveying my confidence in her abilities. Because Shantelle had previously exhibited significant frustration when attempting to create a human figure out of clay during the initial art therapy assessment, I was prepared to provide hands-on assistance when she embarked on the endeavor of creating a female figure for her cave. Throughout, it was important that my assistance did not distort her own vision of the person. This was challenging to negotiate because of her desire to re-create my sculpture. However, the small ways in which she differentiated her figure from mine, such as by



Figure 5

choosing to have part of the face visible as well as the inclusion of a small cat, indicates that this was accomplished.

Discussion and Summary of Treatment Gains

From the outset, Shantelle was attracted to clay because of the opportunities for regression it afforded. She initially showed little concern for the aesthetic quality of the first several objects she created, most of which emerged as after-thoughts to her regressive exploration. After a period of play and exploration, her work gradually shifted towards formed expression. She became more concerned with technicalities and aesthetics. Prior to the cave sculpture, she worked in close collaboration with me on the creation of the coil pot. Though she was very concerned with the outcome of the coil pot, there was little connection to the immediacy of her life experience in the work itself. However, the coil pot was important in giving her fragile ego feelings of mastery and success so that she could subsequently begin to take more risks with her art making.

The emotional significance of Shantelle's final work (Figure 6) stands out when looking at the works that preceded it and, indeed, it was a more risky endeavor. Though she largely modeled it on another work, it represents her first foray within the art therapy arena using the medium as a means of connecting more authentically with a deeper aspect of her self. I served as a model from which she could borrow ego strength and gain technical support, but I feel that my most important function was as a witness to her emotional process.

Concerning her desire to replicate my sculpture, I was initially apprehensive when Shantelle saw it and voiced wanting to create one similar to mine. I was concerned that she had now been unduly influenced to follow in my aesthetic style rather than being expressive in her own right. I cannot deny that she was influenced as, indeed, she mainly copied what she saw. However, two things came to mind that significantly reduced this apprehension. First, there was an entire table filled with clayware by which she might have been influenced. Without knowing that this cave was made in direct relation to her experience, she saw it and

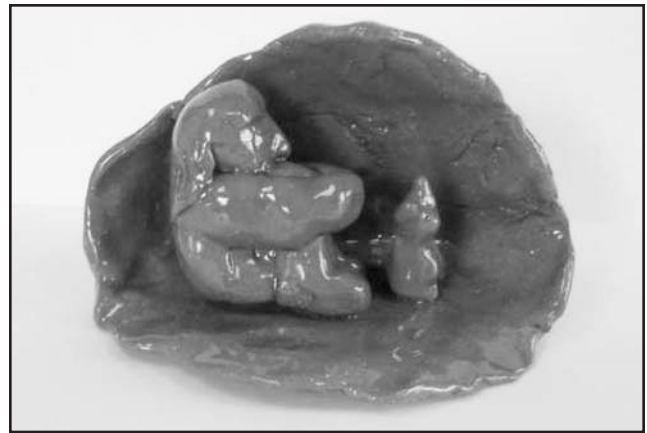


Figure 6

was immediately attracted to it. I believe that she saw a part of herself in this image and was attracted to it because of her deep need for self-integration, even before she knew the motivation behind the image. Second, trauma theory may help to explain why Shantelle desired to replicate an object that perhaps represented, unconsciously, the embodiment of an emotion with which she wished to make contact.

As discussed by van der Kolk (2005), severe learning difficulties result from the inability to imagine, which impacts the ability to think creatively and abstractly, and to take risks. Thus, a key component of treatment for children with developmental trauma is giving them experiences in a safe and predictable environment through which they can experience mastery and competence. That said, Shantelle needed experiences of success and mastery to accompany movement towards approximating a more authentic side of her self and therefore she relied on emulating my work to make this shift. It is important to note, however, that she did make several of her own aesthetic choices in the creation of this piece, suggesting some movement towards creative autonomy.

Over time, Shantelle became more willing to ask for help when needed, trusting more fully in my interventions and the creative process overall. Various aspects of her process indicated increased feelings of mastery and competence. For example, upon completing the cave sculpture, Shantelle's attitude towards the work suggested a palpable sense of accomplishment. Despite its emotional content, she desired to have the work displayed in the art therapy room and became known among her peers as a "clay expert." Consequently, her strengths became more visible to the community at large, in turn, building her self-esteem and helping to improve her relationships with others. Furthermore, during the sessions she took growing pleasure in doing little things, such as being the one to open the clay slip container or turn off the light, evidencing her increasing mastery over her environment. She eventually took over from me the responsibility of cutting the clay and setting up the working area for both of us. Being able to provide for herself and give back to me in this manner appeared empowering for Shantelle.

Conclusion

This paper has attempted to show that responsive art making, whether in-session as a means of responding empathically to the client through modeling and mirroring, or post-session as a means of exploring countertransferential reactions, was fundamental to the client's progress towards achievement of treatment goals. The conception of Developmental Trauma Disorder identified by van der Kolk (2005) was important in understanding the mechanisms involved in Shantelle's maladaptive affect and behaviors, as well as identifying and creating art therapy treatment goals accordingly. Thus, the most critical goals in working with Shantelle were (a) providing a safe and consistent art therapy environment in which she could work towards experiences of mastery and competence, (b) recognizing and working towards resolution of traumatic reenactments within the treatment relationship, and (c) helping her work towards integration of body and mind by promoting art making experiences that encouraged relaxation and exploration, as well as feelings of empowerment, being in charge, and solving problems.

My own processing of countertransference through post-session response art was crucial to my ability to safely witness and contain Shantelle's externalized material in the therapeutic relationship and art. Response art provided an important means of releasing strong feelings that were projected onto me during the course of a session, but more importantly, served as a concrete record of my own feelings and reactions to the client in order to better facilitate understanding of complex countertransferential issues. Additionally, response art that occurred in session, whether through mirroring or the offering of an art symbol as a means of communication, was paramount in providing empathic attunement and validation to Shantelle's efforts towards growth. Unquestionably, one of the most significant moments in treatment occurred when the response art itself was unexpectedly discovered by the client and, in this way, became an unintentional form of therapist self-disclosure. The specific question of response art as therapist self-disclosure is a unique and interesting one that needs further exploration.

Response art is a visually concrete method in which the therapist can explore his or her own feelings outside of session or to communicate with a client in-session. The value of response art should not be underestimated when working with adolescent survivors of developmental trauma in consideration of the overall potential impact it can have on the course of treatment.

References

- Agell, G., Levick, M., Rhyne, J., Robbins, A., Rubin, J., Ulman, E., Wang, C., & Wilson, L. (1981). Transference and countertransference in art therapy. *American Journal of Art Therapy, 21*, 3-23.
- Allen, P. B. (1988). A consideration of transference in art therapy. *American Journal of Art Therapy, 26*, 113-118.
- Amini, F., & Burke, E. (1979). Acting out and its role in the treatment of adolescents: An object-relations viewpoint. *Bulletin of the Menninger Clinic, 41*(2), 249-259.
- Dopart, T. (1983). The cognitive arrest hypothesis of denial. *International Journal of Psychoanalysis, 64*, 47-58.
- Fish, B. (1989). Addressing countertransference through image making. In H. Wadeson, J. Durkin, & D. Perach (Eds.), *Advances in art therapy* (pp. 376-389). New York: John Wiley.
- Haeseler, M. P. (1989). Should art therapists create work alongside their clients? *American Journal of Art Therapy, 27*, 70-79.
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Klorer, G. (1993). Countertransference: A theoretical review and case study with a talented client. *Art Therapy: Journal of the American Art Therapy Association, 10*(4), 219-225.
- Lachman-Chapin, M. (1979). Kohut's theories on narcissism: Implications for art therapy. *American Journal of Art Therapy, 19*, 3-8.
- Lavery, T. P. (1994). Culture shock: Adventuring into the inner city through post-session imagery. *American Journal of Art Therapy, 33*, 14-20.
- Marano-Geiser, R., Ramseyer, J., & Wadeson, H. (1990). Through the looking glass. *Art Therapy: Journal of the American Art Therapy Association, 7*(3), 107-118.
- Mishine, J. M. (1986). *Clinical work with adolescents*. New York: Free Press.
- Moon, B. L. (1998). *The dynamics of art as therapy with adolescents*. Springfield, IL: Charles C Thomas.
- Riley, S. (1999). *Contemporary art therapy with adolescents*. London: Jessica Kingsley.
- Robbins, A. (1988). *Between therapists: The processing of transference/countertransference material*. New York: Human Sciences Press.
- Rubin, J. A. (1984). *The art of art therapy*. New York: Brunner/Mazel.
- van der Kolk, B. A. (2005). Developmental trauma disorder. *Psychiatric Annals, 35*(5), 401-408.
- Wadeson, H. (1987). *The dynamics of art psychotherapy*. New York: John Wiley.
- Wolf, R. (1985). Image induction in the countertransference: A revision of the totalistic view. *Art Therapy: Journal of the American Art Therapy Association, 2*(3), 129-133.