

# **Art Therapy and Internal Family Systems Therapy: An Integrative Model to Treat Trauma Among Adjudicated Teenage Girls**

Majie Lavergne, MA, CHT, CGT

## **Abstract:**

*The first part of this paper examines the clinical definition of Post Traumatic Stress Disorder (PTSD), how it is different among adolescents, and its incidence among adjudicated teenagers in particular. The second part of this paper presents an integrative model for working with trauma among adjudicated teenagers. This model combines two different approaches: Art Therapy and Internal Family Systems Therapy (IFS). The argument is made that this particular model is well suited for adjudicated teenagers. In the third part, a three-phase treatment plan is outlined and a case study is reviewed in detail. Artwork and standard PTSD pre- and post-test are included.*

## **Introduction**

In the last ten years, trauma has become one of the most researched areas in the field of psychology. However, most of the research has focused on adults. Trauma among children and teenagers remains a fairly new area of exploration and even less attention has been paid to the adjudicated teenage population.

In the United States, the term "adjudicated teenager" refers to a juvenile (between ages 10 and 17) who has been found guilty or pleaded guilty of an offense, either a misdemeanor or a felony. Depending on the severity of the offense and other factors, adjudicated teenagers can live at home, in placement (such as in a group home or in a treatment center) or in jail. In Canada, the equivalent term used by the justice system is "young offender".

The first part of this paper looks at the clinical definition of Post-Traumatic Stress Disorder (PTSD) and its incidence among teenagers and adjudicated teenagers. Although research shows that the incidence of trauma and PTSD is much higher among adjudicated teenagers than among the general teenage population, trauma therapy remains in large part inaccessible to adjudicated teenagers. Effective trauma therapy that meets the needs of adjudicated teenagers requires the consideration of their specific life situations and developmental needs.

The second part of this paper presents an integrative model for the treatment of trauma among adjudicated teenagers. This model represents a synergy of two distinct modalities: Art Therapy and Internal Family Systems Therapy (IFS). I will briefly discuss the theoretical underpinnings of each modality and discuss why the integration of the two is appropriate for this population.

The third part of this paper presents a case study and illustrates this the integrative synergetic model. A seven-week treatment plan is outlined and discussed in detail. The participants' as well as standard PTSD pre- and post-tests are included. Finally, the limits and possible future applications of this model are discussed.

## **Post-Traumatic Stress Disorder (PTSD); A Clinical Definition of Trauma and its Variability Among Teenagers**

A traumatic experience is generally defined as one in which an individual experiences a threat to his or her or someone else's life or physical integrity and responds with intense fear, helplessness, or horror. The diagnostic criteria for trauma in the Diagnostic and Statistical Manual Version Four (DSM IV) include three symptom clusters lasting more than one month after the traumatic event that cause clinically significant distress or impairment (Morrison, 1995). The three main symptom clusters are:



- 1) Intrusions (flashbacks or nightmares, where the traumatic event is re-experienced);
- 2) Avoidance (the person tries to reduce exposure to people or things that might re-trigger the intrusive symptoms);
- 3) Hyper-arousal (physiological signs of increased arousal, such as hyper-vigilance, increased startle responses or numbness).

However, the definition of PTSD as described in the DSM IV may be insufficient to adequately understand PTSD among teenagers. Terr (1991), for example, formulates two different types of PTSD based on the frequency and duration of trauma. Terr distinguishes between a single traumatic event such as accidental injury (Type I) and on-going trauma over a period of years such as repeated sexual abuse (Type II). While the classic triad of re-experiencing, avoidance/numbing, and hyper-arousal symptoms may adequately describe Type I trauma, Type II trauma can lead to a number of additional symptoms including, denial, dissociative symptoms, emotional numbing, and anger. In addition, academic decline, depression, suicidal thoughts, physical complaints, substance abuse, withdrawal and isolation may also be signs of Type II trauma in adolescents. Terr (1991) emphasizes that these symptoms may not fit the exact PTSD profile set by the DSM IV, and that the full symptom complex may not develop until later or may fluctuate substantially over time. Rosenberg (2001) states that among teenagers, variability in PTSD symptoms is the rule, and PTSD as described by DSM IV may be the exception. Terr recommends that consideration be given for PTSD treatment even when only partial diagnostic criteria are met among teenagers. Trauma, PTSD and Adjudicated Teenagers

Studies among the general U.S. population show that 14% to 43% of girls and boys have experienced at least one traumatic event in their lifetimes. Of those children and adolescents who have experienced a trauma, 3 to 15% of girls and 1 to 6% of boys will be diagnosed with PTSD (Hamblen, 2002).

However, rates of trauma are much higher among adjudicated teenagers.

Experiences of abuse are common for girls involved in the juvenile justice system. For example, in the state of California, 81 % reported physical abuse, and 56 % reported sexual abuse (Acoca & Dedel, 1998). A Florida study showed similar victimization rates among juveniles in secured detention: 65 % of females and 24 % of males were sexually victimized and over half reported some form of physical abuse, with 17 % requiring medical treatment (Dembo, Williams, Wothke, Schmeidler, & Brown, 1992).

Given the fact that juvenile offenders are at a high risk of victimization, one might expect the prevalence of PTSD to be much higher among juvenile offenders than among the teenage population as a whole. In fact, this seems to be the case. Chapman (2003) reported alarming data, stating that 80 % of U.S. adjudicated teenagers suffer from PTSD. In their studies of incarcerated youth in California, Cauffman and Feldman (1998) reported lower, though still startling, figures -- 65 % of adjudicated girls experienced PTSD at some point in their lives.

While many types of trauma can lead to PTSD, 50 % of adjudicated boys with symptoms of PTSD witnessed an interpersonal violent act, such as the killing of a family member or friend (Cauffman, Feldman, Waterman, & Steiner, 1998). Similarly, adjudicated girls reported both witnessing and experiencing violence, with 60 % reporting having been raped or in danger of being raped.

Researchers have raised the concern that rape, battering, child sexual abuse, and other forms of victimization could be potential pathways to substance abuse and crime (Chesney-Lind, 1997; Richie & Johnson, 1996). Hamblen (2002) reports that adolescents who have suffered trauma are more likely than adults to exhibit impulsive and aggressive behaviors. Unresolved trauma also seems related to antisocial behaviors, common among adjudicated teenagers (Lavergne & Warson, 2003). For both males and females, Foy and



Guevara (1996) posit that there is a correlation between traumatic exposure (Terr's Type II trauma) and the development of mental health illnesses, substance abuse, and delinquency.

In conclusion, the alarming incidence of PTSD symptoms and the correlation between PTSD and other psychological and behavioral problems among adjudicated teenagers raises serious questions for mental health professionals. As Stone (1993) writes, "No diagnosis in the history of American Psychiatry has had a more dramatic and pervasive impact on law and social justice than post-traumatic stress disorder," (p.23). How can this population be reached and these teens be helped to integrate past traumas? What therapeutic modalities will appeal to adjudicated teens? How can a safe container be provided, resources be developed, and members of this population be helped to integrate their pasts and move on?

### **Treatment: An Integrative Model**

The following integrative model, interfacing Art Therapy and Internal Family Systems Therapy (IFS), is intended to provide some answers to these challenging questions. Theoretical underpinnings of each approach, as well as their synergy, will be discussed.

### **Art Therapy, Trauma and Teenagers**

Powell and Faherty (1990) have extensive experience running creative arts groups for sexually abused latency age girls. They point out that communication through creative arts is now seen by many in the mental health field as the most appropriate and least stressful way to assess and treat sexually abused children. They have also found that children are more easily engaged through art making (related either directly or indirectly to the traumatic event) than through talking.

Criticisms raised by some therapists about the efficacy of talk therapy to access and process traumatic memories are now being supported by recent developments in neuroscience. Recent research shows that traumatic memories are held in the right

hemisphere of the brain (Parnell, 1999). Appleton (2001) states that art directly accesses the right brain, and that creating art is an effective methodology in recalling, processing and resolving held memories of trauma. In addition to accessing the right hemisphere, creating art also stimulates the left hemisphere functions of the brain through, for example, planning and organizing. Art making therefore engages both hemispheres and allows for both implicit memory (non-verbal, perceptual, somatosensory memory) and explicit memory (narrative memory) to integrate traumatic memories. Hence, a traumatic memory located in the right hemisphere is made clearer and more explicit through the formation of an image in the left hemisphere (Appleton, 2001).

While creating art helps to process traumatic imagery, it also provides a safe degree of distancing between the content of the imagery and the self (Anderson, 1991; Cohen, 1995; Estep, 1995). Dalley (1984) emphasizes that drawing and engaging symbolized feelings and experiences can render the traumatic memories less threatening. Golub (1985) concludes that creating art offers the client the opportunity to reflect, integrate, reframe, and practice mastery over his or her traumatic experience.

Riley (2001) posits that art therapy groups are perfectly suited to the developmental needs and defenses of teenagers. First, such groups address the need for peer support and second, the need for privacy, separation and autonomy from adults. An artistic statement is a projection of self and is thus identity affirming (Riley, 2001). Creating art can be self-esteem building (Franklin, 1992). Malmquist (1978) also points out that creativity is a sorely neglected but dominant trait of adolescence.

In summary, Art Therapy supports teenagers' needs for peer support and privacy from adults and provides a less threatening modality to address difficult issues. It taps into their creativity and is self-esteem building. It supports right and left brain functioning. Finally, artistic expression creates a certain distancing from the traumatic memory which supports psychological integration.



## Internal Family Systems Therapy

Internal Family Systems Therapy (IFS), developed by Richard Schwartz, is a trauma model that draws upon systems theory and family systems in particular (Schwartz, 1995). IFS proposes that we each have different inner "parts" that can get stuck in rigid roles similar to the way members of a family can get stuck in roles. In addition to these parts, IFS proposes that we each have a Self that is inherently clear, calm, compassionate, wise and capable of leading. IFS uses specific therapist-client dialogues and techniques to help clients access and un-blend their parts from their true Selves. Usually IFS is used in individual therapy and clients are asked to turn *within*, towards their own intra-psychic system.

According to IFS parts can be thought of as sub-personalities with likes, dislikes, histories and burdens. Parts are autonomous yet are in various forms of relationships with each other. All parts try to accomplish something positive. Parts are valuable. Unfortunately, because of traumatic or difficult life events, parts often acquire extreme and rigid qualities. Parts end up burdened and stuck in the past and this creates disharmony within the internal system. Some parts may be polarized, merged or form fixed alliances. While some parts may be over-protecting through extreme means, others may be using compulsive behaviors to numb out the pain. In general, parts tend to fall into three categories: exiles, managers and firefighters. The following discussion describes the three types and their roles.

**Exiles.** These parts are often developmentally young. They are vulnerable, wounded and sometimes damaged. They are the receptacles of trauma and/or developmental injuries. They feel isolated from the rest of the system. They carry burdens (i.e. memories, secrets, deep loneliness, confusion, freezing, dissociation, etc.) and are stuck in the past. Positive attributes, such as creativity, sensitivity and power can also be exiled. Exiles are isolated from the rest of the internal system and feel a great need for protection and acknowledgement, yet they are forced by other parts to stay in exile

in order to protect the rest of the internal system from being overwhelmed by pain. Exiled parts are containers of somatic constrictions and tensions as well as negative introjects (i.e. "I am a failure," "I deserve to be badly treated," etc.). Victims of incest and sexual/physical abuse often hold potent exiles. Under stress, exiles may eclipse the Self.

**Managers.** These parts manage our lives; they run our day-to-day experience. Their job is to make sure that the person is functioning and that everything is under control. Managers keep tight rein over the exiled parts. Behaviorally they can look like care taking, intellectualizing, avoiding risk-taking, looking for approval, being passive, detaching emotionally, perfectionism, worrying, and so on. Managers tend to compensate in order to keep the system in homeostasis. They are highly protective and invested in controlling the environment for continued safety. They are usually forced into their roles; they work overtime and feel very identified with their jobs. They also eclipse the Self and would actually rather relax and release their gripping control if they really knew it was safe to do so.

**Firefighters.** Like the managers, the firefighters' job is to keep the exiles away, though they act from a more intense and impulsive place. They leap into action to contain or extinguish feelings, sensations or images coming from the exiles. They act up when the managers can no longer contain the exiles. Firefighters will do anything to keep the exiles away. Firefighters are compulsive parts that stimulate drug or alcohol use, gambling, suicidal ideation, rage, self-destructive eating behaviors, over-spending, self-mutilation, sex binges, dissociations and freezing.

**The Self.** The Self is the seat of consciousness. It is the witnessing "I." It is not visible because it is the one who is observing. The Self holds qualities of compassion, confidence, creativity, calmness, connectedness, wisdom, courage and good leadership. Differentiating the Self from wounded and/or protective parts is a main tenet of the IFS model.



Ultimately the idea is to unburden all the parts and assist the emergence of a healthy system organized around trust, acceptance and integration of differences under the compassionate leadership of the Self. Deep down, parts want to be released from their extreme and destructive roles and will transform when it is safe to do so. Restoring the Self, with its inherent capacity to lead, is key to creating a harmonious internal system. As the healing energy of the compassionate Self is reinstated, the internal system goes through growth and transformation. The exiles, managers, and firefighters let go of their grip and extreme positions. Under the umbrella of the Self, parts learn to find a more harmonious way to relate to each other, thus bringing new balance to the internal system and outer life of the client. In IFS the Self, when unblended from the parts, becomes a co-therapist working towards healing and transformation.

### **Art Therapy and IFS: A Synergetic Model**

When combined, Art Therapy and IFS may provide a powerful and synergistic model for working with trauma among teenagers. Both models address critical developmental needs of adolescence and both provide effective means for safely and effectively processing traumatic experiences.

Developmentally, adolescence is marked by a need to individuate and to affirm one's self. The constant quest towards achieving some answer to the question "Who am I?" is the focus of adolescence (Riley, 2001). This search for identity and self-understanding can be helped and facilitated by exposing teenagers to a "parts" model such as IFS. Teenagers' abstract thinking abilities have reached a level that allows an understanding of the language of parts. They can identify and relate to a sad part of themselves, an angry part, a bored part, and so on. To experience that behind an angry part is a hurt part fosters self-awareness and leads to valuable insights, especially for a teenager who tends to display aggressive and violent behaviors. Identifying the Self, with its qualities of compassion and good leadership, can be a

profound shift for teenagers who have formed an identity around their angry parts.

While a model such as IFS helps self-awareness and identity formation, Art Therapy creates a safe and inviting environment. Teenagers typically feel more at ease engaging and giving voice to psychological aspects of themselves through art than through talking, especially in the presence of adults such as group leaders and therapists. In Art Therapy, participants do not have to comment about their art if they do not want to. When teenagers' needs for privacy, separation and autonomy from group leaders are respected and supported, they typically feel more empowered and the therapeutic process is facilitated.

While Art Therapy and IFS match teenagers' developmental needs, both of these approaches are also effective therapies for processing hurtful and traumatic life events. IFS proposes a solid, non-pathological map to work with various parts of the person, including the exiled parts that usually hold traumas and/or painful life events. Artistic expression gives voice to these parts. The parts are given a chance to express themselves, and to be externalized.

Once a traumatized part has been externalized through drawing or sculpting, a psychological distance is created which helps to differentiate and un-blend the traumatized part from the Self. Because IFS assumes that the Self, with its positive attributes, is always present, un-blending parts from the Self is key to restoring the system to its greatest state of health. In short, artistic expression helps to un-blend parts from the true Self, an essential element in IFS therapy.

Making art also stimulates left and right hemispheres of the brain and therefore may help with the accessing of painful and traumatic events. In IFS terms, art making facilitates the unburdening of the exiles.



## Conclusion

Both Art Therapy and IFS offer valuable contributions for working with adolescents and with trauma. Both modalities support key developmental needs of teenagers (autonomy from adults, identity formation, self esteem, etc.). Both offer effective ways to process painful and/or traumatic life events. Combined, they support and enhance each other. Artistic expression can give voice to the exiled parts that hold past pain and injuries. This process of un-blending and unburdening the exiled parts in turn helps restore the Self. Art making helps to externalize and un-blend parts, while Self energy provides the confidence and safety to express and transform past hurts.

## Clinical Application: A Case Study

The following case study illustrates the use of this integrative approach. I designed a protocol that integrated Art Therapy and IFS specifically for teenagers struggling with painful/traumatic life events.

Originally, I planned to run a ten-session group (two hours per session) with four to six adjudicated teenagers selected with the cooperation of the director and probation officers of Judicial District A, located in the suburb of a major Western U.S. city. The probation officer and center director recommended that all participants be of the same gender to minimize sexual and competitive undertones. After having interviewed eight adjudicated teenage girls, only two were able to make a full commitment to the group. This ratio is not unusual in group activities among adjudicated teenagers.

Transportation to the site where the dyad-group was run was challenging for both participants (they lived far away and public transportation was not easily accessible). Both participants depended on the good will of the sister of one of them (who was pregnant) to transport to and from the group site. In order to accommodate the participants' problems with transportation and to ensure completion of the treatment plan, the group's schedule was

adapted. Instead of ten two-hour sessions, there were seven sessions, each lasting between two and a half hours and three and a half hours. The treatment plan remained unchanged.

Before starting the group, I interviewed each participants and explained that the purpose of the group was to give voice (through artmaking) to hurtful and challenging life events to which they had been exposed. I purposely avoided clinical jargon such as "trauma". During the interviewing process, I made my two requirements clear: (1) participants needed to have some interest in making art (though no experience was required) and (2) they needed to have an understanding of the purpose of the group and see some benefits in giving voice to hurtful events through art.

One of the basic tenets of the treatment plan was that parts can be effectively accessed and experienced through art making. Interventions included drawing, painting, embellishment of masks, clay work and visualizations. The treatment plan had three stages or phases (see table 1), moving from one phase to the next only when and if the goals of the prior phase were met. Phase One goals (sessions one through four) were to foster safety, to introduce parts, to develop internal resources and access the Self, and to promote inner parts dialogue. The Phase Two goal (session 5) was to process the hurtful/traumatic event(s) and losses. Phase Three (sessions six and seven) focused on integration and containment.

The dyad/group was comprised of two late adolescent girls. Amelia, a seventeen-year-old Latina, had been found guilty of two misdemeanors. Her probation office recommended the group. She joined voluntarily. Reena, an eighteen-year-old Native American girl, had been found guilty of one misdemeanor. She was mandated to attend the group by the same probation officer. Both names have been changed to maintain confidentiality.

Neither of the girls were enrolled in school. While both came from chaotic and unstable family situations, each was living with family members at the time. While both were

**Table 1**

<b>Phase</b>	<b>Goals</b>	<b>Art Intervention/Visualization</b>
Phase 1	Foster safety	Safe place
	Introduce the concept of parts	Mask work and drawing
	Develop internal resources and access the Self	Create helper/ally
	Promote inner-parts dialogue	Inner-parts gathering Parts dialogue with ally/helper
↓		
Phase 2	Process hurtful/traumatic event (s) and losses	Making of booklets Telling the stories through images and words
↓		
Phase 3	Integration and containment	Part checking Clay pot

adjudicated, neither had been incarcerated. For this reason and others, some may consider Reena and Amelia to be relatively high functioning adjudicated teenagers.

### **Assessment**

Both participants were tested using the PCL-C, the most standard PTSD assessment tool (see Appendix A). The PCL-C consists of a self-reporting form with 17 items organized

around three symptom clusters: hyper-vigilance, intrusions and avoidance. A PTSD diagnosis requires a score of 44 points.

Only Amelia, came close to meeting the criteria for full PTSD. With a score of 39 Amelia demonstrated significant symptoms, especially flashbacks, disturbing dreams and a need for avoidance. As mentioned above, Terr (1991) recommends treatment for teenagers who partially meet the diagnostic criteria.

Reena, the other participant, scored 23. Since Reena did not meet the criteria for PTSD,



this case study will focus on Amelia. However, I have included Reena's art work and process to show contrast between two young women with differing severity of symptoms.

### **Building the Container: Signing In and Signing Out**

At the beginning and end of each session, participants "signed in" and "signed out" by making a mark on a large piece of paper. The following drawing is the end product of the 7 sessions.

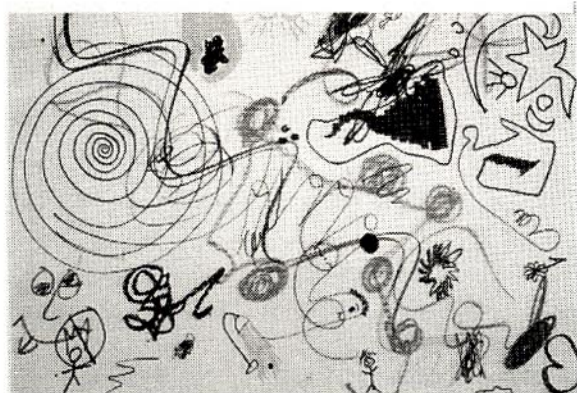


Figure 1: Signing In and Signing Out

Because making a "mark" meant the beginning and the end of each session, this short ritual was helpful in creating the therapeutic container and group cohesiveness. Over time, the participants made bolder and more creative marks, which I perceived as signs of increased safety and creative freedom. This collective drawing reflected the group's growth and became valuable therapeutic information. By the fourth session, the participants were also invited to make a sound that went with the mark. The intention behind this new intervention was to promote increased self-expression. After being initially self-conscious, both participants enjoyed the ritual. I was pleasantly surprised when Amelia reminded me, twice, that I had forgotten to initiate the sign out ritual. It became clear that she had come to enjoy the consistency of the structure.

### **Phase One: Fostering Safety, Inner Resources, and Inner Parts Dialogue**

In the first session, I guided participants in a visualization leading to their safe place. White and colored paper were provided. I chose to include colored paper because it offers a sense of control and helps with the initiating stage of art-making. Participants were then asked to draw or paint their safe place.



Figure 2: Safe Places: Amelia's drawing (top) – Reena's drawing (bottom)

Reena depicted her safe place as a castle. Amelia (top drawing) described her safe place as a path leading to a lake. On the left of the lake, there is a bed where her boyfriend is waiting for her. Art therapy research (Cohen, Hammer, & Singer, 1988) suggests that using half of the page or less, as in Amelia's drawing, may be an indicator of depression. Their research on the use of space in drawings may also apply to people who suffer PTSD symptoms. Although it is impossible to draw any conclusion it is worth noting the differences between Amelia's and Reena's artwork and their respective diagnoses.



Next, I initiated a group discussion about safety. Using a scale from 0 to 10 (10 very safe, 0 very unsafe) I asked participants to rate their level of safety outside of the group and inside the group. Amelia rated her level of safety outside the group at 2 and Reena rated hers at 5. Amelia's low score regarding her level of safety is congruent with her PTSD symptoms and with recent events in her life: prior to joining this dyad/group Amelia had been physically assaulted by three female teenagers.

Participants were also asked to rate their level of safety within the group. Both rated safety at 10, indicating an early and a high level of group cohesiveness. This may seem like an unusually high level of safety for a first session. It is my clinical impression that both participants were sending a meta-message to each other, conveying mutual appreciation.

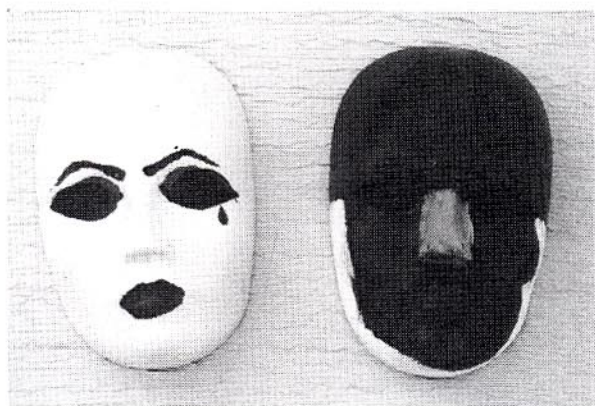
### Moving from an external to an internal focus

In the following two sessions, the participants worked with white masks. I asked each to paint the outside of the masks using acrylic paint to depict, "how you show yourself to others, to the outside world."

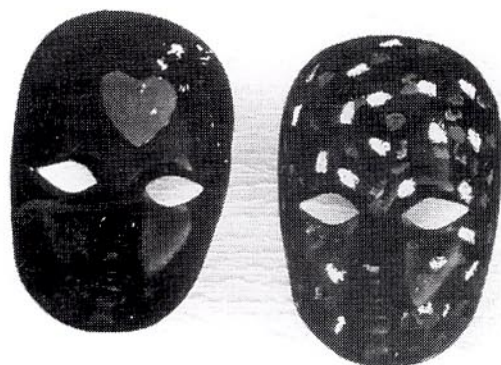
Amelia (on the left) painted only the eyes, the mouth and a single tear. She said that she did not want to talk about what her mask meant to her. In this moment, Amelia clearly expressed her need for privacy and the single tear may be communicating as much as she could in that moment. Unlike Amelia, Reena was eager to talk about her mask. She said she liked her mask and was excited by her choice of colors.

In contrast to the outer focus of the previous intervention, the following intervention focused on each participant's internal world and feelings, towards her intra-psyche ecology. I invited the participants to paint the inside of the mask to depict, "how you really feel inside."

Amelia's mask (left) depicted a red heart against black. Again Amelia did not want to share much about the inside of her mask. She said however that the black meant "anger and



Amelia's mask      Reena's mask  
Figure 3: What Others See



Amelia's mask      Reena's mask  
Figure 4: What's Inside

disappointment." Reena, on the other hand, associated each colored dot to a feeling or state: white equaled emptiness, blue equaled calm, green equaled anger, red equaled love, yellow equaled sadness. Following the IFS model, Reena was already showing through her art and verbal sharing an understanding of her different emotional parts (a sad part, an angry part, etc.). In contrast, the inside and the outside of Amelia's mask could be viewed as stereotypical art. According to Kramer (1971, 1979), the use of stereotypical art indicates a psychological defense.



The following art intervention continued to direct the focus inward and started to introduce the concept of parts. I asked participants to pick a part of the inside of the mask (e.g. a sad part, happy part) and to make a drawing of it.

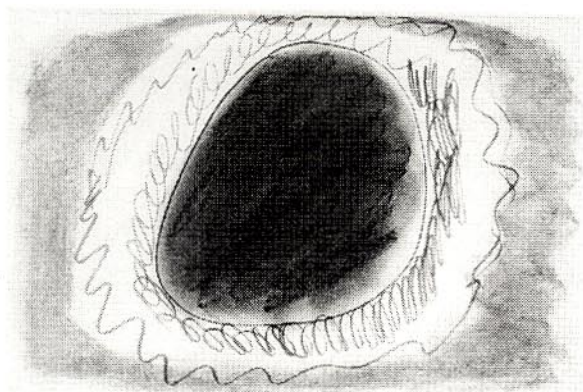


Figure 5: Reena's feelings

With respect to the above drawing, Reena referred to the black circle as sadness, the other colors representing "feelings covering other feelings." Again each color was associated with a specific feeling. Reena commented that she now understood her various feelings better.

Amelia refused to do this art activity. She argued that if "everything was black, there was clearly nothing to draw." Following Amelia's refusal, she and I engaged in something of a power struggle. Once I became aware of the power struggle, I named it and told Amelia that she was free to do whatever she wanted. In IFS terms the art intervention had triggered one of Amelia's managers, which in turn triggered one of my managers. In IFS, a therapist's awareness of parts helps not only in understanding his or her clients but also in understanding him or herself and in managing counter-transference.

Towards the end of the session, I initiated a discussion about parts (angry parts, sad parts, protective parts). I used the blackboard

for a visual representation of the parts they described. Amelia was clearly less engaged and quieter than Reena.

### **Engaging the Self, developing resources and inner parts dialogue.**

IFS therapists use specific techniques to help clients access the Self. Such individualized attention is difficult to accomplish in a group setting. The concept of the Self is also fairly abstract. The following intervention was designed to help Amelia and Reena understand and access Self energy in a concrete way.

Using guided imagery, the participants were led back to their safe places where they were invited to imagine a helper or ally. The helper/ally could be a real person in their lives, an imaginary person or thing or whatever they wanted. I defined the helper/ally as a positive force, a force to be trusted. Then, I asked the participants to go back to their safe place drawings and to add their helpers.

Amelia drew a lamp "that shines light and diminishes the blackness, disappointment and anger in my life." Referring back to her mask she said, "The heart inside would grow bigger as the lamp shines on the blackness, the disappointment and the anger." Amelia's lamp marks a turning point; she identified an internal helper and accessed the power of metaphor. From this point onwards Amelia started gradually to take more part in discussions and shared more about herself. Reena's helper was her boyfriend Mike.

As we ended the session and were about to "sign out," I checked inside myself and realized that there was a part of me that was saddened by my recent power struggle with Amelia (following her refusal to draw a part of the inside of her mask). In signing out, I made a little black circle and said that the black circle



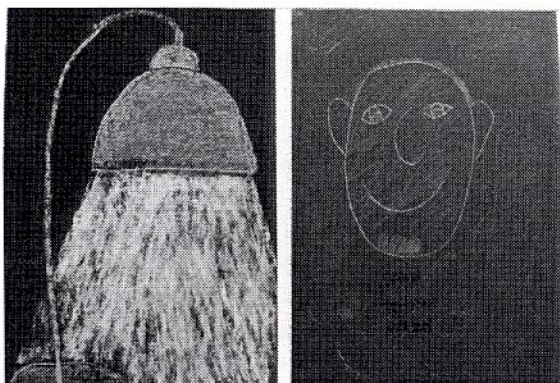


Figure 6: Internal Helpers (Accessing the Self)  
Amelia's drawing      Reena's drawing

was the part of me that felt sad and upset because of my power struggle. Amelia exclaimed, "Oh, that is not a problem," and she drew her lamp/ally over my black circle. She added, "I'll just shed some light onto you and your disappointment will go away." This was a touching moment for all of us. Not only was Amelia using her new helper to help herself, but to help others as well. The power of images was clearly apparent.

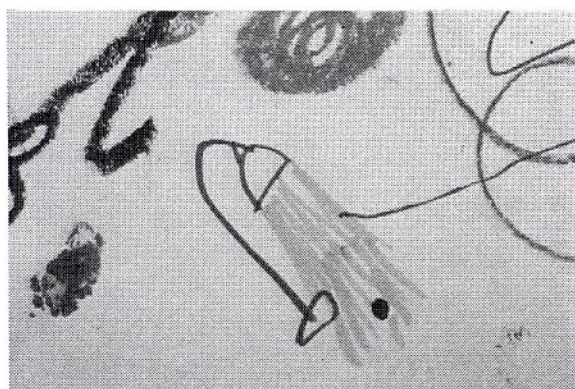


Figure 7: Amelia shares her "helper"

### Promoting inner parts awareness/dialogue and continuing to resource.

The focus of the next session was to help the participants have an experience of inner parts dialogue and to continue to anchor resources. Again, I led the participants in a visualization. I asked them in their minds' eye to travel to an open field and to build a campfire. Once the campfire was built, I asked them to invite their inner parts to gather around the campfire. I also asked them to include their allies/helpers.

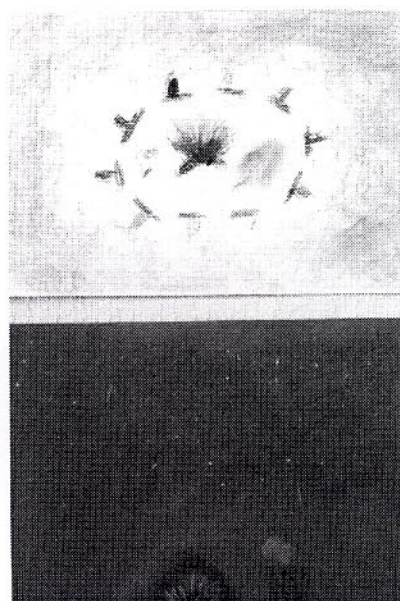


Figure 8: Inner parts gathering  
Amelia's drawing (top) – Reena's drawing (bottom)

Amelia drew different parts of herself (sad part, happy part, etc.). Reena drew herself and her ally (Mike, her boyfriend) with a special blanket given to her by her aunt.

The next art intervention brought inner parts into a visual dialogue with the ally/helper (Self energy). I asked each girl to do a drawing of her ally/helper in dialogue with one inner part from the campfire. The idea was to facilitate a dialogue and to continue to resource.



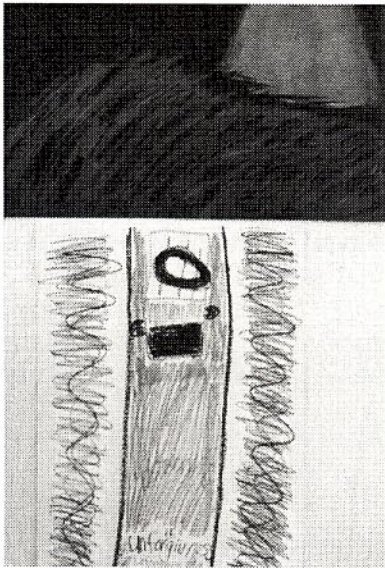


Figure 9: Parts dialogue with helper/ally  
Amelia's drawing (top) Reena's drawing  
(bottom)

Amelia drew (top drawing) her lamp shining light that was "diminishing the blackness of my life". Here again Amelia used her new helper, the lamp, as a resource to negotiate her life's difficulties. Reena's drawing depicted Mike's truck on a road running over something and "helping me in getting rid of my unforgiving feelings."

Throughout the session, I kept facilitating a discussion about inner parts. Based on my input and on Reena's and Amelia's understanding of their parts, we established that (a) parts are parts of us but not all of us, (b) some parts protect other parts, (c) parts have gifts and connect with each other, and (d) parts can take over and hijack our system. Clearly, the participants had reached a greater understanding of their parts and self-awareness was gaining momentum.

By the end of the fourth session, it became clear that alliance and cohesiveness were strong, that the participants had developed internal resources, accessed Self qualities and were able to engage in an inner parts dialogue. Phase One was successfully negotiated, and we could move to Phase Two. First, I asked both participants if they felt ready to tackle their hurtful events. Both said they were ready.

## Phase Two: Processing the Traumatic Event

In Phase Two, the participants each chose a hurtful and traumatic event to focus on and told the story using images and words. This phase consisted of one extended session that lasted three and a half hour.

To tell their stories, the participants began by making a booklet from colored paper and string. Amelia had some experience in making booklets and I purposely let her take the lead. Booklets provide a "container" and facilitate the telling of a story through their pages.

To tell the story, I suggested the following guidelines: "in the top portion of the page, tell the story with images; in the mid-left section of the page, do a feeling drawing; in the right-mid section of the page, write a sentence reflecting what you started to believe about yourself; and at the bottom of the page, write or draw what your ally/helper would say to you now". By suggesting such a structure I hoped to help the participants organize their feelings and thoughts around the event and to remember to access their ally/helper. Amelia used the suggested structure and added a text on the left page. Reena chose to tell her story by mixing words and images in her own way. Amelia elected to tell three stories, one story per page.

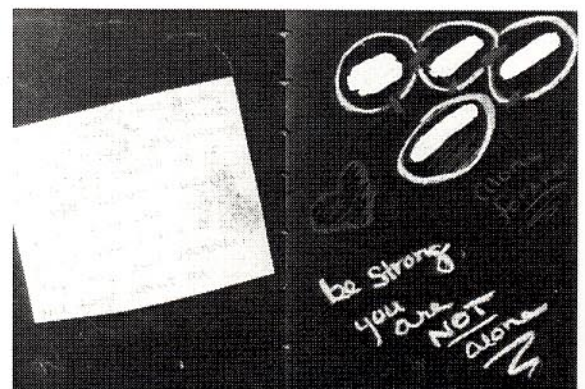


Figure 10: Amelia's first story

Amelia's first story focused on her feelings of loneliness and isolation within her family when she was young. We see a heart



covered with black as her feeling drawing. She identified her limiting belief as being "alone forever". Her ally/helper's message is: "Be strong, you are not alone". She adds on the left page: "Always when I was growing up, my mom, her boyfriend and my brother were always so close. It seemed as if I was distant or separated from them. Like I was always alone, I felt as if they only loved each other and forgot about me."

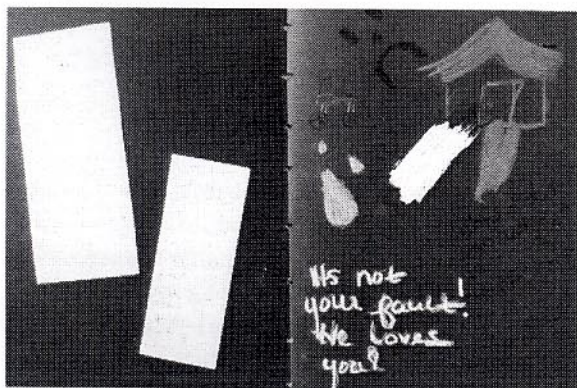


Figure 11: Amelia's second story

The second drawing focuses on her father's abandonment. Through her drawing and her words Amelia tells us about her parents' divorce when she was three years old. The mark resembling tears (feeling drawing) represents her pain and sadness. Her ally/helper reminds her: "It's not your fault!". She also writes about her father's sudden disappearance five years ago. She concludes by writing "Then one day, May of 2003, he called me, I was happy at first but now his name is smeared in my heart."

Amelia's third and last drawing told the story of a good friend of hers. He was nineteen years old and died in a car accident. Amelia wrote about her visit to the location of the crash; she added "I had never had anyone close to me die before and I thought about death a lot after the accident.... I miss him." Her ally/helper tells her: "We all die at some point in time!"

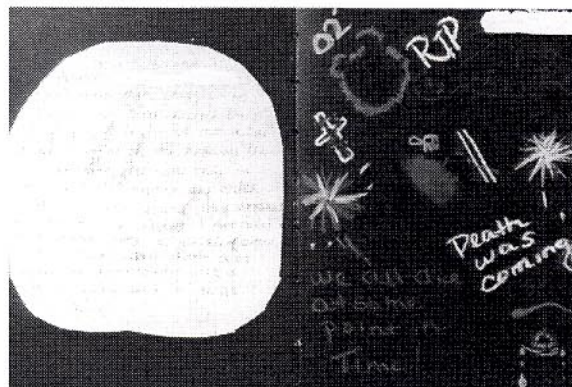


Figure 12 Amelia's third story

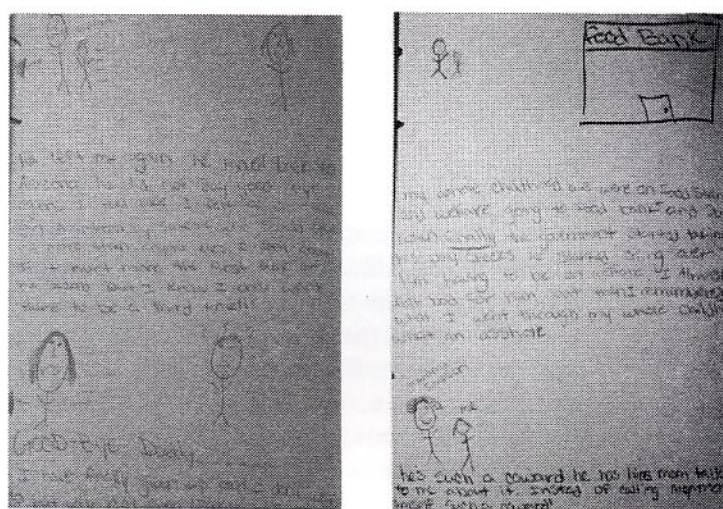


Figure 13: Reena's Stories page 3 and 4

Reena used six pages to tell the story of her painful relationship with her absent and rejecting father. She combined stick figures and text. She wrote that her father left before she was born, yet came back into her life when she was sixteen. When they finally met for the first time, she added: "he did not even know how old I was, much less what day was my birthday.... that hurts. He always told me lies and told us things that got our hopes up...He then left me again...He did not say goodbye again. I feel as I felt like a little girl. Abandoned by someone who should care for me more than anyone else. I don't know if it hurts more the first time or the second time but I don't want there to be a third time!!!..Goodbye Daddy!!!"



Abandonment, isolation, death and rejection appeared to be the over-riding themes for both participants. Once they had completed their booklets, Amelia and Reena decided to read each other's. The option to show or not to show one's booklet to others allows for a sense of control, which can be especially empowering for teenagers and trauma survivors. Once they had shared on a peer-level, I asked if they would be willing to share their work with me. Both gave me their booklets willingly.

A lot of material was process in this marathon session. Ideally, Phase Two should be covered over a minimum of two sessions. As mentioned earlier, transportation restrictions required that we process the hurtful/traumatic events in one extended session.

### Phase Three: Integration and Containment

The following week, we began Phase Three. To facilitate integration of the new awareness and containment of the trauma, I first guided the participants in a visualization leading back to the campfire. I then asked the Amelia and Reena to call forth the part of themselves that held the hurtful, painful memories that they drew in their booklets, and to "check how that part is now." Then they made drawings of those parts.

Amelia (top drawing) drew a blue circle on black colored paper. She commented that her "blue part felt lighter". It is interesting to notice that the color black is no longer overwhelming to her. Reena reported that she first saw her ten-year-old part, but as the visualization evolved, the ten-year-old grew up to her current age of eighteen years old. IFS suggests that once exiled parts have let go of their burdens, they are often able to leave the past and begin to progress developmentally.

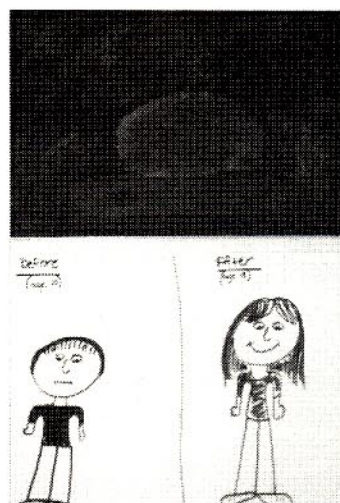


Figure 14: Checking with Inner Parts  
Amelia's drawing (top) Reena's drawing (bottom)

### Unburdening and containment.

I then invited participants to make a pot using non-firing clay. Once the pots were made, I asked them to write on small pieces of paper the thoughts/feelings and behaviors that they wanted to let go of or have the pot contain for them. The focus was on the "negative" learning that may have occurred as result of the painful events they had experienced. They buried the small pieces of paper in their pots with dirt. As a symbol of new life growing out of old pains, they then planted a red tulip bulb in their pots.

This art intervention parallels the concept and practice of unburdening used in IFS. The unburdening process starts by telling the story, which may include emotions, sensations, limiting beliefs and detailed memories associated with the painful event. The next stage is a letting go, a giving up of the painful memories, beliefs and sensations to a larger container, such as light, water, the air, the earth, or fire. Here we used the pot as a symbol for the larger container. Staying in the realm of metaphor, planting a tulip bulb in the pot conveyed the idea that from this old painful material, new life will grow, and a new sense of hope is possible.



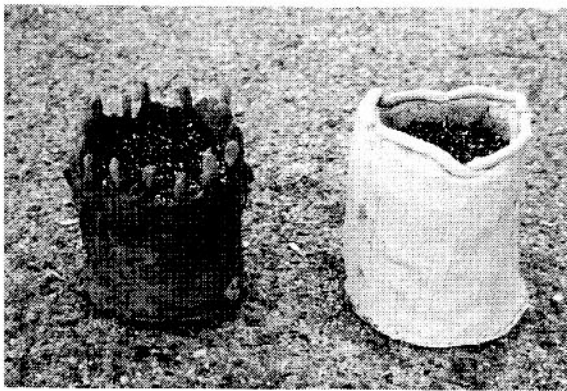


Figure 15: "Unburdening" Containers  
Amelia's pot (left) – Reena's pot (right)

This final art intervention was especially important to Amelia; she reported that "the best part of the group was the pot with the thoughts we wanted to move on from. Also taught me forgiveness."

#### Discussion

At the end of the group, Amelia's PCL-C post-test showed a change, from 39 points to 23, a 41% reduction, suggesting that the group was helpful in reducing Amelia's partial PTSD symptoms.

In general, Reena and Amelia responded positively to doing art and to the concept of inner parts. My hope that such work would help with hurtful/traumatic events and increase self-awareness was also confirmed by Amelia's written comments about the group: "The group helped me to better understand my feeling deep inside that I didn't want to come out. Feelings I wanted to forget. I dealt with in a healthy way." Reena added, "This group helped me more than any other counseling that I have ever had."

Although an ideal number would have been 4 to 6 participants, this dyad presented advantages. During one of our sessions, Reena and Amelia spontaneously discussed this matter, stating that they liked the fact that it was so small and enjoyed the special attention they were getting. It seems to me that the high level of safety and cohesion that emerged early in the group's life was in large part due to the fact that this group was small and that the participants liked each other.

The fact that one participant had partial PTSD while the other did not may have been a

blessing in disguise. Reena's initial higher level of participation may have encouraged and challenged Amelia to open up more quickly. Had both participants satisfied the criteria for PTSD diagnosis, I would speculate that the group would have required more time to complete the treatment plan.

Towards the end of the group sessions, I attempted to run a larger group with male adjudicated teenagers who lived in a transitional treatment center. Although I made it clear from the start that this kind of treatment plan requires participants' steady attendance, that each session builds on the last, and that this would not an open group, participants' attendance was unpredictable, erratic and chaotic. I cancelled the group after three sessions.

It is clear that the kind of treatment plan I had designed could not succeed in a setting where adjudicated teenagers' stays were too short and too unpredictable. In addition, the group was composed of boys who showed defiant behaviors and clearly resented being part of the group. Successfully negotiating Phase One (fostering safety, inner resources and inner parts dialogue) could easily have taken up to ten sessions. There are major difference between detained adjudicated teenagers in a transitional treatment center and adjudicated teenagers on parole, living with family members, as was the case for Amelia and Reena.

When working in a more challenging environment, the brief therapy approach of seven or ten sessions presented earlier was found not to be appropriate. This model, like any, needs to be adapted to the specific characteristics of each situation. Art interventions, schedules and contact hours will need to be modified accordingly to context. For example, male teenagers may not respond very well to planting a bulb in a pot, whereas they may respond better by creating a more masculine symbol. Painting the inside and outside of masks may also be too triggering for some individuals. An alternative might be to paint a box, the outside representing the outer self, the inside the inner self. The timing of each art intervention is also important. The



group leader needs to assess participants' readiness. To paint the inside of a mask with the directive, "how do you really feel inside?" may require other art interventions as preparation.

Whether or not modifications in art interventions and schedule are needed, the three-phase approach needs to be maintained. This structure mitigates the risk of moving too quickly into threatening material. For example, before moving into Phase Two (processing the hurtful/traumatic event) it was essential that Phase One goals (i.e., fostering safety, inner resources, accessing the Self and inner-parts dialogue) were successfully negotiated. Each phase addresses a critical step in the treatment of trauma. Focusing on participant strengths through establishing safety, accessing the Self and building inner resources is a key to the success of this model.

In addition to adhering to a three-phase approach, three additional requirements should be met: (1) a closed group structure should be established in which the need for participants' steady attendance is mutually acknowledged and supported by participants and staff, (2) participants should show some interest in making art, and (3) participants should demonstrate some openness about giving voice, through art, to hurtful events in a group setting.

The success of this or any treatment plan is in large part the result of the group leader's ability to create a genuine rapport. This is especially true in working with teenagers. During Phase One, I was particularly aware of being as authentic and transparent as I could. I also fostered our budding alliance with invitations to bring favorite music, which became the topic for engaged conversations. The Self of the therapist is at least as important as the strength of a protocol. As in IFS, which places the Self at center-stage, I attempted to model good leadership, compassion and curiosity.

## **Future applications**

It is my belief that this synergetic model with its treatment plan can be successfully applied to individual work and to larger groups, as long as the above criteria are maintained (i.e. 3 phase approach, closed group, and participants' willingness).

Future applications of this model could include the general teenage population with a wide variety of issues besides trauma. Traumatic or hurtful events exist on a continuum from chronic, long term and severe traumas with PTSD symptoms (capital "T" traumas), to single traumas (small "t" traumas), to less-traumatic but nonetheless challenging life events such as moving to another school, loss of friendships, sibling rivalry, divorce, and so on. Some issues that I have considered include: grief and loss, eating disorders, self-mutilation (cutting), low self-esteem, loneliness/isolation, racial/cultural/socio-economic segregation, emotional difficulties resulting from learning disabilities, and divorce.

In the dyad/group with Amelia and Reena, processing the art was limited to talking about it. Future work can and should move beyond reflecting on the art verbally. It is my belief that this experiential approach could be developed further by adding: (1) various forms of verbalization (e.g. giving voice to the art, engaging in a verbal dialogue between parts of a drawing and/or a person, having participants' parts or art dialogue with each other), (2) expressing a part through movement, and (3) dramatic enactment (e.g. having group members play out their parts, the Self or other participants' parts). Adding these layers could bring new life and energy to a visual symbol, expand on a powerful metaphor, access new sub-conscious layers or tap into un-used creative energies.



## Conclusion

The fact that the incidence of PTSD among adjudicated teenagers in the U.S. varies from 50% to 80% demands a response from the mental health field. Adjudicated teenagers are not receiving appropriate treatment and this lack of care leads to comorbidity and further delinquency. However, designing trauma treatment developmentally suitable for adjudicated teenagers is not an easy task. The integrative model presented in this paper constitutes one attempt to do so.

The purpose of the model is to provide safe and effective means to process traumatic and/or hurtful life events. The case study showed that blending Art Therapy and IFS Therapy fosters self-awareness and can help to resolve hurtful or traumatic life events. The concept and language of parts (sad part, angry part) helps to clarify participants' own experience while art making gives voice, using non-verbal means, to these parts. The process of externalization inherent in artistic expression tends to un-blend parts from the Self. IFS provides a theoretical map to help unburden exiled parts as well as foster a sense of Self. Combined, Art Therapy and IFS support and enhance one another.

This model offers flexibility. As long as the three-phase approach is maintained, the number of sessions and the art interventions can be modified to the needs of the participants. Interviewing each potential participant and assessing their level of willingness and readiness is, however, key to the success of such a group.

The dyad/group presented in this paper had both a diagnosed participant and a participant with no diagnosis. Future groups may benefit from combining diagnosed participants and participants with no diagnosis to effect positive peer influence, as may have been the case with Amelia and Reena.

In conclusion, this model shows promise for the treatment of trauma in adjudicated teenagers. Future research, extending to the general teenage population beyond the anecdotal evidence presented in this case study, is needed to test the validity and wider applications of this model.



**INSTRUCTIONS:** Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?	1	2	3	4	5
2. Repeated, disturbing <i>dreams</i> of a stressful experience from the past?	1	2	3	4	5
3. Suddenly <i>acting or feeling</i> as if a stressful experience were <i>happening again</i> (as if you were reliving it)?	1	2	3	4	5
4. Feeling very <i>upset</i> when <i>something reminded you</i> of a stressful experience from the past?	1	2	3	4	5
5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when <i>something reminded you</i> of a stressful experience from the past?	1	2	3	4	5
6. Avoiding <i>thinking about or talking about</i> a stressful experience from the past or avoiding <i>having feelings</i> related to it?	1	2	3	4	5
7. Avoiding <i>activities or situations</i> because <i>they reminded you</i> of a stressful experience from the past?	1	2	3	4	5
8. Trouble <i>remembering important parts</i> of a stressful experience from the past?	1	2	3	4	5
9. <i>Loss of interest</i> in activities that you used to enjoy?	1	2	3	4	5
10. Feeling <i>distant or cut off</i> from other people?	1	2	3	4	5
11. Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?	1	2	3	4	5
13. Trouble <i>falling or staying asleep</i> ?	1	2	3	4	5
14. Feeling <i>irritable</i> or having <i>angry outbursts</i> ?	1	2	3	4	5
15. Having <i>difficulty concentrating</i> ?	1	2	3	4	5
16. Being " <i>super-alert</i> " or watchful or on guard?	1	2	3	4	5
17. Feeling <i>jumpy</i> or easily startled?	1	2	3	4	5



## References

- Acoca, L., & Dedel, K. (1998). *No Place to Hide: Understanding and Meeting the Needs of Girls in the California Juvenile Justice System*. San Francisco, CA: National Council on Crime and Delinquency.
- Appelton, V. (2001). Avenues of hope: Art therapy and the resolution of trauma. *Art Therapy Journal of the American Art Therapy Association*, 18(1), 6-13.
- Cauffman, E., Feldman, S. S., Waterman, J., & Steiner, H. (1998). Post-traumatic stress disorder among female juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(11), 1209-1216.
- Chapman, L. (2003, November 2003). *Neurodevelopmental Art Therapy: Treating acute & chronic post-traumatic stress disorder & symptoms*. Paper presented at the "Creative Response: Art Therapy's Witness to Our Times" - 34th Annual Conference of the American Art Therapy Association, Inc., Palmer House, Chicago.
- Chesney-Lind, M. (1997). *The Female Offender: Girls, Women, and Crime*. Thousand Oaks, CA: Sage Publications.
- Cohen, Hammer, & Singer. (1988). The Diagnostic Drawing Series: A Systematic Approach to Art Therapy evaluation and Research. *The Arts In Psychotherapy*, 15, 11-21.
- Dalley, T. (1984). *Art as Therapy*. New York: Tavistock.
- Dembo, R., Williams, L., Wothke, W., Schmeidler, J., & Brown, C. (1992). The Role of Family Factors, Physical Abuse, and Sexual Victimization Experiences in High-Risk Youths Alcohol and Other Drug Use and Delinquency: A Longitudinal Model. *Violence and Victims*, 7(3), 245-272.
- Estep, M. (1995). To Soothe Onself: Art therapy with a woman recovering from incest. *Art Therapy Journal: American Journal of Art Therapy*, 34(August), pp. 9-18.
- Franklin, M. (1992). Art Therapy and Self-Esteem. *Art Therapy: Journal of the American Art Therapy Association*, 9(2), 78-84.
- Golub, D. (1985). Symbolic Expression In Post-Traumatic Stress Disorder: Vietnam Combat Veterans's In Art therapy. *The Arts In Psychotherapy*, 12, 285-296.
- Hamblen, J. (2002). *PTSD in Children and Adolescents*. National Center for Post-Traumatic Stress Disorder. Retrieved, from the World Wide Web:
- Kramer, E. (1971). *Art As Therapy for Children*. New York: Schoken Books.
- Kramer, E. (1979). *Childhood and art therapy*. New York: Schoken Book.
- Lavergne, M., & Warson, L. (2003, November 2003). *Art, Somatic Resourcing, and IFS: A Model For Treating Adolescent Trauma*. Paper presented at the "Creative Response - Art Therapy's Witness to Our Times" - 34th Annual Conference, Chicago.
- Malmquist, C. P. (1978). *Handbook of Adolescence*. New York: Jason Aronson.
- Morrison, J. (1995). *The DSM-IV Made Easy - The Clinician's Guide to Diagnosis*. New York: The Guilford Press.



- Parnell, L. (1999). *EMDR in The Treatment of Adults Abused as Children*. New York: W.W. Norton & Company.
- Powell L., & Faherty S, L. (1990). Treating Sexually Abused Latency Age Girls. *The Arts in Psychotherapy*, 17, pp. 35-47.
- Richie, B., & Johnson, C. (1996). Gender Violence, Incarceration and Women's Health: The Prevalence of Abuse History Among Newly Incarcerated Women in a New York City jail. *Journal of the American Medical Women's Association*, 53(2), 89-93.
- Riley, S. (2001). *Group Process Made Visible*. Philadelphia, PA 19106: Brunner-Routledge.
- Rosenberg. (2001). Forensic Aspects of PTSD in Children and Adolescents. In Spencer (Ed.), *PTSD in children and Adolescents* (pp. 33-58). Washington DC: American Psychiatric Publishing, Inc.
- Schwartz, R. (1995). *Internal Family System Therapy*. New York: Guilford Press.
- Stone, A. A. (1993). Post-Traumatic Stress Disorder and the Law: Critical Review of the New Frontier. *Bulletin of the American Academy of Psychiatry and the Law*(21), 23-36.
- Terr, L. C. (1991). Childhood traumas: an outline and overview. *American Journal of Psychiatry*( 148), 10-20.
- Weathers, Litz, Huska, & Keane. (1994). *PCL-C*. National Center for PTSD - Behavioral Science Division.