Integrating Art Therapy Practices with Adolescents Diagnosed with Severe Emotional and Behavioral Disorders: A Review of Current Evidence-Based Research

A Literature Review

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By:

Meghan Laird

Chair: Craig Balfany
Reader: Erin Rafferty-Bugher

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Abstract

There is an alarming increase in mental health issues within the adolescent population who are struggling with Severe Emotional Disorders (SED) (Burns, & Hoagwood, 2009). Finding successful treatment approaches to help support the adolescent population with beneficial treatment options that may hinder emergent Mental Illness is imperative. Art Therapy research literature will be reviewed to support evidence that suggests that art therapy is an effective and beneficial form of treatment for adolescents with emergent mental illnesses and may effectively help to prevent further emergent mental illness in adulthood. The connection between Adlerian concepts and art therapy practices in adolescents diagnosed with severe emotional and behavioral disorders, will be emphasized as an effective method of treatment and prevention with this populations.
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Integrating Art Therapy Practices with Adolescents Diagnosed with Severe Emotional and Behavioral Disorders: A Review of Current Evidence-Based Research

Introduction

“One in five children ages 13 to 18 have, or will have a serious mental illness,” (National Alliance on Mental Illness [NAMI], 2015), further research suggests that “50 percent of all lifetime cases of mental illness begin by age 14 and 75 percent begin by age 24” (NAMI, 2105). The National Alliance on Mental Illness also suggests that the average delay between the onset of symptoms and any interventions taking place for a child is between eight and ten years. Perhaps this delay in intervening is due to a lack of recognizing symptoms or an understanding of effective preventive treatment strategies. Interventions including medical and nonmedical, (i.e. therapy.) The impact of mental health on children and young adults is incredible relevant, as a recent NAMI (2015) statistic suggests that suicide is the third leading cause of death in youth ages 10 to 24; and of those who completed suicide, 90 percent had underlying mental illness. These statistics suggest the alarming need for successful mental health treatment for adolescents. Additionally, much of the literature reflects lack of inclusion of research on the effective use of art therapy treatment with adolescents who may have a severe emotional behavioral disorder. Through the brief exploration of literature on adolescent mental health and art therapy, the purpose of this paper is to provide awareness of and encourage the use of art therapy from Adlerian perspective when working with adolescents diagnosed with SED.

Overview of Mental Illness in Adolescents

“‘Severe and persistent mental illness’ (SPMI) is a term that is commonly used to refer to a collection of mental disorders that usually affect people 18 to 25 years of age, and often have
profound effects on family relations, educational attainment, occupational productivity, and social role functioning over the life course” (Carey & Carey, 1999, p.1). According to Blue Cross Blue Shield (n.d.), disorders categorized as severe and persistent mental illness include Schizophrenia; Paranoid and other Psychotic Disorders; Bipolar Disorders (hypomanic, manic, depressive, and mixed), Major Depressive Disorders (single episode or recurrent); Schizoaffective Disorders (bipolar or depressive); Pervasive Developmental Disorders; Obsessive-Compulsive Disorders; Depression in childhood and adolescence; Panic Disorder; Post Traumatic Stress Disorders (acute, chronic, or with delayed onset); Bulimia Nervosa; and Anorexia Nervosa (Blue Cross Blue Shield, n.d.). The persistence and severity of the adult determination of SPMI is an extremely important risk factor that must be considered when working with SED adolescents. The trajectory of the adolescent experience if there is a lack of effective and beneficial treatment interventions is dire.

Diagnostic symptoms related to mental illness can be managed with proper care and therapeutic services/interventions. Offering alternative means of treatment such as art therapy, individuals may begin to understand their diagnosis and their symptoms and work on effective strategies to prevent an emergent SPMI.

By understanding the profound effects of these serious and persistent mental illnesses, researchers and professionals within the field of mental health will continue to find ways to assist in treatment options and interventions to prevent adolescents from following the course of SPMI.

A Brief History of Mental Health in Youth

In a handout by the National Institute of Mental Health, a few facts were given about mental health during childhood, from a perspective of “past, present, and future.” The past facts admitting that, “Thirty years ago, it was thought that children did not experience mood disorders
like depression.” So, up until the 1980’s and 90’s mental illness was not recognized in children and prevention or methods of support did not seem available. The handout continues to state that, “youth diagnosed with mental disorders show patterns of development different than in unaffected youth” (National Institute of Mental Health, 2011, Yesterday). Understanding that 1) this handout was written in 2011, so there can be some forethought that mental health within adolescents and support for those individuals experiencing mental health symptoms has improved and 2) the information about adolescents with severe emotional and behavioral disorders has significantly improved. Additionally, there is more awareness about the effects on the development of the child/adolescent neurobiology and how it impacts cognitive, social, and emotional development.

When thinking about diagnosing adolescents with a SED, most practitioners appear to do so with caution and with the understanding that age and hormonal make-up can affect the mental health of an adolescent. Vann (2011) discusses the fact that children and adolescents are less likely to be diagnosed than adults because, “…kids are expected to ‘grow out’ of their emotional problems.” (p. 1). Perhaps the “expectation” to “grow out” of an emotional problem causes a clinician to be tepid in their diagnosing process. An example that is provided by Vann suggests that an adolescent’s care giver and clinician may not only not recognize the symptoms, but if they do they may be hesitant to support a diagnosis for fear of any stigmas associated with a mental health diagnosis. In a conversation with Vann, psychiatrist William M. Klykylo MD gives the example that depression in an adolescent may often be accompanied with hyperactivity. (Vann, 2011). If most clinicians practice by this thought of an adolescent outgrowing their “emotional problems”, it would make sense that the clinicians would use caution when diagnosing a severe and persistent (or emergent) mental illness.
When specifically considering the appropriateness of diagnosing adolescents with severe emotional and behavioral disorders, it is important to understand the age range and typical onset range. In a study facilitated by the National Comorbidity Survey Replication (as cited by Merikangas et al., 2010), data was collected as a nationally representative epidemiological survey of mental disorders. This information suggested that, “… about half of the population fulfill criteria for one or other psychiatric disorders in their lifetimes. The majority of those with mental disorders have had the beginnings of the illness in childhood or adolescence.” (Merikangas et al., 2010). They go on to say that, “Psychiatric disorders with childhood or adolescent onsets tend to be more severe, are frequently undetected early in the illness, and accrue additional co-morbid disorders especially if untreated. It is therefore critical to focus efforts on early identification and intervention” (p. 2). Knowing that most psychiatric disorders are frequently undetected in adolescence, it is critical that mental health practitioners find ways not only to identify symptomology, but to also find beneficial and successful ways to treat the adolescent. Due to the risk factor of increased severity and chances of co-morbidity if an adolescent’s symptoms go untreated, it is essential to find ways that allow the adolescent to communicate and express themselves; in a manner that is safe and developmentally appropriate. Art therapy allows for both the verbal and non-verbal style of communication that can be experienced as less intrusive and threatening.

According to Merikangas et al., the largest category of mental health diagnosis in adolescents was anxiety disorders with 31.9 percent of adolescents in a survey of 10,123 adolescents aged 13 to 18 within the United States. Following anxiety disorder diagnoses, were behavior disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%). The study goes on to say that “the overall prevalence of disorders with severe impairment and/or
distress was 22.2%” (Merikangas et al., 2010, p 2.) While only at 22.2 percent, the number of adolescents suffering from severe and persistent mental illnesses is astounding when the onset of symptoms begins from ages six to 15. The authors conclude that, “one in every 4-5 youth in the U.S. meets criteria for a mental disorders with severe impairment across their lifetime.” (Merikangas et al., 2010, p 2).

“Identifying mental disorders in children can be tricky for health care providers. Children differ from adults in that they experience many physical, mental, and emotional changes as they progress through their natural growth and development. They are also in the process of learning how to cope with, adapt, and relate to others and the world around them. (Mental Illness in Children, n.d.).

It is imperative to consider the physical and hormonal changes that typically developing adolescents experience when conceptualizing the understanding of an adolescent experiencing a mental health crisis. The effects of hormones on the developing brain make it challenging to
fully understand the diagnostic picture of mental health symptoms for practitioners. By adding “emerging” at the forefront of a diagnosis, can allow for symptoms to be recognized by the practitioner, yet can be adjustable incase the symptoms are related to hormonal changes. While it may “just be” the hormonal changes most noted when working with children and adolescents, the changes they experience both mentally and emotionally also attribute to difficulty in diagnosing. In a study examining the possible effects of “raging hormones” on an adolescent’s mental health, researchers discuss four potential effects, two being “activation effects” and “adjustment effects” (Buchanan, Eccles, & Becker, 1992, p. 63). “Activation effects” being the “rising tonic or average concentrations of hormones” causing a possible rise or decline in moods or behaviors. “Adjustment effects” being the lack of appropriate adjustments by an adolescent to the rise and decline of tonic and other hormonal activity. The study concludes that adolescents experience different moods and behaviors differently from younger children and adults.

All of these characteristics [anxiety and self-consciousness], if in fact they do pertain in a unique way to adolescents, undoubtedly have roots in the social, cognitive, and environmental changes associated with adolescence. This fact, however, does not rule out possible hormonal influences on these moods and behaviors. (Buchanan et al., 1992, p. 98)

When discussing the adolescent brain, it is important to note just how significant a role that hormones play. As more research and science is done about the adolescent brain, the connections to mood, behavior, and decision making have becoming clearer and clearer. Specifically, “the growth of neuroimaging technologies has enabled a more detailed understanding of the adolescent brain than ever before” (Kelly, 2012, p. 946). Researchers, continue to say that,
…it is claimed that: ‘Today, we know that the brain continues to grow and change in important ways well into young adulthood. Specifically, the neural systems underlying emotion, motivation, and cognition are in flux in this period.’ Their account suggests that the ‘prefrontal cortex (PFC) of the brain is perhaps the last areas to mature, and it may not be fully developed structurally and functionally until the early 20s or later’. In this way of understanding the relationships between brain functioning and design, and young people’s behavior and dispositions the ‘PFC is most often implicated in coordination attention, impulse control, and planning. Prefrontal functions include those that allow an individual to pause long enough to take stock of a situation, assess his or her options, plan a course of action, and execute it. (Kelly, 2012, p. 947)

Kelly’s (2012) research suggests that an adolescent brain is almost completely different than an adult’s brain; that the brain of an adolescent lacks “pro-social behavior” and has the added elements of a social influences that imbedded themselves in love, friendship, fairness, and common sense. Beyond the development of the adolescent’s brain, the influences placed upon them can add significant implications to the adolescent’s mood, behavior, and overall mental health. Influences (from an Adlerian perspective) including, environmental opportunity, birth order, family values, family atmosphere, and gender guiding lines and role models for the adolescent. While the brain is still being influenced and developed, there is a significant age in which the adolescent and their brain becomes “ready” to receive a full mental health diagnosis.

Laurence Steinberg (2012) suggested that most of the research and understanding of adolescent brain development has appeared just within the past 15 years, he believes that brain development is significant enough to inform public policies. In his research, Steinberg noted that four major changes in an adolescent’s brain are taking place, changes including; a decrease in
gray matter, causing an “improvement in basic cognitive abilities and logical reasoning” to be seen; changes in activity, “involving the neurotransmitter dopamine occur”, where emotions are processed and sensation-seeking is experimented with. The third change is the “increase in white matter in the prefrontal cortex”, which proves to be important for higher-order cognitive functions, such as “planning ahead, weighing risks and rewards, and making complicated decisions.” Finally, the fourth major change that Steinberg discusses is the increase in the “strength connections between the prefrontal cortex and the limbic system”, resulting in emotion regulation and self-control (Steinberg, 2012, p. 70).

In Steinberg’s work, he recalled a time when he was asked to provide information about a prison convict who had been involved in a gang robbery, which ended in one of the group members shooting and killing the shop owner. Even though this person had fled the store before the shooting took place, he was still sentenced to 33 years, without parole. Steinberg argued that this was a 17-year-old boy who could not have foreseen the events that took place, (someone being murdered) and discussed that the adolescent brain “clearly indicates that regions of the brain that regulate such things as foresight, impulse control, and resistance to peer pressure are still developing at age 17” (Steinberg, 2012, p. 73). This example is brought to attention when considering giving an adolescent a diagnosis of a severe emotional and behavioral disorder, because of the strong evidence that the brain is still changing, developing, and learning. It is possible that a combination of the adolescent’s hormones, mental health symptoms, and brain development are all affecting them, simultaneously. According to Steinberg’s research that a 17-year-old’s brain is still developing significant aspects of their brain, it is interesting that the Diagnostic and Statistical Manual of Mental Disorders could allow for 18-year-olds to be given such impactful diagnoses.
Most of the “requirements” of DSM-V disorders, for a person to be diagnosed with a serious mental illness, they must be

Persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental or substance use disorders) or sufficient duration to meet diagnostic criteria… that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. (SAMHSA, 2016, p. 2)

The prevalence of adolescents experiencing symptoms that critically impair their functioning is possible, even though they are not the appropriate age to be “fully” diagnosed. Perhaps it is possible that adding the label “emerging” as a cautionary term within the person’s diagnosis, potentially allows for the child and family to feel as if they can lessen the symptoms through therapy/treatment.

To identify a specific cause of SED among adolescents can be difficult and may often provide no one answer. It instead may be the causes of multiple factors (such as stress from an emotional or social aspect blending into limited distress tolerance or susceptibility to mental illness) taking place at once, inside the individual. Giedd, Keshavan, and Paus (2008) analyzed the relationship between the adolescent brain and psychopathology, noting that, “typical changes in the adolescent brain and the onset of psychopathology is not a unitary phenomenon, but an underlying theme may be conceptualized as ‘moving parts get broken’” (Giedd et al., 2008, p. 948). Between the various hormonal changes an adolescent may experience, their neural, cognitive, and social functioning may also change. It is perhaps, because of these changes that an adolescent may begin to become at serious risk with developing symptoms of a serious and persistent mental illness.
With the expanding information on adolescents experiencing mental illness, it is interesting to see how different practitioners decide what the best way is to help this population. Whether it is through looking solely at the brain, or the “pro-social” behavioral of the adolescent, through assessing the available research, it appeared that most practitioners left out one concept or another when trying to understand the mental health of an adolescent. It is imperative that clinicians include brain development, neurobiology, and hormonal changes. It appeared that the mental health of the adolescent was just a dissection of who they were, the individual was seen in pieces, and not as a whole.

Within the Adlerian perspective, holism is discussed and encourages practitioners to view whomever they work with as a whole entity. Symptoms of a mental illness do not necessarily describe who someone is as an individual, they are still a part of that person. An example could be that if a person is experiencing neurotic (safeguarding) behaviors, such as anxiety/anxious behaviors; by examining them through an Adlerian perspective, the practitioner would be able to see that they are not “just” an anxious person, they would be able to see the individual as someone experiencing more than “just” the symptoms and pathology but also see the person’s strengths.

The Adlerian Perspective on Mental Health and Mental Illness

Of the many different benefits that Adler (see in Ansbacher & Ansbacher, 1956) provided the world of therapy/psychotherapy, was his detailed understanding of the significance a person’s childhood could have on their adult life. Adler’s theories are still influencing research today. (An example being Adler’s concept of birth order determining the success of siblings). Many of Adler’s concepts begin to form from a person’s childhood, i.e., their birth order position; family atmosphere; family values; gender guiding lines; genetic possibility; and others.
These subjective perceptions placed on the child/adolescent, in turn, affect the individual’s personal responses and how they come to develop their ideas about social interest and how they determine their own significance. Adler understood children/adolescents and how their earliest memories and their interpretation of the memory created their foundations and outlooks as adults. Adler built his theory on the belief that, “…the skills needed for successful transition for adolescence to adulthood are available within the social context of the world around them” (Kriščiūnaitė & Kern, 2014, p. 31).

From Adler’s vast research and publications (such as The Collected Clinical Works of Alfred Adler, dating from 1898 to 1937), he creates recommendations for raising mental healthy children to become mentally healthy adults. Of those recommendations, Adler focused on the relationship between the child and their caregiver and what is needed to “prevent” the creation of a mentally unhealthy child and a mentally unhealthy adult. Adler defined mentally health people as individuals with “relative self-determination”, social interest/a sense of community feeling, view life as problem-solving, and a strong sense of self-confidence and social interest.” (Ansbacher, 1992). The term, “relative self-determination” being defined as, “the view that individuals are neither produced by heredity nor shaped by environmental press. Rather, ‘genetic possibility and environmental opportunity’” (Powers & Griffith, 1987, as referenced in Griffith & Powers, 2007, p. 164) are understood as elements of the situation in which the individual creates his or her own unique style of living” (Griffith & Powers, 2007, p. 164). Addressing the term “social interest/community feeling” can briefly be defined as follows;

…encompasses the individual’s awareness of belonging in the human community and the cosmos of which it is a part, and an understanding of his or her responsibility for the way
the life of the community is being shaped by his or her actions. It is a fundamental sense of being one amongst the others as a fellow being. (Griffith & Powers, 2007, p. 11)

Adler’s concept of social interest/community feeling is critical when discussing adolescents, as it involves basic needs that can have profound effects when they are not met. Social interest includes the need for an individual to feel safe, significant, and a sense of belonging. If an adolescent (or anyone really) does not feel that they have these three needs met, it is likely that their mental health is not fully intact. It is during the incredibly important time of childhood and adolescence that an individual’s mental health is the most fragile; it is when they first learn how to take care of themselves (whether it is a baby crying when it needs food) or learning about the world around them. Many examples come to mind from Bruce Perry’s novel, *The Boy Who was Raised as a Dog* (2006) in which Perry offers example of when a child’s basic needs of social interest were not met, leading to pathology of a serious mental illness.

Of Adler’s many concepts, inferiority feelings are something that unites every individual. Adler believed that while everyone experiences feeling inferior, some individuals could better distinguish the difference between inferiorities and common sense.

Similarly, Griffith and Powers (2007) also define Adler’s concept of inferiority feelings as being in two different categories, “normal” and “abnormal”. Children with “normal” inferiorities were those able to adjust and appraise their feelings of inferiority into a more socially interested frame of thought. Children with “abnormal” inferiorities, including organ inferiorities, often strived to overcompensate their feelings of being inferior and would not act in a pro-social manner. Adler believed that the “type” of inferiority depended on the interpretation of the child; stating, “Certainly the degree of objective inferiority is significant and will make itself felt. But we must not expect that the child will make correct appraisals in this connection,
any more than will the adult” (Ansbacher & Ansbacher, 1956, p. 116). Furthermore, from Adler’s research, it appears that children/adolescents develop their sense of inferiority based on their own individual interpretations of who they are and the world around them. Griffith and Powers continue to elaborate on Adler’s concept of inferiority feelings stating:

[Inferiority feelings] are those universal human feelings of incompleteness, smallness, weakness, ignorance, and dependency included in our first experiences of ourselves in infancy and early childhood. Inferiority feelings continue to be experienced to greater or lesser degree throughout adult life. For the well-adapted individual, whose sense of solidarity and belonging among others is cultivated by education and encouragement, these feelings serves as spurs to effort and as a source of motivation to overcome obstacles, to grow, and to improve oneself and the community. (Griffith & Powers, 2007, p. 60)

In this context, it is possible that an adolescent would begin to gain a sense of their inferiority feelings and moreover a lack of their community feeling/social interest. It is possible that an adolescent’s behaviors could indicate a sense or feeling of inferiority, similar to the four goals of misbehavior, which will be addressed later in this paper. An adolescent experiencing mental health symptoms of an emergent mental illness, may be struggling to gain the three principles within social interest/community feelings such as feeling safe, having a sense of belonging, and feeling significant. Within their lack of social interest, the developing adolescent may begin to develop what Adler called a “superiority complex”. An example of a “superiority complex”-type behavior is when a child/adolescent is bragging continuously or showing off to try and gain a sense of superiority. Another example given by Ansbacher and Ansbacher (1956) is when “two children are comparing their height. The one who is afraid that he is smaller will
stretch up and hold himself very tensely; he will try to seem bigger than he is” (p. 260). The child would not admit that he is small and instead would attempt to hide his feelings of inferiority by any means possible. It is Adler’s concept of “superiority complex” is defined by Griffith and Powers as;

An appreciation for the evolutionary struggle of all living things to adapt successfully inspired Adler to apply the concept of superiority striving to the understanding of human being. He saw the goal of success as drawing the individual forward toward mastery and the overcoming of obstacles. He observed that, for socially-interested individuals, the goal of superiority is on the useful side of life and contributes to the developing human community. By contrast, the discouraged person, operating on the useless side of life under the burden of increased feelings of inferiority, makes the error of supposing that his or her task is to attain a position of superiority over others. (Griffith & Powers, 2007, p. 99)

It could be assumed then that a child/adolescent striving for superiority would be limiting their views on their life tasks and seeing them as complete and fulfilled when they are not. If an adolescent’s sense of striving is so great, perhaps they will begin to demonstrate signs of neurosis or symptoms of a disordered personality, thus effecting their various life tasks. When an adolescent is stuck on striving for superiority, they have the potential to lose sight of what is real in their life, and instead can attempt to domineer over everything (relationships, jobs/school, etc.) just to seem like they are functioning in a superior way.

Unlike other psychologists/psychiatrists during Adler’s time, he made the distinction between mental health and mental illness/mental disorders. Adler defined mental health as,
…self-confidence and well-developed social interest which assures identification and empathy with the surroundings community feeling. Such a person feels at home in the world and confident to be able to cope with the life tasks. It is the life-style of the courageous fellow human being, whose goal of success includes, consciously or otherwise, contribution toward the progression of humanity. (As cited in Ansbacher, 1992, p. 12)

In contrast, Adler believed mental disorder to be, “characterized by strong inferiority feelings (inferiority complex), which may be hidden behind a façade of superiority (superiority complex), with underdeveloped social interest (Ansbacher, 1992, p. 12). Taking an Adlerian perspective on mental health and mental illness allows for a more holistic approach to prevention and intervention in the treatment of adolescents.

By taking an Adlerian approach to working with adolescents suffering from a severe emotional and behavioral disorder, a more holistic understanding to a potential approach to treatment is offered. Additionally, an Adlerian perspective helps facilitate an adolescent’s gain a sense of increased social interest and community feeling.

**Brain Development and the Adlerian Perspective**

While the main areas of focus in Siegel and Bryson’s book, *The Whole-Brain Child*, (2011) are developing parent skills and stimulating the growth of a mentally health child/adolescent, the authors discussed various ways to support healthy brain development. Siegel and Bryson (2011) explore the importance of integration within a child’s brain; defining integration as, “linking different elements together to make a well-functioning whole” (p. 6). Although the authors discussed the integration of the brain in a less clinical manner, (as it its purpose is for guiding parents) it can offer a connection between the concepts of integration and
Adler’s holism. Siegel and Bryson explain integration as being both horizontal and vertical ways to connect the mind, while Adler defined his concept of holism as, “the idea that the whole is greater than the sum of its parts and that, unified, the parts constitute a new and unique whole.” (Griffith & Powers, 2007, p. 55). Adler continues to describe holism in the context of mental health, stating, “One can never regard single manifestations of the mental life as separate entities, but… one can gain understanding of them only if one understands all manifestations of a mental life as parts of an indivisible whole” (Ansbacher & Ansbacher, 1956, p. 190). Understanding Adler’s outlook on holism, it can be easy to better comprehend Siegel and Bryson’s definition of integration. They discuss the integration between a child’s brain and how critical it is for parents and care givers to first recognize disintegration and to assist their child/adolescent in reintegrating their thoughts, behaviors, and feelings. Similar to Adler (referenced in Ansbacher & Ansbacher, 1956), Siegel and Bryson (2011) both agree that an adolescent (or an adult) is not a functioning whole when they are disintegrated. But how does one become disintegrated? According to both the works of Siegel and Bryson and Adler, a person learns how to be integrated (whether that is successfully integrated or not) through experiences. “What molds our brain? Experience” (Siegel & Bryson, 2011, p. 4). The way an adolescent learns to manage their world is determined by their response to the experiences that happen to them. These responses then internalize within the adolescent and they begin to build their mental health (life); leading to basis of their functioning and ability to handle difficult situations. An example of a negative (impactful) experience could have on a developing adolescent’s brain connects back to Perry’s (2006) research, in which one child (due to an extreme lack of parenting) begins to develop negative coping skills and eventually begins to display signs of an emerging destructive personality disorder.
Unlike Siegel and Bryson, Adler’s (as referenced in Ansbacher & Ansbacher, 1956) work on the development of a child’s brain is limited to the more medical affects that a child’s experiences, such as influenza having physical implications to a child’s brain. While a studier of Adlerian Psychology may be able to recognize that this type of scenario would still affect the adolescent’s brain development, Adler does not appear to focus on the “typical” style of brain development for adolescents. To possibly answer one’s own question, perhaps this could be due to the limited understanding of neurobiology and the lack of proper research tools. Maybe it is possible that Adler dissected his view of typical brain development into his other concepts, such as the life tasks, or social interest. Maybe it is possible that instead of a relying on a medical model that focused on the faults of the body and the person, Adler would want to have the focus of the adolescent be on how they view their world, themselves, the people who surround them. Their interpretations would then influence their mental health. A return to Adler’s concept of the creative self/creative power standing to meant that an adolescent (potentially) has more control and ability to transform and make up their views of life than originally understood (Ansbacher, 1992, p. 11). A child/adolescent has the creative power to transform their beliefs and understanding of the world around them into common sense or feelings of inferiority, which in turn, can shape their overall mental health.

Through the clinical lens of an adolescent’s brain, adding an Adlerian perspective offers perspective on serious mental health symptoms. With the vast changes that the adolescent’s experiencing, both mentally and physically, perhaps it is significant that many of Adler’s principle concepts on childhood and adolescence within the development of the lifestyle of an individual is prevalent in todays’ society. Unfortunately, there appears to be limited information and research about the effectiveness of Adlerian interventions and approaches with severe
emotional and behavioral mental illnesses. Alternatively, there seems to be more research focused on how Adler viewed mental health, compared to ways Adlerian approaches can assist in managing symptoms associated with mental health. This lack of information about the connection between Adlerian psychology and severe emotional and behavioral disorders has challenged the idea that there can be a strong bond between the two and ways that the Adlerian theory can offer support to this population of adolescents experience serious and persistent symptoms of mental illness. For the sake of this review, perhaps it is more beneficial to consider how Adler viewed mental health among adolescents and compare to current (general) therapeutic practices that offer effectiveness.

**Adlerian Outlook on Adolescents and Mental Health**

Adler’s theory focused on the whole of the individual, believing that a healthy person goes through life being able to handle difficulties with courage and common sense. Adler originally viewed the criteria of mental health to be contingent upon the contribution to the welfare of others, and discussed in length the possibility of inferiority feelings arising due to an individual’s sense of social interest and community feeling being “underdeveloped.” An individual appears to then begin to build up their sense of social interest and community feeling and either adjust accordingly or begin to under develop these feelings, resulting in a manifestation within their mental health. Adler believed that there were three different types of children who were potentially at risk to become mentally unhealthy adults. Those children were, “children with inferior organs, pampered children, and neglected and hated children” (Ansbacher, 1992, p. 13). The pampered and neglected child essentially being individuals who were unable to make sense (to put it lightly) of their undeveloped senses of social interest and community feelings. By definition, the pampered child,
…where children are not welcomed, are not encouraged, cannot see the places of value open to them, and are unable to believe in what they can do on the socially useful side of life, the probabilities for the development of courage and cooperation are gravely diminished, and the likelihood of the development of dysfunctional styles of living is markedly increased. (Griffith & Powers, 2007, p. 77)

These children/adolescents were believed to have undeveloped social interest, and would eventually gain an “attitude of discouragement” (Ansbacher, 1992, p. 13). Understanding the approach that Adler had on mental health within children/adolescents would allow for any practitioner working with this population to understand the adolescent on a deeper level.

**Four Goals of Misbehavior**

Everyone is vulnerable to life’s imperfections and failures and their responses lead to the possibility of symptoms of pathology being manifested or not. Adler’s idea of psychopathology containing three core components, discouragement, faulty conceptions, and life-style beliefs; all of which can be argued to have gotten their start in early development. Adolescents with emergent mental illnesses may often exhibit these goals of misbehaving without conscious thought, and it is the care givers’ or practitioners’ response that ultimately aids in deescalating or escalating these behaviors.

Adler was known for his work with children and his encouraging and (non-shaming) approaches. Adler discussed, extensively, ways to understand the child’s behavior and their ultimate goal in life.

Every action of a child has a purpose. His basic aim is to have significance and his place in the group. A well-adjusted child has found his way toward social acceptance by cooperating with the requirements of the group and by making his own useful
contribution to it. The misbehaving child is still trying, in a mistaken way, to feel important in his own world. (Stein, n.d, Understand the child’s goal)

Understanding the purpose of an adolescent’s misbehavior and the useful/uselessness of it, may allow for more client-centered care and approaches to be practiced. Adler identified four goals of misbehavior: attention-getting, power, revenge, and display of inadequacy. Even though an adolescent may not be aware of their misbehaving, it is most likely that the child/adolescent is trying to have a need met. This need possibly being connected to their feelings of social interest and community feelings. An example of an adolescent experiencing a goal of misbehavior, could be with a goal like “power”, and how the adolescent often observes the theme of power and dominance within their living situation. If an adolescent’s care giver is seeking power, and the adolescent is also wanting to show their power, it can create a struggle of who is really in control within the home. This goal is causing the adolescent to understand that “only strong people get what they want.”

The impressions and influences surrounding a developing adolescent assist in building their creative self or creative power. The creative self is described by Adler (As cited in Ansbacher & Ansbacher, 1956) as containing all aspects of the child’s (and adolescent’s) life, including both the subjective perception place onto the child and their personal response. An example being the subject perception/effects of an adolescent’s family atmosphere and their personal response leading to their own interpersonal style. The creative self (creative power) of an adolescent is incredibly important to the development of who they become and what their adult life may possibly look like. The adolescent’s response to symptoms of a serious and persistent mental illness direct their development: the creative self directs the adolescent’s own meaning of significance and how they adjust to outside influences. Besides the adolescent’s
interpersonal style being developed, their creative self assists in influencing their self-assessment, development of a personal code, the confounds of their social interest, and their perceived opening for advancement (Powers & Griffith, 2012).

The Creative Self: When the Individual is Both the Artist and the Painting

When assessing an adolescent’s mental health, understanding the influence of their creative self allows for incredibly valuable information to be discovered. The creative self connects with pathology as it not only drives the creation of an individual’s personality, but it also,

…provides the uniqueness and self-consistency of movement toward an imagined ideal completion, the creative compensation for felt deficiency, and an unfolding of all capabilities toward a totality. Individuals can use this creative power cognitively, emotionally, or behaviorally, and focus it in a socially positive or negative direction.

(Stein, 2013, The Dynamics of Creative Power)

Adler said, “The individual is thus both the picture and the artist. He is the artist of his own personality, but as an artist he is neither an infallible worker nor a person with a complete understanding of mind and body; he is rather a weak, extremely fallible and imperfect human being.” (As cited in Ansbacher & Ansbacher, 1956, p. 177). According to Griffith and Powers, “Adler deferred to the creative power of the individual as at the center of the human development. From the earliest years, ‘how the child assimilates impressions’ and shapes responses depends upon ‘the creative power of the child’ (Adler, 1979, p. 195)” (As cited in Griffith & Powers, 2007). In this sense, Adler seems to regard the “Creative Self” as what a child/adolescent makes of their environment and the impressions laid upon them. The adolescent’s ability to create understandings of an experience is the creative process. In a similar
pattern of thought, Ansbacher and Ansbacher discuss creativity and the “Creative Self” in the following passage:

The drive in the child is without direction as long as it has not been incorporated into the movement toward the goal which he creates in response to his environment. This response is not simply a passive reaction but a manifestation of creative activity on the part of the individual. It is futile to attempt to establish psychology on the basis of drives alone, without taking into consideration the creative power of the child which directs the drive, molds it into form, and supplies it with a meaningful goal. (Ansbacher & Ansbacher, 1956, p. 177)

One Adlerian approach that may offer insight into the adolescent’s creative self and the influences their creative power has had over their lives, could be by assessing their sense of belonging. Shifron (2010) examined an individual’s sense of belonging as the “key” to their mental health; noting that each child uses their creative power to assess their feelings of worthiness in the world and their relationships with others. Understanding Shifron’s research, perhaps by involving an adolescent in a creative form of assessing their early recollections, their creative self will appear. This technique being suggested as it is an Adlerian intervention that offers great insight into how the individual views themselves, their relationships with others, and the world around them. “The feeling of belongingness, the social interest, takes roots in the psyche of the adolescent and leaves the individual only under the severest pathological changes in his mental life (Adler as quoted in Ansbacher & Ansbacher, 1956, p. 138).

Perhaps an adolescent’s creative self is most visible in a creative process, such as art, music, and dance/movement. These creative modalities offer the possibility to be utilized to gain insight into the adolescent’s style of life and ability to handle the life tasks. Observing the
impressions made upon their developing brains and, in turn, understanding the way they make art can be truly informative. A benefit of using art therapy with adolescents (or all ages) is that many other Adlerian concepts can be seen through both the product of the artwork and the process of how it is made. Such as, the uncovering of an adolescent’s development of their lifestyle, private logic, mistaken beliefs, world view, and strengths of the creative self. A term familiar in Adlerian psychotherapy, Malchiodi (2012) discusses the influence of “the phenomenological approach” when working with adolescents in an art therapy setting. This idea of phenomenology within Adlerian context being paraphrased as a way of learning about oneself and the world around them, through one’s own subjective lenses. Malchiodi connects this influence to, “…the opportunity to acknowledge many different aspects of art expressions, including cognitive, emotional, interpersonal, and developmental” (Malchiodi, 2012, p. 142). Understanding this phenomenological approach within art therapy would allow for the art therapist to gain a better look at the adolescent’s life tasks and functioning.

Art therapy interventions when used with adolescents experiencing mental health symptoms in combination with an Adlerian framework can allow for “subjective evaluation” (Malchiodi, 2012) and for the adolescent to understand themselves in a different light. Assessing the adolescent’s creative self through artistic/creative approaches appears to also allow for a healthier, more “pro-social” form of interrupting the individual’s environment and confounding impressions. Perhaps it is possibly that an adolescent’s mental health symptoms begin to build up as a result of not being able to process or properly interrupt their surroundings.

Discovering the most optimal forms of treatment and therapeutic services for adolescents with emergent mental illnesses is a continuous and growing conversation. Whether it is through the rise in interest and popularity of certain types of therapy such as music therapy or equestrian
therapy, finding peer reviewed and published research that shows significant benefits to adolescents with symptoms of severe emotional and behavior disorders is minimal.

**Research in Working with Adolescents with Emerging Mental Health Diagnoses**

Almirall and Chronis-Tuscano (2016) examined the benefit of various interventions that aid in the treatment and prevention of adolescent mental health and suggest that “[mental health] disorders often require an individualized, sequential approach to intervention, whereby treatments (or prevention efforts) are adapted over time…” (Almirall, & Chronis-Tuscano, 2016, p. 1). The idea of adaptive interventions from Almirall and Chronis-Tuscano suggests that each adolescent received individually tailored tools and interventions that better suit their mental health diagnosis.

In review of the literature on the most effective forms of therapy for adolescents with emergent mental health diagnoses, art therapy is rarely mentioned. (This is not to say that art therapy among adolescents does not offer valuable research, it is among this population that appears to lack the most information). Instead, inclusion of medication/medication management and various forms of psychotherapy were highlighted. The American Academy of Child and Adolescent Psychiatry (2017) lists various types of psychotherapy that they deem effective when working with both children and adolescents. That list containing, Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), Family therapy, Group therapy, Interpersonal Therapy (IPT), Play therapy, and Psychodynamic Psychotherapy. While play therapy is included as an effective form of therapy when working with children and adolescents, the AACAP fails to mention other alternative types of therapy, such as creative and expressive arts therapies.

Bone, O’Reilly, Karim, and Vostanis (2015) collected data on what children, adolescents and their caregivers found to be the most influential aspects of mental health services. The
researchers identified three “themes” that determine whether mental health services will be successful or not: 1) the “fear of the unknown”, 2) “therapeutic engagement”, and 3) “making services more acceptable (or accessible) for families” (pp. 1-3). From their data collection, Bone et al., incorporated different techniques to increase participation from their young clients: of those techniques, art and creative mediums were used. Other techniques used in the “semi-structured” interviews included use of technology, such as implementing “emoticons” and traditional talk-therapy techniques. Overall, the results of this study did show an increase in therapeutic participation by both parents and children, as well as an increase of positive feelings (Bone et al., 2015).

Apart from identifying the most influential aspects of mental health services for adolescents, there is little research on the availability of resources for this population. A longitudinal study by “Health Affairs”, beginning in 1995 aimed to study the “development of psychiatric disorders and the need for mental health services among rural and urban youth” (Burns et al., 1995, p. 148). While this study is rather dated, it goes to show the limited services available to adolescents with varying mental health symptomology. The results provided reported the following:

The education system was clearly the major player in the de facto system of care for children with mental health problems. Between 70 and 80 percent of children who received services for a mental health problem were seen by providers working within the education sector (mostly guidance counselors and school psychologists). For the majority of children who received any mental health care, the education sector was the sole source of care. (Burns et al., 1995, p. 152)
This study can represent a large gap within the services provided and that are available to adolescents with mental health symptoms. This study offers insight to the limitations of its own sample, stating that the services provided “present without respect to the amount or the adequacy of the care received. For many children, the amount of care received may have been small, thus reducing the number of children who might be considered to have been adequately treated” (Burns et al., 1995, p. 154). Again, this study, while older, offers insight to the limited recognition, services, and support that adolescents who experience mental health symptoms (in general, not to mention those experiencing severe emotional and behavioral disorders).

The Burns et al. (1995) study also offers an example of how mental health in children and adolescents were viewed at that time. In the article, the researchers appeared to “clump” all of the children and adolescents experiencing mental health as “emotionally” or “behaviorally” disturbed. Although this article is from over a decade ago, the hope is that mental health services and screenings have been updated, as well as a decrease in stigma surrounding severe emotional and behavior disorders seen in adolescents.

This section examines the lack of information and resources specifically for adolescents experiencing mental health symptoms. A majority of the research appears to show the effects of “typical” talk therapy, and the effects on adolescents, rather than creative therapies and modalities. This large lack of information and the Burns et al., study suggest that other professional fields (such as schools) are carrying the brunt of identifying mental health symptoms within adolescents and providing them with resources. While the Burns et al. study was originally published in 1995, it is possible that there is still validity to the fact that school systems see the onset of mental health symptoms before most doctors and therapy professionals.
In a more recent look into the barriers and/or lack of information about support offered for this population, researches Nanninga, Reijneveld, Knorth, and Jansen (2016) suggested that there could be a multitude of barriers that inhibit an adolescent from receiving the services they need. One barrier being the belief that services would not be productive (treatment irrelevance), meaning that either the adolescent or a family member had a strong belief that mental health services would not be beneficial and would not cease the symptoms from occurring. Whether it be a reflection that the family members “prefer to solve problems on their own or with their informal networks” or “it might also mean a lack of confidence in the quality of the treatment and its effectiveness” (p. 114). Acknowledging that there is a gap for resources offered to this population is critical.

The Science of Art Therapy

Art therapy and the brain. As many art therapists know, the art making process can affect brain functioning in ways that other mental health practitioners may not understand. Specifically noting the connecting of the Expressive Therapies Continuum, (Hinz, 2009) in which various art materials have the ability to connect to different levels of brain functioning. But before discussing the complexities of the ETC, authors Prendiville and Howard (2016) briefly assess the ways that art therapy connects the two hemispheres, saying, “When the art has been created, the client is guided to explore the meaning of their work, using words, symbols and metaphors. This begins to cross hemispheres and integrate cortical and limbic functioning (lateral integration). Images also have a powerful effect on our physiological state (vertical integration), increasing the neurological benefits of art therapy” (Prendiville & Howard, 2016, p. 144). The authors continue saying, “State regulation at the brainstem level is foundational, helping the client feel safe in the therapeutic environment. Experimenting with art materials
involves the midbrain in the sensory aspect of the experience, allowing the client to embody the experience and move on to higher processes to process difficult emotional material. Connecting body and mind, art therapy supports integrations and well-being.” (p. 144).

Art therapy has been identified as a beneficial way to promote pro-social behaviors from an exterior standpoint, but appears to have limited information about the internal, neurological affects. As citing in Kapitan (2011), Bruce Perry is quoted in saying, “art therapy is good for the brain because it involves the following key aspects: Art therapy provides experiences that are *relevant* and appropriately matched to developmental needs.” (Perry, 2008, cited by Kapitan, 2011, p. 159). Kapitan continues by saying, “Because we are psychosocial beings who are hardwired for relational learning, the interpersonal environment of art therapy creates a foundation of security that is necessary for brain development.” (p. 159). Taking Kapitan and Perry’s assessments of the neurological effects of art therapy on the brain, it can be encouraging to imagine how this research will continue to expand the fields of art therapy and mental health.

**The effectiveness of art therapy when working with adolescents.** When thinking about the effectiveness with art therapy interventions, author Andrea Gilroy (2009) identified an additional problem of finding evidence based research for adolescents; specifically, the fact that adolescents are often described in a “generic way that makes it difficult to organize the literature according to discrete populations or services.” Gilroy continued on to say that, “There are more than 500 therapies used in the treatment of children and adolescents (As cited in Kazdin, 2000) but little evidence either for or against the effectiveness of psychodynamic therapies” (Gilroy, 2009, p. 139). Furthermore, Gilroy cited a 2003 study by Wiesz and Kazdin, noting that “behavioral and cognitive-behavioral treatments account for 70 percent of the published outcome studies, but that non-behavioral treatments are the most favored in practice” (Gilroy, 2009, p.
139). Considering the data offered by Gilroy, it can be possible to assume that art therapy interventions/treatments may account for some of the studies that do not have outcomes published, yet are more favored by practitioners.

While completing this brief literature review, the impact and effectiveness of art therapy has little evidence and research to support art therapy interventions have beneficial results in adolescents experiencing symptoms of an emergent mental illnesses. While discouraging as it can be for an art therapist, the work that is seen being done with patients has served as evidence enough of the power of art therapy interventions with adolescents. Reynolds, Nabors, and Quinlan (2000) suggest a more concrete reason for this lack of evidence when working with this population. The authors noted that “…even with almost a century of widespread clinical use, it is difficult to identify empirical evidence regarding the effectiveness of this treatment. Much of the published literature on art therapy focuses on theoretical concepts and the results of case studies. Case studies are useful for descriptive purposes and generating hypotheses, but they provide little evidence about outcomes associated with art therapy” (p. 207). Similar to the evidence that Reynolds et al., found on the lack of research that measures the effectiveness of art therapy, Richard Carolan discussed the great need for a joining of art therapy professionals and scientists (2001). Carolan assessed that the need for blending of both art and therapy was critical for the future of both fields of art therapy and mental health; noting that it is important to include the holistic nature of art and how it appears to organically create results, but it is also important to question how these results happen. Carolan suggested that the commonplace phrases used in an art therapy setting are not to be seen as “absolutes” and instead should be asked with the intent of clarification and further exploration for others outside the art therapy profession.
Lynn Kapitan defined the idea of an “artistic bias” as a “reductive process of traditional science…that makes reality ‘more real’ when colored with aesthetic, subjective experiences.” (Kapitan, 2011, p. xxii). Kapitan continues to connect the bias that many art therapists have towards traditional sciences, referencing Junge and Linesch (1992), “concluding that the process of art and art therapy did not fit easily with scientific research” (p. xxii). If this statement still maintains to be true, how can art therapy grow and become a more evidence-based treatment option? Kapitan suggested that a large issue in connecting science and art therapy-based research was due to the “distrust of how science could address the complexities of art therapy theory and practices, on the other hand, has contributed to the “science neglect” (Kapitan, 2011, p. xxii).

Slayton, D ’Archer, and Kaplan (2010) named several art therapy interventions that have proven the effectiveness of art therapy interventions with multiple populations and age groups, and specifically mentioned art-based interventions with adolescents experiencing severe emotional and behavioral mental health symptoms. Within the research that Slayton et al., provided, results from various art based interventions are examined, and highlighted the positive growth seen with both the adolescent and their mental health. In one qualitative study, done by Ball (2002; as cited in Slayton et al., 2010), young children (and adolescents) seen as “emotionally disturbed” were assessed as through the incorporation of weekly individual art therapy sessions. The effectiveness of drawing, painting, and sewing for these adolescents suggested “positive change/growth” in the study and offers as a beneficial example of the effectiveness of art therapy with this population.

Another example provided by Slayton et al., was the research done by Saunders and Saunders (2000) with “Outpatient emotionally and behaviorally disturbed children and teens
Saunders and Saunders found that individual art therapy sessions offered over a period of three years provided “significant findings in success of art therapy overall; severity of 23 of 24 behaviors decreased; significant correlation of sessions attended and higher ITR (Initial Therapeutic Relationship) score” (Slayton et al., 2010, p. 112). The authors provided research and results concerning the efficacy of art therapy interventions through the examination of qualitative studies. They also examined pre/posttest studies, and clinical trials with random (and non-random) group assignments.

**Art therapy research; what does it entail?** Offering a more concrete reason for the large separation between art (therapy) and science, Kapitan noted that, “art therapy has had its own historic, polarized debates on the importance or place of art versus science, therapist versus artist, products or outcomes versus processes, and philosophy versus pragmatism. It makes it difficult to sort out art therapy research… because of a tendency to emphasize the binary roles of what is essentially an interdisciplinary field” (2011, p. xxiii). The question of what specifically constitutes as research in art therapy is a growing one; one filled with great significance and weight on the entire field of art therapy. As Deaver (2002) stated, “There is no doubt that research has become a priority in our profession” (p. 23). But with certainty of where art therapy needs growth, there appeared to be hesitation and divisiveness on what art therapy research actually looks like.

Connecting with the beliefs of Malchiodi that the field of art therapy needs more art and science-based research, the research that Slayton et al. (2004) provided, suggested that while the “results of [the] 35 studies provide varying degrees of support that art therapy does work. Compared to 10 years ago when Reynolds et al. (2000) found only 17 studies that met the criteria in their review, the fact that there are 35 studies… provides clear evidence of improvement”
The excitement could be understood through Slayton et al.’s writing, that identified how their research was ground-breaking and had in itself, confirmed that “a small body of studies now exists in which art therapy as a treatment modality has been isolated, measured, and shown to be statistically significant in improving a variety of symptoms for a variety of people with different ages” (Slayton et al., 2010, p. 115).

In support of the claim that more research is needed to build the field of art therapy, Malchiodi (2012) suggested that, “Part of the struggle to produce research is due to the nature of art therapy itself, a blending of art, psychology, and medicine, among other influences. In Malchiodi’s research, she cites the input and information of several other prominent art therapists, including Junge (2010) and McNiff (1998). As cited in Malchiodi, Junge (2010) notes, ‘conflicts about art therapy research reside in the interdisciplinary nature of the field’ (p. 272). Opposing this opinion was McNiff (1998) (as cited in Malchiodi, 2012) who believed that research should be ‘art based’ to capture the uniqueness of art therapy’s effects” (Malchiodi, 2012, p. 45). Continuing with this idea that more research is needed with the art therapy community, there seems to be a divide between art therapists who are more “pro-science-based” research and those who are more interested in building the effectiveness/reputation of “art-based” science. One example that Malchiodi gives is the differencing in opinions from previously mentioned McNiff and Kaplan (2000) who suggested that “art-based research may serve more as an illustration rather than as a validation of results. In other words, art-based inquiry may help researchers to see new possibilities, but not necessarily to confirm or validate findings” (Malchiodi, 2012, p. 45).

Continuing with this thought of integrating scientifically-based art therapy assessments, Junge (2010) suggested that, “more attention needs to be paid to clinical versus statistical
significance.” Noting that, “…the history of art therapy research indicates that from their drawings, the troubled can be separated from the well-functioning with a certain degree of accuracy… It can provide the first signal that certain individuals might need special attention” (Junge, 2010, p. 247). From this assessment, Junge appeared to be placing a great deal of weight on art therapy interventions for the “detection” of pathology among “troubled” and “well-functioning” adolescents (and adults for that matter.) By making this statement, it is almost a seemingly impossible task to prove with evidence-based practices.

Art therapy-based practices and interventions offer evidence that cannot always be measured; components such as insight to new ideas and alternative ways to express and communicate. Hopefully, because of the research done by art therapists throughout the course of history, the effectiveness of art therapy will become more justified and accepted within the world of mental health. Whether evidence-based science “needs” to play a part in art therapy interventions or not, one of the most important aspects of involving art therapy with adolescents is that it must (at first) appear to be nontreating. Riley (2001) reviewed clinical art therapy among children and adolescents and notes the difficulties in attempting to understand this complicated population. Riley suggests that art therapy practitioners use art-based interventions based on the belief that art serves as a non-embarrassing or shaming way that adolescents can reveal and provide insight to concerns and life circumstances (Riley, 2001, p. 57.) This “nonthreatening” way of communicating separates adolescents’ views of, “’talking’ psychotherapies…shaped by the movies, and they often think that these therapies are only for serious ‘mental’ cases. In contrast, they come to art therapy without such preconceived ideas, and this form of therapy has proved effective with adolescents” (Riley, 2001, p. 54).
To reiterate, while the growth of evidence-based practices within art therapy interventions continue to emerge among the field, it is important to remember that offering a more approachable service to this fragile population is necessary! By allowing a different form of therapeutic expression, adolescents can continue to express themselves and produce their own forms of insight to their problems.

**Conclusion**

**Negative Implications and Biases**

While the benefits of art therapy and creative arts therapy services are vast and may offer various populations increased support, insight, and alleviation of mental health symptoms, the need to understand the possibility for negative implications and bias is critical. In a study that examined the efficacy of both art therapy and writing therapy, in relation to an increase in positive mental health outcomes with individuals exposed to traumatic experiences, author Judith Pizarro creates a discussion about the negative implications and biases of art therapy. When comparing the effectiveness of art therapy and writing therapy within the adolescent population, Pizarro discussed the benefits of writing therapy as showing a “significant decrease in social dysfunction,” in that “writing about a stressful or traumatic experience improves mental health outcomes at a later time” (Pizarro, 2004, p. 5). In comparison, Pizarro argued that art therapy or “generating art” (in general) “may not provide sufficient cognitive organization and, therefore, may not be able to provide the same positive health benefits” (Pizarro, 2004, p. 10). From Pizarro’s research, a biased implication could suggest that art therapy based interventions may have limited insight to what (if specific) health benefits art therapy can provide, due to many of the participants becoming frustrated with the writing processes of the study. Suggesting, that if
the participants of Pizarro’s study became increasingly upset by the writing processes of the study, naturally their preference for the art therapy based interventions would rise.

It is an important concept to discuss; one that may seem like a splitting of hairs to which creative process creates the most health benefits, yet important non-the-less to consider. While the population that is being discussed in this literature reviewed is focused on adolescents diagnosed (or suggested to have emergent) severe emotional and behavioral mental illnesses, mental health practitioners who assume a general bias of how art therapy interventions work and the possibility of negative implications is a real and consistent issue.

In a cumulative research study by the Health Technology Assessment in 2015 (Uttley et al, 2015), 15 randomized controlled trials (RCTs) were assessed based on their “clinical effectiveness and cost-effectiveness of art therapy”, including their various biases. Within the study, bias such as “allocation bias, performance bias, reporting bias, detection bias, and researcher allegiance” (Uttley et al., 2015, p. 7). Of these various forms of biases, a standout is the “researcher allegiance” bias, seen in several of the RCTs. Uttley et al., discuss that the RCTs that had researcher allegiance were trials that, “… are published by one another are unlikely to have been conducted as collaborative projects adhering to standards of good clinical practice. The risk of researcher allegiance in these studies is, therefore, high” (Uttley et al., 2015, p. 15). With the information provided by Uttely et al., developing evidence-based research specific to art therapy seems to come with a high possibility of risk variance. Perhaps this high risk for bias is due to the process/nature of art therapy itself; going back to separation of art and science.
Call for Information

In a study completed in 2002 by Kataoka, Zhang, and Wells, assessed various demographics focused on children and adolescents (ages 3 to 17) and if their need for mental health services was being met. Within Kataoka et al.’s (2002) research, “in a 12-month period, 2 to 3 percent of children 3 to 5 years old and 6 to 9 percent of children and adolescents 6 to 17 years old used mental health services. Of children and adolescents 6 to 17 years old who were defined as needing mental health services, nearly 80 percent did not receive mental health care.” (p. 1548) Unfortunately as previously discussed, if an adolescent with severe emotional and behavioral mental health symptoms is being left untreated, the possibility of their diagnoses becoming severely debilitating increases (2002). Understanding this and knowing that the number of adolescents being diagnosed with both emergent (severe) and non-emergent mental health diagnoses is increasing, it is more important than ever to demonstrate the effectiveness of art therapy and other creative arts therapies.

Not only is the implementation of art therapy and other forms of creative arts therapies increasingly important, offering those therapies in as many different places and facilities is also important. Creative arts therapist, Heather Hutchinson (as quoted in Riell, 2017), calls for art therapy services to be offered in places, outside of hospitals and clinical settings. Co-founder, Aili Lopez, of the CREATE program (Capital Region Expressive Arts, Therapy, and Empowerment) studios states, “When these clients leave, their access to that [art] therapy ends, the progress they made might be cut short and their troubles might return” (Riell, 2017, p. 3).

Beyond the need for more research, there is also a great need for understanding how reaching diverse populations will ultimately grow the profession. Within the research of Talwar (2004), that was briefly discussed, the authors discuss the power art therapists and mental health
practitioners must become “change agents for transcending our legacy…” Failing to do so (to recognize the limitations and biases that are within art therapy), “…could result in placing counselors and psychologists (and art therapists) at risk of being viewed as irrelevant, unethical, and ineffective by persons from diverse backgrounds and groups” (Talwar, Iyer, & Doby-Copeland, 2004, p. 47).

In the most recent issue of the Art Therapy: Journal of the American Art Therapy Association, a study was created on the opinions of art therapists towards implanting more evidence-based practices into their art therapy interventions. Bauer, Peck, Studebaker, and Yu (2017) examined whether a majority of art therapists believed that incorporating evidence-based practices would be beneficial and (even) possible to incorporate. The results of this study showed that while most art therapists felt generally positive towards the idea of implementing evidence-based practices and art therapy, “they also reflect the complexity of the task” (Bauer et al., 2017, p. 89). The reason this study is mentioned when discussing implementing art therapy interventions with adolescents, is in large part due to the complexities of both issues; the complex issues of diagnosing adolescents with severe emotional and behavioral disorders and the other complex issue of implementing evidence-based practices into art/art therapy. By having a positive outlook on the implementation of evidence-based practices into art therapy interventions, it could be suggested that the field of art therapy would begin to develop more as a scientific field. If art therapy practitioners begin to embrace the ideas of evidence-based practices, perhaps the field of art therapy can become more widely accepted by other fields within mental health.

Slayton et al. (2010) assessed that “As artists and people with life experience, we intuitively know that art therapy works. On any given day we may feel that ‘of course it was the
art therapy’ that allowed a client to make a certain improvement” (Slayton et al., 2010, p. 116). Those who are more orientated to evidence-based practices may not always see the hidden benefits of art therapy interventions and may not realize that this can cause a limitation to the individuals they work with. When considering the need for art therapy practices to become more standardized, precise, and evidence-based, it is possible that the art therapist may feel discouraged; “…it can feel discouraging to work in the art therapy field without a reminder that what we are doing not only has meaning but also makes tangible headway in the areas where our clients are suffering” (Slayton et al., 2010, p. 116). Being able to remember that the field of art therapy has been able to continue to advance even within the seven years that the Slayton (2010) research was published, is a nice and hopeful reminder to continue the advancement.

Slayton’s (2010) quote relates well to working with adolescents experiencing mental health symptoms, as it can often feel discouraging and as if there is little progress being made in support of art therapy as a vital treatment approach. Knowing that the field of art therapy and the understanding of mental health in adolescents has already made advancements in research and practice, this discouragement of evidence based research can serve as a call for even more research to be done.

Discovering more ways to spread the power that art therapy can bring is, to this writer, some of the most important work that can be done within the fields of mental health and art therapy. Art therapy has proven to be effective in countless places (Art Therapy Credentials Board, n.d.; American Art Therapy Association, 2013) with many different populations; so why is there a lack of art therapy specific research with adolescents being diagnosed with emergent mental illnesses? While this question cannot possibly be answered in a brief literature review, it
can, hopefully, be the spark that reminds art therapist and mental health practitioners alike that there is much more work to be done.

Throughout this review, core Adlerian principles appear to be the unifying factor between the best aspects of art therapy and the most critical points of traditional therapy. Within the adolescent population, those experiencing symptoms of a severe emotional and behavioral disorder, may find it beneficial to utilize the use of Adlerian principles that focus on what the adolescent really needs (social interest/community feelings). Perhaps it is possible that a richer experience may occur. By using both Adlerian concepts and art therapy interventions, it could be possible then that an adolescent’s wellness could be achieved through two different therapeutic theories that seemingly allow for a nonthreatening approach to take place and a chance for the adolescent to use their creative self (creative power).

Through this literature review, it appears that there is still much work to be done in the field of art therapy in connection to adolescents experiencing symptoms of severe emotional and behavioral disorders. Developing an understanding of an Adlerian perspective and art therapy interventions while working with this population offers potential benefits. While it appears evident that there is still a large lack of research specifically focused on adolescents experiencing emergent mental illnesses, the research that was assessed in this paper is a small portion of well-intended (yet not recognized as evidence-based) research; and this results in art therapy not being fully recognized as a professional field that can thrive off of non-evidence based information and resources. It has been assessed in this literature review that art therapy offers an array of benefits for this population and should be considered a valuable component of an adolescent’s mental health treatment. Again, what appears to be lacking is the acceptance and implementation of art therapy services by those who see evidence-based practices as critical for mental health
practices. This belief then can cause a limited understanding of how beneficial art therapy can be.
References


