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Outpatient art therapy with a suicidal adolescent female

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Introduction

This article suggests that suicidal adolescents can be treated on an outpatient basis using art therapy. Since art therapy was first reported as an intervention with adolescents (Naumberg, 1950), it has been used extensively to treat teenagers who are emotionally disturbed (Linesch, 1988; Moon, 1999; Tibbetts & Stone, 1990), sexually abused (Carozza & Hersteiner, 1982), have substance abuse disorders (Cox & Price, 1990) or eating disorders (Crowl, 1980; Wolf, Willmuth, & Watkins, 1986), and who are hospitalized (Conger, 1988; Kymissis, Christenson, Swanson, & Orlowski, 1996). Literature concerning this treatment modality in work with suicidal adolescents has been restricted to its application to inpatient group therapy (Conger, 1988; Honig, 1975; Walsh, 1993), without reference to its use on an individual basis in outpatient settings. The dearth of such literature is surprising given that annual estimates of suicide attempts by youth from 15 to 24 years old surpass one million in the United States and 130,000 in Canada (Safer, 1997). These estimates correspond to a rate of completed suicides in 1997 of 11.4 per 100,000 in the United States (Hoyert, Kochanek, & Murphy, 1999), 13.7 in Canada, and 22.1 in the province of Quebec (Statistics Canada).

It has recently been demonstrated that the majority of adolescents presenting to an emergency room for assessment of suicidality have the same clinical outcome, whether predominantly treated as outpatients or hospitalized (Greenfield, Larson, Hechtman, Rousseau, & Platt, 2002). In that study, outpatient management was found appropriate for the treatment of the majority of suicidal adolescents. It was shown to be less disruptive to family functioning—including the youth's academic calendar, parents' work schedule, and the

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family's recreational and social activities—despite the prospect of hospitalization at any time, if warranted by the outpatient's condition.

Perhaps of greatest significance, outpatient management spares the patient and family the stigma of hospitalization and its associated inconveniences (invasive admission procedures, verification of vital signs, etc.). Of course hospitalization is essential if the family and/or community fail to provide the necessary social and emotional support for the patient, or are frankly rejecting. If the patient's security may not be assured on an outpatient basis (where, for instance, there is ongoing physical or sexual abuse), then hospitalization is indicated and occasionally unavoidable. Round-the-clock supervision can be provided to assure the patient's safety, compensating for the disadvantages of hospitalization. Eighty-three percent of these adolescents do not require these measures and can be safely treated on an outpatient basis.

This corresponds with the observation that such adolescents, burdened by complex co-morbidities, can be treated with alternative approaches, such as the creative arts therapies, in outpatient settings. This article will describe the scientific literature concerning art therapy for adolescents in general, most of whom have manifested some improvement either in self-esteem or in depression as a result of the intervention. The literature will also be reviewed in connection with hospitalized and suicidal adolescents, with an overview of technical considerations when working with such youth. A case study will then describe the therapy context of a suicidal adolescent who presented for assessment to a metropolitan, university-affiliated pediatric hospital, and her therapeutic course during 48 weeks of 1-h sessions on an *individual*, *outpatient* basis. Several themes in her therapeutic process will be highlighted to illustrate the use of art therapy for suicidal adolescents; these themes will be presented as they emerged within the framework of the beginning, middle and final phases of treatment. In the beginning phase, the adolescent worked on themes of mistrust and despair. She then moved to anger and finally to self-esteem. In our observations, while working with suicidal adolescents these themes are often central to the process.

Scientific investigations of art therapy with adolescents

A review of the literature produces only seven empirical studies using art therapy interventions with adolescents: one a case study (Stanley & Miller, 1993); three with historical controls (Chin et al., 1980; Rosal, McColloch-Vislisel, & Neece, 1997; Saunders & Saunders, 2000); two employing control populations (Kymissis et al., 1996; Tibbetts & Stone, 1990); and one with a randomized design (White & Allen, 1971).

These studies affirm that art therapy with adolescents helps improve their attitude toward their surroundings (Rosal et al., 1997), their self-esteem (Chin et al., 1980; Stanley & Miller, 1993; White & Allen, 1971), interpersonal skills (Chin et al., 1980), and global functioning (Kymissis et al., 1996). It was also seen to decrease levels of depression (Tibbetts & Stone, 1990) and disruptive behaviors (Saunders & Saunders, 2000), indicating that art therapy offers effective treatment for certain adolescent disorders.

Several limitations complicated the replicability and generalizability of these studies. For example, several lacked a control group (Chin et al., 1980; Rosal et al., 1997; Saunders & Saunders, 2000; Stanley & Miller, 1993), a description of the intervention (Chin et al.,

1980; Saunders & Saunders, 2000; White & Allen, 1971), and a comparable number of treatment sessions, both within and between studies (Saunders & Saunders, 2000). Others confounded art therapy with other treatments in the experimental group (Chin et al., 1980; Rosal et al., 1997), or had small sample sizes (Chin et al., 1980; Stanley & Miller, 1993; Tibbetts & Stone, 1990).

To date, Walsh (1993) has conducted the only controlled study known to these authors using art in the treatment of suicidal adolescents suffering from co-morbid depression. Experimental group subjects ($n = 21$) were administered two sessions of a group art therapy technique, while control group subjects ($n = 18$) had two sessions of informal recreational activities. Experimental group subjects showed greater improvement at three-month follow-up on measures of self-esteem, depression, and future perspectives of themselves. The study was limited by the fact that some subjects were concomitantly administered individual therapy.

Research on the art work of suicidal adolescents

The literature notes that the artwork of suicidal adolescents can be an effective assessment tool for this condition (Conger, 1988; Honig, 1975), and that such art work is qualitatively different from that of patients suffering from other illnesses. Drawings by hospitalized suicidal adolescents typically manifest *themes* of death (gravesites), death obsessions (slashed wrists and self-hangings), and violence (house robberies), and *feelings* of failure (a jail cell), isolation (a person huddled in a corner), hopelessness, and helplessness (Conger, 1988; Honig, 1975). *Symbols* of death include the "grim reaper," headstones, and weapons (e.g., knives, ropes or guns; Conger, 1988). An intense red-orange fire and explosions often depict rage.

Working with suicidal adolescents on an outpatient basis: some considerations and challenges

Pivoting on concerns of identity formation and consolidation, the pressures of adolescence may create an environment of vulnerability to any additional strains deriving from family conflict, traumatic events, or a proclivity to psychiatric illness in general (Gould, Greenberg, Velting, & Shaffer, 2003). Adolescents occasionally manifest a confluence of these struggles in the form of suicidality, which presents a spectrum ranging from suicidal ideas to threats to attempts. Among other potential treatments for this population, such as cognitive behaviour therapy, dialectic behaviour therapy, interpersonal therapy and other verbal therapeutic approaches, the present authors chose art therapy based upon our observation that many adolescents have difficulty verbalizing their emotions. We believe that the creative arts therapies, and in this case, specifically art therapy, are appropriate for treatment of adolescents because they combine both verbal interventions and creativity and that adolescents respond very well to this combination. In this case, it was felt that the art-making would provide both a container for emotions and a transition to making connections verbally. In addition this intervention was easily integrated into a multi-disciplinary team approach.

Certain questions must be answered when working with suicidal outpatients. First, what are the characteristics of a crisis team whose mandate it is to contain these youth until longer

term follow-up treatment can be arranged in the community? How will new crises be dealt with during treatment, and an alliance established to ensure compliance with the treatment process? As well, how will a specific therapy fit into the overall management of the patient?

Our crisis team, the Emergency Room Follow-Up Team (ERFUT), identifies the probable causes leading to the patient's distress and recommends ongoing care, either by the team (depending on its resources) or in the community. ERFUT employs specialists in the social services, nursing, psychiatry, psychology, and art and drama therapy to address the treatment needs posed by the variety of co-morbid conditions characterizing such youth and their families. A further benefit from the team approach is a rapid outpatient follow-up after Emergency Room assessment, which, as we have observed, serves to diminish the family's anxiety that ongoing care may not be available.

During treatment by our follow-up team, patients and families have access to Emergency Room health care professionals 24 h daily, seven days per week, to assess the patient and family in the event that there is an expression of a recurring wish to suicide, threat to suicide, or an actual attempt during the therapy process. Ideally, practitioners who work with this population of adolescents would have access to similar resources.

Alliance building, both with the adolescent and with the family, is crucial to ensuring compliance with treatment. That alliance is partially created in the context of a team assessment of the family, where core conflict issues are elucidated. Our team members seek to empathize with all family members, building a sense of trust in the treatment process. To strengthen the alliance, the parents are informed that a confidential, bi-monthly meeting with the youth, parents and therapist will take place, "pre-approved" by the youth, to monitor the progress of the patient and family.

As the alliance consolidates, the family is often amenable to further family or parent/child dyadic work as needed, and is either treated briefly on the team or referred to the community for ongoing management. We have found that as the adolescent begins to feel better, the role of the identified patient in the family shifts, and core family issues emerge that can be addressed. Social services are involved in the treatment process when the family does not collaborate.

To further build the alliance, we explain to the family and adolescent the framework of the therapeutic process. For example, the therapist informs the parents that the contents of the art therapy will remain confidential unless the patient's life, or someone else's, is in danger—at which point both the parents and appropriate health professionals will be recruited to deal with the emergency. It is stressed that the therapy will otherwise be a private space for the adolescent. One hour per week of art therapy contributes profoundly to the consolidation of an alliance with such patients. As it does not require a strictly verbal medium to communicate feelings and conflicts, art therapy is particularly suited to adolescents who have experienced considerable trauma in their lives and are uncomfortable with the verbal expression of those feelings. A crucial component of the therapy process, the artwork serves as a vehicle for the conscious and unconscious identification and articulation of affect and conflict for youth raised in families unaccustomed to such forms of verbal expression. It serves, too, as a creative outlet.

Art therapy has another useful function for this population, in that it specifically targets poor self-esteem and identity confusion. These are predominant issues with suicidal adolescents, whose risk factors include a history of sexual and physical abuse, family discord,

parental psychopathology and drug use, and conduct and depressive disorders, to name a few. In addressing these specific issues, the art therapy process invites interchange with other areas in the overall management of such youth. The art therapist has direct access to the individual's inner world. Without breaking confidentiality, the art therapist can provide a more whole picture of the adolescent. This furthers the team's understanding of the adolescent and their struggles in a more complete way and with more compassion, which complements the management of the family unit.

Through this interchange, and within the art therapy session itself, we have observed benefits to these adolescents from a combination of non-verbal and verbal mediums.

While art is a central component of this therapeutic process, it is conducted within the context of a verbal medium, for which reason the therapist must be comfortable with both forms of intervention. Verbal interventions are necessary to bridge the sense of isolation and alienation experienced by many of these adolescents in their family and daily lives. The therapist conveys a sense of empathy, acceptance and insight through the verbal medium, which in turn provides structure and a form of containment for the isolated youth.

Examples of what the therapist said during treatment are offered in the following case study by one of the present authors. It serves to illustrate the individual outpatient application of art therapy with a suicidal adolescent who suffered from co-morbid depression and post-traumatic stress disorder (PTSD).

Case vignette

Mary (assumed name) was a 14-year-old female attending Grade Eight. She, and three stepbrothers, had been abandoned by her mother several times until her final departure when Mary was seven. Mary had witnessed violence between her mother and stepfather, and had also been a victim of his physical violence. She lived with her father from the age of seven until he was jailed for drug possession, whereupon she was placed under the care of Social Services. Contact continued with her father, who was sporadically imprisoned and therefore inconsistent in his visits. Father's girlfriend, however, was a reliable support figure in Mary's life, despite her father's shortcomings.

Social services arranged for Mary to live in a foster family. Mary had friends, was an avid reader, and did well at school. She presented for psychiatric evaluation shortly after it was disclosed that she had been sexually molested from age six to ten by one of her father's friends. As a consequence of her numerous traumatic experiences, she displayed many symptoms of post-traumatic stress disorder. She complained, for example, of frequent nightmares, sleepless nights, lethargy, feelings of depersonalisation, emotional numbing and intrusive thoughts of the traumatic events. She exhibited avoidance of reminders of those events (she had trouble talking about events), and feelings of being 'disconnected,' 'on the edge,' and isolated from her peers and family. At the time of paediatric examination in the ER, Mary linked her suicidal wishes with a sense of despair and hopelessness that the mistreatment in her past would simply be repeated in the future. Although her weight was stable, her depressive symptoms included a decreased energy level, diminished interest in her activities (partial anhedonia), and hopelessness that were associated with suicidal thoughts

of three months' duration, without plans, however, to kill herself, having no history of prior attempts.

Mary was appropriately dressed, intelligent, and co-operative with the examiner, but affectively flat. She disclosed that she could not trust adults, and was certain she was not loveable. During the course of the assessment the interviewer made links between Mary's history of mistreatment and her current symptoms. Mary neither accepted nor denied the interventions made by the interviewer. Due to the fact that she had trouble verbalising past events, it was felt that she could benefit from an art therapy intervention, and our team had the resources available to conduct the treatment.

Due to space restrictions, issues related to Mary's work on her experience of sexual abuse will be omitted, and consideration of all themes condensed. The Creative Arts Therapist on our team has presented the phases of treatment in the first person. The major themes that appeared during the course of her year-long therapy follow.

Beginning phase of treatment: mistrust and despair

Like many of the suicidal adolescents I work with, Mary struggled throughout the first month of treatment with her feelings of hopelessness, despair and mistrust, all of which she had difficulty articulating during the sessions. These, in turn, further exacerbated her dysphoric state. The mistrust was derived from multiple sources, including the necessity for her to reside in a group home, negative experiences at that institution, and the traumatic events she had endured during her young lifetime, not the least of which was repeated abandonment by primary caregivers. The mistrust was particularly problematic as it interfered with the formation of a therapeutic alliance.

I asked her to make a drawing of these feelings for me. When she showed reluctance, I said to her, "I know there is a part of you that wants to trust me, and another part that doesn't. I know you don't want to get hurt again. I won't hurt you. Although you want to trust me, I know you are disappointed that I will only see you once per week, and that I cannot save you, nor can I take you home with me." Mary replied, "How did you know that was what I was thinking?" and her face showed relief.

She then drew a Star of David inside a cross, with a dagger piercing it (Fig. 1). "This is my symbol," she said. The cross and the star, which she said was weaker than the dagger, represented hope and faith: "the part of me that believes that maybe things can work out, and that life can be better than it has been so far." Mary said the cross was understood as her wish to trust and confide in an adult. It was the catalyst for her to verbalize "all of the bad things that [had] happened" to her, permitting her to express feelings previously inaccessible. The cross also represented "a feeling of peace." I silently wondered if it also represented a tombstone, and Mary's wish to escape through suicide, "finding peace." The image provided a springboard for discussion, and was referred to throughout treatment. To help clarify how they perceive themselves—a step toward identity formation—I ask suicidal adolescents to draw a symbol representing themselves, encouraging the inclusion of a symbol of suicide in their drawing as a partial reflection of who they are until that point in their lives.

In this beginning phase of treatment (sessions 1–9 approximately), Mary explained that the dagger symbolized her fear that "like the dagger, you [the therapist] will be another adult

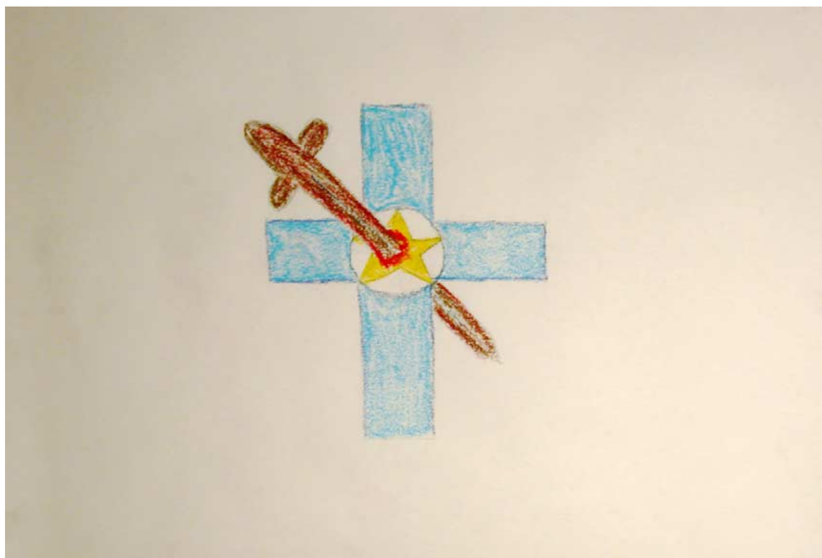

Fig. 1. This is my symbol.

that will hurt and abandon me." "The dagger," she said, "represents death, destruction and despair; all of the bad things that I see in the world, and that have happened to me." She then expressed her belief that her life would never get better. This image was a very important symbol for Mary, as it encapsulated extremes of her life experiences thus far: hope versus violence and abuse. I worked hard to communicate hope to Mary, pursuing this, as is my practice, from several perspectives:

- identifying and approving signs of hopefulness,
- identifying and approving the patient's strengths and past successes,
- affirming the possibility of change.

First, I indicated that I was moved by whatever hope Mary was able to garner. For example, I asked how, with all of the bad things that had happened to her, she could still be hopeful that things would get better. "I want them to, but I am not sure they will," she answered, again voicing her despair.

I next strove to instil hope by letting the patient know that I was impressed by her emotional strengths, given what she had accomplished despite adversity. In this sense, as with so many suicidal adolescents, the therapist must be the container of the hope by saying such things as, "I believe in you, Mary. Look at what you have already accomplished. Look at your courage in dealing with past problems." Mary responded very positively to this encouragement. Like Mary, many adolescents have not had the experience of being mirrored and encouraged by a caring adult. They are consequently unaware of all the beauty and strength they possess.

The therapeutic stance, in general, is one of hopefulness, wherein the therapist, the holder of the hope, imparts this feeling throughout the process, suggesting that the adolescent's life can be different.

Middle phase of treatment: anger

A number of other themes emerged during the middle phase (sessions 10–23 approximately) of Mary's treatment which, again, are typically encountered during work with suicidal adolescents. Many such youth fear that the therapist will not have the emotional or physical fortitude to endure the rigors of the treatment process, including the intense negative feelings (e.g., rage) that such youth often bring to therapy. As the treatment gradually unfolds, the youth will want to show these emotions to the therapist, fearing, however, that the therapist will neither contain nor survive them.

Accordingly, Mary's concern about her destructive potential was manifested in her drawing of a huge red wall which, she stated, "protects me, keeps people out, and protects people from me" (Fig. 2). She was sad and angry that she had been abandoned, unprotected or abused by adults in her life that she should have been able to trust. "It's easier to show

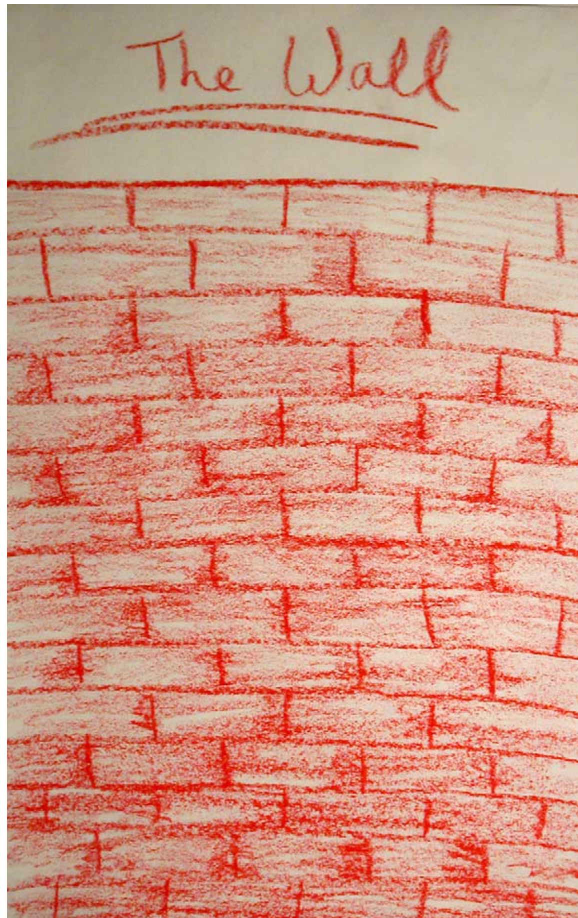

Fig. 2. The wall.

people a tough front rather than get close to them," she said, fearing she would destroy anyone she grew close to, and be harmed in the process. These feelings were expressed in vividly coloured symbols of rage that she drew under the red wall. Mary had learned to use her anger to protect herself by presenting a tough exterior to the world, thereby keeping people away.

When the distance between us was acute, I said to her, "The wall is up today. How can you let it down to let me closer to you? How can I climb the wall to get closer to you?" By frequently expressing a desire to be closer to her, I showed that I was not deterred or discouraged by her tough wall. Instead, I treated it with respect, understanding that she needed the wall to sustain her through tough experiences. I would often ask, "Where am I in relation to the wall today?" The therapeutic relationship developed in direct proportion to my demonstrations of respect for her need for distance as an important defence. I gave Mary the space to move closer and farther away depending on what she needed, while I remained constant.

The relationship developed over many sessions, during which I gently observed her discomfort in getting close to me, and identified her mistrust of me. Simultaneously, the negative feelings (e.g., her wish to lash out) that she felt toward her abusive and neglecting caretakers were transferred onto me, while her ambivalence toward me and the therapeutic relationship were manifested in, and mediated by, her artwork. We spoke at lengths about this. At one such time during the therapy, Mary spoke abruptly to me with an angry expression on her face. I said, "I can tell you are angry at the things that happened to you. I would be angry too, had these things happened to me."

When I sensed that Mary's anger was directed toward me I would encourage her to express it by asking outright, "I wonder if you are feeling angry at me right now?" or, "How do you feel about us this week?" By speaking in the "here-and-now" I gave Mary the chance to express her fear and terror at being close to an adult. This helped show me where we stood, and showed her that I wanted to get close to her, no matter how many barriers she put up. Through an attitude of empathy, acceptance, consistency and positive regard on my part and as Mary perceived that I survived her anger, she came to trust me to guide her in experiencing and metabolizing her feelings of rage and fear.

This rage and fear were also related to Mary's internalized parent, another issue worked through in the middle phase of treatment. I said to her, "Sometimes, Mary, when I see you want to hurt yourself, I wonder about several things. You often say you feel that you are bad and that that was what your parents told you."

"You know, Mary, our parents live inside of us. Even when they are not there in reality, everything they ever said to us stays inside of us: the good and the bad. At these times your mother hurt you so much that I think you sometimes hear her voice in your head telling you that you are bad. I wonder if it is that voice that you are trying to hurt and kill off when you try to hurt or kill yourself?"

She responded thoughtfully, "When I think about all those bad things my mother and father said and did, I really do want to hurt myself." I then told Mary, "You're not bad, though. In fact, I see you as good, and I hope you will too."

This vignette is a condensation of many scenarios repeated throughout the treatment. In each, my message to Mary was that she should see herself in the same good light in which

I saw her. Mary needed to quarantine the voice of the bad, internalized parent, and permit space for my positive message to replace it.

Her ensuing drawings depicted positive memories, which then resulted in drawings of age-appropriate adolescent themes, or child-like themes with images of play including a collage of images that she identified with and related to also.

By this time in the treatment, although Mary reassured me that she no longer felt like killing herself, she nonetheless noted that the dagger was also a vehicle by which she might do so, thus symbolizing the ongoing theme of rage and her wish to act destructively, both to herself and others. The cross and dagger were intrusive and pervasive images responsible for nightmares and insomnia. These symptoms resolved as links were made between the nightmares, traumatic experiences, and her own projected rage. I told Mary, "You had a lot of terrible things happen to you that should not have. Yet you survived, although those experiences made you angry at all people, including those you are getting close to now. I wonder if your anger occasionally comes out in your dreams. You know, Mary, that we are the directors of what happens in our dreams. We often portray angry and scary things in dreams, because we ourselves are sometimes angry. It is a normal process. However, we don't often want to see ourselves as angry, so we let someone or something else express that anger for us in the dream."

While addressing these issues, I was also providing Mary an experience of a relationship with a safe adult who could coach her in new ways of protecting herself in interactions with others.

As we discussed her need for distance, Mary's sense of isolation emerged in her drawings throughout the treatment as well. In one image, two figures, representing herself and her mother, reached out to each other, separated by a river (Fig. 3). "They are in a snowstorm," she explained. "They need each other but cannot see each other because of the snow." She then described how she and her mother had once escaped the mother's abusive boyfriend in a flight through the deep snow. Soon after that incident, Mary had been forced to leave her mother to live with her father, while her mother moved to a distant city.

Reminded of the isolation beneath her tough exterior, I guessed that Mary experienced me as being out of reach, just like her mother. I asked, "How does this image relate to what you are experiencing right now in your life, Mary?" To which she replied, "I feel lost. No one can find me." I responded, "I wonder if you sometimes feel I cannot find you either, and cannot connect?" "Yes," she said, "Sometimes I feel like you are my mother, reaching out to me through the snow. You might find me, or might not. Sometimes I make it easy for you to find me, and sometimes very hard."

I wondered whether the feeling of isolation could be bridged, but Mary feared that I, like her mother, would be overwhelmed by the affects linked with her prior traumatic experiences. She said she felt numb and "disconnected" from her surroundings, as though she was continually lost "in a snowstorm, where no one can find me." Her blunted affect at such times appeared congruent with the content of her associations, and her feeling of dissociation from that trauma and from everyday experiences, consistent with the profile of post-traumatic stress disorder. She gradually began to understand that her feelings of isolation derived from the real isolation she was forced to endure when her mother abandoned her to her relatives, and her father would enter and exit from her life without warning or preparation.

Fig. 3. They are in the snowstorm.

Mary's isolation also came from exposure to the overwhelming feelings associated with the trauma, which she was forced to endure alone, in the absence of the containment of a safe adult. To bridge this sense of isolation, the art therapist needs to encourage the expression of these feelings through artwork as well as through the therapeutic relationship—again, with a focus on the 'here-and-now.' This regular reference to the 'here-and-now' helps adolescents experience feelings in relation to another person in a safe way.

With continued attention to this theme of isolation, Mary began to express pleasure in interacting with new friends at school, a development marking the close of the middle phase of treatment. At this time Mary also reported that she no longer had suicidal thoughts or wishes.

Final phase of treatment: self-esteem

Until the final phase of treatment (sessions 24–33 approximately) some of Mary's art productions manifested poor self-esteem. After finishing a drawing she would often say, "It's terrible. It is no good," and I would have to prevent her from throwing it away.

In an effort to improve Mary's self-esteem, I told her how powerful her images were, and how well they reflected her past experiences. As I took pride in her, Mary began to develop a sense of her own importance. She made frames for her artwork, which we hung on the walls to discuss during the sessions. As this exchange unfolded, she also became more relaxed

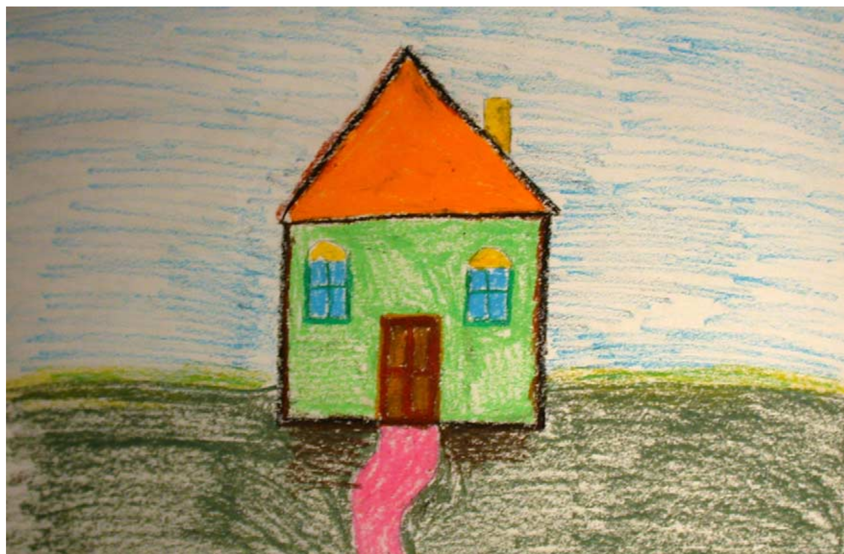

Fig. 4. A new symbol of strength and courage.

and comfortable, even playful. In her work with the clay, for instance, we threw lumps of it to one another, accompanied by iterations that she felt understood.

As well, I commended Mary on her gift for insight, which she attributed to her past attempts to try to make sense of difficult circumstances. Even her tough façade, at times a negative quality, occasionally proved to be a strength, as I pointed out, protecting her in adverse situations. I coached Mary to harness these strengths in the selection of healthier relationships, and to practise new ways of defending herself emotionally. With this evolved a new self-confidence enabling her to trust people, and resulting in the drawing of a wall, which she could build and destroy as demanded by the situation. This wall symbolized her ability to protect herself when needed, together with a growing trust and comfort with new relationships, in contrast with her past routine of keeping people at bay. Through the growing closeness in the therapeutic relationship, Mary had learned to trust others.

Concomitantly, Mary's self-concept changed from that of an unloved, alienated, and angry adolescent to one strengthened and edified by her past experiences, capable of making better choices, and endowed with previously untapped creative energies. New symbols emerged depicting strength and courage, notably one of a colourful house with solid doors, large windows and a strong foundation (Fig. 4). Discussions ensued with respect to age-appropriate developmental concerns consistent with Mary's new ability to protect herself emotionally, develop safe relationships, and continue in school to pursue her career goals.

Mary now drew a cross and star with the *dagger removed*, containing both her name and that of her therapist on either side of the symbol (Fig. 5). This symbol of hope and faith that had grown within Mary throughout the therapeutic process was discussed and highlighted with her throughout this phase of treatment.

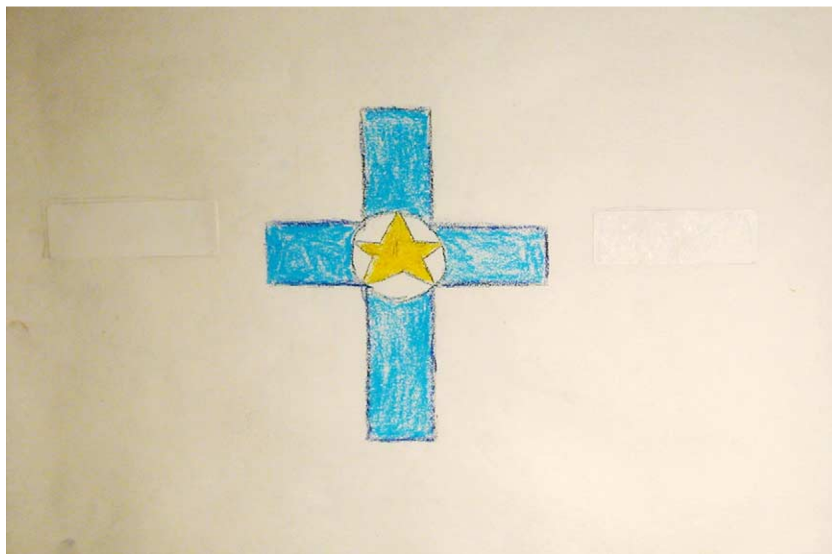

Fig. 5. A new symbol of hope and faith.

The therapy was discontinued during this phase of treatment, after 48 sessions. The team and Mary agreed to this decision as Mary was no longer feeling suicidal, her depression had resolved, and her functioning at school and interpersonal relationships in her foster family had improved. They were aware that they could consult with us in the future, and were informed of the availability of community resources should the need arise.

Bi-monthly meetings with parents

The content of the meetings between the treatment team and the patient's family varies in accordance with the difficulties that arise during the patient's treatment, and sometimes includes recommendations for other treatments (e.g., family and/or couple therapy), and a consideration of the progress of all treatments received by the family members. As Mary no longer lived with her parents, bi-monthly meetings were instead held with her foster mother. During these meetings, the team discussed several issues of importance in her management, without breaching confidentiality, and with the explicit permission of Mary, and often in her presence. In view of Mary's history of multiple abandonment, we were concerned that she would repeat behaviours which could potentially sabotage her relationship with the foster parents (e.g., through suicide threats or acting-out behaviour). In Mary's particular case, then, the team coached the foster parents in how to deal with her efforts to maintain an emotional distance from them.

Suicidality

Mary's suicidal feelings began to attenuate after several months of treatment, and were considered to have derived from several sources. As was manifest in her history and her

discourse, the cycle of abandonment and trauma that she had been subjected to, and the resulting feelings of powerlessness and despair that these sentiments evoked, were justification for her rage and mistrust of caregivers. That mistrust was generalized to her relationship with adults in general, so that the rage could be neither discussed nor metabolized, and thus exacerbated her feeling of isolation. When directed to her internalized parent, the rage led to a wish to destroy that part of herself, resulting in suicidal thoughts and depression. When externalized, it intensified her distance from others. As she said, "Sometimes I just don't know what to do with all of the anger inside of me. I want to hurt all the people around me, or myself, but I withdraw instead." Resolution of the above-mentioned negative feelings occurred as they were experienced and examined in the here-and-now of the therapeutic relationship.

The use of drawings in Mary's treatment

Mary was able to use drawings to reveal painful experiences, which she had not previously, articulated. The medium of art allowed her to feel less frightened of her affects, especially the intense negative emotions associated with past traumatic experiences, and to express them in a safe and distanced way. Further, the art served as a mediator between herself and the therapist, allowing her to get closer to the latter as they worked through issues of trust, abandonment and self-esteem, and feelings of rage and isolation. These qualities of the art were felt, in large measure, to have facilitated the therapeutic alliance, thus permitting interpretation of feeling states and conflicts in relation to people outside of, and within, the therapeutic relationship. This, in turn, contributed to resolution of her depression and reduction of her post-traumatic stress disorder symptoms, and to examination of her developmental needs and identity formation.

Discussion

Since its inception as a therapeutic modality for adolescents, art therapy has been reported in the treatment of an array of disorders, including suicidality, but such reports have been restricted to inpatient and group settings. We have found it a useful tool in the management of suicidal adolescents on an individual and outpatient basis, with provision (although not needed in the case presented) for access to other health care professionals should further crises arise during the treatment.

A case report has described the use of art therapy in the treatment of Mary, a 14-year-old suicidal female who had experienced neglect and abuse, and suffered from depression and post-traumatic stress disorder. Consideration was given to her artwork as it manifested feelings of mistrust, despair, rage, and isolation, poor self-esteem, and the need to keep a distance from friends and caretakers. Most of these, as the literature points out, are issues of concern with the majority of suicidal adolescents. Each of Mary's drawings led to the surfacing of new material, contributed to the consolidation of an alliance with the therapist and gave further insight into her conflicts. This resulted in an increased self-esteem, decreased sense of hopelessness and depression, and resolution of her desire to commit suicide and of her symptoms of post-traumatic stress disorder.

Given the lack of research on the use of the art therapy with outpatient suicidal adolescents, this study clearly indicates the value of art therapy within this context and provides a basis for ongoing research in this area. The authors strongly encourage other clinicians to consider art therapy as a viable treatment option for suicidal adolescents, as it presents a powerful tool to overcome the emotional constraints inherent in a therapeutic process with such a population. Using art therapy opens the window into the adolescent's internal world and therefore can stimulate a therapeutic process that might otherwise be challenging to initiate.

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