

**An Art Therapy Intervention with African-American Male Adolescents Assessed
with a Depressive Diagnosis**

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Abstract

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This study examined the impact of art therapy intervention over the course of eight individual sessions with one adolescent African-American male at an Approved Private School. This research was conducted after having found little research and resources pertaining to art therapy interventions with African-American male adolescents assessed with a depressive diagnosis such as Major Depression, Bipolar I Disorder or Dysthymic Disorder.

The design of this study was conducted through a single subject design in ABA format. The participant was given a pre and post-test measure in sessions one and eight, using the Children's Depression Inventory scale to assess his level of depressive symptomatology. Sessions two through seven included individualized art therapy and goal-oriented art therapy directives.

The subject who participated in this study was a 16-year-old African-American male diagnosed with Bipolar I disorder. The results of the pre and post-test Children's Depression Inventory were recorded, the individual art therapy session notes were presented and the artwork created in each session was analyzed.

Even though he scored low and not within statistically significant ranges in both the pre and post-test, the findings suggest that there was an increase in depressive symptomatology suggesting that art therapy aided this participant in self-exploration and less regression in his responses.

Despite his increase in depressive symptomatology, the results of this study suggest that individual art therapy had some positive effects on his understanding of his persona, self-esteem, coping skills and depressive affect. With increased number of sessions, this and other areas may increase his understanding of these aspects.

Dedications

I would like to dedicate this work to several people who inspired me before, during and after graduate school. To all of the professors who shared their insight, inspiration and creativity, thank you for your expertise and guidance. I would like to thank my parents and their continued support throughout this process. I would also like to thank my husband who endured the editing process with me and who continued to stand by my side through each and every day. Without your guidance, continued encouragement, and daily humor, I may not have made it to this point. Finally, I would like to thank the children who inspired me to pursue this research topic. Without them, research in this area may have continued to be nonexistent. More specifically, I would like to thank my single participant who was open to art therapy and its potential benefits.

“If we don’t change the direction we are headed, we will end up where we are going.”

-Chinese Proverb

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CHAPTER I: INTRODUCTION

The purpose of this thesis was to explore, understand and record potential changes in levels of depression of African-American adolescent males who experienced art therapy as an intervention. Over eight individual sessions, this case study intended to review the impact of art therapy as an intervention with African-American male adolescents who were assessed with a depressive diagnosis. Through clinical internship experiences, it was observed that, despite depressive affect and depressive qualities revealed in their artwork, these African-American male adolescent clients were not diagnosed with Major Depression but rather Conduct Disorder and Attention Deficit Hyperactivity Disorder. It was proposed that art therapy may have been an effective therapy for this population. As young men in this population continued to grow physically, emotionally and cognitively, some of them may have reflected a higher tendency to exhibit significant fluctuations in mood swings than younger children or adults (Newman and Newman, 2006). As this constant shift in emotions continued, verbal communication may have been difficult. Therefore, symbolic speech and the use of art therapy may have proved beneficial to this population (Naumberg, 1987).

Research was conducted at a designated suburban Approved Private School. At this facility, students were referred by staff members or counselors. Research was to be conducted with approximately three individuals. During and after each session, all therapy notes, observations and data were taken by this researcher. After all notes were written, they were typed and entered into a log and kept by this researcher.

This researcher met with each client for a total of eight times. The case study had an alternating ABA treatment design. Each week, each client received art therapy tasks

related to their individual treatment plans and goals. During session one, the clients received the Children's Depression Inventory as a pre-test measurement. During sessions two through seven, the individual goals were addressed through art therapy intervention. During session eight, the clients were re-administered the Children's Depression Inventory as a post-test measurement. The Children's Depression Inventory was intended to record any changes in affect or depressive qualities based on art therapy as the intervention. This 27-item inventory assessed affect and signs of depression in children between the ages of seven and seventeen (Pearson Assessments, 2008).

According to Teen Depression, approximately 20% of teens experienced depression (2005). Additionally, approximately 5% of adolescents suffered from Major Depression during this transitional period in their life (2005). Within the Philadelphia area, the Philadelphia Urban League stated that the African-American community may mistrust medical health professionals and therefore be reluctant to seek help for depression (2007). They also noted that there may have been cultural barriers and poor relationships between doctors and clients (2007). In working with this population, it was important to understand these misgivings and potential barriers as they may have impacted therapeutic treatment. Additionally, socioeconomic factors may have reflected limited access to medical care. Because of these issues, it was important to address depression in urban or suburban adolescent African-American males.

As reported by Teen Depression, depression may have affected any age group, sex, social background, income level, or ethnic group (2005). Psychiatric depression in children was once understood from the model of adult depression. Over the past thirty

years, recent research has indicated that depression in children may have presented differently than stereotyped adult depression (Reynolds and Johnston, 1994).

As cited by the National Institute of Mental Health, depression in adolescents occurred when the teens were forming their identity and attempting autonomy from their family and parents (National Institute of Mental Health, 2008). The DSM-IV TR outlined several diagnostic categories of the disorder e.g .such as Major Depressive Episodes, Dysthymic Disorder, Adjustment Disorder with Depressed Mood and Depressive Personality Disorder. Essential features in children included depressed mood, loss of interests, irritability, changes in appetite, hypersomnia, insomnia, observable changes in psychomotor activity, lessened energy levels, feelings of worthlessness, guilt, difficulty concentrating, suicidal ideation, low self-esteem, feelings of hopelessness, pervasive and persistent dejection, gloominess, unhappiness, inability to have or accept happy thoughts and harsh self-judgment (American Psychiatric Association, 2000). Because depression may have been pervasive and persistent, adolescent depression or depressive qualities may have negatively impacted family lifestyle or home environment, how they functioned in school and how they interacted in their social peer relations.

Within urban environments, such as Philadelphia, PA, levels of poverty, illicit drug use and violence were often higher than that of suburban neighborhoods and children exposed to these types of negative influences may have been exposed to murder, violence, poverty or poor health coverage (Urban League of Philadelphia, 2007). These cultural and environmental influences may further have exposed this population to depression and inability to receive proper and effective treatment. According to the Philadelphia Urban League, socioeconomic factors included limited access to medical

care (2007). According to the National Institute of Mental Health, treating depressed adolescents with Prozac or psychotherapy may have been financially costly and time consuming for families (NIMH, 2008).

Because adolescents were not as cognitively, physically or emotionally developed as adults (Newman and Newman, 2006), traditional verbal or cognitive behavior therapy may not have been as effective as art therapy (Levick, 1983). Art Therapy may have proved to be an effective tool in helping adolescents address and cope with different types of depression or depressive qualities (Levick, 1983).

According to Reynolds and Johnston, depression in children and adolescents was described as a serious mental health problem (Reynolds and Johnston, 1994). Reynolds and Johnson further stated that a majority of the research already conducted on this adolescent population was conducted during the 1970s and therefore resulted in a delay in understanding the existence of depression in adolescents (1994). Reynolds also reported that

The current level of attention to depression in children and adolescents is well warranted, especially when we consider the results of epidemiological studies that suggest that as many as 5% of children and between 10% and 20% of adolescents from the general population have experienced a depressive disorder (P. 4)

Reynolds and Johnston stated that most children and adolescents did not receive any type of treatment (Reynolds and Johnston, 1994). Teen Depression reported that 80% of adolescents who were diagnosed with depression may have been treated successfully if they sought help from a mental health professional or a doctor (2005). During the course

of adolescence, children underwent emotional, physical and chemical changes within their body (Clarizio, 1986).

Several elements may have played a role in adolescent depression. Depression in adolescents may have derived from environmental or biological factors. Environmental factors may have included childhood stressors, familial relationships, interpersonal relationships, or traumatic events (Reynolds and Johnston, 1994). Biological factors may have included genetic predisposition toward depression (1994). In addition a child raised by a guardian who was clinically diagnosed with depression may have developed some form of depression based solely on being raised by someone who was depressed (Reynolds and Johnston, 1994).

As previously stated by Reynolds and Johnston, a majority of children and adolescents did not receive any type of treatment for their depression. According to the National Institute of Health, scientists and doctors were taking adolescent depression more seriously as it may have led to suicidal thoughts, suicidal intentions, attempted suicide and completed suicide (National Institute of Mental Health, 2008). Early intervention of depressive symptoms may have led to prevention or implementation of effective coping skills of depressive diagnoses. The National Institute of Health research indicated that childhood depression typically persisted through adulthood, especially if it was untreated (2008).

Research has been conducted with depressed adolescents in general and with depressed adolescents exploring an art therapy intervention. Gap analysis revealed little or no research conducted with depressed African-American male adolescents from urban or suburban Philadelphia who experienced art therapy as an intervention. Adolescents

who did not participate in treatment for their depression had a higher likelihood to develop substance abuse problems, reduced social networks, attempted or completed suicides (Teen Depression, 2005). There may have been a significant difference in success rates of depressed adolescents through understanding success of depressed adult populations (Clarizio, 1986).

The research question was: What impact did art therapy intervention have on urban or suburban African-American male adolescents with depressive diagnoses? The objective of this study was to understand and record the impact, if any, of art therapy as an intervention with this population.

Limitations of this study included inconsistent attendance by the clients. Clients may not have wished to participate in the study or may have been reluctant to participate in the reading and answering of the questions from the Children's Depression Inventory scale. Additional limitations included the effect of medication on the client during the process, or noncompliance of taking prescribed medication. Delimitations included the small number of subjects and the selection from a designated Approved Private School.

Delimitations of this study included only one participant. Additionally, this one participant was from only one Approved Private School.

The research question was what impact might an art therapy intervention have on African-American male adolescents.

CHAPTER II: LITERATURE REVIEW

Overview

This literature review section reviews early adolescence, both in traditional normal development as well as early adolescence marked with a depressive diagnosis and its compounding effects on the individual, family, friends, school impact, and community. Additionally, it reviews the effect of depressive symptoms and complaints, the impact of poverty and socioeconomic class, healthcare and substance abuse among African-American urban male adolescents assessed with a depressive diagnosis. This literature review also discusses the limited diagnoses of Major Depression, Bipolar I Disorder and Dysthymic Disorder and the more prevalent diagnoses of Conduct Disorder and Attention Deficit Hyperactive Disorder of African-American male adolescents from urban and suburban Philadelphia. This contextual literature review will look at the broad scope of African-American male adolescents in an urban or suburban environment who may experience these elements. Beginning with a broad range and then narrowing down to specific elements, this literature review is intended to provide the reader with a fuller understanding of these elements, its impact on this population and addressing art therapy intervention.

The review of the literature has clarified that there is little research found within this age group, racial background, and depressive diagnoses triad. It examines pertinent literature regarding African-American male adolescents between the ages of 12 and 18 who are diagnosed with Major Depression, Bipolar I disorder, or Dysthymic Disorder. Furthermore, this chapter reviews and discusses the effect of depressive diagnoses, of behavior, self-esteem, interpersonal skills and global functioning within this population.

Finally, it looks at the impact of therapy and the need for further research with this population.

Gap Analysis

There appears to be a significant gap in the literature pertaining to African-American urban male adolescents assessed with a depressive diagnosis. This may be due to the abundance of information relative to the broader scopes of early adolescent depression and that of African-Americans in mental health treatment. This gap may also be a reflection of lack of trust of mental health professionals or it may be a reflection of prevalent diagnosis of Conduct Disorder or Attention Deficit Hyperactivity Disorder. There are significant amounts of information attributed to both of these areas but it is lacking in relationship to depressed African-American males living in both urban or suburban environments.

According to the World Health Organization (World Health Organization [WHO], 2009, Statistics section, ¶1), there are approximately 302,841,000 people currently living in the United States of America. Reports indicate that there are currently approximately 73.7 million children and adolescents in the United States of America (Child Trends Data Bank [CTDB], 2009 Headline section, ¶1). Within the United States, there appears to be a growing number of adolescents with depression. Over the past year, reports regarding adolescents in grades 9-12 indicate that more than one quarter have reported feeling sad or hopeless nearly every day and for an extended period of the day (CTDB, 2009, Results section, ¶1). Within this age group, involvement in substance abuse, promiscuity, and violence is increasing. With adolescents aged 15-19, homicide and suicide were reported as the third leading cause of death in this age group (CTDB, 2009, Results section, ¶1).

More specifically, the Center for Disease Control reports indicate that over a forty-year period, between 1952 and 1992, suicide among adolescents and young adult populations tripled (Center for Disease Control [CDC], 2009, Introduction section, ¶1). It is also reported that although there was an overall reduction in suicide within these age groups between 1980 and 1992, the rates of suicide increased 165.3% for African-American males (CDC, 2009, Introduction section, ¶3). Additionally, the CDC reports an increase of 28.3% of suicide specifically for adolescents between the ages of 15-19, and an increase of 120% for adolescents between the ages of 10-14 (CDC, 2009, Introduction, ¶3).

Normal Adolescent Development

In reviewing normal adolescent development, normal emotion regulation and cognitive development are considered organizing and integrative processes (Rutter, Izard & Read, 1987). These two facets of development are integrative processes that help facilitate the organization of growing emotions, perceptual abilities, cognitive and motor development while helping to create adaptive demands brought on by natural stress and life demands.

It is reported that “developmentally, normal adolescents have a proclivity toward depression” (Shafii & Shafii, 1992, p. 31). They also report that it is important to differentiate between mood swings and pathological depression (Shafiii & Shafii, 1992; National Library of Medicine [NLM], 2009, Signs and Tests section, ¶6). Early adolescence is defined as children between the ages of twelve and eighteen and that this period is outlined by the normal process of maturing, the onset of puberty, and rapid physical and cognitive changes taking place (Newman & Newman, 2006; Department of

Health and Human Services [DHS], 2001; Clarizio, 1986; the National Library of Medicine, 2009, Causes, medicine and risk factors section, ¶2).

There are three major characteristics as children exit the latency period and shift into early adolescence and all include considerable psychological and emotional changes (Sarnoff, 1987). One characteristic is the inner turmoil created by the maturational stages of onset of puberty with its physical and sexual changes. During this period of life, another influential element includes peer influences and social interactions, including an increase in peer, social pressure and pressure from parents. An increase in sexual activity or promiscuity is the third characteristic specific to this age group (Sarnoff, 1987).

Because of the many changes occurring during this time, early adolescence may be seen as a difficult transitional period, burdened with conflicts as well as an exciting time where complicated thoughts and heightened emotions take place (Newman & Newman, 2006; Reynolds & Johnston, 1994). As part of the developmental process, Blatt (2004) reports the pervasive existence of distortions and exaggerations in day-to-day experiences.

Additionally, Blatt (2004) indicates the emergence of two themes of clinical depression and in normal adolescent depression: increased dependency and increased self-criticism. Development is considered a lifelong process where change and maturation takes place while more specifically it is reported that most of these changes quickly unfold during childhood and adolescence (DHHS, 2001). Physical maturation includes physical growth, development of primary and secondary sexual characteristics and cognitive development (Newman & Newman 2006). Physical changes in boys include increased height and increased muscle mass while secondary changes may

include facial hair, pubic hair, vocal changes, and sexual urges bringing males closer to adulthood.

Cognitive Development

In addition to physical changes, there is also psychological awkwardness in this stage where physical and visual bodily dissatisfaction may take place and early adolescent males may become frustrated with all of these changes (Newman & Newman, 2006). This time period is marked with cognitive developments and increased consciousness. In healthy early adolescents, logical reasoning develops and pre-adults are more able to generate cognitive hypotheses although often marked with anxiety, challenges, demands and that depressive moods may occur. During this stage, romantic relationships, adult decisions, social networks and academic challenges typically develop.

According to Newman and Newman (2006), cognitive development theory “focuses specifically on how knowing emerges and is transformed into logical, systematic capacities for reasoning and problem solving” (p. 68) causing significant changes to take place. Thoughts become more intricate, lasting memories are formed, formal operations and increased consciousness are also developed.

In normal early adolescence, adolescents typically transition into the formal operations stage where thinking becomes more independent and internalized, verbalization significantly improves, problem-solving skills dramatically increase, and they start thinking of themselves in a broader, more conscious sense. Here, adolescents can generate hypotheses and use logical reasoning to prove or disprove hypotheses, and begin to solidify the conscious and ego ideal as their cognitive sophistication increases (Newman & Newman, 2006; Rutter, Izard & Read, 1986; Piaget, 1987).

Social Development

Changes that take place in early adolescence include those in the emotional, behavioral and social realms. Erikson (1963) called this psychosocial crisis within this stage “Identity vs. Role Confusion”. Erikson notes that adolescents during this stage of development are usually concerned with forming social groups and creating a self-concept describing alienation as social estrangement, where there is a lack of social support and social networking. This may potentially impact and exacerbate depressive feelings and emotions of early adolescents during this period in their life.

Lowenfeld and Brittain (1987) present this stage as the Pseudo-Naturalistic Developmental Art Stage, ages 12 to 14, and the later art stage of the Period of Decision, ages 14 to 17. In the early portion of this early adolescent stage, Lowenfeld and Brittain report that the greatest changes include physical, mental, emotional and social changes,

Lowenfeld and Brittain (1987) agree with Piaget (1963) and Potash (2009) that children in this stage develop abstract thinking. Mentally healthy children in this stage develop self-awareness and self-consciousness. The authors note that concern with how they look, dress and what they say increases. In the Period of Decision, adolescents are concerned about their social network and independence from their parents (Lowenfeld & Brittain, 1987). Adolescents in this stage seek to establish their sense of identity and to better understand the future world of responsibility.

Within the Period of Decision, typically expressed art characteristics and elements include conscious efforts in attempting to develop one’s artistic skills, subjective interpretations, visual details, addition of adding light and shading, mastery and control of any art materials, accompanied with prolonged attention span. Human figure

representations within this adolescent stage include exaggerated details, increased awareness of proportions, naturalistic attempts, and satirical figure drawings (Lowenfeld & Brittain, 1987).

Depression

Depression can impact any race, gender, ethnicity, nationality or age group affecting approximately 121 million people worldwide (WHO, 2008, Facts, ¶1). Within the United States, approximately 44 million Americans experience a mental disorder (United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration [SAMHSA], 2006, Mood Disorders Section, ¶1).

Within the United States, 8% of adults aged 18 and older are affected by Major Depression (Donnelly, 2008). Bipolar Disorder, formerly addressed as manic depression, affects approximately six million adults in the United States and approximately 6% of children aged 9-17 (Donnelly, 2008; Bright Futures, Key Facts section, 1999, ¶1). Approximately 20% of teenagers will experience depression each year (Teen Depression, Statistics section, 2005, ¶1).

Depressive disorders, including Major Depression, Bipolar Disorder and Dysthymic Disorder, do not discriminate against age, gender, social class, ethnicity, religion, sexual preference or race (Sadock & Sadock, 2007). According to Depression and Bipolar Support Alliance, [DBSA] Dysthymia affects approximately 3-6% of the population in the United States (Depression and Bipolar Support Alliance, 2007, ¶6). Within the United States, Major Depressive Disorder, Dysthymic Disorder and Bipolar Disorder are the most common and primary types of depression, and possibly the most diagnosed in children (The Children's Hospital of Pittsburgh, 2008, What is Dysthymia

section, ¶3; Children's Hospital of Philadelphia, [CHOP] 2009, Three types of depression section, ¶1). In reviewing these diagnoses, many of the typical characteristics of Major Depression, Bipolar I Disorder and Dysthymic Disorder similarly overlap and parallel those of Conduct Disorder and Attention Deficit Hyperactivity Disorder.

Major Depression

According to the Diagnostic Statistical Manual IV-TR, depression in adults is classified as a mood disorder that includes Dysthymic Disorder, Bipolar Disorder and Major Depression (American Psychiatric Association [APA], 2000). The NIMH (2008) reports that Major Depression may include several factors such as:

- Irritability
- Restlessness
- Loss of interest in activities or hobbies once found pleasurable
- Feeling fatigued or having decreased energy

In regards to emotions, NIMH (2008) states that depressed individuals may feel:

- Sad
- Anxious
- Empty
- Hopeless
- Pessimistic
- Guilty
- Worthless
- Helpless

Loss of self-esteem is considered a major element and identifiable characteristic of depression (Rutter, Izard & Read, 1986). Depressed individuals may also have a difficult time concentrating, may suffer from insomnia or excessive sleeping, overeating or appetite loss. Somatic complaints may include persistent aches, pains, headaches, cramps or digestive problems that do not ease with medical treatment (NIMH, 2008, p. 5).

The DBSA (2007) states that depression stems from an imbalance of chemical neurotransmitters and life events (Depression section, ¶1). Depression has several key characteristics. In adults, symptoms may affect eating habits, sleep, energy levels, self-esteem, concentration and feelings around hope (APA, 2000). Individuals who suffer from depression may have persistent thoughts of suicide or have attempted suicide (NIMH, 2008, p. 5).

In reviewing Major Depression and comparing it to Attention Deficit Hyperactivity Disorder, there are many similarities between the two diagnoses. Loss of interest in activities may be mistaken for avoidance or reluctance to participate in activities, a typical characteristic of Attention Deficit Hyperactivity Disorder (APA, 2000). It is relevant to mention ADHD as a differential diagnosis because of the similarities and potential for misdiagnosis.

Bipolar I Disorder

According to the Diagnostic Statistical Manual IV-TR (APA, 2000), Bipolar Disorder is considered a Mood Disorder and within this category, there are six different sets or types of Bipolar Disorder:

- Single Manic

- Most Recent Episode Hypomanic
- Most Recent Episode Manic
- Most Recent Episode Mixed
- Most Recent Episode Depressed
- Most Recent Episode Unspecified

More specifically, Bipolar Disorder is categorized by either a first manic episode but with no past Major Depressive Episodes or the recurrence of depressive episodes (APA, 2000). The criteria for a manic episode includes abnormal mood that is elevated or irritable and lasting at least one week. In addition to this disturbed mood, three or more of the following must also be accounted for and at a significant degree:

- Heightened self-esteem
- Lack of sleep or need for sleep
- Excessively verbose or more so than usual
- Flight of ideas or racing thoughts
- Easily distractible
- Increased activity or psychomotor agitation
- Excessive involvement in activities that may increase harm such as buying sprees or increased sexual indiscretions (APA, 2000).

Bipolar Disorder is considered and characterized as a mood disorder that is pervasive and affects one's behavior and perceptions (Sadock and Sadock, 2007). There appears to be an equal prevalence of Bipolar I disorder in both men and women. It is stated that age of onset may be as early as age five or six or as late as 50.

Between Bipolar I and Bipolar II disorders, there are distinct differences. As noted earlier, Bipolar I disorder is characterized by six categories whereas, according to the Diagnostic Statistical Manual IV-TR (2000), Bipolar II disorder is categorized by Recurrent Major Depressive Episodes with Hypomanic Episodes. In this disorder, patients must have a presence or reoccurrence of at least one Major Depressive Episode, and Hypomanic Episode.

More specifically, the DSM IV-TR reports that the characteristic symptoms of Bipolar II Disorder cause significant impairment and distress on the individual in that it negatively affects their social, occupational or other areas of functioning. In looking at depression in Bipolar I disorder, Miller (2008) concludes that disrupted sleep, neurobiological changes, and goal attainment, are all elements found in manic bipolar episodes but that neither of these were found to predict depression. Miller also summarized that “both goal attainment and negative life events are related to symptoms in bipolar disorders” (p. 269). More specifically, it was suggested that “goal-attainment life events predicted increases in manic but not depressive symptoms” (p. 275) and that “negative life events increase risk of depressive symptoms” (p. 275).

In comparing Bipolar I Disorder with ADHD, many similarities exist between the two diagnoses. Specifically, these include excessive talking, racing thoughts, distractibility, and psychomotor agitation or fidgeting of hands or feet (APA, 2000). In reviewing Bipolar I Disorder with Conduct Disorder, there are two common elements: increased sexual activity and impairment in social, occupational or academic functioning and performance (APA, 2000). This may be paralleled with racing thoughts and

distractibility. It is important to review these differential diagnoses as potential for misdiagnosis may occur.

Dysthymic Disorder

The Diagnostic Statistical Manual- IV-TR (APA, 2000) specifically states that two or more of the following must be present in Dysthymia:

- Poor appetite or overeating as a symptom
- Insomnia or hypersomnia
- Low energy
- Low self-esteem
- Poor concentration or feelings of hopelessness

Sadock and Sadock (2007) and the DSM-IV-TR (APA, 2000) indicate that Dysthymic

Disorder includes:

- Irritability
- Feelings of anger
- Withdrawal
- Guilt
- Reports of feeling depressed

The authors also report that Dysthymic Disorder is nearly identical to that of Major Depressive disorder but to a lesser degree. The DSM IV-TR has determined that in children and adolescents, the disturbance of mood must exist for a majority of the day and for at least a year (APA, 2000).

It is relevant to note that similarities exist between the diagnosis of Dysthymic Disorder and that of ADHD. Low energy, low self-esteem, withdrawal, and poor

concentration may be perceived as a lack of interest, a major characteristic seen in ADHD. Additionally, in reviewing Conduct Disorder and Dysthymic Disorder, irritability and feelings of anger may overlap with characteristic disturbances in behavior causing social, academic or occupational impairments, a typical characteristic of Conduct Disorder (APA, 2000). Because of these similarities, it is important to mention both ADHD and Conduct Disorder as rule-out diagnoses because these disorders may be diagnosed more so than that of depression.

Depressive symptoms and complaints

Depression is considered an affective disorder and a serious medical condition. It includes persistent sadness and pervasive loss of self worth (National Library of Medicine, 2009, definition section, ¶1; CHOP, 2009, overview of depression section, ¶1). Harrington (1993) states that

Depression of mood is by its very nature an individual behaviour, that does not depend for its definition on the presence of external factors. It is an intrapsychic phenomenon that can....exist in a child without any other person being aware of it (p. 135).

In reviewing depressive symptoms and complaints, Robbins (1998) states that depressed patients may have issues around separation. “The depressive position has also evolved the early maternal holding environment, but rather than presenting problems of bonding or maternal privation, it concerns issues of separation” (Robbins, 1998, p. 93-94). Depressed patients can feel hopeless, overwhelmed, exhibit poor self-esteem, feel withdrawn, dead, heavily, burdened, experience great despair, somatic complaints,

primitive thinking and use primitive defenses (Robbins, 1998; Sholevar & Schwoeri, 1994; Harrington, 1993; Newman and Newman, 2006; Reynolds and Johnston, 1994).

Matson (1989) and Newman and Newman (2006) describe depression as a cluster of symptoms that may appear simultaneously. Erickson (1987) agrees with Beck (1967) reporting that depression is cognitively weighted and individuals who are depressed typically view events and themselves negatively and that they inaccurately perceive their environment. Erickson (1967) contends that these are cognitive distortions and key aspects of depression. Erickson (1987) states that depressed youth

Perceive their environment as making excessive demands on them and tend to interpret interactions in terms of failure. The negative cognitive patterns are projected to the future in the belief that the current situation and feelings will continue indefinitely. (Erickson, 1987, p. 281)

Erickson (1987) also states that depression is reflected in an individual's negative cognitions, irrational thought, and unrealistic expectations. "Once a pervasive attitude of self-blame is developed, other symptoms, such as indecisiveness and increased dependency, may result" (p. 281)

In comparing symptom differences between men and women, the Mayo Clinic reports that depressive symptoms tend to be different (The Mayo Clinic [TMC], 2008, The Issues Behind Male Depression section, ¶2). Men's symptoms may include violent behavior, rage, escapist behavior where they are overly involved in work or extracurricular activities, risky behavior, alcohol or substance abuse, and more persistent thoughts of suicide. These symptoms are also similar to typical characteristics and negative acting out behavior of Conduct Disorder (APA, 2000). Female isolation may be

seen as either a cause or consequence of depression (Newman & Newman, 2006). Women who are clinically depressed may have issues with intimacy and feeling devalued. They may overzealously judge themselves, be more prone to put a man's needs before their own, attempt to avoid conflict in their relationships, repress their own views, needs and harbor resentful feelings (Newman & Newman, 2006).

Riley (1999) and Trombetta (2007) argue that there is a distinct difference between males and females but also reports that between males and females there are internalized and externalized emotions. *Internalizing problems* generally comprise cognitive, affective, and somatic disorders, such as anxiety, depression, eating disorders, and suicidal thoughts and feelings. *Externalizing disorders*, on the other hand, typically include delinquency, aggression, drug abuse, high risk sexual activity, and school problems (Blatt, 2004, p. 177). Externalizing disorders may also be interpreted as Conduct Disorder as there are many similarities between the two characteristics, including the aforementioned delinquencies, increased sexual activity, and disturbance in academic functioning (APA, 2000).

In reviewing gender and depression, Sadock and Sadock (2007) indicate that there is a greater prevalence of depression in females than in males. The authors hypothesize that this may be due to "hormonal differences, the effects of childbirth, differing psychosocial stressors for women and for men, and behavioral models of learned helplessness" (p. 529).

Depression in males

Approximately six million men experienced depression each year (NIMH, 2008, Depression in Men section, ¶1). Women tend to experience depression at double the rate

of men. The Mayo Clinic reports that depression in men may go undiagnosed (TMC, 2008, The Issues Behind Male Depression section, ¶3). They hypothesize that men may be reluctant to discuss their depressive symptoms, emotions and feelings with friends, family members or with health care professionals. Additionally, because of the similarities between ADHD and Conduct Disorder, depression may be difficult to diagnose, possibly increasing the diagnoses of ADHD and Conduct Disorder. If left untreated, NIMH states that depression may impact one's personal or family life and may lead to financial difficulties (NIMH, 2008, Depression in Men section, ¶3). The Mayo Clinic also indicates that detecting male depression may be difficult because symptoms may be less apparent because of masked depressive symptoms due to the use of alcohol or substances (TMC, 2008, Male Depression May Go Undiagnosed section, ¶4).

In comparing men and women, there are different symptoms of depression emphasizing that men with depression are more prone to suicide than women with depression because men have learned to be independent, competitive and emotionally stoic in the United States society and fearing that seeking out professional help may be a threat to their masculinity (TMC, 2008, Male Depression Symptoms section, ¶2). Over the course of researching and understanding depression, Klerman (1986) reports that depression no longer is considered with just middle-aged women.

Gilligan (1982) reports that the concept of separation and independence are crucial elements in the development and maturity of men. Through traditional growth, separation from family and independence are expected and considered learned behaviors. The Mayo Clinic also reports that men may fear a stigma associated with being diagnosed with depression (TMC, 2008, Male Depression May Go Undiagnosed section, ¶5). The

Mayo Clinic proposes that a stigma of diagnosed depression may impact their career, family lifestyle or losing respect and may therefore refuse treatment.

Depression with urban African-Americans

Boyd-Franklin (2003) reports that, when socioeconomic status is reviewed, African-Americans and depression is similar to depressed White people. Davis and Stevenson (2006) agree stating that psychological symptoms of African-Americans may include lowered self-concept and hopelessness. Lefley (1998) also reports that African-American families may rely more heavily on family and extended families than turn to mental health facilities. African-Americans may devalue mental healthcare because of their socioeconomic condition, their negative and stigmatic beliefs about mental illness and belief that their family caregivers will provide necessary network support. Joe and Kaplan (2001) agree that African-Americans are not likely to use mental health services as a resource for mental health concerns (2007). Because of the potential for mental health workers to misdiagnose clients with Conduct Disorder or ADHD rather than Major Depression, Bipolar I Disorder or Dysthymic Disorder, this may also be reflected in the lack of trust in and the low incidence of mental health services.

African-American History

In looking at the history of African-Americans, Vargas and Koss-Chioino (1992) report that African-Americans were considered “objects of the United States’ slave trade” (p. 63) and that “from slavery in previous centuries to institutional racism today, African Americans have experienced many forms of control by the White American society” (Wadson, 2002, p. 43). Hampton and Gullock (2006) contend that

Descendants of Africa have to contend with complex and mediating factors, beginning with the violent and ruthless ripping from Africa, continued with the violence during the middle passage, right up to the reinforcement of discriminatory acts of modern-day systems (e.g., the mental health system, the child welfare system, and the criminal justice system). (p. 122).

Today, African-Americans live in a hostile environment “fostered by the dominant culture” (p. 63) and that they have had to learn to survive and adapt to these elements. Because of these adaptive skills, it is reported that African-Americans may consciously or unconsciously teach these skills to their children, showing their children how to “deflect and negotiate a hostile environment” (p. 63).

Today, racism against African-Americans continues to exist but the effects of discrimination tend to vary “depending on the family’s economic and personal resources” (Vargas & Koss Chioino, 1992, P. 64). McGoldrick, Giordano and Garcia-Preto (2005) report that, nationally, a majority of African-Americans live in urban or metropolitan areas. Additionally, in 2001, 23% of all African-Americans lived below the poverty line. Persistent poverty, low life expectancy and oppression have increased drug and alcohol abuse among African-Americans. They suggest that lower life expectancy may be due to incarceration, mental disabilities, health disabilities, drug and alcohol abuse, dangerous occupations and violence (McGoldrick, Giordano & Garcia-Preto, 2005).

Healthcare is difficult to attain and this fact may be devastating for African-Americans and their children (Vargas & Koss-Chioino, 1992; Davis and Stevenson, 2006). Because of this, minorities may become disadvantaged “by having less plentiful

and qualified culturally relevant skilled clinicians” to help with emotional struggles or depression (Davis & Stevenson, 2006, p. 303).

There is a large gap in life expectancy between African-Americans and their white counterparts and according to Vargas and Koss-Chioino (1992), this may be due to the lived experience of being exposed to or involved in violence. This may mislead African-American youth to view little purpose in planning for their future or in seeking healthcare. “This may be particularly salient for African-American children in impoverished, crime-ridden areas where deaths in their families, whether due to inadequate healthcare, AIDS, or homicide, make the possibility of a future appear remote” (Vargas & Koss-Chioino, 1992, p. 66).

A majority of African-American children attend public school systems that are not formally racially segregated but remain de facto segregated.

Furthermore, children from lower socioeconomic groups are most likely to be referred for special class placements for problematic behaviors that their parents do not necessarily view as problems (Vargas & Koss-Chioino, 1992, p. 66).

Edelman (1985) reports that 10-25% of African-American children who are hospitalized are at significant risk for developing childhood clinical depression.

Additionally, the result of negative acting out behaviors due to increased violent neighborhoods and low socioeconomic status may be overly diagnosed by the mental health field as Conduct Disorder, rather than that of a diagnosis of depression.

External elements

African-Americans in an urban or suburban environment may have additional factors that can affect their physical or mental health. The Philadelphia Urban League

(Philadelphia Urban League, [PUL], 2007) states that influences, such as poverty, drug abuse, violence, murder and poor healthcare are more prevalent in urban culture than in suburban environments. Because of the inability to control these external elements, they report that these environmental factors may contribute to depression in the urban population. From a socioeconomic perspective, individuals living in urban poverty may not be able to afford medical care or be able to afford prescriptions for mental illnesses. More specifically, poverty can play a relevant part in this population's urban culture and depressive symptoms.

Vargas and Koss-Chioino (1992) indicate that African-American children are exposed to higher rates of poverty and this may result in greater issues such as economic recessions and adversely affected quality of life. More specifically, even though these compounding elements may negative affect any American family, Vargas and Koss-Chioino state that these elements "have historically hurt African American families even more. The interaction between racial discrimination and economic hardship intensifies the effect of impoverishment alone" (Vargas & Koss-Chioino, 1992, p. 66).

It is also reported that "illness and death rates are higher in the working classes and that stressful life events are more common in the lower classes" (Campbell, Liebmann, Brooks, Jones & Ward, 1999, p. 140). Poverty may also affect many other areas. Several additional components may negatively influence the incidence of suicide and these include work problems, economic stress, and unemployment, thus a fundamental contributor to mental illness (Campbell, Liebmann, Brooks, Jones & Ward, 1999. Research also indicates that "the health of ethnic minorities is poor, many of whom

suffer bad housing, poor working conditions and a high risk of unemployment” (Campbell et al., 1999, p. 141).

In addition to external elements such as poverty, environmental factors may include childhood stressors, relationships in the family, social and interpersonal relationships, or traumatic events (Reynolds & Johnson, 1994). Continuous or frequent environmental stressors may lead to depression in adolescence suggesting that becoming increasingly more independent may also make adolescents more susceptible to stress and therefore more vulnerable to depression (Rutter et al., 1986). Additionally,

...children who are reared in chaotic or stressful home environments may be less well-equipped to negotiate successfully the critical developmental tasks that need to be accomplished; they may be more prone to becoming incompetent, thereby placing them at a greater risk for encountering problems in the resolution of subsequent issues throughout childhood. This in turn may make them more vulnerable to developing alternative modes of functioning that permit their own unique way of adapting to their environmental conditions (Rutter et al., 1986, p. 88).

In looking at socioeconomic status, minority families experience higher levels of poverty and inadequate education than White families (Lefley, 1998). Because of their poverty levels, they may have an inability to receive proper healthcare and proper treatment. According to Shaffer and Waslick,(2002), the effects of poverty are included as a risk factor for mental illness. Additionally, they also state that no existing studies currently link poverty to any specific mental health disorders.

The Philadelphia Urban League reports that, within the Philadelphia urban area, African-Americans may be reluctant to seek help for depression because they may mistrust medical health professionals stemming from cultural barriers or poor relationships between doctors and the community (Philadelphia Urban League, 2007). Parental misgivings may also have a potential impact here, as parents may not trust the idea of taking their depressed children to the doctor.

Agee (1979) states that violent youth do not seek out therapy but are typically court-mandated to attend. In traditional therapy, Agee states that violent youth or violent offenders are often hostile and present with defensive behavior and that talk therapy may illicit nonverbal or hostile responses making it difficult in the therapeutic process for therapy to progress. Adolescents who do not receive medical or psychiatric treatment for their depression have a higher prevalence for substance abuse problems, poor networking skills, reduced social groups and attempted suicides (TD, 2005).

Adolescents may be exposed to a variety of external stresses, including socioeconomic factors, living in dangerous neighborhood, or discrimination because of race or color. The perils of drug and alcohol abuse, violent victimization, and delinquency.....stresses within their own families, including physical or verbal abuse, neglect, poverty, divorce, and parental unemployment. Both societal and familial stressors can create a depressive environment, and under these circumstances, adolescents' depression is appropriate.... (Malchiodi, 2003, p. 222-224)

Adolescent Depression

Because early adolescence is marked with many physical, emotional and cognitive changes, understanding adolescent depression can prove to be difficult. During adolescence, depression appears to exist on a continuum, ranging from normal to severe (Blatt, 2004). In depressed youth, loneliness may be pervasive, persistent and ultimately damaging (Klerman, 1986). Traditional normal developmental transitions and stages in adolescent development may include the struggle to understand and build social and intimate relationships. Traditional development may also aid in increasing both positive relationships and failed relationships, as well as potentially increasing rejection. Types of isolation may include emotional isolation or social isolation (Klerman, 1986). Emotional isolation often stems from loss of attachment figures and behavior while social isolation refers to poor social integration and poor networking.

In trying to better understand adolescent depression and its history over the past several decades, the NIMH reports that the risk of childhood and adolescent depression in some children is on the rise (NIMH, 2008, How do Children and Adolescents Experience Depression? section, ¶1). Reynolds and Johnson (1994) and Oster and Caro (1990) emphasize that early adolescent depression is considered a serious mental health situation that needs further attention and consideration (1994). Oster and Caro (1990) also report that research has proven that childhood depression is persistent and may recur in adulthood. NIMH states that this is especially true if depression is left untreated (NIMH, 2008, Symptoms section, p.5).

As of 1994, as many as 20% of adolescents have experienced a form of depression (Reynolds and Johnston, 1994). Teenagers are especially vulnerable to

depression and depressive characteristics and they may experience general unhappiness and overall hopelessness (Newman & Newman, 2006; Rutter et al., 1986). Symptoms may be exhibited through hyperactivity, aggressiveness, poor academic achievement, delinquency, or psychosomatic problems (Klerman, 1986; NLM, 2009, symptoms section, ¶5). Additionally, few adolescents receive treatment for their depression. If diagnosed and treated, 80% of adolescents can be treated successfully from mental health professionals or doctors (TD, 2005, Teenage Depression Statistics section, ¶5).

It is postulated that “many disruptive experiences in adolescents as well as in adults may be enactments of the pain and pathos of intense dysphoria and of an underlying depressive state” (Blatt, 2004, p. 174). It is also reported that “antisocial behavior and acting out.....can serve as a way of avoiding painful dysphoric affect” (Blatt, 2004, p.174) and that individuals “who have a tendency to express their difficulties in behavioral activity..... may express their dysphoria in various forms of disruptive and destructive activity” (p.174). Blatt (2004) indicates that in this regard, anger, rage, dysphoria and depression may be directed inward and seen through suicide attempts “or outwardly, through violations of social norms or attacking others (the latter, of course, can result in self-destruction as well)” (p. 174)

Depressed children in early adolescence often internalize their sadness and depression, and Reynold’s and Johnston (1994) observe that depressed children may not cause discomfort to others, yet they may feel or experience immense misery and distress themselves (Reynolds and Johnston, 1994). It is hypothesized that, during puberty, there may be an increased vulnerability to stress, but state that the increased vulnerability is higher in females than in males (Rutter, Izard and Read, 1986). This may be due to

female adolescents increased need to be accepted by their peers and their tendency to internalize emotions (Newman and Newman, 2006).

Klerman (1986) indicates that depression is a serious health problem, more so for young women than for men. In comparison to men, he states that young women are reported to have the highest rates for depression in the United States. More specifically, Riley (1999) indicates that female adolescents mostly turn their emotional distress inward and thus it can be more difficult to understand their problems because of this emotional and verbal shutdown. As part of their externalization, Riley (1999) postulates that emotional distress can be seen in eating disorders or suicidal attempts. Newman and Newman (2006) speculate that adolescent female depression may be connected to the estrogen cycle, becoming more critical of their maturing bodies, and looking inward to attempt to better understand their failures or problems. Adolescent females tend to be more sensitive to problems. This may be seen as internalized blaming whereas males externalize and blame others. Insecurities, lack of confidence and worthlessness may be increased in female adolescence due to sexism or media exposure and bias (Newman & Newman, 2006). Blatt (2004) posits that

A depression characterized by dependence or loneliness appears to be a primary issue in internalizing problems, such as somatic concerns, especially in females. Self-critical dysphoria appears to be a primary issue in externalizing problems, such as delinquency and aggression, especially in males. (p. 176)

Within adolescence, several risk factors or elements may cause depression and depressive affect. Risk factors for adolescents may include prior episodes of depression or depressive affect and/or experiencing some form of trauma or a family history of

depression (TD, 2005, Teen Depression Statistics section, ¶4). The occurrence of adolescent depression is higher than that of pre-pubertal children (Matson, 1989).

If a parent is depressed, the depressed child may have learned this coping style from that specific parent (Matson, 1989). Being genetically predisposed to depression may also impact the child (Reynolds and Johnston, 1994). Parental lifestyle and behavior may dramatically impact their children. A child who is raised by a caregiver who suffers from depression or depressive qualities may have a higher predisposition to depression than someone who is not raised by a depressed caregiver (Reynolds and Johnston, 1994; Matson, 1989).

The diagnostic criteria reports a strong correlation between “depression and disruptive behavior, especially in adolescence” (Blatt, 2004, p. 172-173) stating that there is a “frequent occurrence of depression in children and adolescence with Conduct Disorder, Attention Deficit/Hyperactive Disorder, and Oppositional Defiant Disorder” (Blatt, 2004, p. 172-173). Blatt (2004) also emphasizes that “disruptive behaviors are often accompanied by mood disturbances, even in severe depression, as well as low self-esteem and underachievement” (p. 173). McCracken, Cantwell and Hanna (1993) report that when looking at either Attention Deficit Hyperactive Disorder or Conduct Disorder, or both, depressive symptoms may also be present. More specifically, Blatt (2004) indicates that there appears to be a strong co-occurrence of depression and conduct disorders. Harrington (1993) indicates that their emotional “symptoms distinguishes them from conduct problems which are for the most part *defined* by the interaction between the individual and his environment” (p. 135). Harrington also suggests that adolescents diagnosed with Conduct Disorder typically show

A number of social problem-solving deficits, such as the inability to anticipate obstacles in the pursuit of a social end. The implication is that the social skills deficits of adolescents with conduct disorder may have a different origin from those of children with depression (p. 130).

In reviewing depression in the DSM-IV-TR, Blatt (2004) states that differing types of depression may be associated with disruptive behaviors such as poor academics, substance abuse, sexual promiscuity, truancy, vandalism, aggression and reckless behavior. More specifically, with Bipolar Disorder, disruptive behaviors may include promiscuity, recklessness and hyperactivity.

Disruptive behavior and antisocial behavior may provide increased distancing from exposure to depression, from both the patient and the clinician (Blatt, 2004; Spirito & Overholser, 2002). Additionally, clinical depression may be perceived as “a passive yielding to intense underlying dysphoria, whereas destructive behavior, similar to mania, may be a defensive attempt to avoid and forestall experiencing intense dysphoria and a painful clinical depression” (Blatt, 2004, p. 174). Additionally, risk factors increase if depression in adolescents is left untreated. Risky sexual behavior, suicide or suicidal attempts, substance abuse problems, experiencing trouble in school, and other physical illnesses may take place if adolescent depression is untreated.

Family history/prevalence/Biological/learned behavior

In addition to urban environmental factors and the impact of poor healthcare coverage and poverty, depression in adolescents may be influenced by biologically inherited traits or from learned behavior (Matson, 1989; Reynolds and Johnston, 1994). Depressive symptoms and depressive affect may be genetically inherited or may be a

learned quality from repetitive family behavior such as untreated parental depression. Adolescent depression may impact the child's personal, family and social life as well as their education. Depressed adolescents are impacted by academic and school problems, social deficits, suicidal thoughts, suicidal gestures or suicidal attempts and may include severe mood swings, irritability and frustration and may impact an adolescent's psychomotor or somatic state.

Drugs/alcohol

There exists a relationship between depression and alcohol or drug abuse with early adolescents (Reynolds and Johnston, 1994). Alcohol and drug abuse may be seen as an attempt to self-medicate in order to relieve a depressive state. Adolescents in high school "show a higher level of illicit drug use than those of any other industrialized nation" (Newman and Newman, 2006, p. 341).

By 17 or 18, more than half of American students have engaged in illicit drug use. Adolescents who frequently engage in alcohol consumption do not considerate it risky behavior (Newman and Newman, 2006). "Some adolescents can be characterized by levels of *sensation seeking* including thrill seeking, adventure seeking, disinhibition, and susceptible to boredom" (Newman and Newman, 2006, p. 342). Peer group involvement may also contribute to alcohol consumption and drug use.

Depressive Symptoms

There are several components that may have an impact on adolescent depression. Depression in adolescents may be due to poor school performance, involvement with drugs or alcohol, or antisocial behavior (Sadock and Sadock, 2007). Other factors may include running away, truant behaviors, or being sexually promiscuous. Additional signs

may include negative self-view, ruminating on loss, guilt, suicide, death, somatic complaints. Early intervention of identifying and treating depressive symptoms has the potential to prevent a full depressive episode. Additionally, Major Depressive disorder appears to be increasing in people who are younger than age 20 and that this may be related to substance abuse of alcohol or drugs.

Adolescents who are depressed reflect low self-esteem, hopelessness and poor social skills (Matson, 1989). Depression may impact any individual, regardless of their age, sexual preference, social status, race, ethnicity or religion (TD, 2005, Teenage Depression Statistics section, ¶3). The NIMH reports that depression in adolescents may occur when adolescents are attempting to form their own identity (NIMH, 2008, How do Children and Adolescents Experience Depression? section, ¶4). This is important to understand as early adolescence is demarcated with physical, emotional and maturational changes in this period of transition.

In reviewing research on depressed adolescents and adults, prominent characteristics of depression and depressive affect includes feeling dejected, discouraged, and lonely (Rutter et al., 1986). Depressed individuals rely heavily on defense mechanisms such as repression and denial. McWilliams (1994) considers denial to be a primitive or primary defense mechanism while she includes repression as a higher order or secondary defense mechanism.

Rutter et al. (1986) conclude that:

The fight against depression involves harnessing constructively the motivation and informational functions of shame-anticipation and shame-induced anger in developing social, cognitive, and motor skills and competencies that strengthen

the self and make it less vulnerable to further shame and the pattern of emotions in depression (Rutter et al., 1986, p. 65).

Among growing and developing adolescents, diagnosis can be difficult because teenage moods can appear transient in nature and within normal development (Oster and Caro, 1990). These transitioning moods may appear to be maladaptive in nature and in behavior but that special attention needs to be made to these moods and behaviors as there may be an underlying disturbance of mood. Rutter, Izard and Read (1986) emphasize that, along with depression, shame and guilt are considered primary symptoms.

Emotion “influences the way we see the world, think, and act...” (Rutter et al., 1986, p. 41) and “the principal functions of emotions are to motivate adaptive cognition and action to facilitate social communication, and emotions to do these things naturally” (p. 48-49). They also report that emotions as symptoms play an important role in depression stating

...while the feelings states associated with emotions in depression contribute to the subjective misery and possibly to cognitive and biochemical disturbances, they are also the source of motivation for the coping behavior that counteracts depression (Rutter et al., 1986) p. 50).

Emotions may be biological, learned, adaptive, or a cognitive behavior reaction. Rutter et al., also state that these intense emotions and behaviors may lead to maladaptive behavior. Additionally, they indicate that “anger and fear intensify to rage and panic because of a genetic predisposition or lack of coping skills in stressful situations, or both”

(p. 34). They state that the primary causes of depression must therefore be viewed through genetic, biochemical and experiential factors.

Effect on: behavior, self-esteem, outlook, interpersonal skills, global functioning

There appears to be a significant impact of depressive symptoms on behavior, self-esteem, interpersonal skills and global functioning of early adolescents with depression. In contrast to their white counterparts, differing environments, lifestyles and in the media,

Survival becomes an ongoing struggle for most African American parents and their children. The fact that African American parents are vulnerable to the whims of racism in the dominant culture means that their children are vulnerable as well, often in ways from which their parents cannot protect them.....African American children may more easily resign themselves to frustration, hostility, and self-destructive behavior. As they operate in an atmosphere where they feel placed in a double bind and where different standards are applied to the conduct of African American and white persons, it is surprising that a preponderance of African American children are not dysfunctional or deficit ridden. African Americans must use a variety of adaptive strategies to cope with racism and the sequels of racial discrimination (Vargas and Koss-Chioino, 1992, p. 67).

Additionally, African-American children exposed to the media are surrounded by constant negative and distorted images of other African-Americans. Vargas and Koss-Chioino (1992) suggest that "Our language emphasizes the symbolic "goodness" of whiteness and its corollary, the bad unattractiveness of the color black, a symbolism particularly manifest in children's fairy tales, books, and cartoons" (p. 69).

Reduced social groups/social networking

With depressed adolescents, impaired social functioning typically exists because “depressed children frequently have problems in this area and because severity of social impairment is often a good indicator of the clinical significance of a disorder” (Harrington, 1993, p. 62). Social skills are also typically impaired in children and adolescents who are depressed. In looking at social relationships, Harrington speculates that it may be possible that “depression leads to a lack of social support rather than the other way around” (p. 105) and that “the association of depression and absence of a supporting social network could reflect social selection as much as social causation” (p. 106). Another factor that may influence deficiency in social relationships is the personality of the individual. Additional elements may include poor parent-child, sibling or poor peer attachment relationships (Harrington, 1993). Despite this important information, Harrington indicates that the “meaning of the association of depression in young people and impaired interpersonal relationships remains, however, poorly understood” (p. 107).

Additional elements in looking at reduced social networking or peer relationships may include social withdrawal and irritability. Reynolds and Johnston (1994) indicate that diminished socialization is common in depressed youth. Both Reynolds and Johnston (1994) and Harrington (1993) indicate that adolescents are traditionally peer-oriented but that criticism or rejection may cause distress and depression. Harrington (1993) also reports that “children actively seek social competency feedback from others and if they suffer negative feedback too frequently they can develop negative self-schemata that will predispose to depression, especially when they experience stress” (p. 130).

Impact on the family

Family conflict may play an important role in childhood depression as well as in a depressed adolescent having a negative impact on the family. In contrast to normal children and adolescents, depressed youth perceive their families negatively, reporting that they view their families as “less cohesive, more conflictual, and less expressive” (Reynolds and Johnston, 1994, p. 346). There may be a genetic or biological component within the family dynamic that may negatively impact the family unit (Harrington, 1993).

Additionally, Harrington (1993) states that depression may be behaviorally learned from parents or siblings. Possible mechanisms may include “genetic processes or exposure to family discord or through the modeling of a parent’s negative attributional style” (p. 134). Dysfunctional maintenance within the family equilibrium may also play a role in increased depression in adolescents. “Depressive symptoms may also occur because the adolescent mirrors the symptoms of the parents or because adolescents in such families are often socially isolated and lonely” (p.134).

Divorce and family discord may be a factor in adolescent psychiatric conditions stating that “parenting styles and parental dysfunction have a significant association with child psychopathology” (Sholevar and Schwoeri, 1994, p. 80) and that parental neglect, “conflict exposure to hostility, abuse, deviant value systems, and family discord” (p. 80-81) may negatively impact an adolescent who is depressed. Continued exposure to these factors tends to increase depressive affect and adolescent psychopathology.

Harrington (1993) indicates that depressed youth “often come from families in which there are difficulties of one kind or another...mental illness or personality problems in one or both parents, chronic marital difficulties, and/or parenting problems”

(p. 163). In looking at etiological theories of depression, the existence of genetic, parent-child interaction, “neuroendocrine, cognitive, psychoanalytic, behavioral, learned helplessness, and decreased self-esteem” may all play a role in adolescent depression (Sholevar and Schwoeri, 1994, p. 82).

School and academic performance

As they become socially withdrawn, research indicates that depressed adolescents’ school performance tend to suffer (Newman and Newman, 2006; Harrington, 1993; Reynolds and Johnston, 1994). Adolescents who suffer from depression or depressive symptoms typically report interference with schoolwork (Rutter, et al., 1986). This may escalate the situation in that poor grades, inability to concentrate and interference with the process of learning may “lead to low self-esteem and so lead to further academic failure” (Harrington, 1993, p. 192). It is important to mention that these characteristics are similar to those listed for ADHD (APA, 2000). Additionally, aggressive behavior and impulsivity, often seen in depressed adolescents, may also play a role in decreased school performance (Spirito & Overholser, 2002; Harrington, 1993). In comparing these characteristics, overlaps can be seen in the diagnosis of depressed adolescents and that of adolescents who may suffer from Conduct Disorder or ADHD.

Violent Behavior

There appears to be a number of factors that may impact depressed African-Americans. Some of these factors may include past history of enslavement, grief, rage, violence, low socioeconomic status, or poor health care. Within a cultural context, violence and violent behavior may exist. Violence is considered risky for many reasons. It is perceived as perilous for the individual engaging in the behavior, for their respective

families, friends, neighborhood community, school community, and for those they offend. Violence is also considered a serious public health problem, an epidemic, a pervasive societal health problem, and a criminal justice concern (DHHS, 2001).

There are several risk factors that play a role in violent behavior of minority male adolescents and these may include being involved in serious but nonviolent crimes and behaviors, using drugs, being young males who are physically aggressive, having low socioeconomic status, impoverished, and having parents who are antisocial. More specifically, for children aged 12 to 14, involvement in violent acts may include risk factors such as restlessness, problems concentrating, risk taking behaviors, aggression, being male, physical violence, antisocial beliefs, behavior or attitudes, crimes against persons, low IQ, or substance abuse. These symptoms and risk factors resemble those associated with Conduct Disorder or Attention Deficit Hyperactivity Disorder (DHHS, 2001; Reynolds and Johnston, 1994).

The period of adolescence is marked by substantial physical, emotional and cognitive changes and vulnerabilities, which have the potential to increase the risk of violent behavior (DHHS, 2001). The more risk factors a young person is exposed to or involved in, the greater the possibility that they will become violent (DHHS, 2001). Youth who begin their violent careers in childhood, before puberty, are considered more likely to engage in and become chronic violent offenders later in life (Loeber, Farrington & Waschbusch, 1998).

Family, school, community and peer relations may influence youth involvement in violent activities. Family risk factors may include poor parent-child relations, harsh or lax discipline, poor monitoring, supervision or parental involvement, antisocial parents,

broken home, low socioeconomic status or poverty, abusive parents and family conflicts. Parental risk factors are often learned violent behavior rather than genetically inherited behavior (DHHS, 2001; Spirito & Overholser, 2002).

School risk factors may play a compounding role in early adolescent violence and these may include weak social ties, antisocial behavior, delinquent peer group, or gang involvement. In this respect, school failure may be seen as a predictor of violence. In addition to antisocial behavior, Agee (1979) reports that many violent youth have few genuine friends and are regarded by societal norms as delinquent or truant youth. They also encourage and practice self-destructive behavior and are impacted by negative peer influence. Ethnic or minority adolescents or young adults are at a greater risk of being killed in school-affiliated violence or in urban districts (DHHS, 2001).

Community risk factors may include neighborhood crime, drugs, social disorganization, high turnover rates of residents, poor parental or adult supervisions, exposure to violent adults, violent youth gangs, and few if any after school activities (DHHS, 2001).

Ultimately, young individuals may be attracted to violence or violent behavior. Being involved in violence may be considered a way to proclaim their independence from their parents or to gain respect from peers. The impact of physical and emotional maturation during early adolescence may alter one's relationships or interactions with others, therefore increasing independence from parents and creating one's own set of values, personal identity and sexual identity (DHHS, 2001).

Co-occurring problem behaviors overlap and intertwine with violent offenders in that there is a high prevalence of violent youth involved in property crimes, substance

use, early drop-out rates, owning a gun, gang membership, early sexual activity and reckless driving (DHHS, 2001).

DHHS (2001) declares that problem behaviors present a challenge to implement interventions and that minority youth may be limited to opportunities, exposed to prejudice, family stresses or cultural conflicts within dominant U.S. culture (DHS, 2001). Within minority groups, a large number of arrests are those of minority young men.

Due to increased understanding of sexual identity, impulsivity and aggression, research indicates that involvement in violent behavior is learned rather than genetically inherited (DHHS, 2001; Spirito & Overholser, 2002). DHHS (2001) demarcates that two of the strongest predictors of violence include involvement with delinquent peers and gang membership.

Across the United States, gangs thrive in cities and in towns. Within gangs, there is active recruitment, violent initiations, drug trafficking, and violent crimes. Through gang involvement, early adolescents may be seeking love, acceptance, money, prestige or protection. “Adolescents who join gangs are often unsuccessful in school and may have been suspended or expelled. School failure leads to periods of unsupervised time in the community and an inability to find work” (Newman and Newman, 2006, p. 338).

In addition to these aspects, early adolescent teens affiliated with gangs may be seeking group identity and acceptance. Even though there are great risks associated with gang involvement, elements exist that indicate a need to be accepted, “needs that are not being met by communities, school and families” (Newman and Newman, 2006, p. 338).

A large portion of gang members are involved in selling drugs and carrying weapons (DHHS, 2001).

Adolescents who have weak social ties...are at high risk of becoming violent, as are adolescents with antisocial, delinquent peers. These two types of peer relationships often go together, since adolescents who are rejected by unpopular with conventional peers may find acceptance only in antisocial or delinquent peer groups. (DHHS, 2001, p. 65).

Schools that have high violence rates typically have students involved in gangs. This includes both inner-city schools as well as suburban or rural schools.

Suicide

In addition to violence, murder, and gang involvement, attempted suicide and successfully achieved suicide also exist in adolescent development. For adolescents 14 and older, the rate of suicide continues to increase (Sadock and Sadock, 2007; Sholevar and schwoeri, 1994). Sadock and Sadock (2007) state that “about two thirds of all depressed patients contemplate suicide, and 10 to 15 percent commit suicide” (p.543). Even though depression is higher in females than in males, there is a higher prevalence of suicide in males than in females (Suicide Prevention as reported through the Mental Health Division, Suicide Among Diverse Populations section, ¶4). Within adolescent youth, a high percentage of suicides are committed by minorities, specifically in Native-Americans and African-Americans (SAMHSA, 2008, Suicide Among Diverse Populations section, ¶4). The leading cause of death in children aged 15 to 24 is suicide (SAMHSA, 20080, Suicide Among Diverse Populations section, ¶2). It is also reported that

Suicidal behaviors in young people are usually the result of a process that involves multiple social, economic, familial, and individual risk factors with

mental health problems playing an important part in its development (SAMHSA, 2008, Suicide Among the Young section, ¶3).

SAMHSA (2008) indicates that a substantial number of risk factors include mood and substance abuse disorders, personality disorders, low socioeconomic status, “childhood maltreatment, parental separation or divorce, inappropriate access interpersonal conflicts or losses.” (SAMHSA, Suicide Among the Young section, ¶4).

Suicide Prevention reports that there was an increase in suicide among adolescents and young adults, nearly tripling from 1952 to 1994 (SAMHSA, 2008, Suicide Among the Young section, ¶6). The two most common methods of completed suicide among persons aged 0 to 24 were that of firearms (60%) and hanging (26%) (SAMHSA, 2008, Suicide Among the Young section, ¶8).

The CDC finds that, although African-American youth in the past have had lower rates of suicide than their White counterparts, during a fifteen year period between 1980 and 1995, the rate of suicide for this ethnic group between the ages of 10 and 19 “increased from 2.1 to 4.5 per 100,000 population” (CDC, Suicide Among Black Youths section, ¶1).

The CDC indicates that suicidal identifiers for African-American youth may include hopelessness, depressive affect, depression, suicidal genetic history, impulsiveness, aggressive behavior, social isolation, one or more previous suicide attempts, and easy access to alcohol and drugs (CDC, Editorial Note section, ¶1). Additionally, the CDC reports that lethal suicide methods are also considered a contributing risk factor (CDC, Editorial Note section, ¶2).

Adolescents typically do not willingly participate or share their deepest thoughts, emotions or conflicts (Harnden, Rosales & Greenfield, 2004; Klerman, 1986). This is particularly true in discussing their inner most thoughts with adults. During this adolescent period of turmoil, there exists teenage conflicts, questioning of life and death, coming to a better understanding of individual perspective and living within the macrocosm of society and within the world around them. Additionally, there is greater potential for disturbances of self-esteem and development of the ego-ideal. He states that

The ego-ideal is a structure in the personality that connects the self with other human beings, and provides a link between self and society. It contains the internalized expectation of the individual. It is distinguished from the superego...by being more deeply tied to narcissism and early hurts..... (Klerman, 1986, p. 63)

Additionally, as part of the separation and individuation from parents is necessary in traditional maturation, there is also a better understanding of object relations and the need to review parental conflict, peer and sibling interaction, teacher's roles, loss of important relationships, depression, isolation, social isolation, personification of death (Klerman, 1986). Klerman indicates that

It is possible that suicide-prone individuals may have had a particularly intimate relationship with death during their lives....a tendency to romanticize death may be a dangerous sign of suicidal risk for a particular adolescent. Concern may be raised when thoughts of death transition from scary and dangerously threatening to beautiful and friendly (p. 67).

Klerman (1986) also reports that precipitating factors may include disturbing events, recent family moves, poor support systems, high exposure to criticisms, disappointments, poor relationships, school or academic failures. Warning signs or clues may include changes in a youth's behavior, withdrawal from interests formerly familiar, somatic complaints, changes in daily routines or habits, suicidal ideation and expressions of low self-worth.

Depression with African-American male adolescents

In the literature on African-American male adolescents battling depression, African-American men have a high risk for death due to violence, poor or inadequate healthcare, low life expectancy and increased unemployment or imprisonment (Parham & McDavis, 1987). The rate of suicide is increasing within African-American men. Despite this, Grant & Potenza (2007) and Davis and Stevenson (2006) report that African-American adolescent boys are unlikely to use mental health services.

Kaye and Lingiah (2000) report concern over the care of ethnic minorities in psychiatric care, positing that over-diagnosis or under-diagnosis of depression may exist. They indicate concern that minorities may not be receiving proper treatment or proper care and that the needs of ethnic minorities may not be met through psychiatric healthcare and that this concern is extended when minorities are hospitalized. Because adolescents typically have a difficult time verbalizing their day-to-day issues and emotions, "traditional therapies may fail to help adolescents with depression, because their resistance to therapy is so strong and their sense of disillusionment is so pervasive" (Malchiodi, 2003, p. 220; Harnden et al., 2004)).

It is important to consider racism when working with African-Americans as slavery and oppression may have had an impact on how African-American individuals perceive themselves or the influence of parental misgivings (Matson, 1989).

Lefley (1998) contends that African-Americans may devalue mental healthcare because of their socioeconomic condition, their negative and stigmatic beliefs about mental illness and belief that their family caregivers will provide the necessary network support. Because of universally broad interventions, such as psychotherapy or other traditional verbal therapies, past usage of mental health services with African-Americans has not wholly proven beneficial to this population and there may be carried over inhibition because of this (Hampton & Gulotta, 2006).

Therapy with Adolescents

Therapy with adolescents is an important factor in preventing depression or depressive symptoms as well as providing effective coping skills in dealing with depression. Adolescents who do not seek out or receive treatment for their depression are more likely to indulge in or develop problems with alcohol or drugs (TD, Teenage Depression Statistics, ¶4). It is also reported that, under these same circumstances, teens with depression will have a small or insignificant social network, poor peer relations, or suicidal attempts.

Behavior therapy

Behavior therapy is an effective therapeutic technique for those persons who have been exposed to poor behavioral patterns resulting in little to no positive feedback or by rejection (Sadock and Sadock, 2007; Corey and Corey, 2009). Additionally, Corey and Corey (2009) report that behavior therapy typically focuses on observable behavior and a

client's learning experiences to date. In this respect, the authors indicate that it is important to promote changes in any maladaptive behavior and making treatment as specific as possible to each client. Through behavior therapy, clients learn to address these maladaptive behaviors and learn to function in society where they can receive positive reinforcement. Little research has been conducted with major depressive disorders and this specific population and that currently the limited data that does exist indicates that behavior therapy is an effective and appropriate treatment for these disorders (Sadock and Sadock, 2007).

Cognitive Therapy

Cognitive therapy focuses on cognitive distortions and misinterpretations (Sadock and Sadock, 2007; Corey and Corey, 2009). The focus and intent behind cognitive therapy for this population with this disorder includes alleviating depressive episodes as well as preventing reoccurrence of depressive episodes (Sadock and Sadock, 2007). This can be implemented through identifying and testing negative cognitions and creating alternative positive ways of thinking, viewing and rehearsing new cognitive and behavioral responses. Additionally, Corey and Corey (2009) agree that depressed clients can work through these cognitive distortions and negative biases with this approach. They state that cognitive therapy is directive, present-centered and problem-oriented. They also report that this therapy is highly effective with depressed clients because it helps the clients identify the problems, why and how they occur as well as employing preventative measures to keep them from reoccurring.

Psychotherapy

Psychotherapy is an effective form of therapy for depressive disorders in children and adolescents (Sadock & Sadock, 2007). In psychotherapy, treatment is focused on understanding the underlying causes and issues, challenging maladaptive behaviors and increasing problem-solving skills. Corey and Corey (2009) indicate that psychotherapy is seen as a collaborative process between patient and counselor where it is important to co-construct solutions. With this type of treatment, the authors indicate that psychotherapy is an effective treatment for this population and age group and consistent improvements are seen. To promote and increase conflict resolution, Sadock and Sadock (2007) recommend family education with depressed children and adolescents.

Creative Art Therapies- Art Therapy

The creative art therapies predominantly include dance movement therapy, music therapy and art therapy. All place emphasis on the emerging and developmental therapeutic relationship, promoting individual integration through cognitive, emotional and psychological techniques, decreasing psychological distress, improving quality of life, and working with verbal and nonverbal communication. Dance movement therapy, music therapy and art therapy incorporate their specific modalities to address deficits and accomplish individual goals within the therapeutic relationship. Creative art therapies focus on insight-oriented development, increasing self-concept, building self-esteem, social skills and social interactions (Naumberg, 1987; Hudson, 1995; Jeong, Hong, Lee, Park & Suh; 2005).

The creative art therapies emphasize the unconscious material provided by the client and they place emphasis on nonverbal communication. Dance movement, music

therapy and art therapy are considered expressive therapies that do not rely wholly on verbal qualities. Through nonverbal communication and unconscious material, the creative art therapies look at client's underlying issues. These creative art therapy modalities stress the importance of personal healing, growth, self-exploration and self-expression (American Art Therapy Association, 2009; American Dance Therapy Association, 2009; American Music Therapy Association, 2009; Drexel University, Philosophy section, 2008, ¶1).

Through conscious or unconscious means, art therapy provides a nonverbal outlet for communicating life experiences, emotions, feelings or thoughts (Malchiodi, 2007). Art therapy may be especially helpful and productive for populations who have a difficult time verbally expressing themselves. Malchiodi (2007) believes that art therapy creates an emotional release and catharsis. Rubin (2005) views it as an opportunity for individuals to better understand themselves through the use of art. In this respect, art therapy may be seen as ego-supportive and supportive of self-esteem growth. Rubin (2005) uses art as a way to communicate and better understand the inner child in all of us. In order to reduce emotional distress, one needs to increase their creative thinking and behavior by using art to enhance a better understanding of oneself and of others (Malchiodi, 2007). Making art may be a normalizing experience where one can be creative. She also emphasizes that art therapy can provide an enriching experience (Malchiodi, 2007).

Within the construct of art therapy, art psychotherapy and art as therapy exist on a continuum. On this wide spectrum, two founding art therapists helped define and create the concept and theory of art therapy: Margaret Naumberg, a founding leader of the art

psychotherapy model, indicating that art therapy is directly derived from psychoanalysis, a profession that has endured for over a century stating that art therapy is a recognized as a well-established form of psychotherapy (Naumberg, 1987). Naumberg's (1987) concept of art therapy is dynamically oriented and was conceptualized through the use of symbolic speech, the unconscious and spontaneous artwork using free association, and individual interpretation. Malchiodi (2007) emphasizes the importance of symbolic communication in art psychotherapy stating that the image can become an important vehicle in increasing communication and increasing insight.

Edith Kramer (Kramer, 1972; Rubin, 2001), founding leader of art as therapy, exists on the other end of the art therapy continuum. Kramer views art as therapy as placing emphasis on the final art product and the healing aspect of creating itself. Additionally, Kramer's model of art as therapy includes less verbal processing of the art created during the session (Levick, 1983). Malchiodi (2007) reports that art as therapy has health enhancing benefits and provides an experience of growth. In Kramer's model, there is less focus on the process and more focus on the drives and engaging of client's ego strengths (Rubin, 2001). Both constructs of art psychotherapy and art as therapy aide the client in therapeutic healing. Art Therapy's ultimate potential is to be able to aide clients through difficult situations via art therapy.

Similarly, Judith Rubin's (2005) concept of art therapy reflects a curiosity and need to understand the unconscious through the images portrayed in artwork created by clients. Through art therapy, the creative expression can be seen in the client's artwork stating that art is revealed as an acceptable and permissible form of regression. She also

states that art therapy is a way to cope with trauma or traumatic events and the importance of creating art as a way to cope with their illness.

Myra Levick (1983) believes that the artwork of patients may reveal ego functions and defense mechanisms. Levick also states that the goal of dynamically oriented art therapy is to uncover internal conflict, to make verbal what was once considered nonverbal, and to understand the connection between conscious and unconscious through the use of symbolic images. Through the use of symbolic images, much can be said and understood through client artwork (Levick, 1983). Additionally, Levick describes goals of art therapy as a way to strengthen the client's ego, providing an emotional and cathartic experience, and providing an outlet for anger, guilt, impulse control and mental illness or deficits (Levick, 1983).

In agreement with Naumberg, Helen B. Landgarten (1981) describes Art Psychotherapy as a way to aid individuals in understanding and gaining self-awareness. She also states that art psychotherapy may reveal deficits or strengths in reality-testing and problem-solving. Landgarten reports that art psychotherapy may be cathartic and a way to work through one's conflicts and provides necessary integration, individuation or autonomy.

Landgarten (1981) considers clinical art therapy as non-threatening and interpersonally connected. She states that art therapy helps reveal individual strengths. Although art therapy may initially be nonverbal, it allows patients to view their artwork through verbal and nonverbal communication. She states that art therapy may provide individuals with nonverbal tools to express themselves in a different and accepting manner.

Art therapy is a way to connect to and better understand oneself through visual self-expression. Malchiodi (2007) also postulates that art therapy has the potential to increase personal expression and personal interpretations, leading to insight and resolution of conflicts or experienced trauma.

Malchiodi (2007) reports that art therapy can be helpful with children because children, who have not fully matured emotionally or physically, typically have a difficult time expressing or describing their feelings and experiences. She has reported that, when creating and processing art therapy, a physiological response may occur where one's mood is altered and emotional stress and anxiety can be alleviated. Malchiodi (Ed., 2003) states that "traditional verbal therapies may fail to help adolescents with depression, because their resistance to therapy is so strong and their sense of disillusionment is so pervasive" (p. 220). By creating a tangible object, a patient has the ability to create, contain and display their experiences and emotions.

Art therapy with adolescents has the potential to help improve their personal views and attitudes about their surrounding environment (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). "Traditional approaches to psychotherapy and models of psychotherapy often are not as effective with African Americans who are already overwhelmed by life's demands and socioeconomic deprivations" (Hiscox and Calisch, 1998, p. 46). Additionally, "cultural awareness...is essential for effective therapeutic relationships" (Campbell, Liebmann, Brooks, Jones and Ward, 1999, p. 42). In specifically working with African-American female adolescents and in reviewing depression through the Hopkins Symptom Checklist, one Philadelphia

study from 1982 reported that adolescent females were found to have low or mild depression (Freeman, Rickels, Mudd, Huggins, Garcia, 1982). In a 1985 comparison study of San Francisco public schools and 116 adolescent females, including 84 African-Americans, Gibbs (1985) found minimal to mild levels of depression reporting that this may be due to low socioeconomic status, poor living conditions, poor “school work, future vocational and educational goals, interpersonal relationships, and family relationships” (Gibbs, 1985, p. 56).

Wadson (2000) reports that depressed youth may reflect hostility, violent behavior, aggressiveness, impulsivity, “low frustration tolerance, difficulty relating to others, and trouble” (p. 42) expressing their feelings. Harnden et al. (2004) state that characteristic symptoms of depression in adolescence may include themes of mistrust, despair, poor self-esteem, interpersonal skills, and low global functioning. In their artwork, themes may include death, death obsessions, failure, violence, hopelessness, helplessness and isolation. They also indicate that adolescents who experience art therapy are positively affected by its use of verbal interventions in combination with creativity and the art process. Additionally, Harnden, Rosales and Greenfield (2004) indicate that art therapy with depressed adolescents can “provide both a container for emotions and a transition to making connections verbally” (p. 167). Rubin (2005) states that art therapy has the potential to release internal and external feelings and confusion with this population.

Newman and Newman (2006) state that adolescents, in contrast to adults, are not as cognitively, physically or emotionally developed and because of these temporary deficits, Levick (1983) reports that traditional or cognitive therapies may not be as

effective as art therapy. In helping depressed individuals, art therapy may prove to be an effective tool by providing these individuals with nonverbal ways to cope with their inner turmoil and unconscious conflicts.

Wadeson's (1971, 1980) observations of depressed patient's and their artwork included psychomotor retardation, flat affect, lack of expression, poor interpersonal skills, lack of communication, lack of productivity throughout the creation, and diminished ability for self-expression. She also observed that increased depressed patient artwork "revealed less color used, more empty space, less investment of effort or less complete, and more depressive affect or less affect than when less depressed" (1971, p. 197).

In working with male depression, Barbee (1996) emphasizes the importance of understanding male resistance to art therapy, societal sex role expectations, themes of anger and sadness that may reveal itself in the artwork. According to Koss-Chioino and Vargas (1992), ethnic minority children "may experience psychotherapy to be emotionally unsettling, perhaps thought provoking but confusing, and out of line with their expectations and views of the world" (p.1).

Scales and Measures

The Children's Depression Inventory Scale

The Children's Depression Inventory is a 27 item self-report questionnaire that was developed by Maria Kovacs in 1977 and assesses depressive symptoms of children between the ages of seven and 17. It provides a measurement of depression that may help indicate early identification of depressive symptoms, severity of depressive symptoms and diagnosis of depression in adolescence. It assesses affect and signs of symptoms

through five major categories: Negative Mood, Interpersonal Problems, Ineffectiveness, Anhedonia and Negative Self-Esteem.

The publishers of the Children's Depression Inventory indicate that this questionnaire is not considered a diagnostic tool but can help determine the state of the child or adolescent over the course of the two weeks prior to filling out the questionnaire. Although it is not intended to be used as a diagnostic tool, the Children's Depression Inventory is considered a valid and reliable measure that can help identify depression in children (Kovacs, 1992; Reynolds and Johnston, 1994).

Respondents who complete the self-report questionnaire may include the child, parent or their teacher. This questionnaire was originally normed on 1,266 respondents (Finch, Saylor, & Edwards, 1985). The normative sample originally included public school students between the ages of six and 17 (Pearson, 2008). The sample was divided into two groups based on age. One group was aged between six and 11 and the second group was aged between 12 and 17. The sample included 592 boys and 674 girls. Twenty-three percent of this normative sample included African-Americans and 20% of this total population came from single-parent homes (Pearson, 2008).

Assessors who interpret the Children's Depression Inventory may include a psychologist or in the case of this thesis, an art therapy graduate student/researcher. In reviewing ethnicity, particularly in comparing African-Americans with Caucasians, the Children's Depression Inventory reports that there were no significant differences between these two ethnic populations (Kovacs, 1992).

Additionally, Reynolds and Johnston (1994) note that the Children's Depression Inventory can be helpful "in assessing the severity of depressive symptomatology" (p

213). The Children's Depression Inventory is considered a standardized self-report measure for depressed individuals (Matson, 1989). Through the use of a scale, this inventory was intended to safeguard individuals from responding randomly (Matson, 1989).

Draw-A-Person

In 1949, Draw-A-Person was designed by Karen Machover (1949), an assistant professor in New York at the Emeritus Department of Psychiatry Downstate Medical School. This tool is considered a personality projective drawing technique where the administrator requests that the subject "draw a person" using 8 ½ x 11 paper and pencil with an eraser. Once completed and then contingent upon which sex is drawn first, the subject is then asked to draw an additional drawing of the opposite sex. Completed figure drawings are encouraged. Direct observations include sequence of drawn body parts, omission of body parts, spontaneous comments and resistances.

Once completed, a series of questions follow the process of creating art and the subject is asked to explain any associations, meanings or imagery that is not clearly identifiable in the drawings. In understanding personality projections, other intended elements may include the size of the figure drawn, its placement on the paper, movement evidenced in the artwork, line pressure and quality, background environment, extension of body parts, details and stance of the figure (front view or profile).

In analysis, consideration is also given to the proportions of each part of the body, the tendency to incompletions, the amount of detailing and the area of concentration of detail, the amount and focus of reinforcements, of erasures and line changes, the degree of symmetry, treatment of midline, and above all, the

mood expressed in the face or in the postural tone of the figure. Male and female figures of a set of drawings are compared in all of these characteristics (Machover, 1949, p. 36).

Culbertson and Revel (1987) report that the Draw-A-Person intellectual assessment instrument is simplistic in its administration and design, and they do not consider it demanding of many characteristics. It is reported to indicate and reflect self-perceptions and how one views the self. It is an instrument that is frequently employed as part of a child's diagnostic workup and can be used to evaluate emotional functioning.

Kinetic Family Drawing

The Kinetic Family drawing was designed by Burns and Kaufman in 1970 and involves one drawing of human figures. The administrator asks the participant to draw everyone in their family *doing* something. It is considered a kinetic drawing where action is implied. It tends to elicit more information than typical akinetic drawings requests and was designed to better understand children through movement. Figure drawings provide “an excellent method of exploring the world of the child” (Burns and Kaufman, 1970, p. 13).

It is easy and simple to administer and is not considered threatening. It “can be used where other techniques are limited by such factors as language barrier, cultural deprivation, and inability to communicate” (Burns and Kaufman, 1970, p. 13). The Kinetic Family Drawing has the ability to provide dynamic information and was intended to provide more information and data than the comparative House-Tree-Person and the Draw-A-Person projective techniques.

The Six Part Assessment

There is little data and literature on the Six Part Assessment and it is not clear when it was developed or initially administered, however it is commonly employed in art therapy. The purpose of this six drawing series is to better understand and assess a client's emotional and cognitive stage of development. It is typically conducted over an hour but is not necessarily confined to this time limit (Wilson, 2007). There are six requested drawings: a Free drawing, Draw-A-Person, Draw the opposite, Kinetic Family Drawing, Dot-to-dot or Scribble, and a Free Drawing, although many clinicians modify this sequence and administration. Materials used in this assessment include 8 ½ x 11 and 12 x 18 white paper, pencils, colored pencils, markers and crayons (Wilson, 2007).

The Free Drawing sets the tone and environment of the patient-art therapist relationship. It provides a sense of control for the patient and may help them free associate. The Draw-a-Person drawing may indicate how the client views his or herself. The Draw the Opposite drawing provides a better understanding of the client through their cognitive associations and being able to identify whether or not they comprehend the opposite and gender issues. Both the second and third drawings (draw a person; draw the opposite) typically illicit human figure drawings. In both of these, interpersonal relationships, concept of reality, body image and gender issues may be viewed and better understood through the artwork. The Kinetic Family Drawing portrays how the subject views their family and how he views himself and his position within his family. The Dot-to-Dot drawing is a projective drawing which may help relieve stress or anxiety brought on by the Kinetic Family Drawing. The last drawing (Free Drawing) provides a bookend experience and may help the client regain control. Once the series is completed, the first

and last free drawings are compared and contrasted for differences. The first drawing is typically more defended than the last drawing and defenses can more readily be seen. In the last drawing, fewer defenses are exhibited. In addition to defenses, one may also see potential regressive behavior between the first free drawing and the last free drawing. Overall, the entire set of drawings is also reviewed for defenses, transference and overall affect (Wilson, 2007).

Over the course of the past few decades, the Six Part Assessment has been revised several times and treatment objectives may also be derived from it. Additionally, a client's progress may also be evaluated through this measurement tool (Art Therapy, Art Therapy Assessment section, ¶1). Wadeson (1987) summarizes the importance of assessments stating that "assessments are designed and conducted with the clear intention to gather information for one or more of the following purposes: clinical assessment for treatment, evaluation to obtain specific information, research" (p. 177).

Research indicates that little has been conducted with art therapy and depressed African-American male adolescents from urban and suburban areas such as Philadelphia. It is postulated that this may be due to inaccurate diagnosis or diagnosis of Oppositional Defiant Disorder, Conduct Disorder and Attention Deficit Hyperactive Disorder.

Mental health services are becoming more common with African-Americans in the middle class but little research has been conducted with lower socioeconomic status African-Americans (Vargas and Koss-Chioino, 1992). Additionally, Erickson (1987) and Harrington (1992) report that little attention has been paid to children who suffer from depression.

...depression as a childhood psychological disorder has often been omitted from textbooks on childhood psychopathology probably because many clinicians have had serious doubts that depression or other affective disorders exist in children prior to later adolescence....during recent years, however, there has been an increasing acknowledgement that depression can and does occur in children, but most of the important questions regarding assessment, etiology, and treatment remain to be answered (Erickson, 1987, p. 278).

Hampton and Gulotta (2006) contend that traditional and mainstream interventions are ineffective when working with African-Americans stating that this may be due to their African heritage or upbringing. "It is unrealistic that services remain fragmented and ineffective, further afflicting African-American families as a result of absent and salient cultural-specific treatment and intervention models" (Hampton and Gulotta, 2006, p. 135). In addition, there may be cultural sex role expectation resistances (Barbee, 1996; Trombetta, 2007). In regards to adolescence, resistance to cultural and sex role expectations may be compounded with an adolescent's pervasive disillusionment, making it more difficult to work with this age group (Malchiodi, 2003). Because of this gap in the literature, it is important to understand depression in adolescents and more specifically, with African-American males from urban or suburban areas such as Philadelphia.

In reviewing relevant literature in adolescence, symptoms, African-Americans, depression and it's affect on several aspects of daily living, functioning, and behavioral aspects, art therapy may prove beneficial to this age group and population as it emphasizes nonverbal expression.

CHAPTER III: METHODOLOGY

Design

The proposed research design for this study was a Qualitative Case Study of single-subject design. Single-subject design studies allowed the investigation of treatment and intervention effectiveness. Single-subject design studies also have had potential to provide high internal validity (Goodill & Flaum, 2004). Additionally, single-subject design allowed for change to occur naturally in subjects and over the course of therapy, research and time (Goodill & Flaum, 2004). Within this design, the subject was administered a pre and post-test measure in an alternating treatment format. According to Mertens, this ABA design included one treatment as it is applied in this proposed research (Mertens, 2006).

Five cases were to be examined of African-American male adolescents assessed with a depressive diagnosis (Major Depression, Dysthymia or Bipolar I) between the ages of twelve and eighteen. Data and information were collected from case files, individual session notes and artwork from each individual art therapy sessions. Additionally, these along with the pre and post-test measurement of the Children's Depression Inventory were reviewed, analyzed and compared. The focus of this research was to examine, analyze and compare art therapy as an intervention with the Children's Depression Inventory with depressed African-American male adolescents. This research posed the question of how art therapy intervention will affect African-American male adolescents assessed with a depressive diagnosis.

Location

Research was conducted at an approved private school in suburban Philadelphia that was part of a multipurpose agency. The multipurpose agency provided services to the Philadelphia area. This agency provided educational, residential and community-based services to the greater Philadelphia area. Additionally, this facility provided mental health and education services for children and adolescents. Specific services included outpatient therapy and residential treatment. Within these outreach programs, there were approximately 600 children and adolescents who participated. There were approximately 1,500 children and family members who used the community mental health services.

The Approved Private School, located in suburban Philadelphia, provided educational services to its students. This school also offered experiences for varying student needs such as behavioral, emotional, therapeutic and educational needs along with supportive services. These services included counseling, therapy, case management and behavior modification reward systems. The Approved Private School was client focused and encouraged its students to further their development through increasing their strengths and maximizing their potential through academics, behavioral and emotional functioning.

Time period

The study began after approval of Drexel University's Internal Review Board and was to continue until December 2009.

Enrollment information

Three to Five participants were to take part in this study. Intended age range included adolescents aged from twelve to eighteen. Client's gender were male. Clients were African-American.

Subject type

Subjects included African-American male adolescent students at an Approved Private School in suburban Philadelphia. The intended participants were from the urban or suburban Philadelphia. Participants were referred by staff members or counselors. Staff members and counselors were trained regarding appropriate referral.

Subject source

Subjects for this study came from a suburban Approved Private School who were assessed with Major Depression, Dysthymia or Bipolar I.

Recruitment

Recruitment was based on a referral list based on the inclusion and exclusion criteria and compiled by the staff members or counselors at the Approved Private School. A counselor or staff member at Wordsworth Approved Private School compiled a list of potential participants using inclusion and exclusion criteria. All participants were given a packet. The packet included a flyer regarding the study, a letter of explanation to the parents from the researcher, a telephone script, and a letter from the designated Approved Private School regarding their agreement to allow the research study at the Approved Private School.

Clients received and needed to complete consents to take part in a research study (parent) and assent forms (adolescent). The flyer and co-investigator letter introduced the

co-researcher and briefly outlined the study and inclusion and exclusion criteria. The first five families who responded by telephone, met with the researcher or reviewed the consent by phone, and signed the consent were admitted into the study. Once the consent had been received by counselor or staff members of the designated Approved Private School, the researcher met with the adolescents whose parent(s) or legal guardian signed the consent and reviewed the assent form and signature needed. If participant parent(s) or legal guardian(s) were unable to meet, due to transportation or other issues, they were to consent over the phone. The telephone review of the permission to participate form included a conference call with a staff counselor as witness to provide verification and also to sign the form.

Parent/Legal Guardian phone call was made one week after parents had received the packet. They were asked if they have read the packet. If they had, they were then asked if they agreed to their child being in the study. Two consent forms and a self-addressed stamped envelope were mailed home to the parent/legal guardian requesting their signatures. The telephone review of the permission to participate form included a conference call with a staff counselor as witness to provide verification and also to sign the form. If they consented over the phone and returned the two forms via mail, this constituted verbal phone consent and their child was to become eligible for enrollment in the research study.

If parent/legal guardian had not read the packet sent home to them, they were asked if the researcher may call them back in three days to discuss the packet and participant enrollment. If they agreed to this, they then received a call three days later asking for verbal consent over the phone. If they agreed to consent, two consent forms

and a self-addressed stamped envelope were sent home to the parent/legal guardian requesting their signature. If they agreed to their child participating in the study, their child then became eligible for enrollment into the study.

Subject Inclusion Criteria

- Participants must have been placed in the designated Approved Private School in suburban Philadelphia.
- Participants included 12-18 year old African-American adolescents from urban or suburban Philadelphia.
- Participants were diagnosed with: Major Depression, Dysthymic Disorder or Bipolar I Disorder.

Subject Exclusion Criteria

- Not attending the designated Approved Private School in suburban Philadelphia.
- Participants who were not diagnosed with: Major Depression, Dysthymic Disorder or Bipolar I Disorder
- Participants younger than 12 or older than 18.
- Female participants.
- Participants who were not African-American.

Investigational Methods and Procedures

The procedures for this intended study followed a single subject case study design. An ABA format, with pre and post-test measures were administered to assess the effect of art therapy intervention.

Eight individual sessions were scheduled over a four week period. If there were scheduling conflicts, sessions were made up at another rescheduled time. In the first session, the adolescents completed the Children's Depression Inventory. They also completed an art therapy assessment in order to aid in determining initial individual therapy treatment. In the following six sessions, participating adolescents received individualized art therapy interventions based on the subjects therapeutic goals and needs. In the final session, participating adolescents again completed the Children's Depression Inventory.

Over this eight session study, the researcher completed a therapy session note for all sessions. All artwork was photographed, catalogued and used in the thesis. Participant artwork was analyzed for changes in affect, treatment progress, treatment goals, dynamics, transference, countertransference, art elements, changes in behavior, changes in relationships, and changes in art material.

Instrumentation

Adolescents received the Children's Depression Inventory. The Children's Depression Inventory was intended to record any changes in affect or depressive qualities following the art therapy intervention. This 27-item inventory assessed affect and signs of depression in adolescents between the ages of seven and seventeen. When applicable, the Children's Depression Inventory may have been read out loud to participants.

The Children's Depression Inventory was intended to be administered quickly therefore, the authors designed this scale to be comprehended at a first grade reading level (Matson, 1989). This inventory was constructed to be administered to adolescents aged seven to seventeen (Matson, 1989). The participants in this study included early adolescents aged twelve to eighteen (Newman and Newman, 2006). The Children's Depression Inventory was considered standardized and a uniform measure for depressed individuals (Matson, 1989). Through responses, this inventory was intended to safeguard individuals from responding randomly (Matson, 1989).

The normative sample originally included 1,266 public school students between the ages of six and 17 (Pearson, 2008). The sample was divided into two groups based on age (Pearson, 2008). One group was aged between six and 11 and the second group was aged between 12 and 17 (Pearson, 2008). The sample included 592 boys and 674 girls (Pearson, 2008). Twenty-three percent of this normative sample included African-Americans (Pearson, 2008). Twenty percent of this total population came from single-parent homes (Pearson, 2008).

Informed Consent

The consent for participation in a research study was reviewed with the parent and all questions were addressed and answered. There was a choice of two methods of consent, in person and by telephone conference call with an Approved Private School witness. Because of transportation needs or other extenuating circumstances, the consent may have needed to be conducted over the phone. They were informed about participant confidentiality and privacy. After reviewing the form, the legal guardian/parents were asked to repeat back their understanding of the purpose and procedure of the study and if

they agreed to allow their child to be in the study, they were asked to sign two copies of the consent form and return by mail. Any 18 year-old adolescent was considered an adult and did not require a legal guardian to sign the informed consent. A copy of the signed consent form was provided to the legal guardian/parents and one was stored in a locked file in the Drexel University Creative Arts in Therapy office for seven years after the subject turns 18.

The assent form only needed to be obtained for participants aged 12 to 17. The assent form was reviewed with the participant and all questions were addressed and answered. Once having reviewed with the participants, they were asked to repeat back their understanding of the purpose and procedure of the intended study and were asked to sign two copies of the assent form. One of the two copies were stored on site at the designated Approved Private School for their records, and one was stored at Drexel University Creative Arts in Therapy office.

For consenting participants, weekly meeting appointments were scheduled. Meeting times were approximately one hour and kept consecutively for eight weeks, unless scheduling needed to be adapted to the subject's schedule. Once parental consents had been received by a counselor or an Approved Private School staff member, a telephone review of the permission to participate form included a conference call with a staff counselor as witness to provide verification and also to sign the form.

Participants were informed that a pseudonym was to be used when the artwork was presented or discussed. In addition, they were informed that storage of their artwork was to be locked on site at the designated Approved Private School and that color

photographs would be taken of the artwork. The original art was to be returned to them if desired.

Data Collection

Throughout this study, there were eight sessions scheduled over four weeks. If there were scheduling conflicts, sessions may have needed to be made up at another rescheduled time.

Data Collection Session One

This session were approximately 60 to 90 minutes in length. Adolescents completed the Children's Depression Inventory. If questions were not understood or needed to be read out loud for further explanation, the co-investigator did so (Kovacs, 1992). Once completed, a five-minute break was allotted. Adolescents were involved in individual art therapy immediately following completion of the Children's Depression Inventory.

Data Collection Sessions Two through Seven

These sessions were approximately 45 to 50 minutes in length. Clients received art therapy individualized to their treatment goals and needs. These will varied based on their individual therapy goals, behaviors and attention span.

Data Collection Session Eight

This session was approximately 60 to 90 minutes in length. Clients again completed the Children's Depression Inventory and the remainder of the time was used for the final art therapy session.

Additional collected data included the participant's artwork and this researcher's therapy notes from each session.

Data Analysis

Analyzed data included results from both the pre and post-test Children's Depression Inventory, artwork and therapy notes from each session. Test scores were reviewed, measured and analyzed for any changes that may have taken place between the first week and the last week of administration. Analysis included the test scores and individual comparison and across subjects from the first test to the second. Therapy notes included the date the notes were taken, directive given, the intervention for that day and the analysis for that day. Any changes and/or progress in the treatment were examined and noted for patterns both individually and across all subjects

The artwork was reviewed and analyzed for any possible changes in initiative in starting the directive, organization of the artwork, use of art materials, changes in content, pressure of the line quality and affect. Additionally, notes recorded any changes in behavior and changes in the therapeutic relationship.

Possible risks and discomforts

Clients may have been inconsistent or noncompliant with their weekly attendance. There may have been some minor anxiety related to drawing and/or verbalizing personal material. Clients who may have become overwhelmed during art therapy sessions may have needed additional time or breaks during the sessions. In these extreme situations, clients were referred to clinical staff members.

Special precautions to minimize risks and hazards

Because clients may have experienced some minor anxiety or become overwhelmed during individual art therapy sessions, special precautions included taking

breaks as needed. If participants became overwhelmed during art therapy sessions, they may have needed to meet with the Approved Private School staff member or counselor.

CHAPTER IV: RESULTS

The major findings of this research study were presented in the following section. The participant was discussed through a reference to his case history, a review of his pre and post-test Children's Depression Inventory results, and progress notes during each session and detailing the art directive, process, analysis, and treatment goals. This study derived from the research question regarding the use of art therapy intervention with African-American male adolescents assessed with a depressive diagnosis such as Major Depression, Bipolar I Disorder and Dysthymic Disorder. Three to five participants from the selected site were sought in recruitment for this study. Due to recruitment issues of guardian misgivings or lack of trust, only one student participated in the research study. The name of the participant who took part in this research study has been altered to ensure his identity remains confidential.

Subject 1: Portrait

Chris was a 16 year-old African-American male of average height who was in the 11th grade, had attended the selected Approved Private School for approximately two years, and was referred to the school as a result of his criminal behavior (delinquencies included stealing a bike and getting into fights) when he lived with his father in New Jersey. At this time, he was the only one of several siblings who lived with his mother in Pennsylvania. His teachers reported that, even though he was a bright child, he needed constant redirection, had poor peer relationships and had difficulty resolving conflicts without making threats or presenting threatening behavior. They also reported that he lacked effort in achieving academic excellence. His teachers also reported that he exhibited anxious behavior and often appeared bored when in the classroom. Chris was

diagnosed with Bipolar I disorder and Attention Deficit Hyperactivity Disorder and was prescribed 70mg of Vyvanse for his Attention Deficit Hyperactivity Disorder. He was not prescribed any medication for his diagnosis of Bipolar I Disorder. According to his reports and reports by his mother, Chris was not receiving psycho-therapeutic treatment outside of school for either disorder.

Subject 1: Children's Depression Inventory Results

The Children's Depression Inventory (CDI) was administered during the first session. Chris was initially asked if he would like to fill out the questionnaire on his own or if he would like to have it read to him; he chose the latter. The researcher read each question aloud and paused for a response. According to the CDI, this did not deviate from the manual. In this self-report questionnaire, there were 27 items and for each item and there were three answers from which to choose. Each choice corresponded to a level of symptomatology: 0 reflected the absence of a symptom; 1 indicated mild or probable symptom; 2 revealed that there is a definite symptom. The three offered choices were intended to reflect how the participant had been feeling over the past two weeks and the participant was advised to answer each question accordingly. Approximately 50% of the items began with responses reflecting the greatest symptom severity and the other sequence of items were reversed reflecting the least symptom severity. To eradicate random responding, the questions were randomized. Higher scores revealed increased depression severity.

In this questionnaire, there were five factors that were evaluated: Negative Mood, Interpersonal Problems, Ineffectiveness, Anhedonia, and Negative Self-Esteem. Negative Mood referred to feelings of sadness, excessive worrying, and not being able to make up

one's mind. Interpersonal Problems reflected the child's difficulties in interacting with others, social avoidance and social isolation. Ineffectiveness reported the existence of the respondent's negative evaluation of personal abilities and school performance. According to the writer of the Children's Depression Inventory, Anhedonia was classified as including depression, inability to experience pleasure, lack of energy, sleep or appetite problems, and isolation. The Children's Depression Inventory also categorized Negative Self-Esteem as including low self-esteem, personal dislike of oneself, existence of feeling unloved and suicidal thoughts. The total score then reflected the overall depressive symptomatology across all of these areas.

Table 1 reflected the results of Chris' pre-test results on the Children's Depression Inventory self-report questionnaire. There were two scores represented in this table: the raw score and the *T*-score. Using the QuikScore Form enabled automatic conversion of the raw score into the *T*-score. The raw score reflected the calculated subscale scores from the self-report. The *T*-score represented the score for the identified age and gender group. *T*-scores of 65 or greater were considered clinically significant, therefore the greater the raw and *T*-scores, the greater the incidence and measure of depression may have existed.

According to the results listed in Table 1, Chris' CDI raw score of 6 and *T*-score of 44 resulted in an associated percentile of 26, which indicated that his score on this scale was higher than 26% of scores for other males in his age group that were in the normative sample. Given that his score was low and clinically insignificant, it was possible that Chris was not completely honest in his responses. His artwork and verbal discussions appeared to contradict the results of this written self-report questionnaire.

Table 1
Chris' Children's Depression Inventory Pre-Test Results

Session #1	Raw Score	T-Score
Total CDI Score	6	44
Scale A (Negative Mood)	0	39
Scale B (Interpersonal Problems)	1	50
Scale C (Ineffectiveness)	3	53
Scale D (Anhedonia)	2	44
Scale E (negative self-esteem)	0	40

In the eighth session, the art therapist administered the Children's Depression Inventory again in order to assess any changes or fluctuations in depressive qualities. The researcher again asked Chris if he wanted to fill out the questionnaire or if he wanted it read to him. He chose to have it read to him. As there was only one packet to fill out, the researcher read each question aloud and paused for a response.

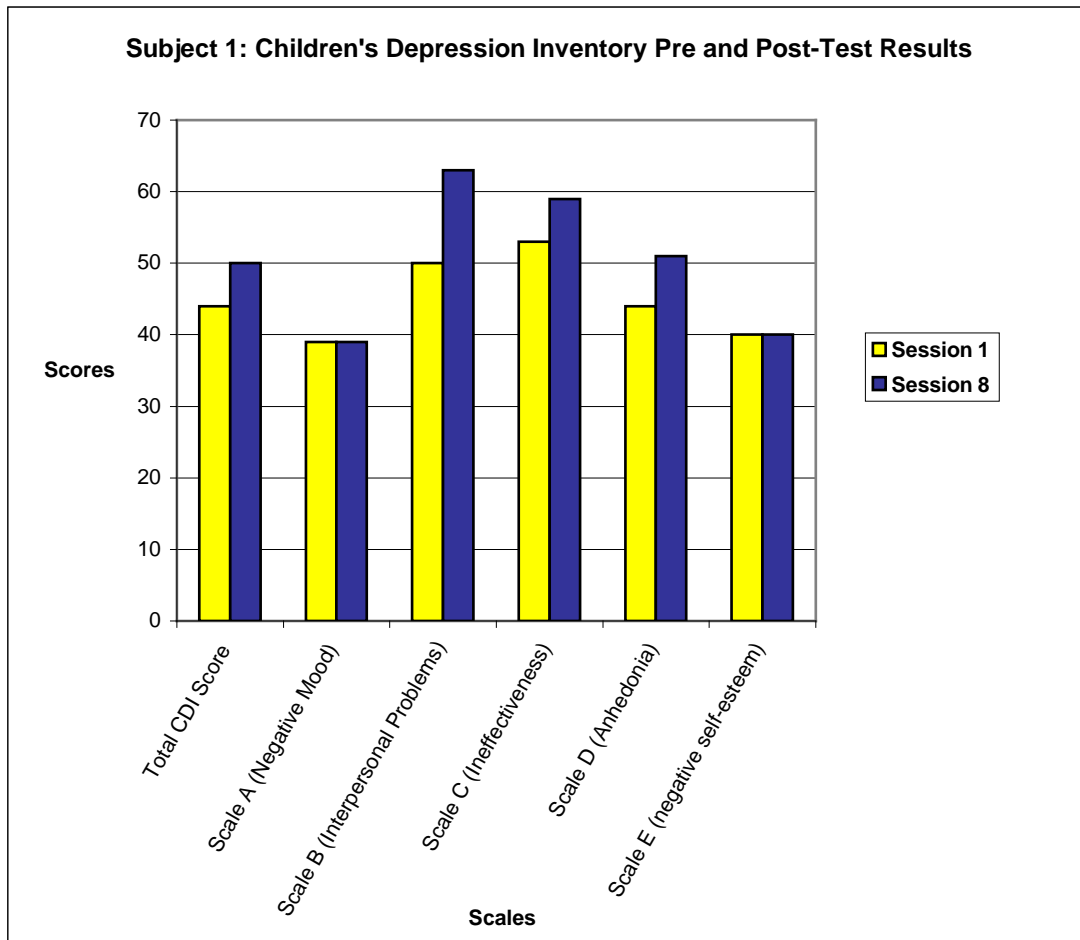
Table 2 listed the results of Chris' post-test measure on the Children's Depression Inventory self-report questionnaire. According to the results, there was an overall increase in both the raw score and the *T*-score. Despite this increase, interpreting the *T*-score results per the Children's Depression Inventory revealed that Chris's score was not considered statistically consistent. In specifically comparing both Table 1 and Table 2, there was an increase in three areas: Interpersonal Problems, Ineffectiveness and Anhedonia. There was no change in two areas: Negative Mood and Negative Self-Esteem.

Table 2
Chris' Children's Depression Inventory Post-Test Results

Session #8	Raw Score	T-Score
Total CDI Score	11	50
Scale A (Negative Mood)	0	39
Scale B (Interpersonal Problems)	3	63
Scale C (Ineffectiveness)	4	59
Scale D (Anhedonia)	4	51
Scale E (negative self-esteem)	0	40

Figure 1 compares Chris' pre and post-test scores on the Children's Depression Inventory scale.

Figure 1
Comparison of Pre and Post-Test Children Depression Inventory Scores



In comparing the changes in responses to specific questions between session 1 and session 8, Table 3 reviewed these changes and reflected an overall increase in depressive symptomatology through his responses on seven different questions reflecting increases in Ineffectiveness, Anhedonia and Interpersonal Problems.

Table 3
Changes in Verbal Responses to Specific Questions Between Session 1 and Session 8

Q#	5/4/2009	6/1/2009	His Verbal Response/ corrections to these questions	Q#	Pertains to:	Change
15	I have to push myself many times to do my schoolwork	I have to push myself all the time to do my schoolwork		15	Ineffectiveness	Increase
16	I sleep pretty well	I have trouble sleeping many nights		16	Anhedonia	Increase
17	I am tired all the time	I am tired once in a while		17	Anhedonia	Increase
19	I do not worry about aches and pains	I worry about aches and pains many times	From basketball	19	Anhedonia	Increase
21	I have fun at school many times	I have fun at school only once in a while		21	Anhedonia	Increase
22	I have plenty of friends	I have some friends but wish I had more	He said to leave off "but I wish I had more"	22	Anhedonia	Increase
26	I do not do what I am told most times	I never do what I am told		26	Interpersonal Problems	Increase
27	I get along with people	I get into fights many times		27	Interpersonal Problems	Change/Increase

At the time of this study, it was found that the following scale was frequently administered by the Approved Private School teachers and staff and was familiar to all Approved Private School students. This scale was incorporated into the procedure at a later time because of information received from the Approved Private School. The administered scale was a Cognitive Behavior Therapy rating scale where students were often asked how they are feeling on a scale from one to 10, one feeling “Horrible” and 10 feeling “Great”. Table 4 reflected Chris’ responses to this self-rating scale question.

Table 4

Chris’ self-rating scale representative from session one through session eight.

Session #	# 1	# 2	# 3	# 4	# 5	# 6	# 7	# 8
Self-rating scale	5	7 or 8	6	8	6	4	6	10

Subject 1: Individual Art Therapy Session Notes

Session 1:

Art Directive: No art directive was used in this initial session.

Process: Chris was escorted by the art therapist into a secure and quiet room. His affect appeared to positive and appropriate for this initial meeting. The art therapist briefly reviewed with Chris the assent form that he had signed and assisted him in completing the Children's Depression Inventory questionnaire. The content, length, number of sessions, and art therapy techniques and process were also reviewed with the participant. Throughout this session, Chris asked several questions regarding the questionnaire and the research study. He specifically wanted to know what his responses might mean and the purpose of the research study was again explained to him. He stated that he did not anticipate dropping out of the study and was happy to be out of the classroom at this specific time because he tends to become bored and tired at this time of day. He was asked if there were any materials that he liked or did not like to work with and he responded that he liked paint but did not like glue, specifically reporting that he has sensitive skin. Due to this issue, no art therapy directives included glue.

Analysis: Throughout the session, Chris positively interacted and engaged in appropriate conversation regarding his artistic likes, dislikes, and questions regarding the research study and the Children's Depression Inventory scale. He appeared cooperative and interested. In reviewing the results of the pre-test Children's Depression Inventory, Chris scored low on the CDI in the following areas: Overall (*T*-Score 44), Negative Mood (*T*-Score 39), Interpersonal Problems (*T*-Score 50), Ineffectiveness (*T*-Score 53), Anhedonia (*T*-Score 44), Negative Self-Esteem (*T*-Score 40). At the time that he completed this

questionnaire, these results indicated that his depressive symptomatology was not clinically significant.

Treatment Plan:

- Built rapport
- Administer the Six Part Assessment
- Through art therapy directives, provided Chris with a means to express himself

Session 2:

Art Directive: Administered the “Six Part Assessment”.

Provided Art Materials: 8 ½ x 11 white paper, 12 x 18 white paper, colored pencils, crayons, fine tipped colored markers.

Process: He stated that he had been involved in an argument with a teacher earlier that day. To better understand his cognitive, developmental and emotional level, the Six Part Assessment was administered in this session. The Six Part Assessment was often used in initial art therapy sessions to better understand a client’s level of functioning, self-concept, family and peer relationships, as well as to better understand issues. The following drawing requests were asked of Chris:

- Drawing one (Free drawing)
- Drawing two (Draw a person)
- Drawing three (Draw the opposite)
- Drawing four (Kinetic Family Drawing-draw you and your family doing something)
- Drawing five (Dot-to-dot)
- Drawing six (Free drawing)

His first drawing (free drawing), he asked “I gotta draw me?” He was advised that it was a free drawing and he could draw whatever he wanted. He then said, “I’m gonna draw me, but can I just draw a head?” When completed, he said that the “eyes look weird”. During the second drawing (draw-a-person), he asked if he had to draw a person “with feet and stuff?” and then when he reached the face, he said that he didn’t “know how to draw a face”. During this drawing, his chin rested on his hand and he was leaning very closely to the paper. When he completed this drawing, he said “I even gave him clothes”.

During the third drawing request (draw the opposite), he spent approximately two minutes staring at the paper and around the room before asking, “me? I should draw the opposite of me?”, and “So if I’m a dude, I should draw me as a girl?” He was advised that there were no wrong answers and that he was to draw what he thought was the opposite. He then leaned in so that he was physically closer to the drawing and said he drew a picture of him as a “rich and famous basketball player; this is the opposite of what I am now.”

During the fourth drawing (Kinetic Family Drawing), Chris asked if he had to draw “me and my family? You mean me and mom?” He then began to draw a picture of himself and his mother (in stick figures) standing in front of their kitchen stove cooking dinner and he said that they were talking. He drew both of them on the left hand side of the paper stating that she was very easy to talk to, they talk frequently, and they talk about everything. During the fifth drawing request (dot-to-dot), he appeared to delicately and strategically place the dots in a cluster on the paper. Although his eyes were closed, he was able to keep the dots on the paper. While rotating his image of dots, he was asked

what he saw. He replied that he saw the following images: a windmill, the layout of his house (with the door to his bedroom, living room, bathroom, his mom's room and the kitchen), a bike, and the letter "B". When asked which one he would like to draw, he stated that he wanted to draw the layout of his house.

During the final drawing (free drawing), he needed two pieces of paper. On the first piece of paper, he said "I'll show you what I said I was good at: bubble letters". He then noticed that he made a spelling typo in the first word and said "Whoa, I spelled it wrong; I gotta start over." He then pushed the paper out of his way, picked up another and switched from using his black pen to a black pencil with no eraser. He wrote "Free PFF". When asked what this meant, he replied that PFF was his best friend who was sent away to bootcamp for possession and intent to sell marijuana. He stated that he could not wait until his friend was able to come back home.

Analysis: Drawings one through five were drawn using his own black pen whereas in his last two drawings he used a red colored pencil and a black pencil. In this respect, he may have felt more comfortable and safe using his own pen to draw rather than use the provided materials and a lack of trust in this early therapeutic relationship.

Throughout his drawings, his lack of color may have reflected isolation of affect and potential depressive affect. Despite this, his first three drawings depicted himself, potentially reflecting a strong sense of self-concept and self-esteem. Specifically and as evidenced in a self-portrait, drawing #1 (free drawing) may have reflected the participant's strong sense of ego or egocentricity. His portrait of a head may have indicated a separation from mind and body possibly indicating a separation between thinking and affect. Additionally, when drawing portraits of himself (as seen in the first

three drawings), he neglected to include body parts. Excluding body parts may also have reflected denial, avoidance or lack of motivation. These images appeared to be floating in space, as there was no baseline or environment and this may have suggested a lack of grounding with no connection to reality or understanding of his surroundings. All of his drawings in this administration were centered to the page which may have indicated a strong sense of self and ego identity.

In comparing his first and second drawing, he stated that he did not know how to draw a face. This comment was contradictory to his action as he was able to draw a face in his first drawing which included eyes, nose and mouth, but neglected to add detail in the second drawing. This may have been seen as avoidance, denial or not wanting to put forth the effort to complete the drawing. Additionally, when he completed his second drawing, he stated proudly that he drew clothes on the figure, possibly seen as an attempt to impress to the researcher or to show pride in his detailed artwork.

In drawing # 2 (draw a person), also reflecting another self-portrait, he may again have presented with a strong sense of ego. Consistent with the first drawing, missing arms, hands and feet may have indicated denial, avoidance or lack of effort. In drawing #3 (draw the opposite), another self-portrait may have further reinforced the concept of a strong ego or again egocentricity. In this specific drawing, he also neglected to include hands or feet. Again, this may have been seen as denial or avoidance. In this drawing, he also drew the head and neck disproportionately small to the rest of the body, possibly contradicting the two earlier drawings. This may be have been perceived as poor self-esteem or reflecting the continued theme of a disconnection between mind and body,

affect and action. Despite this, Chris demonstrated understanding of the meaning of the opposite and his wish to be a successful and famous basketball player when he grows up.

In drawing # 4 (Kinetic Family Drawing: draw you and your family doing something), Chris seemed to have a strong relationship with his mother. He made several positive comments about his mother and discussed the strength of their bond. In drawing #5 (dot-to-dot), the participant appeared to specifically and strategically place each dot by staying on the page and within a small centered area. This may have been seen as an attempt to contain, control or regain control of the situation and session. In this drawing, he said that he saw the layout of his house and began to identify the specific rooms. Seeing this image may have reflected a safe environment or a wish to be at this location instead of being in a therapeutic setting.

In drawing #6 and #7 (free drawing), he used bubble letters to write out “Free PFF” and this is common in adolescent artwork. Because of the lack of color, this may have revealed isolation of affect, intellectualization and potential depressive symptomatology characteristic of depression. With the exception of his depiction of himself and his mother, there was a void of relationships in all of his drawings. He openly shared, discussed and revealed in the artwork this void in his life. This may have reflected early therapeutic trust or that, like his mother, he may have considered the researcher a trustworthy person.

According to Lowenfeld and Brittain’s drawing stages, this participant was between the Gang Age (9-12) and the Pseudo-Naturalistic stage (12-14). The Gang Age was marked with attention to detail in the human figure representations and greater awareness of details. This stage represented more self-conscious recognition of one’s

own drawings and reflects less exaggeration and distortion, but there was a greater reflection of figure stiffness. In the Pseudo-Naturalistic stage, early adolescents were aware of their own artistic shortcomings and are critical of it. Figure representations were also seen closer to more accurate proportions. Therefore, this participant was approximately two developmental stages behind where other adolescents tend to be. At 16, it was anticipated that Chris would be at the higher developmental stage of the Period of Decision (ages 14-17). In this stage, adolescent drawings did not require as much direction or instruction and conscious development of artistic ability was expected. Additionally, visual details were enhanced and shading was more natural looking in this stage. Mastery of any provided material and expressive control were also typically seen. Lastly, extended attention span was also considered normal within this stage of development.

Treatment Plan:

Short-term goals include:

- Built rapport
- Explored and addressed interpersonal relationships (family and friend)
- Understood things he likes/dislikes
- Provided emotional support to better understand his sense of self and his level of self-esteem

Long term goals include:

- Discussed effective coping skills related to anger management, violence, frustration, jealousy, anxiety and depression
- Supported expressivity through administration of art therapy directives

- Understood his self-concept
- Addressed current coping skills
- Implemented coping strategies to help facilitate de-escalation of anger

Subject 1: Artwork Created During Individual Art Therapy Sessions

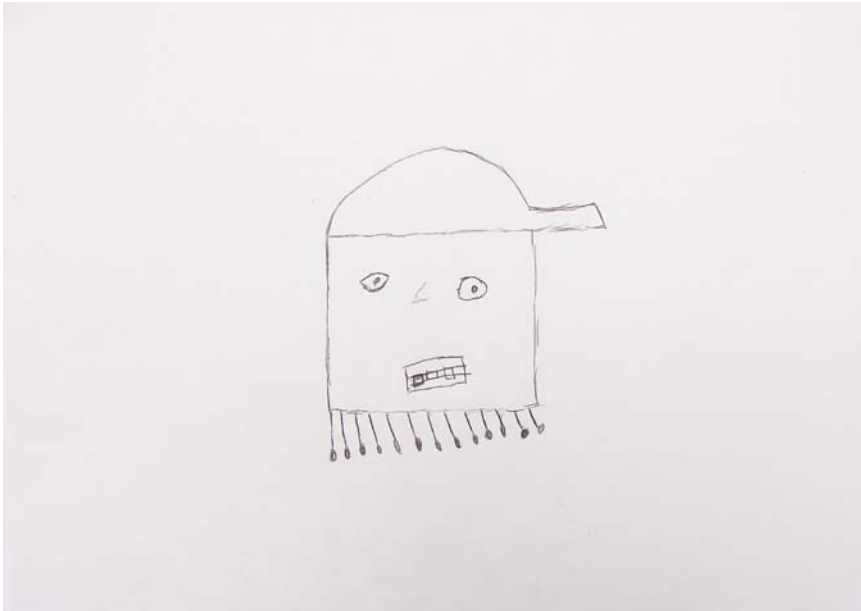


Figure 2. Session 2: Drawing 1 of 7 in the “Six Part Assessment”. “Free Drawing.” Black pen on 8 ½ x 11 drawing paper. This is a self-portrait of Chris.



Figure 3. Session 2: Drawing 2 of 7 in the “Six Part Assessment”. “Draw-A-Person”. Black pen on 8 ½ x 11 paper. This is a self-portrait of Chris.



Figure 4. Session 2: Drawing 3 of 7 in the Six Part Assessment (“Draw the opposite”). Black pen on 8 ½ x 11 paper. This is a self-portrait of what Chris wishes to be: a rich and famous basketball player.

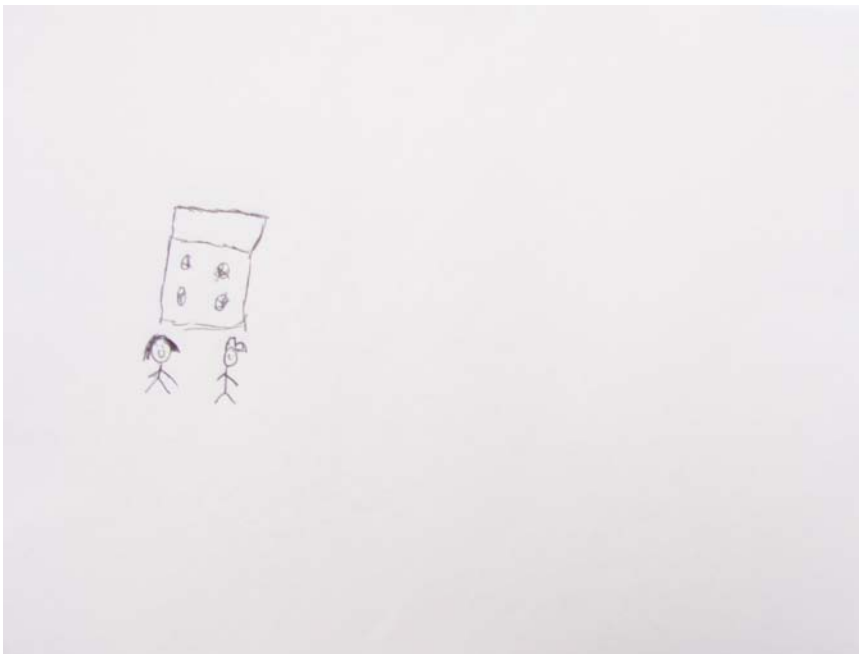


Figure 5. Session 2: Drawing 4 of 7 in the “Six Part Assessment.” “Kinetic Family Drawing”. Black pen on 8 ½ x 11 paper. This is a drawing of him and his mother talking.

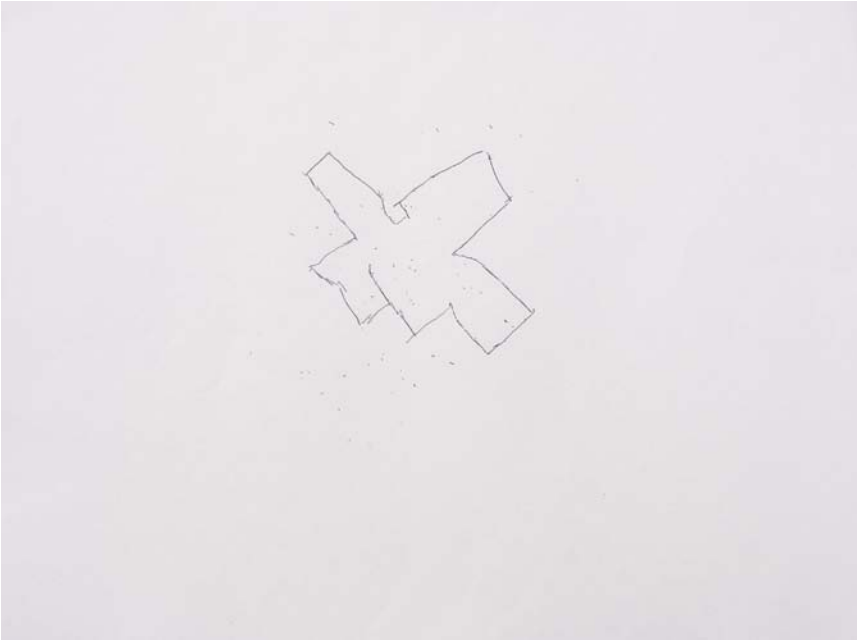


Figure 6. Session 2: Drawing 5 of 7 in the “Six Part Assessment.” “Dot-to-dot”. Black pen on 8 ½ x 11 paper. This is a drawing of the layout of Chris’ house.



Figure 7. Session 2: Drawing 6 of 7 in the “Six Part Assessment.” “Free Drawing (first attempt)”. Black pencil on 8 ½ x 11 paper.



Figure 8. Session 2: Drawing 7 of 7 in the “Six Part Assessment.” “Free Drawing (second attempt)”. Black and red pencil on 8 ½ x 11 paper. This is the second attempt to write “Free PFF”.

Session 3:

Art Directive: The participant was asked to draw something you like/draw something you do not like.

Provided Art Materials: 8 ½ x 11 white paper, 12 x 18 white paper, colored pencils, crayons, fine tipped colored markers.

Process: The participant was asked to draw his favorite activity. He chose to use 8 ½ x 11 paper and drew both images on the horizontal plane. He stated he liked to play basketball and proceeded to use a black pencil and draw a basketball hoop, a backboard and a basketball. No people or actions were displayed in the depiction of his favorite activity.

Chris was then asked to draw something that he does not like to which he responded that he did not like fake people, stating that he did not like the people he went to school with and that was why he kept to himself. He said it was easier to ignore people that were fake and to not start trouble because they were not worth his time. He also stated that he hated it when he feels “boxed in”, reporting that he did not like to argue with his mother or girlfriend, especially when they were focused on their own issues. Specifically, he stated, “when people don’t let you talk, like when you are angry because they have a one-track mind”. He placed his pencil down and reported that he did not like to discuss his feelings with anyone and preferred to keep them to himself. In his second drawing, he drew a box and shaded it in stating that he hates being in a box and hates “having only a couple of options. Being outside, you can go anywhere; in a box, you can’t go anywhere...At school, I’m in a box everyday.”

His criminal record (included stealing a bike and getting into fights) was also

discussed during this session and he reported that he was “not a violent person unless I need to do what needs to be done.”

Analysis: Themes in this discussion included violence, anger, frustration and anxiety. Chris chose to use only the 8 ½ x 11 paper and his black pen. This may have indicated that he liked to work with things that he is familiar with. Additionally, this size paper was significantly smaller than the 12 x 18 and his use of the smaller paper may have indicated an attempt at containment. In both drawings, isolation of affect and isolation of objects could be seen in his drawings of his favorite activity and his least favorite thing.

Both drawings appeared to be floating on the page with no baseline, with no figures and no environment present. This may have been a reflection of poor interpersonal relationships or lack of close friends. Additionally, his comments pertaining to feeling boxed-in or not being able to talk may have reflected poor anger management skills and low levels of frustration tolerance.

In reviewing the therapeutic relationship, it appeared that Chris was becoming more vocal about his feelings, possibly reflecting more trust in this early therapeutic relationship. Even though he clearly stated that he does not like to discuss his feelings with anyone, he continued to retell the story about becoming frustrated and angry when he was not listened to.

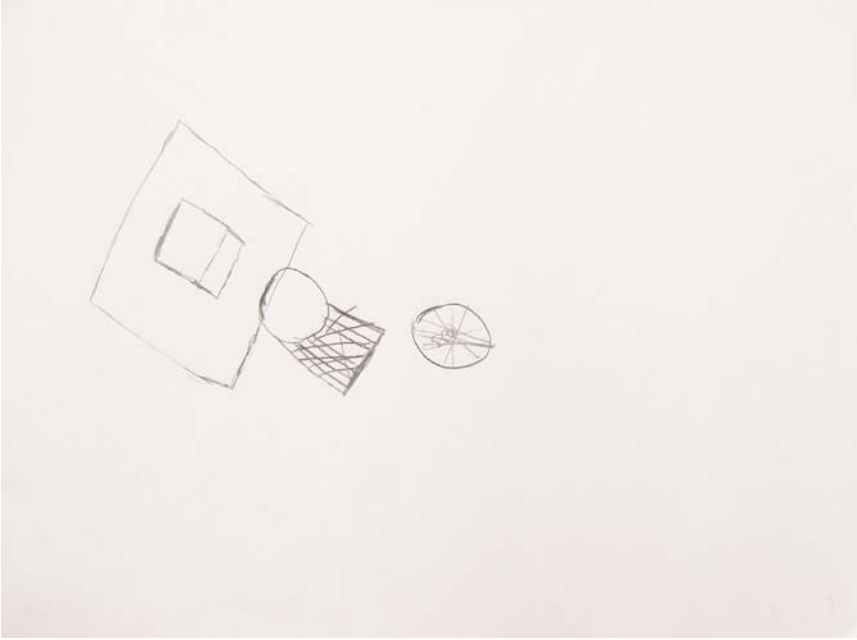


Figure 9. Session 3: Drawing 1 of 2. Draw something you like. Black pencil on 8 ½ x 11 paper. Chris chose to draw his favorite activity.

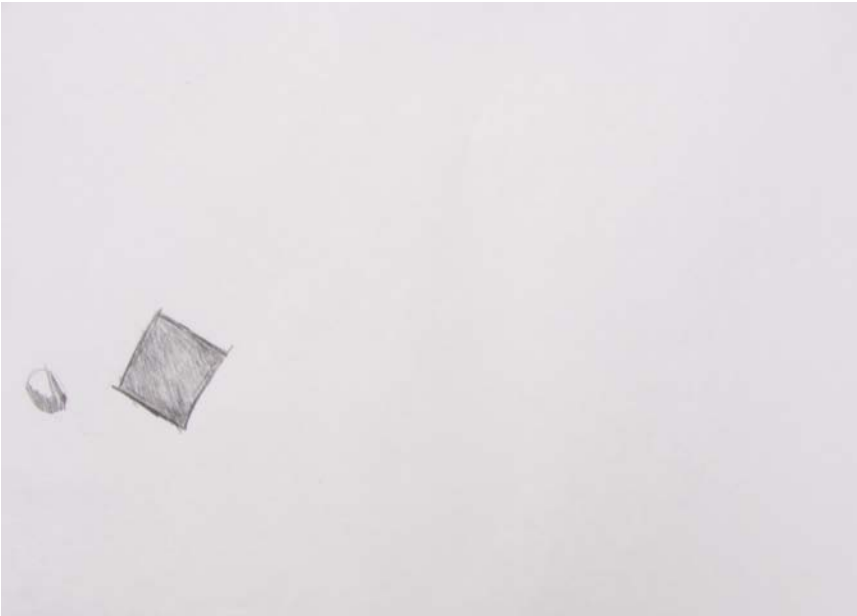


Figure 10. Session 3: Drawing 2 of 2. Draw something you do not like. Black pen on 8 ½ x 11 paper. Chris drew a box because he does not like to feel “boxed-in”.

Session 4:

Art Directive: The participant was asked to create a comic strip progression with escalation of anger and then de-escalation of anger (coping skills).

Provided Art Materials: 8 ½ x 11 and 12x18 paper, crayons, colored pencils and markers.

Process: During this session, themes from the last session were discussed, especially Chris' anger and situations that made him angry or frustrated him. He expressed many things that made him angry (people saying negative things about his mom or girlfriend, fake people, when people hang up the phone on him).

Chris was asked to create a comic strip showing the progression and escalation of his anger. He was shown how to fold the paper into sixths. He chose to work with 8 ½ x 11 inch paper and a black marker for all of his drawings.

Initially, as per the researcher's instructions, the first set of three drawings was intended to be the escalation process, to better understand what bothers him, and what leads up to angry feelings where he acts out on those feelings. The second set of three drawings was intended to be the de-escalation process and what he does to calm himself down. Because of this, it was suggested that he use the first top portion of the paper to address his escalating anger and use the bottom half for de-escalation. Because he cited many levels of escalating anger with many examples, there appeared to be many steps leading up to his acting out behaviors. Because of his manner of using this drawing method and getting fully invested in the process, he needed additional structure in order to complete this drawing request. Therefore, the series was not completed in this session and only the escalation of anger was discussed. In this regard, all six images pertained to escalation of anger.

Chris started over a couple of times. While deciding on an issue, his final drawing incorporated a specific incident where his girlfriend's ex-boyfriend made threats against him, his girlfriend and his mother. In the first two sections of the comic strip, he depicted his girlfriend's ex-boyfriend as a snake. He also drew the measures he (Chris) took to stop this teenager from saying negative things about him, his mother and his girlfriend.

In the last section of this series, he wrote that he "can't progress in my life until I reach my goal." Here, he described this goal as beating up this person, stating that he wants the other kid to "feel what I feel". When asked what he meant by this, he reported that he wants this other boy to "feel like a mouse [small and insignificant], a domino [to be knocked over], that he wanted him to hurt mentally, and to feel "like the bottom of the barrel, with no pride."

Analysis: Chris chose to work with 8 ½ x 11 paper for all drawings in this session. This may again indicate that he preferred to work within his comfort zone of familiarity.

Themes in this session reflected anger, frustration and violence. Art indicators may have reflected isolation of affect, anger, and poor coping mechanisms. When discussing his levels of escalating anger, he appeared to have many examples. Specifically, in trying to stop his girlfriend's ex-boyfriend from saying negative things about him may have indicated poor coping skills in dealing with his anger and poor peer relations. This may have also revealed that he has poor emotional regulation and low self-concept.

He appeared to become frustrated and angry when talking about his girlfriend's ex-boyfriend. His description of his girlfriend's ex-boyfriend may have also reflected a poor concept of others, lack of trust in others or inability to create positive relationships. This boy as a snake may have directly indicated Chris' poor concept of others or need to

elevate himself. This may also have indicated some level of anxiety and jealousy. This may also have indicated a desire for Chris to be stronger and a desire to be stronger than someone else.

Chris appeared to openly and insightfully discuss the theme of anger. In this session, it appeared that he had become more open with the researcher and with himself in discussing this level of acting out behavior, suggesting his ability to connect and relate in the therapeutic relationship.



Figure 11 Session 4: Drawing 1 of 3. Create a comic strip progression of anger. Black thin tipped marker on 8 ½ x 11 paper.

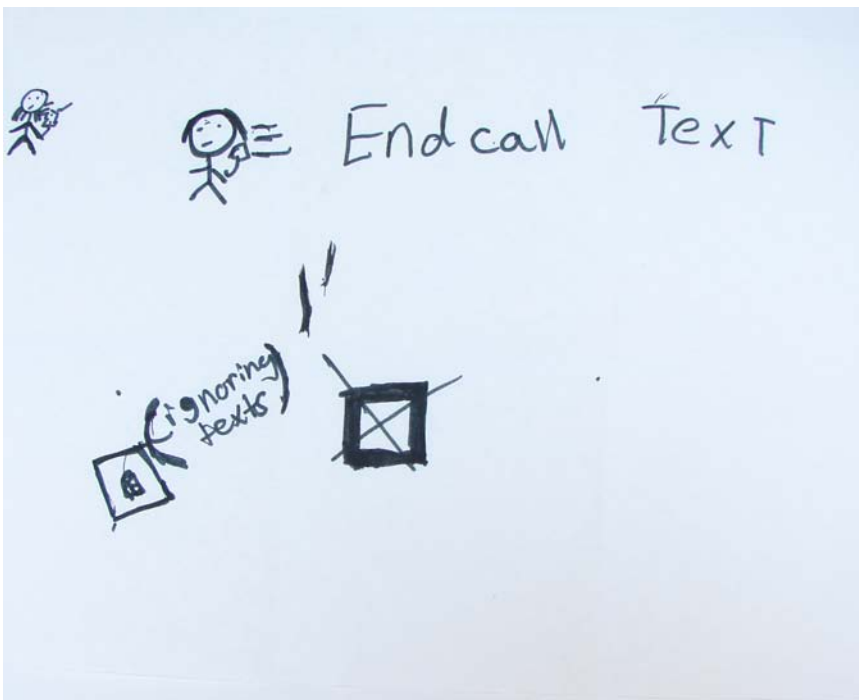


Figure 12 Session 4: Drawing 2 of 3. Create a comic strip progression of anger. Black thin tipped marker on 8 ½ x 11 paper.

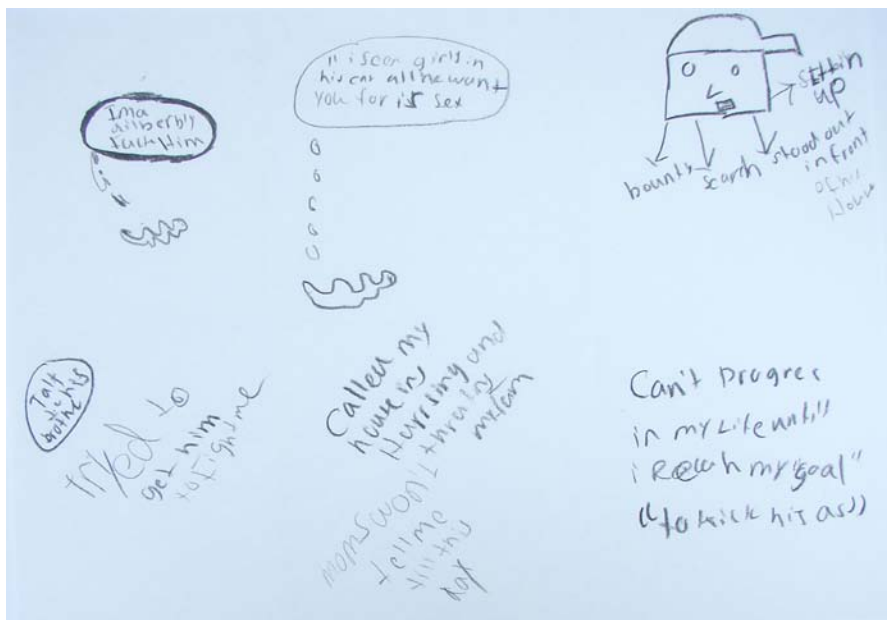


Figure 13 Session 4: Drawing 3 of 3. Create a comic strip progression of anger. Black thin tipped marker on 8 ½ x 11 paper. Chris' final attempt to create a comic strip progression.

Session 5:

Art Directive: De-escalation of anger, discussed and drew currently coping mechanisms.

Provided Art Materials: 8 ½ x 11 white paper, 12 x 18 white paper, colored pencils, crayons, fine tipped colored markers.

Process: After reviewing the prior session, he was asked to start with the feeling of anger and discuss and draw coping mechanisms he currently used to help calm himself down. His first drawing depicted a lightning bolt, which he later described as “fierce, unpredictable”. He also said that lightning comes with other things such as rain and wind, which he described as his friends from his neighborhood.

As part of his de-escalation, Chris said that he liked to listen to music and always had his I-pod with him. This was depicted in the second drawing. He also reported that he liked to listen to rap music, more specifically NAS and Eminem. When asked what he likes about that music, he said that he just liked to listen to them. When it was mentioned that those artists sometimes sing about violent things, he agreed saying that sometimes this particular music or these specific artists helped him to get angry and he then wanted to fight because of it.

In his third drawing, he drew a sidewalk or path stating that he likes to take walks. He also stated that he sometimes will start walking and is unclear of his direction because he has friends in either direction.

In his fourth drawing, he drew a cell phone with his best friends from home displayed on the screen. Chris said that, when he is angry, one of the things he does is call a friend. If they do not answer, he stated that he would go play basketball near his

house (seen in the fifth drawing). When asked what works best for him to help calm him down, he said that calling his friends was most effective.

In drawings two through five, Chris drew four things that he viewed as affecting coping skills when dealing with his anger. In the sixth and final drawing, he was asked what calm might look like to him or what he looks like when he feels calm. He mentioned that he likes to smoke cigarettes or marijuana but neglected to draw these. Instead, he drew a river stating that a river “flows at a specific pace, nice and slow at times....anxious, calm; a river can be all of that”.

Because of his comments pertaining to polarities, such as feeling anxious or calm, and being unclear of which direction to walk, he was asked to make a connection between two images. Here, he pointed to the lightning bolt and the drawing of his cell phone (calling his friends). He reported that when he is angry like a lightning bolt, he prefers to call his friends in order to help calm him down. In further exploring polarities, he was asked to make a connection to the river. Here, he pointed to his drawing of the sidewalk but did not report why.

In exploring the issue of fighting, he was asked about what he thought the purpose of fighting was. He replied “to shut people up. Some people need to be shut up (e.g. fake people)”. When exploring this topic further, he also said that fights serve the purpose of getting something done that “can’t be done with words.” When asked what the world would be like if no one fought, he said it would be filled with “a bunch of fake people.” In this session, the topic of respect also came up. He stated that when someone is disrespectful, Chris would “teach them a lesson”, especially when someone is talking negatively about his girlfriend or mother. He described respect as “being able to walk

around with your head up high” and that respect was important in his group of friends (from home) because “you don’t want people walking all over you.” When asked how to earn respect with his friends, he said that he smokes weed with them and spends time with them. “When someone invites you to smoke (weed), that’s respect.” When asked if he noticed any themes in his drawings from this session, he said that all of his drawings were about his friends from home.

Analysis: Themes in this session included violence, anger, ambivalence and friendship. In this series of drawings, Chris drew several inanimate objects (lightning bolt, Ipod, sidewalk, cell phone, basketball backboard). Despite the action implied in his description of these coping skills (listening to music, taking a walk, calling friends, playing basketball), neither of his drawings incorporated action, human figures or interpersonal relationships indicating poor peer relationships and/or poor social skill interactions.

He also appeared to become frustrated when talking about his coping skills and things he tried to implement for de-escalation. Two of his drawings pertained specifically to nature (lightning bolt and river). In his description of lightning, he said that it can be fierce and unpredictable. Ultimately, lightning can also be seen as destructive and violent, much like Chris’ personality and negative acting-out behaviors. Specifically, in describing the water and similar to his personality and escalation of anger, he described the water by stating that it tends to “flow at a specific pace” but can be “fierce and unpredictable”, relating to his own feelings.

Additional polarities included his description of the river being both “calm and anxious”. He was asked what calm looked like and he chose to draw something that could be both calm and anxious, possibly also depicting himself and his behaviors. When

making a connection to the river, he pointed to his drawing of the sidewalk. Even though both images were familiar, they reflected some level of ambivalence and contradiction and this may have been consistent with his poor choices and acting-out behaviors in both school and in fighting. Specifically, in his third drawing of a sidewalk/path where he stated he liked to take walks, he exhibited ambivalence and confusion by reporting that he was unclear of which direction to go, thus revealing that he may have had a difficult time making appropriate decisions.

He said that, in order to calm himself down or de-escalate, he liked to smoke cigarettes or marijuana, suggesting poor coping skills where he preferred to alter his mood through illegal drug enhancement. In contrast, he commented that he liked to listen to violent music in order to facilitate his anger, another poor coping skill. Chris appeared comfortable discussing issues with the researcher, sharing with thoughtfulness and insight.

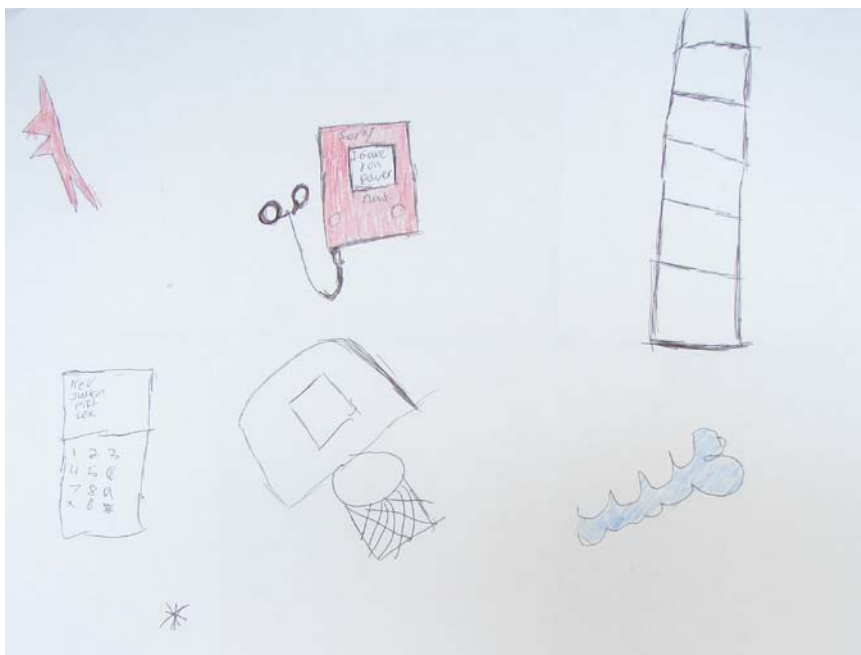


Figure 14 Session 5: Create a comic strip de-escalation of anger. Black pen, red colored pencil, blue colored pencil on 8 ½ x 11 paper. Chris used the comic strip to reveal his current coping mechanisms: listening to his Ipod, going for a walk, calling his friends, playing basketball, acting like a river.

Session 6:

Art Directive: Addressed consequences of negative behaviors, anger, fights, and resulting behavior of acting out on anger.

Provided Art Materials: Markers, crayons, colored pencils, oil pastels, craypas, model magic, water color paint.

Process: Throughout this session, Chris stated several times that he was bored and wanted to go home. He also said that he did not feel like drawing and that he could not wait to get on the local highway (route 309) to head home.

Instead of using the provided materials, Chris pulled a black pen from his pocket and used it for all of his drawings in this session. In first discussing consequences, he stated that he might get grounded for his negative behavior (acting-out, getting into fights). For him, being grounded may have meant that he could not go outside, he could not hang out with his friend, he was not be able to talk on the phone, or that his phone may have been taken away. He also reported that his current negative behaviors might get into trouble with the police and also get him grounded. In an attempt to assess if he understood the consequences of his actions, he was asked what it might mean in a couple of years if he continued this behavior. He replied that he might go to jail but said that he did not care because he did not expect to get into trouble after he turns 18 and graduates from high school.

When asked what he wanted to do after graduation, he stated that he wished to move out of his mother's house, live on his own, and work. During this time, he was asked to draw consequences related to his behavior and he chose to doodle instead. He chose to throw out his first doodle calling it "stupid". He picked it up and threw it in a

nearby wastebasket.

He began to draw another square on another piece of paper, instead of throwing this one away, he pushed it to the side and began drawing a third. He was asked how he thought people viewed him. As seen in his hesitation and initial lack of motivation to draw, he appeared to have a difficult time with this. When he began to draw, he stated that he was viewed as annoying from both students and staff members at the Approved Private School. He also reported that he did stupid things in class to purposefully annoy others. He was asked why and he responded that he was never in the right mood to be in school, but being annoying to others keeps him occupied and helped him get through the day. When asked specifically what he does to purposefully annoy others, he said that he laughed at inappropriate times, he made noises (e.g. tapping on his desk), he created weird slogans, and that he purposefully messed things up for others (positive class rewards). When asked to replicate or further explain how he laughs or some of the weird slogans he invents, he said he did not feel like recreating them at that moment.

In his fourth and fifth drawings, he was asked how he viewed himself. He said that he is a “weirdo” and “long hair, don’t care”. When asked what he meant by this, he said that he cares about things, and at the same time he does not care about things. He said that he lives “life by the seconds” and that he could “draw me a million different ways” depending on his mood or how he is feeling in that moment. In drawing number four, he wrote “309” and circled it. He said that he wished he was on highway 309 heading home.

In his fifth drawing, he drew a thin black line. On the right hand side, he drew things that described himself and how he viewed himself. He first said that he saw

himself as a “lone wolf” and then reported he saw himself as a “nomad”. He asked if that meant a loner and he was told that it meant a traveler who goes from place to place: a wanderer. He then said that this was what he thought described him best.

He began to draw an Ipod, a sidewalk, a cell phone, a cloud with the word “weather” in it. He said that this was a drawing of him listening to his ipod walking along a path by himself. He said that his thoughts were portrayed in the clouds. He said that this was “me on my journey with my thoughts” and “I take walks every day by myself”. He said he chooses to “be a nomad. I don’t like being around people that are fake: I don’t like being around people.”

On the left hand side, he then drew “how people view me”. He used perseverance to repeatedly draw a rectangle with a squiggly line at the bottom stating that people see him “as the bottom of the barrel-because I don’t put forth effort towards my popularity...and yet I keep people focused on me...I am on other people’s minds.” When asked about his drawing of the “bottom of the barrel”, Chris also said that when he comes to the Approved Private School, he is a different person. When he is at home, his popularity goes up, describing it as his “essence”. He also said that his day does not start until he gets out of school.

In a prior session, Chris had said that he wanted to make another boy feel like “the bottom of the barrel”. When this was mentioned, he said that there was a distinct difference. He said he (Chris) chooses to be at the bottom of the barrel, as in under the radar, and that he is not losing pride when he comes into the Approved Private School because he does not care about school or his classmates. In regards to the prior session’s drawing, Chris said that he wants his girlfriend’s ex-boyfriend’s “personal pride”, his

“essence”, his “achievements”, his “thought process” destroyed, he wants to make the boy’s life a “living hell.”

Towards the end of the session, Chris said that “judgment day” was coming; that he will be ready to fight his girlfriend’s ex-boyfriend and that everything will “explode”. He said “it’s going to happen” and that there is “no stopping it”. He said that after this fight takes place, he “will be a different person.”

Analysis: Adolescents who experienced depression typically exhibited anger and negative acting-out behaviors. Chris chose to work with his own black pen perhaps seen as regression as he was reverting back to using familiar things.

Use of monochromatic color may have reflected isolation of affect or depressive qualities. In throwing out his first drawing, this may have been seen as undoing. Themes that arose in this session included: boredom, coping skills, getting into fights, consequences of getting into fights, perseveration of repeated images, anger, anxiety, jealousy, ambivalence and isolation.

In looking at several of his comments and as evident in his artwork, Chris had stated that he was bored and wished he was headed home on highway 309. In stating that he was bored, suggesting much of the discussion in this session personally affected him and this was his attempt to avoid the discussion altogether or to dismiss anxiety. Despite this, he did not abandon the session. This may reflect his attempt to deal with the themes being discussed in session but in a passive-aggressive manner.

His comment related to graduating from high school and not getting into trouble with the police appeared to recognize the consequence of his actions seeming to understand that getting into trouble with the police at age 18 may result in a permanent

record or jail time. When asked to draw consequences related to his acting-out behaviors and anger, he chose to doodle. This may have been seen as avoidance and uneasiness in accepting the drawing request and addressing the issue. When he threw out his first doodle drawing, he picked it up from the table and threw it in a nearby wastebasket; in addition to undoing, this may have been seen as being able to follow rules, an attempt at containment or control, or a sign of respecting the therapeutic relationship and the researcher.

In reviewing some of the things he did to purposefully annoy others (laughing inappropriately, ruining class rewards), this may have been seen as attention seeking behavior. When asked to replicate some of his annoying behaviors, he chose not to exhibit these behaviors suggesting embarrassment, loss of pride or not wanting to annoy the researcher, therefore exhibiting respect for the researcher.

Comments about the ex-boyfriend included Chris wanting to take the boy's pride, essence and achievements, suggesting feelings of inadequacy and jealousy. When commenting that he would become a different person after fighting his girlfriend's ex-boyfriend, he implied that he (Chris) would be better off because he will be a bigger and better person because of it. This may have reflected poor self-concept, poor self-esteem, an aggressive attempt to ineffectively cope with his anger, and reflections of jealousy and frustration. In wanting to make this other boy feel like the bottom of the barrel, this may have been seen as Chris' attempt to make himself feel better where he feels he has to put someone else down in order to build himself up. In attempting to raise his self-esteem, he chose violence and negative acting-out behaviors and perhaps a relationship between her ex-boyfriend and potentially Chris' feelings of not being respected by his teachers. His

teachers may have been annoyed with Chris' acting-out behaviors because he is insightful and bright but did not appear to put forth effort to achieve academically. This may have indicated poor self-esteem and inability to effectively regulate his emotions. Instead of trying to positively resolve the situation, he acted out on his behavior resulting in physical altercations instead of addressing his feelings and emotions.

His comments pertaining to caring about things but also not caring about things again reflected a discrepancy and an awareness of this ambivalence but that he did not know how to properly cope with it or become more decisive in his decisions without negatively acting-out.

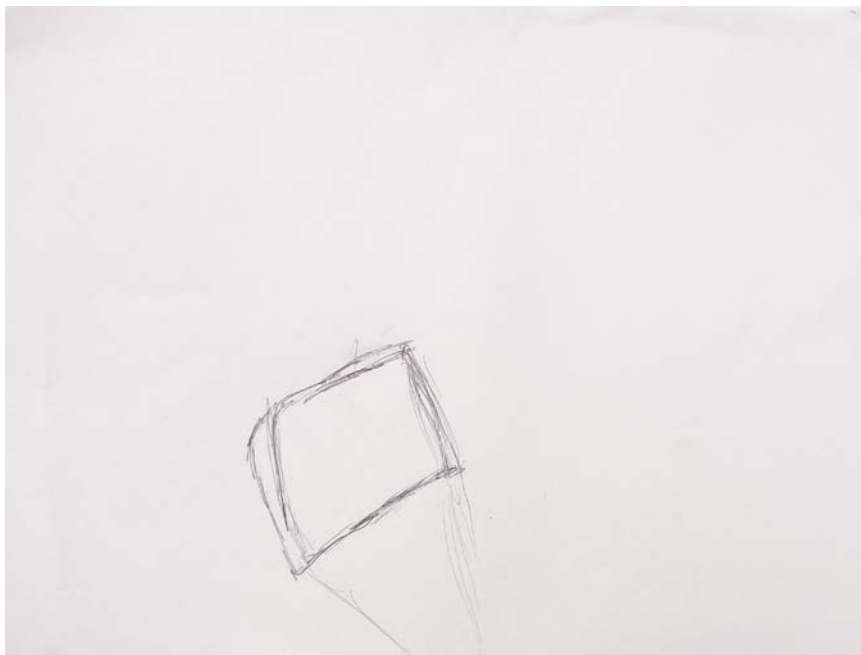


Figure 15 Session 6: Addressing consequences of negative behaviors, anger and fights.
Drawing 1 of 6. Black pen on 8 ½ x 11 paper.

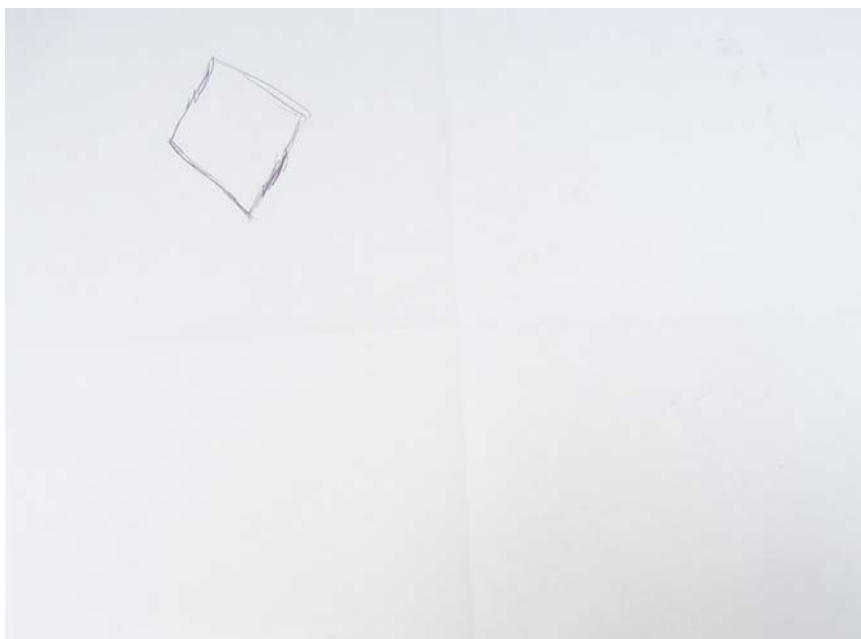


Figure 16 Session 6: Addressing consequences of negative behaviors, anger and fights.
Drawing 2 of 6. Black pen on 8 ½ x 11 paper.



Figure 17 Session 6: Addressing consequences of negative behaviors, anger and fights.
Drawing 3 of 6. Black pen on 8 ½ x 11 paper.



Figure 18 Session 6: Addressing consequences of negative behaviors, anger and fights.
Drawing 4 of 6. Black pen on 8 ½ x 11 paper.

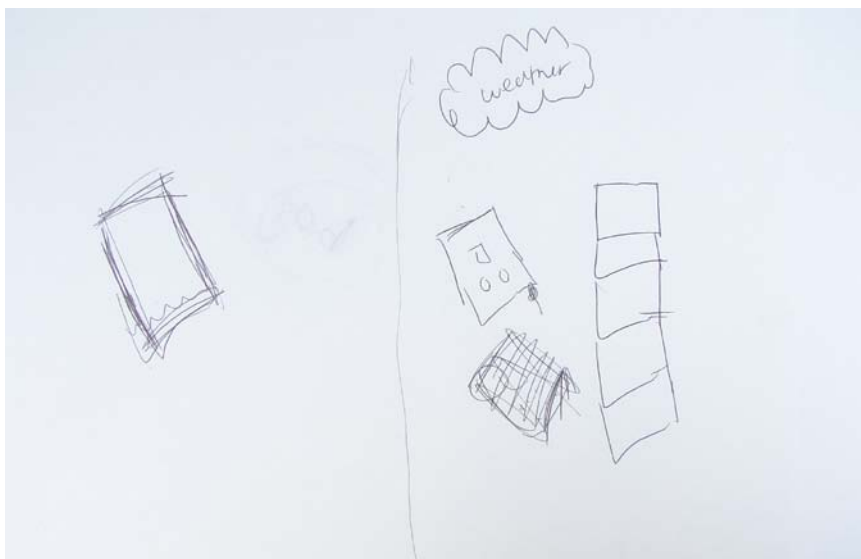


Figure 19 Session 6: Addressing consequences of negative behaviors, anger and fights. Drawing 5 of 6. Black pen on 8 ½ x 11 paper.



Figure 20 Session 6: Addressing consequences of negative behaviors, anger and fights. Drawing 6 of 6. Black crayon on 8 ½ x 11 paper. Chris drew himself and how others view him: as “the bottom of the barrel”.

Session 7:

Art Directive:

1. Created a symbol for themes: anger, jealousy, anxiety, feeling sad/depressed.
2. Created a timeline depicting reoccurring of themes.
3. Created a personal symbol for self.

Provided Art Materials: Markers, crayons, colored pencils, oil pastels, craypas, model magic, water color paint.

Process: As part of his last session and in reviewing themes that came up in prior sessions, Chris was asked to create a symbol for each of the following: anger, anxiety, feeling sad/depressed, jealousy. The rationale for creating these images and timeline was to discuss closure, themes and how they connect with each other.

Here, Chris used 12x18 white paper. For anxiety, he drew an hourglass saying that anxiety sometimes leads him to be angry. When he thought of his friends from home, he reported that they make him jealous sometimes and that is when he smokes cigarettes. In drawing sad/depressed, he drew a marijuana cigarette saying that when he is sad, depressed or happy, he smokes marijuana. He then erased the words for jealousy and sad/depressed and switched them so that depressed/sad was written over the image of the cigarettes and jealousy was written over the marijuana cigarette depiction saying “When I get jealous, I get high” and “I switch to cigarettes when I’m depressed.”

To depict anger, he drew prison bars reporting that he was angry when his friend (PFF) was put in jail and that it will be a “pit of danger” until he gets released. He also said that he currently does not have a “conscience” in regards to his actions or wanting to get into fights. Chris was then asked to draw a timeline and add events that he thought

were important to him (good or bad), to the timeline. Here, he used 8 ½ x 11 paper reporting the following:

From age 0 to 16, he added the following things:

- At age seven, he fell into a pool and almost drowned (but he did not remember this happening).
- At nine, he "accidentally" smoked weed because of his older brother. This was also the first time he was in handcuffs (he was at a park past curfew).
- At 12 he lost his virginity; he had his first drink of vodka (reporting that it was watered down).
- At 13, he said this was the first time he had been locked up/booked because of a fight that took place in New Jersey (at his old house); he also said that he rode a dirt bike for the first time; and he reported this was the age he started growing facial hair.
- At 14, he said he "just lived life when I was 14".
- At 15, he reported that this was his first time being drunk; this was also the age that he met his very good friends from home; between him and his best friend, he said that they made a special pact titled the "Block Star" which means "We are stars on the block; we shine in public in the suburbs; this was the beginning of a legacy." Later, he mentioned that he forgot to add his girlfriend at this age but then reported that he purposefully left her off of the timeline because he did not want to give her the respect of adding her in.

- At 16, Chris said this was the second time that his friend was locked up/booked/sent away and that Chris was "left alone"; that he was the "only Block Star".

On the timeline, Chris was asked to create a key for each element (anxiety, anger, sad/depressed, jealous) and to assign a color for each. Jealous (orange), Anger (gray), Anxiety (purple), Depression (Red). For jealousy, he jaggedly marked the timeline in between 0 and 7 saying that he "used to be a jealous bull" and in parts throughout his timeline, he put smaller dots in other areas on his timeline. For anger, he colored in places such as when he had his first shot of weak vodka, being locked up, when he began to grown facial hair, getting into a fight with his soon to be friends, and after 16 and off the timeline, he also added a gray marking but did not say why.

For anxiety, he added both small and medium size marks where he reported he was anxious when he lost his virginity, when he was locked up/booked for the first time, and when his friend was put in jail (both the first and the second time) reporting that all of these elicited anxiety because he did not know what to expect as outcomes. For Depressed, he only put red marks in two places (when he was locked up and after the timeline ended, the same as he did for "anger"). After marking the timeline, he said that the bigger the color mark, the bigger the emphasis was placed on that element/emotion.

Towards the end of the session, he was then asked to create a personal symbol that he thought was representative of himself. He appeared enthusiastic in these last minutes as he appeared to know exactly what he wanted to create. He said that he had already created a symbol: Brass Knuckles reporting that this is what his friends at home call him. He worked with yellow model magic saying that it was closest to gold using his

thumb to create impressions like a crown and then used his finger to poke holes. He said that when he gets this put into a tattoo, each knuckle mark will have the following words beneath it (from left to right):

- Determined (self-describing adjective)
- Block Star (he and his best friend's pact name)
- Goon (the rest of his friends at home)
- His mother's name

At the end of the session, he said he did not like how the brass knuckles came out. Provided with another pack of yellow model magic, he said he would work on it and bring it back for the next session. He was told that in the final session his artwork would be reviewed to determine any themes or common elements and that he would complete the same questionnaire as he did in the first session.

Analysis: Even though the direction included good or bad events to be included on his timeline, overall, Chris picked negatively perceived life events and milestones to depict. His erasing and reversing the order of sadness/depression and jealousy may have been seen as the defense mechanism of undoing. His images were concrete and his timeline was very personal to his own achievements and failures. By creating brass knuckles, this may have shown metaphorical anger in addition to violence, exposure to alcohol and drugs, feeling alone, isolated, and criminal involvement.

In reviewing his specific symbols, he drew an hourglass stating that anxiety sometimes leads to his anger. This provided insight into his behaviors and actions in that he is aware that his anxiety can lead to anger in a slowly accumulating way like sand in an hourglass. He also commented that when he is sad/depressed, he smokes cigarettes,

and when he is jealous, he smokes marijuana. This may have been seen as attempt to handle anxiety and to alter his current state of mood and affect, through an illegal substance.

Although he did not hesitate in creating his brass knuckles, he did comment that he was unsatisfied with how they turned out, suggesting his dissatisfaction with handling issues in this manner.

By not including his girlfriend on the timeline, he may have exhibited issues with trust or jealousy or a stunted ability to relate. Psychologically, Chris appeared to struggle with many of the themes that came up in this session as well as in prior sessions. Although he did not appear to have a difficult time expressing himself, he seemed to have a difficult time appropriately dealing with his emotions and this was seen in his negative acting-out behaviors and getting into fights.

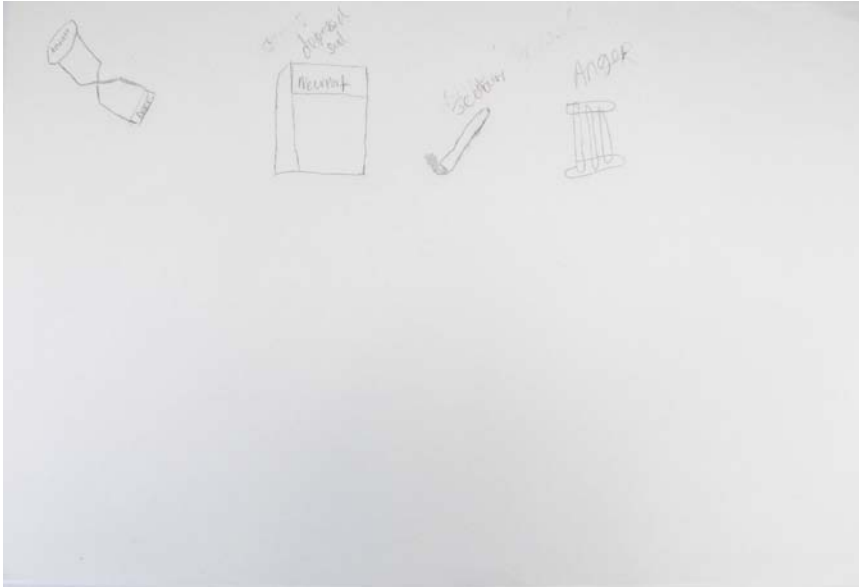


Figure 21 Session 7: Create a personal symbol for themes: anger, jealousy, anxiety, sad/depressed. Drawing 1 of 2. Black pencil on 12 x 18 paper.

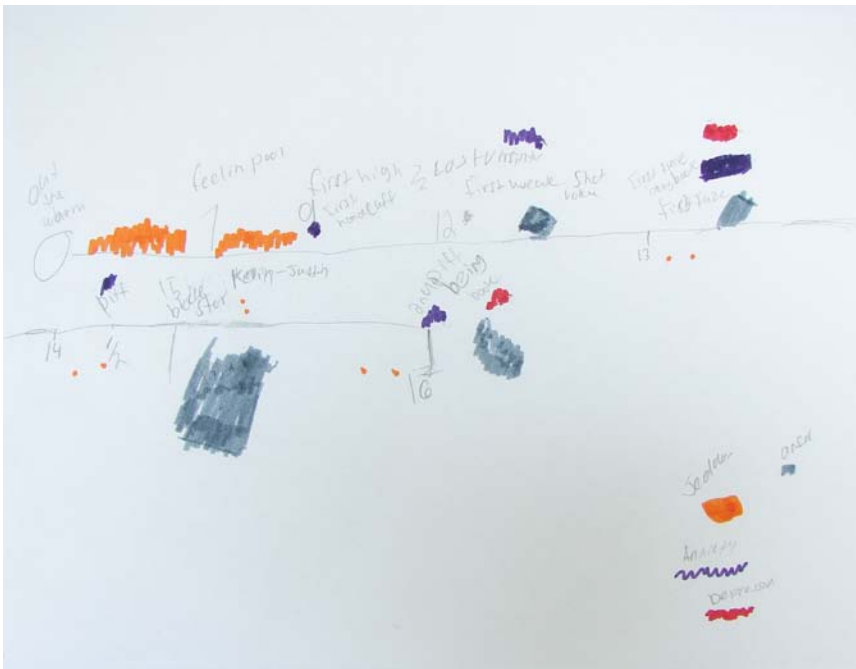


Figure 22 Session 7: Create timeline regarding created personal symbols; show anger, jealous, anxiety, sadness/depression. Drawing 2 of 2. Black pencil, orange thin tipped marker, gray thin tipped marker, purple thin tipped marker, red thin tipped marker on 8 ½ x 11 paper.



Figure 23 Session 7: Create a personal symbol. Yellow Model Magic. Chris created brass knuckles.

Session #8:

Art Directive: Reviewed artwork and themes throughout. Discussed termination.

Process: The Children's Depression Inventory was administered. Chris reported that he felt really good because he was successfully upsetting everyone in his classroom. In looking at the CDI, a majority of the answers were answered the same as on the first questionnaire but his *T*-scores were different.

From his initial CDI, there was an increase in his total CDI score from the previous completion of the scale as well as increases in interpersonal problems, ineffectiveness, and anhedonia (lack of pleasure or of the capacity to experience it). There were no changes to his negative mood or to negative self-esteem. In the first questionnaire, Chris' *T*-score was 44. According to the MHS Manual, a *T*-Score between 40-44 was considered "slightly below average" whereas in the second questionnaire, his *T*-score was 50, representing "average". The test-retest reliability indicated that because the CDI "measures a state, rather than a trait," it may have proven problematic in that a depressive syndrome was not expected to remain uniform or stable over a long period of time. This report indicated that because of this and because the questionnaire measures the level of functioning from the last two week period, the retest interval should have been short; approximately 2-4 weeks. Because Chris was not present at school or did not feel like participating each time, this study went into a 5th week.

Other factors to consider that may also have resulted in his score increase included his being in time-out or having a bad day, his break-up with his girlfriend, the school year ending, his hatred/boredom of school, his ruminations over his friend being taken to bootcamp for possession of drugs, or that he became more honest with himself,

with his responses and with the art therapist. Although there may have been several reasons for his increased *T*-score, there were no changes to his negative mood or to his negative self-esteem. Based on this, there were significant changes or increases in his emotional state from his responses given in the first questionnaire.

Review of the Artwork: After laying out his artwork from each session, many of the images were reviewed. He said he did not want his drawings displayed on the floor because it would be "messy". All of his drawings and artwork remained on a small round table where he looked at them individually. In looking at all of them, he was asked if he saw any themes. He said that he liked what he did in the last session (timeline) because the timeline reflected that "is my life" and it was "about my life". He also commented that his life was full of stress. When asked about this, he reported that he got stressed out from fake people, fake girls, coming to school, waiting to go home, friends and the people he intended to fight when he gets home.

Other themes he saw in his artwork included his friends and his relationships stating "I base my life on my closest friend. Whatever he does, I support him (his friend who was sent away for selling drugs/possession). I will never betray my friend. What's life without friends?" Other elements he noticed included the monochromatic use of color. He observed that he used a lot of black and stated that there was a lot of anger and violence in his artwork saying at first "I'm a bad person, I'm a dangerous person." He then picked up the model magic creation from the prior week (the brass knuckles) and pulled two small pieces off, breaking two of the connecting joints where one's fingers are intended to be placed. He then said that he thinks his ex-girlfriend is cheating on him and corrected the last comment to state that "she thinks I might be a bad person, I might be a

dangerous person." He said she was a liar and that he knew she was cheating on him but did not have any evidence to prove it.

When asked what he thought of being called "dangerous", he said that "it scares me" because it is "wild". As he began talking more about her, his voice became a bit louder and he said that it ticked him off that she called him that. He then broke the brass knuckles in half lengthwise. When this was brought to his attention (both the loudness in his voice and the fact that he broke his own artwork), he said "I've been clumsy all day, heavy handed. If I break these knuckles one more time, it'll have something to do with [her]. She put a hex on me." It was brought to his attention that people can be emotionally layered, that sometimes things that bother them come out in other ways (for example, the loudness in his voice when talking about his ex-girlfriend, and the fact that he broke his artwork).

In reviewing all of the things that had come up in the prior sessions including this one, and the fact that he had been in time-out that day, Chris was asked if he had anyone he could talk to on a regular basis or when he was feeling these emotions surfacing. He said that he did not. It was mentioned to him that it might be helpful to find someone he could talk to when he was feeling this way and he replied that, with the exclusion of the researcher, he could not "talk to anyone because everyone is fake". He said that he might want to talk to specific staff but said that they were extremely busy, and essentially he did not think that they have time for him.

Analysis: His self-observations included monochromatic use of color, depression and themes of anger. Additional observations and themes included horizontal use of image, isolation of affect, poor object relations, poor depiction of interpersonal relationships,

isolation of objects, missing body parts, centered and floating images. Themes in this final session included anxiety, stress, anger, violence, frustration, jealousy and friendship.

When Chris was asked if he wanted to display his images on the floor or on a small table, he chose the small table. This may be seen as respect for his created images and artwork or an attempt at containment. In reviewing his artwork and themes, he commented that he based his life upon his best friend. This may have been seen as a strong relationship or that he is overly dependent upon his friend. In this respect, while his friend is serving jail time for possession and intent to sell drugs, Chris may have been feeling isolative and lonely. In reviewing his artwork, most of his images neglected positive peer interactions and this may again have reflected his feelings of isolation and loneliness.

When he broke his brass knuckles by pulling it apart, this may have been seen as unconscious undoing as well as destroying his own artwork. This may also have been seen as negatively acting-out his frustration, anger and anxiety. It may also have been seen as an attempt to change the subject or avoidance. Prior to breaking up his artwork, he had observed anger and violence in his creations and said that he was a bad person. In breaking his own artwork, he may have been attempting to destroy the connection and trust built between him and the researcher, attempting to attain control over the situation.

In discussing his girlfriend and when he continued to break the brass knuckles, this may have been seen as more anger exertion and being upset at calling himself dangerous. Additionally, it appeared that he may have been trying to destroy the evidence of the conversation and of one of the themes that repeatedly resurfaced throughout these sessions: anger. When reviewing other key words such as “dangerous” and “wild”, this

may have been associated with his repeated theme of nature, which was also described as being unpredictable, wild and dangerous. This may have directly related to his unconscious negative acting-out behaviors, that his actions could be unpredictable or that he may have been perceived as wild and dangerous.

In looking at the therapeutic relationship, Chris had mentioned that, outside of the researcher, he did not want to talk to anyone because he felt they were fake. This may have revealed that a true therapeutic bond had been created between him and the researcher.

Further Treatment: For the purpose of closure, Chris was encouraged to talk to someone at his school, whether he thought they were fake or not. A meeting was set up with his school counselor, himself and the researcher to consider possibilities for communicating next year. This was encouraged because it might help him discuss issues and develop effective and appropriate coping skills/mechanisms. Because he had started treatment and started a therapeutic relationship, the researcher met with the school counselor and the participant. It was important that he continue therapy to ensure that participants who start treatment then have the opportunity to continue, rather than stop at the end of the study.



Figure 24 Session 8: Review of artwork. Yellow Model Magic. After discussing termination, treatment goals, and other topics that came up in this last session, Chris picked apart the brass knuckles (his personal symbol).

Subject 1: Analysis of Qualities of the Artwork

Table 5
Analysis of Qualities of the Artwork

Session #	Artwork	Use of Color and instrument present in the artwork	Line Quality	Use of Space	Themes present in the artwork and discussion	Analysis	Defense Mechanisms present in the artwork
2	Figure 2	Black pen	Light, sketchy	Image is centered/ Floating in space/no baseline or environment	Evidence of self- concept/Missing body parts: no arms, legs, ears.	Helplessness, separation from mind and body, poor grounding, denial, avoidance, lack of effort/motivation, familiarity, depression	Isolation of affect, denial, avoidance
2	Figure 3	Black pen	Darker use of pen than in first drawing	Image is centered/ Floating in space/no baseline or environment	Evidence of self- concept/Missing body parts: no arms, feet.	Helplessness, separation from mind and body, poor grounding, denial, avoidance, familiarity, depression	Isolation of affect
2	Figure 4	Black pen	Light	Image is centered/ Floating in space/no baseline or environment	Poor self concept/Missing body parts: no hands, feet, head is not proportionate to body	Helplessness, separation from mind and body, poor grounding, denial, avoidance, lack of effort/motivation, familiarity	Isolation of affect

Session #	Artwork	Use of Color and instrument present in the artwork	Line Quality	Use of Space	Themes present in the artwork and discussion	Analysis	Defense Mechanisms present in the artwork
2	Figure 5	Black pen	Light	Floating in space/Minimal/ Constricted to top left of the page/no baseline or environment	Figures are small/Importance of Family	Poor grounding, isolative figures, familiarity, lack of effort/motivation, depression	Isolation of affect
2	Figure 6	Black pen	Light	Image is centered/ Floating in space/no baseline or environment	Importance of Family/Structure	Poor grounding, familiarity, lack of effort/motivation, depression	Isolation of affect
2	Figure 7	Black pencil	Light	Floating in space/no baseline or environment	No figures or environment/friendship	Lack of positive peer relationships, familiarity, lack of effort/motivation, depression	Isolation of affect/ intellectualization
2	Figure 8	Black pencil, red pencil	Light/Heavy	Image is centered/ Floating in space/No baseline or environment	No figures or environment/friendship	Lack of positive peer relationships, increased investment in artwork	Isolation of affect

Session #	Artwork	Use of Color and instrument present in the artwork	Line Quality	Use of Space	Themes present in the artwork and discussion	Analysis	Defense Mechanisms present in the artwork
3	Figure 9	Black pencil	Light	Image is centered/ Floating in space/No baseline or environment	Lack of interpersonal relationships	Poor grounding, familiarity, lack of effort/motivation, depression	Isolation of affect
3	Figure 10	Black pencil	Shading	Floating in space/no baseline or environment	Lack of interpersonal relationships	Poor coping skills for anxiety, anger and frustration, increased investment/attention to details	Isolation of affect
4	Figure 11	Black thin tipped marker	Heavy	Floating in space, Constricted to top of the page/ no baseline or environment	Anger, frustration	Poor coping skills for anxiety, anger, frustration/poor peer relations, increased anger	Isolation of affect
4	Figure 12	Black thin tipped marker	Heavy	Floating in space, Constricted to top of the page/ no baseline or environment	Anger, frustration, violence	Poor coping skills for anxiety, anger, frustration/poor peer relations, increased anger	Isolation of affect/ Intellectualization/ Undoing

Session #	Artwork	Use of Color and instrument present in the artwork	Line Quality	Use of Space	Themes present in the artwork and discussion	Analysis	Defense Mechanisms present in the artwork
4	Figure 13	Black thin tipped marker	Heavy	Full use of space/no baseline or environment	Anger, frustration, jealousy	Poor coping skills for anxiety, anger, frustration/poor peer relations, increased anger	Isolation of affect/intellectualization
5	Figure 14	Black pen, red colored pencil, blue colored pencil	Combination of light, shading, perseveration	Full use of space/no baseline or environment	Friendship, violence, anger, ambivalence/nature theme	Polarities, ambivalence, difficulty making decisions, violent behavior, depression	Isolation of affect
6	Figure 15	Black pen	Perseveration	Image is centered/no baseline or environment	N/A	Respect for researcher, being able to follow rules	Isolation of affect/ regression/ undoing/ avoidance
6	Figure 16	Black pen	Perseveration	Image is constricted to top left of page/ no baseline or environment	N/A	Respect for researcher, being able to follow rules	Isolation of affect/ regression/ undoing

Session #	Artwork	Use of Color and instrument present in the artwork	Line Quality	Use of Space	Themes present in the artwork and discussion	Analysis	Defense Mechanisms present in the artwork
6	Figure 17	Black pen	Heavy/ Perseveration	Image is constricted to top left of page/ no baseline or environment	Frustration	Embarrassment, respect for researcher, familiarity	Isolation of affect/undoing/regression
6	Figure 18	Black pen	Light/Heavy/Perseveration	Image is centered/no baseline or environment	Boredom	Desire to change the subject, avoid the discussion, familiarity, depression	Isolation of affect/avoidance/regression
6	Figure 19	Black pen	Perseveration	Heavy/ Perseveration/ no baseline or environment	Poor sense of self, self-esteem, self-concept/isolation, ambivalence	Poor self-esteem, poor self-concept, exemplified inadequacies, familiarity, depression	Isolation of affect/undoing/regression
6	Figure 20	Black crayon	Heavy	Image is centered/no baseline or environment	Poor sense of self, isolation	Poor self-esteem, poor self-concept, inadequacies, depression	Isolation of affect/ intellectualization
7	Figure 21	Black pencil	Light	Images are constricted to the top portion of the page/no baseline or environment	Depiction of concrete images	Anger, jealousy, sadness/ depression, anxiety, poor coping skills	Isolation of affect/ intellectualization/undoing

Session #	Artwork	Use of Color and instrument present in the artwork	Line Quality	Use of Space	Themes present in the artwork and discussion	Analysis	Defense Mechanisms present in the artwork
7	Figure 22	Black pencil, orange thin tipped marker, gray thin tipped marker, purple thin tipped marker, red thin tipped marker	Light, shading	Full use of space	Anger, frustration, jealousy, sadness/ depression/ friendship/ anxiety	Poor self-esteem, poor self-concept, negatively perceived achievements, depression	Isolation of affect/ intellectualization
7	Figure 23	Yellow Model Magic	N/A	N/A	Anger, violence	Desire to be violent	Isolation of affect
8	Figure 24	Yellow Model Magic	N/A	N/A	Anger, violence	Acting out on his anger and frustration	Isolation of affect

CHAPTER V: DISCUSSION

The purpose of this study was to examine the impact of art therapy intervention with three to five participants depressed with a depressive diagnosis such as Major Depression, Bipolar I Disorder or Dysthymic Disorder. Due to recruitment issues, only one subject participated. Even though recruitment packets were mailed to potential participants, recruitment issues included lack of subject participation from more than one candidate, difficulty in getting legal guardians on the phone, potential lack of trust from legal guardians and potential misgivings from the legal guardians in regards to mental health services. Legal guardian misgivings or lack of trust in mental health services may have also been viewed as exploitation of their child. With all of these compounding reasons, there was a lack of engagement, participation and recruitment in this study. Due to school time limitations, sessions took place twice a week. The results of this study indicate that eight sessions of individualized art therapy did have an effect on the participating subject. In reviewing the scores from the pre and post-test Children's Depression Inventory, the subject's results increased reflecting a higher depressive symptomatology at the end of the study than the score at the beginning. Possible reasons for this result will be presented and discussed in this chapter. Additionally, major findings, themes, literature comparison, questions, implications for the clinical field, transference, countertransference, delimitations, limitations and suggestions for future research will be reviewed.

Subject 1: Major Findings and Themes

A major finding of this study was the subject's pre and post-test measure and increase in *T*-Score from the first session to the eighth. Throughout the eight art therapy

sessions, Chris revealed several strengths. In his verbal discussions, he was expressive, insight-oriented, and reflective of his own depressive qualities revealed in his artwork. In looking at object relations, he talked positively about his relationship with his mother and his strong relationship with his imprisoned friend. Other strengths included his resiliency in openly discussing his traumatic life events and high risk factors of inner city life, including exposure to drugs, alcohol, violence and criminal behaviors. An additional strength also included his dual identity and his ability to maintain these two separate identities. African-American males living in an urban environment often have to maintain two personas: the one that is practical, works and is part of the culture in an inner city, and the other one that exists in other environments. Therefore, maintaining this dual identity reveals a major strength.

In reviewing his artwork and related comments, several elements throughout the eight sessions revealed poor peer relations or lack of peer relations, isolation, low self-esteem, poor self-concept, depression, anxiety, frustration, anger, and violence. At the time of the study, Chris was not involved in any other psycho-therapeutic treatment. Similar to his feelings related to his fellow classmates, he stated that he felt all of the psychiatrists, psychologists and therapists he had met prior to this study, were fake. At the concluding sessions, he stated that he did not feel the researcher was fake.

Artwork

In reviewing Chris' artwork, both strengths and deficits were revealed. Themes of strength were seen throughout his artwork and included centered images, possibly reflecting a strong ego and a sense of identity. Other themes of strength included an ability to express himself through the artwork and his discussions as well as the ability to

be insight-oriented, reality-based and lacking psychosis. Despite these strengths, many other elements seen in the artwork reflected depressive qualities and depressive symptomatology. In specifically reviewing the Six Part Assessment, all of his images neglected to include a baseline or environment and his figures appear to be floating on the page. This may represent poor grounding, understanding of his environment, reality-testing, poor peer relations, as well as poor understanding of his impact on others. In addition, it also reflects an aspect of the pre-schematic which may be seen as regression.

In a majority of his drawings, monochromatic use of the color black was used, and this may indicate depressive symptomatology. With the exception of his Kinetic Family Drawing, there are no human interactions or implied interactions. Despite the fact that he depicted himself, his first three drawings showed missing major body parts such as torso, arms, hands or feet. This often reflects denial, avoidance, feeling stuck or ungrounded. In his first free drawing and third drawing (draw the opposite), there also appears to be a separation between mind and body. In the first drawing, he neglected to include a body and the drawing reveals just a floating head. In the third drawing, the head is disproportionate to the rest of the body. This may reflect that he has a difficult time controlling his emotions and acting-out behaviors as there appears to be a separation from head and body. This may be seen as a disconnection between his affect and his actions. Together, there appears to be a disconnection between conscious thought and bodily actions or acting-out behavior.

In later artwork and individual sessions, he compared himself and his actions to that of a lightning bolt stating that lightning is “fierce” and “unpredictable”. Here, the

theme of polarities and ambivalence arises and this may also directly pertain to his own ambivalence and poor self-concept and poor decision-making.

Defense Mechanisms

His major defense mechanisms included secondary defense processes that are considered higher order. They included isolation (isolation of affect seen in the monochromatic use of color), intellectualization (use of words, repeated imagery) and undoing (erasing of images or words, throwing artwork away, destroying artwork). In looking at isolation and dealing with anxiety, Chris unconsciously isolated his feelings from knowing. This can be seen in his separation from body and mind in the first three drawings of the Six Part Assessment. In reviewing intellectualization, Chris may have unconsciously isolated his affect from his intellect by creating a distance between his emotions and his artwork. This was seen in looking at his anger comic strip escalation and de-escalation where he wrote words. Undoing was seen in his artwork, actions and in his comments. Not only did he discard some of his artwork, he also attempted to counterbalance his affect with his exterior attitude and behaviors. This was seen in his comments pertaining to his classmates where he said he hated fake people but sought their attention through making annoying noises so that they would constantly be forced to think of him. These may be seen as attention-seeking behavior and the desire to belong. Both of these are considered relevant issues when evaluating adolescent behaviors.

Emotions

During the course of this study, Chris openly discussed his anger, violent tendencies, anxiety and frustration. Over the course of these sessions, he was honest in his responses and appeared to appreciate the one-to-one individual time stating that he

liked being out of class at this time and as evidenced in his insightful comments and his expressiveness in his artwork. He never hesitated or faltered in the discussion of his feelings, acting-out behaviors or themes present in his artwork and discussion.

Therapeutic Relationship

Through the creative process, Chris became more comfortable in the therapeutic relationship and was more able to discuss his day-to-day emotions. As the sessions progressed, this became evident with his honest responses and his ability to reflect on his own artwork. As seen in his art creations, he was able to address these themes and present them as tangible goals he could work on. These included working with the themes that arose out of several sessions: jealousy, anger, frustration and anxiety. This became evident in the seventh session where he created a timeline of his life to date and was able to identify reoccurring themes of anger, anxiety, sadness/depression. By doing this, he was able to look back and view these themes, how they had affected his life and also how to work through them in the future.

By the end of the eighth session, Chris's review of the artwork revealed the importance of therapy and having someone he could talk to in confidence. This became evident through his openness and candor in revealing personal information in his timeline about his personal milestones (losing his virginity, his first alcoholic drink, getting into trouble with the law). Because this therapeutic door was opened to him, he became more honest in his responses, with himself and with the researcher. It appeared that, in this short amount of time, he built a trusting relationship with the researcher and a bond was created. This is reflected in his increased *T*-Score as seen in the post-test Children's Depression Inventory self-report questionnaire. As part of termination of the individual

sessions and therapeutic relationship, his reaction may have also increased his level of anxiety and depression, thus also elevating his *T*-Score, suggesting less suppression and more expression in dealing with the material.

Comparison of Literature with the Subject

The participant in this research study was in the early adolescent stage of development. Developmentally, by age 16, he was in the normal process of trying to achieve many of the aspects characteristic of adolescence: cognitive and motor development; growing emotional changes; social role; self-identity; issues with authority figures; working through natural stress and life demands (Rutter, Izard and Read, 1987). One aspect that is crucial in this stage of development is emotion regulation and it does not appear that Chris is willing to fully deal with his feelings and issues. Shafii and Shafii (1992) report that normal adolescence typically involves some type of depression and depressive affect but that this is not wholly representative of all children and adolescents. Rosal et al. (1997) indicate that art therapy may be an effective and creative technique in working with adolescence as it has potential expression of thoughts and feelings to improve several day-to-day factors. Through art therapy, defense mechanisms may also be seen concretely. Burns and Kaufman (1970) indicate that isolation or isolative depictions in the Kinetic-Family-Drawing may indicate significant depressive tendencies and impulsive and negative acting-out behaviors may reflect regression.

Hiscox and Calisch (1998) suggest that art therapy may benefit African-Americans who may be struggling with life's demands, racism, and socioeconomic deprivation. Additionally, Wadeson (2000) posits that many depressed adolescents negatively act-out through depression, hostility, rage, violence, impulsivity and through

aggression because they typically have a difficult time expressing themselves. In working with art therapy and the creative process, Chris' openness and honesty are believed to be an important first step in achieving this emotion regulation.

The themes outlined by Wadeson (2000) and Malchiodi (2007), including hostility, violence, impulsivity, aggression and unconsciously working through feelings, thoughts and life experiences, were all witnessed in Chris' artwork. Rubin (2005) indicates that art therapy provides a means for adolescents to express themselves in an ego-supportive and trusting environment.

In reviewing depression with African-American male adolescents, Parham and McDavis (1987) report that there is a higher risk of death for men due to violence, unemployment and inadequate healthcare. The authors reveal that the rate of suicide within this population is increasing. Even though there is an increase in violence and suicide, Grant and Potenza (2007) and Davis and Stevenson (2006) indicate that African-American male adolescents are reportedly unlikely to use mental health services. Kaye and Lingiah (2000) state that this may be due to over diagnosis, under diagnosis or misdiagnosis of depression with ethnic minorities. Because of the similar characteristics between Major Depression, Bipolar I Disorder, Dysthymic Disorder with that of Conduct Disorder and ADHD, misdiagnosis may increase lack of trust with mental health professionals. Additionally, in seeking help for their child, the possible stigma associated with the permanent recording of Major Depression, Bipolar I Disorder or Dysthymic Disorder may also decrease visits to mental health professionals.

Questions that Surfaced

During this eight-session research study, several questions arose. First, how did the length of treatment affect the participant? Will there be long-lasting benefits for this subject? The researcher believes that over the course of therapy and through art therapy directives, eight sessions provided some time to get to know and build rapport with the client but it was a series of brief encounters that seemed to merely scratch the surface with the client. Further research is needed to test the longer outcome effects of more sessions.

Did the researcher's gender affect the client-therapist relationship? The researcher believes that this bond may have been easier to create due to the participant's strong relationship with another female figure: his mother.

Did the race of the researcher impact the therapeutic relationship between the client and researcher? Towards the end of the session, the client reported that the researcher was the only one at the Approved Private School who was not fake, thus revealing acceptance, possibly obviating racial or gender issues.

Implications for Clients and for the Field of Art Therapy

The implications of this research study indicate that art therapy may be an effective form of therapy and intervention with African-American male adolescents assessed with a depressive diagnosis. It is apparent though, that larger sample groups would aid in further exploring this topic. Additionally, more sessions may also prove beneficial in outcome results because it may provide longer lasting positive results as well as more foundational therapeutic relationships. In the eighth session, the Children's Depression Inventory *T*-score rose suggesting that many feelings and emotions were no

longer suppressed but brought into consciousness where they can be appropriately regulated and dealt with. Art therapy may provide adolescents in this specific population a means to better express themselves and to work with effective coping mechanisms. Art therapy may prove beneficial in helping adolescents work with and better understand the fluctuation of their emotions.

Clinical Implications

In reviewing inadequate healthcare, low socioeconomic status, over-diagnosis, under-diagnosis or misdiagnosis of depression in African-American males, developing a safe environment for adolescents to explore their feelings and emotion may help create a strong rapport and therapeutic relationship with clients. Compounded with racism, gang involvement or poor academics, art therapy may provide a safe place for nonverbal and verbal communication, and interactions to exist. Through creating a therapeutic environment and in using these techniques, adolescents may better understand their life issues, aid in emotion regulation, and in developing effective coping strategies.

In reviewing the pre and post-test *T*-scores of the Children's Depression Inventory, it is important to note that both scores are not considered clinically significant and overall do not reflect depressive symptomatology. Additionally, it is relevant to mention that, between the pre and post-test measure, there was only an increase of six points in Chris' total score. While both are still under the depressive threshold, this increase may not be significant but may reflect an anomaly whereas if he had taken the post-test measure a week later, his results may have varied in the other direction. Despite his *T*-score increase and lack of overall recorded depressive symptomatology, contradictions between the Children's Depression Inventory and his artwork exist,

revealing depressive qualities, affect and symptomatology in his artwork. This is relevant in this study because the artwork may reflect conscious and unconscious elements while the Children's Depression Inventory suggests more conscious thoughts. Because of this emphasis, it is important to look at more than one measure of a potentially depressed adolescent. In a larger societal context, it is also important to consider misdiagnosis or over diagnosis of Conduct Disorder and ADHD when working with patients who may actually suffer from Major Depression, Bipolar I Disorder or Dysthymic Disorder.

In looking at both art therapy assessment and the use of the Children's Depression Inventory, it is apparent they have potential to provide a better understanding of the adolescent and their depressive symptomatology. In using the Children's Depression Inventory, it is suggestive that the increase in *T*-Scores was due to the participant's increased consciousness and honesty with himself and with the researcher. It is also possible that his small increase may have been attributed to chance. The art assessment provided a more complete depiction of what the adolescent was experiencing, his emotions and his depressive state. In working with depressed adolescents, administering both the Children's Depression Inventory and the Six Part Assessment may provide a more thorough portrait of the client and may help clinicians determine initial therapeutic goals and treatment plans.

Transference/Countertransference

Clinicians working with depressed adolescents should be aware that depression may exist in a variety of forms and behaviors. Typical depression may include isolation or depressed affect. In adolescence, it may be seen in hostility, violence or acting-out behaviors. In this respect, it is also important to review differential diagnoses such as

Conduct Disorder and Attention Deficit Hyperactive Disorder to increase understanding and view any overlap of symptoms and behaviors. In this respect, reviewing his comments, artwork and Children's Depression Inventory became helpful to better understand his personality, his persona and the reasons behind his behaviors.

In looking at transference and the relationship between Chris and the researcher, the increase in his expressivity and insight may have been a reflection of the positive relationship between him and his mother. He may have viewed the researcher as someone he could easily talk to and build a rapport with, therefore emulating or re-enacting the mother-child relationship in these therapeutic sessions. When looking at termination of this relationship, Chris may have unconsciously recognized the disbanding of the mother-child re-enactment in therapy and his reaction may have resulted in his breaking apart of his own artwork. This act of destroying his own artwork may also have been seen as his no longer wanting to be so aggressive or as an unconscious change in attitude about aggression.

It was evident that, after only a few sessions, Chris had many things to work on. These included anger, violence, frustration, anxiety and depression. In regards to countertransference, it was difficult to terminate the relationship after only eight sessions because these elements were just being uncovered and discussed. From a therapeutic standpoint, it appeared that eight sessions was not sufficient to discuss these personal topics and then reinforce termination.

Delimitations and Limitations

Delimitations of this study included the small number of participants and the low number of art therapy sessions. This research was intended to look at art therapy

intervention with African-American male adolescents assessed with a depressive diagnosis. There were only eight sessions and this small number may have affected the therapeutic relationship or the creative process.

Limitations of this study included a participant who was diagnosed with both Bipolar I Disorder and ADHD. Additionally, this participant was on a prescribed medication for his ADHD and it is not clear if this impacted his emotion regulation or acting-out behaviors.

Suggestions for Further Research

- In conjunction with art therapy, research comparing the Children's Depression Inventory self-report questionnaire with the Children's Depression Inventory Parent and Teacher versions
- Comparing the effect of art therapy with other depressed ethnic minorities
- Comparing the intervention with adolescent females
- Examining the impact of art therapy with depressed youth and their depressed parents; family sessions
- Research with increased number of sessions

CHAPTER VI: SUMMARY AND CONCLUSIONS

This study examined the impact of an art therapy intervention with one African-American male adolescent assessed with Bipolar I Disorder. The design of this study was a qualitative single-subject case study in conjunction with ABA format in administering the Children's Depression Inventory. In this respect, the participant received a pre and post-test questionnaire during weeks one and eight. Weeks two through seven included individualized art therapy interventions and directives that were goal-oriented, focused on the needs of the client, and themes that arose in the sessions.

The results of the pre and post-test measure were recorded, the individual art therapy session notes were presented, and the artwork created during these sessions were analyzed for changes in depressive affect through examining use of color, themes, defense mechanisms, composition of the artwork and statements made by the participant about his artwork. Other goals and expressions were also observed, analyzed and interpreted in understanding the participant.

Although his depressive *T*-Score symptomatology increased in the post-test, he appeared to nonetheless benefit from the individual time and attention. This was seen in the decrease in suppression and the increase in expression of the material, and having a more positive rapport with the researcher. Although he had a difficult time making friends in school and evidenced lower academic performance, his verbal and nonverbal abilities increased through the art therapy sessions. Because of these elements and to ensure therapeutic transition, the participant was encouraged to discuss such issues with the school counselor. The results of this study indicate that art therapy had some positive effects on identifying negative behaviors, developing effective coping mechanisms, and

establishing a therapeutic relationship. Benefits may increase with larger sample sizes or increased number of sessions. It is suggested that art therapy may prove to be a helpful treatment for this population.

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Appendix A



Wordsworth

April 2, 2009

Dr. Betty Hartzell, PhD., ATR-BC, LPC
Assistant Professor
Assistant Director of Art Therapy Education
Hahnemann Creative Arts in Therapy Program
At Drexel University
1505 Race Street, 10th Floor
Room 1047
Mail Stop 905
Philadelphia, PA 19102-1192

Dear Dr. Hartzell:

This letter is to confirm that Deborah Larkin can conduct her research at Wordsworth Academy, Fort Washington. Based on the Approved Private School referrals, packets will be sent home to eligible participants. The packets will include a letter from Dr. Hartzell and Deborah Larkin.

The packets will also contain an outline of the art therapy study, the terms of the criteria, and the consent form for participating children.

Sincerely,

A handwritten signature in cursive script, appearing to read "JoAnn Pierie".

JoAnn Pierie
Vice President of Schools
Fort Washington Campus

Appendix B



Drexel University Recruiting Volunteers for a Research Study

An Art Therapy Intervention with African-American Male Adolescents Assessed with a Depressive Diagnosis

Research Objectives

The purpose of this research is to look at the effect of eight sessions of individual art therapy with African-American male adolescents assessed with a depressive diagnosis (Major Depression, Dysthymia, or Bipolar I) from an urban or suburban environment who currently attend an Approved Private School. All participants will be given the Children's Depression Inventory and then receive 8 sessions of individual art therapy. At the end of the 8 session study, participants will again be given the Children's Depression Inventory.

Information for Research Subjects Eligibility

You or your child can participate in this study if you currently attend an Approved Private School in suburban Philadelphia, you are a male between the ages of 12 and 18 and of African-American descent and are diagnosed with Depression, Dysthymic Disorder or Bipolar I Disorder.

Remuneration

All participants who complete the 8 session study will receive a \$25.00 gift card to Target.

Location of the research and person to contact for further information

This research is approved by the Institutional review board.

If you are interested in participating in this study, please contact

Deborah Larkin
(215) 206-5403

This research is conducted by a researcher who is a member of Drexel University.

Appendix C

Drexel University Consent to Take Part In a Research Study

1. Subject Name: _____
2. Title of Research: **An Art Therapy Intervention with African-American Male Adolescents Assessed with a Depressive Diagnosis**
3. Principal Investigator's Name: **Dr. Elizabeth Hartzell, Ph.D.**

Co-Investigator's Name: **Deborah A. Larkin**

4. Research Entity: **Drexel University**

5. Consenting for the Research Study:

This is a long and an important document. If you sign it, you will be authorizing Drexel University and its researchers to perform research studies on you. You should take your time and carefully read it. You can also take a copy of this consent form to discuss it with your family member, attorney or any one else you would like before you sign it. Do not sign it unless you are comfortable in participating in this study.

6. Purpose of Research:

You/your child are being asked to participate in a research study. The purpose of this research study is to explore, understand and record potential changes in levels of depression of African-American adolescent males who experience art therapy as an intervention. Over eight individual sessions, this case research study intends to review the impact of art therapy as an intervention with African-American male adolescents who are evaluated with depressive diagnoses. As young men in this population continue to grow physically, emotionally and cognitively, some of them may reflect a higher tendency to exhibit significant fluctuations in mood swings than younger children or adults. As this constant shift in emotions continues, verbal communication may be difficult. Therefore, symbolic speech and the use of art therapy, may prove beneficial to this population.

The participants recruited for this study are students of a designated Approved Private School in suburban Philadelphia region. In this study, research there will be up to five participants accepted. The participants will be African-American males between the ages of 12 through 18 years old and diagnosed with Major Depression, Dysthymia or Bipolar I Disorder.

7. PROCEDURES AND DURATION:

You understand that the following things will be done to you.

Data Collection Session One- Session will be approximately 45-60 minutes in duration. Adolescents will complete the Children's Depression Inventory. If questions are not

understood or need to be read out loud for further explanation, the co-investigator will do so. Once completed, a five-minute break will be allotted. Adolescents will also receive individual art therapy immediately following completion of the Children's Depression Inventory.

Data Collection Session Two through Seven– Sessions will be approximately 45-60 minutes. Clients receive art therapy individualized to their treatment goals and needs. These will vary based on their individual therapy goals, behaviors and attention span.

Data Collection Session Eight- Session will be approximately 45-60 minutes. Clients will again complete the Children's Depression Inventory and final art therapy session.

Total approximate hours for this eight-session study is eight hours. In each session, the participant will make art and process the associations and meaning.

Additional collected data includes the participant's artwork and this researcher's therapy notes from each session.

8. RISKS AND DISCOMFORTS/CONSTRAINTS:

There are minimal risks involved in this study. You may notice some minor anxiety when disclosing personal information during the art process and interview. If you start to feel uncomfortable, please inform the researcher immediately to take a break, find staff. You may discontinue your participation from the study at anytime.

9. UNFORESEEN RISKS:

In addition to anticipated/expected risks, certain studies may involve unforeseen reactions, hazards, discomforts, and inconveniences affecting the quality of life including life threatening events or death associated with the use of drug/device/procedure. Participation in this study may involve unforeseen risks. If unforeseen risks are seen, they will be reported to the Office of Regulatory Research Compliance at 215-255-7857.

10. BENEFITS:

There may be no direct benefits from participating in this study. African-American male adolescents assessed with a depressive diagnosis may benefit from the expression aspect of art therapy. Traditional verbal therapy has not consistently been effective therefore art therapy may also provide a good alternative to this population.

This study will provide insight to the therapeutic community of doctors, therapists, art therapists, social workers and other mental health workers, in that it may directly impact their clients or future clients. By understanding the impact of art therapy as an intervention with depressed adolescent African-American males, mental health workers or primary care physicians may view art therapy as another type of intervention that may help with this population.

11. ALTERNATIVE PROCEDURES:

The alternative is not to participate in this study.

12. **REASONS FOR REMOVAL FROM STUDY:**

You may be required to stop the study before the end for any of the following reasons:

- a) **If all or part of the study is discontinued for any reason by the investigator, or university authorities.**
- b) **If you are a student, and participation in the study is adversely affecting your academic performance.**
- c) **If you fail to adhere to requirements for participation established by the researcher.**

13. **VOLUNTARY PARTICIPATION:**

Volunteers: Participation in this study is voluntary, and you can refuse to be in the study or stop at any time. There will be no negative consequences if you decide not to participate or to stop.

14. **STIPEND/REIMBURSEMENT:**

If eligible participants complete the 8 week study, they will receive a \$25.00 gift card to Target.

15. **RESPONSIBILITY FOR COST**

The researcher will be responsible for any costs relating to this study.

16. **IN CASE OF INJURY:**

If you have any questions or believe you have been injured in any way by being in this research study, you should contact Dr. Elizabeth Hartzell, Ph.D., ATR-BC, LPC, Assistant Director, Graduate Art Therapy Program, at telephone number (215) 762-3767. However, neither the investigator nor Drexel University will make payment for injury, illness, or other loss resulting from your being in this research project. If you are injured by this research activity, medical care including hospitalization is available, but may result in costs to you or your insurance company because the University does not agree to pay for such costs. If you are injured or have an adverse reaction, you should also contact the Office of Regulatory Research Compliance at 215-255-7857.

17. **CONFIDENTIALITY:**

In any publication or presentation of research results, your identity will be kept confidential, but there is a possibility that records which identify you may be inspected by authorized individuals such as representatives of the institutional review boards (IRBs) or employees conducting peer review activities. You consent to such inspections and to the copying of excerpts of your records, if required by any of these representatives. At the end of the study, the artwork will be returned to participants. Any unwanted artwork will be destroyed along with all of the notes and inventories. The consents and assents will be kept in a locked cabinet in the Creative Arts in Therapy offices for 7 years after the minor turns 18.

18. OTHER CONSIDERATIONS:

If you wish further information regarding your rights as a research subject or if you have problems with a research-related injury, for medical problems please contact the Institution's Office of Regulatory Research Compliance by telephoning 215-255-7857.

19. CONSENT:

- I have been informed of the reasons for this study.
- I have had the study explained to me.
- I have had all of my questions answered.
- I have carefully read this consent* form, have initialed each page, and have received a signed copy.
- I give consent/*permission* voluntarily. 1/28/2009

 Subject or Legally Authorized Representative Date

 Investigator or Individual Obtaining this Consent/*Permission* Date

 Witness to Signature Date

List of Individuals Authorized to Obtain Consent/*Permission*

<u>Name</u>	<u>Title</u>	<u>Day Phone #</u>	<u>24 Hr Phone #</u>
Dr. Elizabeth Hartzell, Ph.D.	Principal Investigator	(215) 762-3767	(215) 762-3767
Deborah A. Larkin, BA	Co-Investigator	(215) 206-5403	(215) 206-5403

Appendix D

Subjects Initials: _____
Page 1 of 1

Drexel University ASSENT FORM FOR CHILDREN IN A RESEARCH STUDY

The purpose of this study is to look at how eight sessions of individual art therapy with African-American male adolescents who have some kind of depressive diagnosis (Major Depression, Dysthymia or Bipolar I) from an urban or suburban area who currently attend the chosen Approved Private School.

You are being asked to participate in a study. The study will be eight weeks/sessions long. In the first week/session, you will receive questionnaire to fill out. From weeks/sessions two through seven, you will be involved with art therapy sessions. The art therapy sessions will be approximately 45-60 minutes each and will address your therapy goals. During the last week/session, you will complete the same questionnaire as the first week/session.

The only people who will know you are participating in this study will be your parent/legal guardian and the staff at Wordsworth. If we find out someone has hurt you or that you plan to harm yourself, we must report this to the proper people, but not the person who hurt you.

Child's Assent: I have been told about the study and know why it is being done and what to do. I also know that I do not have to do it if I do not want to. If I have questions, I can ask Ms. Deborah. I can stop at any time.

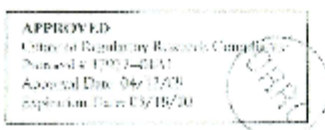
My parents/guardians know that I am being asked to be in this study.

Child's Signature _____

Date _____

List of Individuals Authorized to Obtain Assent

Name	Title	Day Phone #	24 Hr. Phone #
Dr. Elizabeth Hartzell PH.D.	Principal Investigator	(215) 762-3767	(215) 762-3767
Deborah A. Larkin, BA	Co-Investigator	(215) -206-5403	(215) 206-5403



Version 1.2

Appendix E

Client ID: _____		by Maria Kovacs, Ph.D.
Age: _____ Birthdate: _____ mm/dd/yyyy		
Grade: _____ Gender: Male Female		
Today's date: _____ mm/dd/yyyy		

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group of three sentences, pick one sentence that describes you *best* for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example of how this form works. Try it. Put a mark next to the sentence that describes you *best*.

Example:

- I read books all the time.

I read books once in a while.

I never read books.

Remember, pick out the sentences that describe you best in the PAST TWO WEEKS.

<p>Item 1</p> <p><input type="checkbox"/> I am sad once in a while.</p> <p><input type="checkbox"/> I am sad many times.</p> <p><input type="checkbox"/> I am sad all the time.</p>	<p>Item 6</p> <p><input type="checkbox"/> I think about bad things happening to me once in a while.</p> <p><input type="checkbox"/> I worry that bad things will happen to me.</p> <p><input type="checkbox"/> I am sure that terrible things will happen to me.</p>
<p>Item 2</p> <p><input type="checkbox"/> Nothing will ever work out for me.</p> <p><input type="checkbox"/> I am not sure if things will work out for me.</p> <p><input type="checkbox"/> Things will work out for me O.K.</p>	<p>Item 7</p> <p><input type="checkbox"/> I hate myself.</p> <p><input type="checkbox"/> I do not like myself.</p> <p><input type="checkbox"/> I like myself.</p>
<p>Item 3</p> <p><input type="checkbox"/> I do most things O.K.</p> <p><input type="checkbox"/> I do many things wrong.</p> <p><input type="checkbox"/> I do everything wrong.</p>	<p>Item 8</p> <p><input type="checkbox"/> All bad things are my fault.</p> <p><input type="checkbox"/> Many bad things are my fault.</p> <p><input type="checkbox"/> Bad things are not usually my fault.</p>
<p>Item 4</p> <p><input type="checkbox"/> I have fun in many things.</p> <p><input type="checkbox"/> I have fun in some things.</p> <p><input type="checkbox"/> Nothing is fun at all.</p>	<p>Item 9</p> <p><input type="checkbox"/> I do not think about killing myself.</p> <p><input type="checkbox"/> I think about killing myself but I would not do it.</p> <p><input type="checkbox"/> I want to kill myself.</p>
<p>Item 5</p> <p><input type="checkbox"/> I am bad all the time.</p> <p><input type="checkbox"/> I am bad many times.</p> <p><input type="checkbox"/> I am bad once in a while.</p>	

Turn over and fill out the other side.

Remember, pick out the sentences that describe you best in the past two weeks.

Item 10

- I feel like crying every day.
- I feel like crying many days.
- I feel like crying once in a while.

Item 11

- Things bother me all the time.
- Things bother me many times.
- Things bother me once in a while.

Item 12

- I like being with people.
- I do not like being with people many times.
- I do not want to be with people at all.

Item 13

- I cannot make up my mind about things.
- It is hard to make up my mind about things.
- I make up my mind about things easily.

Item 14

- I look O.K.
- There are some bad things about my looks.
- I look ugly.

Item 15

- I have to push myself all the time to do my schoolwork.
- I have to push myself many times to do my schoolwork.
- Doing schoolwork is not a big problem.

Item 16

- I have trouble sleeping every night.
- I have trouble sleeping many nights.
- I sleep pretty well.

Item 17

- I am tired once in a while.
- I am tired many days.
- I am tired all the time.

Item 18

- Most days I do not feel like eating.
- Many days I do not feel like eating.
- I eat pretty well.

Item 19

- I do not worry about aches and pains.
- I worry about aches and pains many times.
- I worry about aches and pains all the time.

Item 20

- I do not feel alone.
- I feel alone many times.
- I feel alone all the time.

Item 21

- I never have fun at school.
- I have fun at school only once in a while.
- I have fun at school many times.

Item 22

- I have plenty of friends.
- I have some friends but I wish I had more.
- I do not have any friends.

Item 23

- My schoolwork is alright.
- My schoolwork is not as good as before.
- I do very badly in subjects I used to be good in.

Item 24

- I can never be as good as other kids.
- I can be as good as other kids if I want to.
- I am just as good as other kids.

Item 25

- Nobody really loves me.
- I am not sure if anybody loves me.
- I am sure that somebody loves me.

Item 26

- I usually do what I am told.
- I do not do what I am told most times.
- I never do what I am told.

Item 27

- I get along with people.
- I get into fights many times.
- I get into fights all the time.

