

16. THE IMPLEMENTATION OF ART THERAPY AS INTERVENTION WITH TRAUMATISED CHILDREN

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Introduction

In 1938, while Adrian Hill was recovering from tuberculosis, he spent most of his time creating art. He called this pastime of his 'art therapy', to imply that "the art does the therapeutic work" (Thomson, 1989: 3).

The origin of art therapy can be traced back to the days when the creative arts were first used in psychotherapy (Henzell, 2003). The Swiss psychoanalyst Carl Jung had used painting and modelling to help patients express their unconscious feelings. Many pioneers of art therapy such as Margaret Naumburg and Irene Champernowne were highly influenced by Jungian psychotherapy. By the 1940s, psychiatrists in hospitals had begun to use art therapy with their patients. Intrigued by the artwork their patients produced, they studied to see if there was a link between the art and the illness of their patients (British Association of Art Therapy, 2004).

Art therapy, according to Cathy Malchiodi (1998a), is in essence the combination of art and therapy. She further explained that art therapy "combines traditional psychotherapeutic theories and techniques with specialised knowledge about the psychological aspects of the creative process, especially the affective properties of different art materials" (1998a: 4).

Art Therapy as Intervention with Traumatized Children

For the purpose of this study, the researcher specifically looked at psychological trauma. According to Pearlman and Saakvitne (1995), psychological trauma is the unique individual experience of an event or enduring conditions, in which:

- i) The individual's ability to integrate his/her emotional experience is overwhelmed, or
- ii) The individual experiences (subjectively) a threat to life, bodily integrity, or sanity.

Thus, a traumatic event or situation creates psychological trauma when it overwhelms the individual's perceived ability to cope. For the child, especially, the sudden and surprising nature of a traumatic event can be very shocking. The real event may be very brief in duration, but it may take a long time for the child to come to terms with the experience.

Sources of trauma for the child include sexual abuse, physical violence, witnessing incidents of violence, suffering injuries or severe illness, catastrophes and disasters, and exposure to single, terrifying experiences. Terr (1991), in her studies of traumatized children, made the distinction between single-blow and repeated traumas. Single shocking events such as natural disasters (earthquakes and floods), technological disasters (automobile crashes, chemical spills, and nuclear failures), and criminal violence (robbery,



rape and homicide) can certainly produce trauma reactions in some people. However, as traumatic as single-blow traumas are, the traumatic experiences that result in the most serious mental health problems are prolonged and repeated, sometimes extending over years of a person's life. This is typical in cases of child abuse, domestic violence, incest, and living in war zones.

For the art therapist who works with children, using the art process as a means of communication to understand the inner world of the child is central to their work in art therapy. Art can offer the child an alternative means of communication that does not involve sophisticated speech. Indeed, the art process can offer the child another language, non-verbal and symbolic, through which the child can express feelings, wishes, fears, and thoughts that are central to his or her inner experience.

Geldard and Geldard contended that art therapy techniques such as drawing, painting and making collages allow children to "make pictures or symbolic representations of issues, emotions and themes related to their story..." (2004: 163). These techniques also provide the child with acceptable channels to express themselves which otherwise would be seen as aggressive or socially unacceptable. For instance, the child may show anger by destroying a drawing he made by scribbling all over it, or even tearing it up and throwing it away (Geldard and Geldard, 2004).

In addition, children are more easily engaged through drawing pictures either directly or indirectly related to the traumatic event than through talking about the event (Powell & Faherty, 1990). Another distinctive benefit of art therapy compared to traditional verbal communication, is that "there is a product, solid and tangible which can be kept and made sense of perhaps later in therapy" (Case and Daley, 1990: 3).

Monahon (1993) postulated that the memory of trauma for a child might be lodged in picture form. Thus, for severely traumatised children to communicate their experience of trauma, they need to be able to use a language beyond words. By using art and the process of creating art, the therapists may be able to help a child reach into their wordless memory to explore and express inaccessible feelings.

Hence, in most western countries, the implementation of art therapy as intervention with children who have experienced a traumatic event is not new. The therapeutic values of this therapy have helped many children heal from their traumatic experiences (Pifalo, n.d.; Malchiodi, 2001; Sagar, 1990; Shockman, 2005). Art therapy is also incorporated into programmes designed to help children cope with loss and bereavement (Finn, 2003).

In Malaysia, however, art therapy is still generally regarded as an intervention tool under the much wider psychotherapy and counselling umbrella. Hospitals such as Kuala Lumpur Hospital's Paediatric Department and University Malaya Medical Centre's Adolescent and Child Psychiatry Unit utilise art therapy as part of their rehabilitative and occupational therapy programmes. Other than the clinical setting, non-governmental organisations such as MERCY Malaysia, Yellow House/Malaysian Friends of the UNICEF and P.S The Children often use art therapy in their work with children.

The December 26 2004 tsunami that devastated some coastal areas in Malaysia and Indonesia showed how art therapy contributed to the therapeutic process of children





who were traumatised by the natural disaster. Through a MERCY Malaysia consultant psychologist interviewed for this paper, the researcher learned how art therapy facilitated the children in their healing process, and that improvements were reported in the children's demeanour after a few sessions of art therapy. Yet, with this significant contribution in human mental health, little is known about this therapy in Malaysia.

There is hardly any substantial research on the use of art therapy as intervention with traumatised children by mental health practitioners in the local context. Thus, there is a gap to be filled to create useful information. This research aimed at exploring how Malaysian mental health practitioners implement art therapy as intervention with traumatised children.

In this study, the researcher attempts to address the following research questions:

1. How is art therapy used for the treatment of trauma in children?
2. What are the limitations and constraints that practitioners face in implementing art therapy in the local setting?

Research Methodology

Research Design

This is a qualitative case study research intended to explore the implementation of art therapy as intervention by mental health practitioners to treat traumatised children. Qualitative inquiry has much to offer in the fields of counselling and psychotherapy as it allows for new understandings of the complexities of the therapeutic process (McLeod, 2001). In this study, a qualitative design provided the key informants—the mental health practitioners—the opportunity to share their knowledge, expertise and experiences with regard to art therapy and its implementation as an intervention tool to treat traumatised children.

Zonabend (1992) stated that a case study is done by giving special attention to completeness in observation, reconstruction, and analysis of the cases under study. A case study is done in a way that incorporates the views of the participants in the case under study. The researcher wanted to gain an understanding of how art therapy is implemented as an intervention tool with traumatised children by mental health practitioners. As such, the case study approach was considered most appropriate.

The methods of data collection in this study comprised semi-structured interviews with the participants to obtain their views regarding art therapy and its implementation, and analyses of relevant documents and materials, which include some artwork by the participants' young clients. The semi-structured, open-ended interviews were carried out with the aim of eliciting opinions on a range of topics including, but not limited to, the practitioners' use of art therapy in their work, the processes involved in implementing art therapy as intervention with traumatised children, and the constraints involved in implementing art therapy in the local context. The interviews were audio-recorded, with permission, and transcribed for analysis.





Participants

The participants of this study were purposively selected. According to Patton, purposive sampling is the most common of non-probability sampling strategy, and that “the logic and power of purposive sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research,” (1990: 169).

Furthermore, this therapy is practised only by some and in certain settings. Hence, the researcher conducted a survey to find out who among local mental health practitioners use art therapy in their work with children. From the survey, the researcher gathered six names of local practitioners comprising child psychiatrists, psychologists, therapists, counsellors, and other mental health professionals. Three practitioners agreed to be interviewed for this paper: an academic clinical psychologist, an early childhood specialist and consultant psychologist, and a counsellor who specialises in play and creative arts therapies.

Findings and Discussion

The researcher analysed the interview transcripts as well as relevant materials and documents to identify recurring themes and significant patterns. Based on the identified patterns, the data was organised and categorised into themes and codes, in accordance with the research questions asked. Those in the same category were grouped together and the researcher analysed and interpreted the data in each category. Yin (2002), in discussing dominant modes of data analysis in case study research, stated that the search for ‘patterns’ is done by comparing research results with patterns from theory or the literature.

The three categories that emerged from the three transcripts are:

1. The implementation of art therapy by indigenous practitioners
2. The process of art therapy as used for trauma recovery with children
3. The constraints and limitations of using art therapy

Art Therapy As Used In Trauma Recovery with Children

The use of art has a great advantage over talk therapy. Malchiodi (1998a) believes that traumatic memories are encoded in images because trauma itself is a sensory experience rather than a solely cognitive experience. For therapists to fully understand the impact of a traumatic incident on a child and to identify the critical trauma references for that child we need to become witnesses to the child’s experiences. Drawing, painting and other forms of art provide the opportunity to view the experience and see it as the child sees it.

The three practitioners interviewed concur that art therapy facilitates trauma recovery in children who have been through traumatic experiences. The early childhood specialist believes that drawing or painting is “calming” for children when faced with strangers (counsellors/therapists they have never met before), and that in trauma situations, art therapy and other forms of expressive therapies, work better for children compared to the more traditional talk therapy.

The clinical psychologist explained that children react to trauma differently from adults. The trauma they experienced may create stress and their bodies react to this stress





by shutting down certain functions in their brain that control speech. Hence, they literally cannot speak to tell their stories or share their experiences. This is when other forms of communication such as art and expressive therapies play crucial roles.

Another factor that makes art therapy more appropriate for traumatised children is their inability to explain to others their emotions. Most traumatic events experienced by children do not occur everyday, especially in disaster-related situations or when they lose a parent. These are special circumstances that evoke feelings that the child does not face in his or her normal, everyday life. Thus, when it happens, the child simply does not possess the vocabulary to explain their thoughts and feelings because the thoughts and feelings they are experiencing are new to them. This is especially so for very young children.

Through the interviews conducted, it can be deduced that art therapy sessions conducted with traumatised children may be used in two ways: (i) for assessment purposes whereby the children are observed while taking part in art therapy sessions to determine severity of trauma, and (ii) as a therapeutic process whereby the child uses art to express his/her feelings and thoughts.

Duration of Sessions and Length of Therapy

Art therapy sessions take approximately 50 minutes per session for individual cases, and around 90 minutes for group sessions. The length of therapy depends on the severity of the trauma; it can take no more than four or five sessions for mild trauma cases, while for more serious ones, they may take up to 10 or more sessions before any improvements can be seen in the child's disposition.

In some instances, changes in children's demeanours can be seen by the second session, while others who were more badly affected, took their time before taking part in any group activities. One child in particular, a participant recalled, took 20 minutes simply staring at the paper and crayons given to her. For this reason, it is best to follow the pace of each child. The child must not be rushed if the goals of therapy are to be achieved.

Materials and Venue for Therapy

Ideally, practitioners should provide as many art materials suitable for children as possible, such as papers of various sizes and colours, paints, crayons, colour pencils, scissors, glue, play-dough, straws and blocks. Nevertheless, practitioners are cautioned to be culturally aware and sensitive as certain communities may not be exposed to certain types of art materials or toys.

For example, the early childhood specialist/consultant psychologist related her experience in Aceh where among the materials provided were Lego blocks. The children, however, did not know how to play with the blocks, as they had never seen such things before. It took several days of watching the counsellors playing with the Lego blocks before they finally figured out what to do with them. The clinical psychologist recounted her experience where the children in some areas she visited had not been exposed to play-dough before. Thus, mental health practitioners deployed to certain areas as relief volunteers need to prepare themselves accordingly by doing extensive research on the





countries and/or communities they will be visiting.

In terms of venue of therapy, the practitioners interviewed suggest a proper play or art therapy room where the materials used for therapy are displayed in an organised and attractive manner. However, working in disaster areas makes it difficult to comply with all the requirements and standards of conducting art therapy. Hence, practitioners have to make the most with what is provided, which is normally a big hall or centre where everyone converges.

Individual versus Group Sessions

The counsellor interviewed professed a preference for individual sessions as he believes this way he could focus entirely on one child at a time and let the child dictate the pace of counselling. Furthermore, most of his cases are depression or stress-related, which call for a more individual approach. However, in cases where parents or other family members might benefit from therapy, he will invite them in for a group session.

The other two practitioners suggested that group sessions are more appropriate for disaster-type trauma where the children of the affected community can be grouped together in the same room. Since this is also a shared trauma, group sessions are more appropriate so that the children may share their individual experiences. Other than that, group sessions are useful for the counselors to observe the interaction amongst the children. They are able to take note of the children's body language, facial expressions and how they interact amongst themselves, to identify those who are withdrawn and keeping to themselves, or rebelling and displaying anti-social behaviours. These children will then be given individual treatment, and if need be, referrals to child psychiatrists.

Structure of Sessions

The first session is known as the ice-breaking session where rapport-building and gaining trust are the main goals. It is proposed that the first few sessions be free-flowing, non-directive and unstructured. As therapy progresses, the sessions should be more structured and directive to guide the children towards healing.

The practitioners interviewed recommend a three-phase process. The first phase is unstructured, and may take only one session or as many as three, if need be. In the unstructured phase, the children form groups of 10 children. Each group will be accorded its own space, or centre, and each centre has different areas where different art modalities are placed. For example, drawing and painting materials are in one corner, clay and play-dough are in another, Lego blocks in a different are, and so on. The children are free to choose which area they feel comfortable to express themselves in, while counsellors mostly stay silent and observe the children. This is when the first screening process starts. The children are observed for signs of trauma and stress in the children's demeanors to identify those who may be more seriously affected by the traumatic experience than others.

The next phase is semi-structured. They begin with an activity called "revisit the trauma", and this is done either through a story-telling session or a sharing session where each child will share his or her experiences with the rest of the group. According





to Malchiodi (1998a), re-exposure to the trauma memories and experiences is a major component of intervention with children who have experienced trauma. Re-exposing traumatised children to their experiences is a necessary process to help them bring their experience into consciousness so that it can then be reordered in a way that is manageable. The ability to learn to tolerate the intense fear and emotional reactions experienced by a traumatic event is a critical part of recovery (Rothschild, 2001).

In this session, it is important counsellors take note of the child's account for any incorrect beliefs or fantasies. One of the practitioners recalled that in Jogjakarta, the children explained to the relief volunteers that the earthquake happened because a giant serpent was coming out from underneath the earth. A lot of folktales and other stories they heard from the elders get mixed into their stories. Counsellors and therapists can facilitate healing by providing correct information to enable the children to form a new narrative that reflects what really happened. In this case, the practitioner and her colleagues explained to the children what an earthquake is, and how and why it happens.

The altering of trauma-driven thoughts is referred to as cognitive reframing. When a trauma is put into a narrative form inclusive of the details of the experience, these details must then be reordered in a way that is manageable. The purpose of this is to enable the child to be in control of rather than reacting to the experience. Cognitive reframing, therefore, helps remove those emotions and behaviours that are driven by dysfunctional thoughts brought about by the trauma. The therapist must be prepared to reframe the child's reaction to the major themes of trauma, such as feelings of fear, terror, worry, anger, hurt, revenge, guilt, and victimisation (van der Kolk, McFarlane and Weisaeth, 1996).

After the sharing session, the children will be asked to again make some art without any directions from the counsellor, similar to the unstructured phase. This time around, however, they may start drawing things more related to the event because of the story-telling/sharing session they had before. The children will again be screened. The counsellors will also start to engage the children in verbal communication, to get them to tell their stories or about their artwork. It is important, the practitioners advised, that counsellors walk through this activity with the child to ensure the child remains feeling safe.

The final phase involves structured sessions where the children will be asked to relive the trauma. Before the activity begins, the counsellors will ensure the children are provided with a safe environment to relive their traumatic experiences in. The counsellors will help to create a backdrop reenacting the traumatic event. In Jogjakarta, for instance, they reenacted scenes of an earthquake on a giant piece of paper with drawings of houses and buildings collapsing, and rubble and debris everywhere. The children will be asked to relate their stories through any of the art materials provided.

Creating art, such as drawing, painting and sculpting play-dough, is used as a form of exposure to assist in constructing trauma narratives while helping children to relive traumatic memories. Malchiodi (1998a) asserted that drawing provides children with an impetus to tell their stories and a way to translate their traumatic experiences into





narratives. Pynoos and Eth (1986) relied heavily on drawing as their primary intervention with children traumatised by violence. They indicate that drawing “invariably signifies the child’s unconscious preoccupation with the traumatic memory” (1986: 316).

Malchiodi (1998a) proposed structured drawing activities that relate to the major themes of trauma. Structure is an important component that promotes safety and must be maintained throughout the entire process for children to actively participate in trauma intervention. In Jogjakarta, the children were asked to draw “what happened” during the traumatic event. The purpose is to trigger sensory memories of the trauma, and by expressing and concretizing the experiences, the child is able to regain control over these memories and reorganize them in a way that is manageable.

After relating their stories through their artwork, the children will then be engaged to talk about their experiences, focusing on their feelings about the event. The counsellors will screen the children for the final time, looking out for those who might be withdrawn or aggressive. These children will then be provided with more intensive individual treatment. For really severe cases, the children will be referred to psychiatrists.

Assessment and Interpretation of Artwork

Case and Daley hold the view that art therapy is a process of communication between the child and the therapist in a safe environment, and thus, they caution against taking a direct diagnostic approach (1990). Therapists, who do, they argue, are at risk of having to turn the ‘evidence’ (the drawings of the child) in court, such as in cases of sexual abuse, and this will put the therapists in an ethical dilemma.

Art therapists who work with children do not automatically take a child’s drawings as literal statements (Case and Daley, 1990; Malchiodi, 2001; Pifalo, n.d.). What is fundamental to them is the sanctity of the therapeutic relationship, and trust between the child and the counsellor or therapist. Case and Daley stated that information is derived through the relationship, and might be communicated through the images. For example, an art therapist is trained to pick up signals through a child intentionally messing up his or her art, and through the process of transference and counter-transference, rather than directly through the drawings. The trained art therapist is not going to jump into early interpretation and conclusion about a particular art creation of the child. The process, therefore, is very delicate and takes time and patience.

The local practitioners interviewed for this study cautioned against making hasty interpretations based on one or two artwork only. It is important for the therapist to look at a sequence of artwork done by a child before making any assessments, or forming any kind of interpretation or diagnosis. Art therapy should also be used in conjunction with other tests before any assessments or diagnoses are made.

If an artwork is a drawing or painting, therapists look at the colours or colour scheme the child chooses, the images he or she draws. Colours used by the child may give an idea of the mood the child is in. They may also indicate how the child perceived the traumatic event. An interviewee recounted that one child, a few days after a tsunami destroyed his village, drew the water with brown crayon, instead of blue. He said that it was seawater,





and the water was muddy. This was exactly how the child had experienced the tsunami. The water that “swallowed” his house was not blue, but brownish in colour. After a few sessions of art therapy, his drawings changed considerably—he still drew water but now the water was blue. The rest of his pictures changed as well. Whereas in earlier drawings he drew dead fish in the brown water, later pictures showed pretty, colourful fish swimming in blue water. Other images started appearing in his pictures, too, such as clouds, birds and trees.

A change in the nature of the images drawn by the child may alert the therapist to a change in perceptions, attitudes, and beliefs. By actively observing children’s sequential art, counsellors can gauge progress or lack thereof. The practitioners noted that sometimes the changes are subtle and take time, while others display improvements in disposition by the second or third session.

Although the practitioners agreed that possessing a degree in fine art or having an artistic background may be helpful, it is not necessary to practice art therapy. Nevertheless, the early childhood specialist proposed that mental health personnel wishing to specialize in art therapy should have some knowledge of child art development. She felt this is a subject area that one needs to understand to be able to “read” a child’s drawing or artwork. It is important that practitioners know that children’s art is different from one developmental phase to another. She explained that as children grow, so do the way they express themselves in art.

Limitations and Constraints of Using Art Therapy

Most critics of art therapy argue that it lacks reliability and validity as it does not have any standard mechanisms to measure effectiveness and it requires a very subjective assessment. Hence, in the mental health field where validity and reliability of a treatment must be demonstrated, art therapy is often attacked by purists as having questionable reliability, and thus not taken as seriously as other empirically-validated therapies. The practitioners interviewed, nonetheless, gave hope that with more exposure and recognition within the mental health sector, more mental health professionals and academics will be inclined to study art therapy and address any issues with respect to its reliability or lack of.

In any case, the practitioners believe that counsellors or therapists must be equipped with the necessary knowledge and experience in counselling to be able to carry out their duties effectively. This means possessing the required counselling skills and strategies, training and experience, as well as personal and professional qualities that would facilitate client’s healing.

Limitations of the Study

This study unearthed valuable insights into the use of art therapy as intervention to treat traumatised children by Malaysian mental health practitioners. The information gleaned from the interviews conducted with the three experienced practitioners provide practical knowledge on how art therapy is being used as an intervention in trauma





recovery with children. This study is expected to prove useful to Malaysian mental health professionals who would like to incorporate art therapy in their work.

This researcher realises that this current study is far from perfect. This study began with the modest aim of exploring how art therapy was being implemented as a form of intervention for children suffering from trauma with regard to the local context. There was difficulty locating participants due to the limited number of mental health practitioners using art therapy and who work with children in the Klang Valley. Although six practitioners were contacted, only three finally agreed to participate in the study. Furthermore, the practitioners involved in the study use art therapy only occasionally when the situation or a particular case calls for it. Due to a small sample limited to the Klang Valley only, the findings of this study may not represent the situation in different parts of Malaysia.

The participants were limited to art therapy practitioners only as expert opinions were required to fully understand the process of implementing art therapy, and to fully appreciate its usefulness in counselling children suffering from trauma. Therefore, clients of the practitioners interviewed were not involved in the study.

Another weakness may be in the research design of the study. Other methods may be able to glean more information that would better answer the research questions. A phenomenological study or a long-term ethnographic study would perhaps be more appropriate. However, due to time constraints and the inability to gain consent from certain quarters to observe art therapy sessions, the researcher decided on the current research design.

This study is also limited to the extent that it is based on one researcher's interpretation of one set of data pertaining to the experiences and views of three local mental health practitioners using art therapy. Although the researcher attempted to account for her biases and expectations in the context of analyzing the data, it is possible that her perceptions uniquely influenced aspects of the investigation, which in turn may have affected the data she acquired.

Recommendations

In order for art therapy to grow as a recognised independent profession in Malaysia, this researcher would like to suggest that an official body or association be established to preside over the field of art therapy in Malaysia. This is necessary to regulate art therapy practice and training in Malaysia so that malpractice, abuse of clients, and unethical practices may be prevented or minimised. Mental health practitioners and others who wish to specialise in or learn more about art therapy will be able to do so through the body. The organisation will also make it compulsory for those who wish to practice art therapy or be called "art therapists", to be registered and licensed before they may start their practice.

Moreover, an officially recognised body can mobilise a systematic and concerted movement to develop the field of art therapy so that it will gain more recognition as a viable form of therapy. In addition, the body can embark on public awareness campaigns to educate the Malaysian public on the benefits and effectiveness of this therapy.





Other than the above, the findings from this investigation may also open up areas for further research. One can embark on a more ambitious study that would make the findings more generalisable to the rest of Malaysia. Also, the phenomenological experiences of the clients would provide for “the-other-side-of-the-coin” perspective. As this study focused on the views of the practitioners, a further research can gain insight on how art therapy works through the eyes of the client, or in this case, the traumatised child. In addition, this data garnered from this investigation is based on the practitioners’ perceptions, which are highly subjective, thus not the most reliable. Therefore, a mechanism to measure effectiveness and successfulness of art therapy in trauma recovery with children is crucial.

Conclusion

As art therapy is a field in its infancy, there is a dearth of literature on art therapy and its implementation in Malaysia. This study, therefore, hopes to fill the gap by creating much needed literature, and will act as a stepping-stone towards contributions of more literature by providing directions for future research. Only then could advances be made to the field of art therapy in the mental health profession in Malaysia. Hence, this study would be able to make current and relevant information about art therapy available to facilitate the mental health fraternity in Malaysia to create a vibrant and dynamic art therapy practice.

In terms of the practice of art therapy, the results and findings of this study is expected to offer important information to mental health practitioners working with traumatised children about art therapy, the procedures involved and the potential constraints. The information could be helpful in enabling them to formulate their own approach towards implementing art therapy in their work.

To conclude, although art therapy is still in its embryonic stage in Malaysia, its progress is looking very promising. Hopefully, with more interest from the mental health community with regard to art therapy, more research will be conducted to contribute to a growing literature on this therapy, and following that, the more stature this therapy will gain.

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