heated, due to the importance there of the "group analytic" tradition. That in turn was based in part on the work of British psychoanalyst Wilfred Bion (1961), the foundation of what is known as the *Tavistock method* of learning about group dynamics by participating in an unstructured group in which the consultants relate only to the group, not to individuals.

Katherine Williams, who wrote about group art therapy in the second edition of *Approaches* (Rubin, 2001), was trained in that model. In 1993 Diane Waller described her model of *group interactive art therapy*, based on concepts derived from group analysis, interpersonal group therapy, systems theory, and art therapy. Waller and several of her colleagues have been trained at the Institute of Group Analysis, enabling them to synthesize what they know about art therapy with what they know about analytic groups. (McNeilly, 2006; Skaife & Huet, 1998)

Interpersonal group therapy, as presented in the widely used books by existential psychiatrist Irvin Yalom, has been popular in both countries and dominant in the United States (Yalom & Leszcz, 2005). Many art therapists work with groups, but few have had formal training in group psychotherapy.

Perhaps because she was a sophisticated family art therapist and the family is, after all, the first group, Shirley Riley's (2001) work in group art therapy is equally thoughtful: "group process made visible." Change in a group can be seen as members develop trust and the group takes on shape and definition as an entity in its own right, becoming more cohesive. In this context, the individuals in group treatment also change, as they utilize the resources in art and each other to work on and solve their conflicts.

The following vignette indicates how much even a brief art therapy group can help one of its members to begin to change and to grow. Members were free to use whatever materials they wished and to make whatever they wanted. After the working time, the group gathered around a table for snacks and discussion.

Individual Growth in a Group: DON (9)

In the first few meetings of a short-term art therapy group of latency-age boys, nine-year-old Don worked apart from the others, drawing compulsively tight abstract designs **(N)**. Gradually, however, he began to interact with the other boys. At first he sat closer to them, but he was still silent. His designs, however, became somewhat freer, and he began to use various kinds of paint, to explore color mixing, and to allow himself a greater range. Stimulated by the other boys, Don then turned to the more tactile and regressive medium of clay. At first he made tame animals, like dogs and cats. Then he made larger and more aggressive ones, like dinosaurs and lions.

Eventually, he was able to model a boy who had been violently wounded, painting red blood streaming out of his maimed body **(O)**. Although Don wouldn't say who it was, the following week he whispered to me that he knew, but was afraid to tell the others. I asked if he could tell me, and he whispered, "my brother." I suggested that it might help the other boys in the group, many of whom had similar angry feelings and wishes toward siblings, to know that they were not alone.

During group discussion time at the end of the session, Don tentatively whispered that it was "somebody younger," then "somebody I'd like to throw something at," and finally, "my brother." The others responded with relief, and an outpouring of their own impulses to hurt younger siblings, along with fears of their strength and destructiveness.

Don was delighted, and responded the following week by becoming uncharacteristically messy, smearing and mixing tempera paint colors with another boy, for the first time

allowing himself to interact playfully with other group members. His products for the next two weeks were not much to look at **(P)**, but the process he engaged in was vital to his eventual recovery. He followed this aggressive/regressive phase with a freer kind of order in his work.

After the eight-week group had ended, Don continued in individual art therapy for several months. When he terminated treatment, he selected a tempera painting with movement, color mixing, and clear-but-not-rigid boundaries as a gift for his therapist **(Q)**. It reflected the integration of freedom and order that he had been able to achieve internally as well.

Art/Image-Based Approaches to Art Therapy (DVD 5.5)

All art therapists share the common ground of *art*. Some have tried to apply aesthetics to assessment as well as to treatment. Rita Simon (1992, 1997) developed a theory based on the formal elements of graphic style. Simon analyzed *style* as *archaic, linear, traditional*, and *massive*, suggesting a unique way to look at pictures, which served the author well in both diagnosis and in therapy. For her it was a coherent and useful system.

Creative analysis was developed by psychologist Ernest Zierer and art therapist Edith Zierer. Although presumably based on psychoanalytic ego psychology, it was unusual for an analytic approach in that there were many specific interventions. The art therapist chose, from among a number of possible artistic tasks, those considered most appropriate for each patient, for the purpose of diagnosis as well as for therapy. Looking at the *form* rather than the *content* of the oil paintings created in their studio, the Zierers assessed the degree of *color integration* in the artwork. This was thought to reflect mental health, while its absence (*color disintegration)* was seen as reflecting mental disorganization or disturbance. Both the Zierers and Simon focused on what they could learn from the art and used their idiosyncratic systems during long careers in art therapy.

There are other more communicable approaches to art therapy that emphasize the *art* or—as some prefer—the *image*. Art-centered theories usually stress either the creative process, the visual imagery that results from it, or both. Since art itself is theory free, these approaches are compatible with a wide variety of theoretical orientations, including Freudian (Lachman-Chapin, 1994; Robbins, 1987, 1989), Jungian (Wallace, 1990), Gestalt (Rhyne, 1995), Cognitive (Lusebrink, 1990), Phenomenological (Betensky, 1995), and Existential (Moon, 1995, 1996).

Pat Allen (1995) focused on the power of art to create meaning in *Art Is a Way of Knowing* **(A)**; Shaun McNiff (1994) stressed its healing potency in *Art as Medicine* **(B)**. As noted earlier, the return to the art studio has brought a renewed interest in art and the image as the core of our work, with a renewal of *studio art therapy* approaches (C. H. Moon, 2002). Cathy Moon **(C)**, author of a book by that name, is currently the chair of the art therapy master's degree program at the Art Institute of Chicago, founded by Don Seiden **(D)**, who published his *Artobiography* in 2006. It is perhaps the most rapidly growing orientation within the United States and is often linked with the other prominent trend, that of *spiritual* approaches. Like with art- or studio-based approaches, its proponents come from a wide variety of theoretical orientations.

Spiritual Approaches to Art Therapy

A strong current in contemporary American art therapy has to do with the spiritual aspect of our work. Shaun McNiff, for example, wrote a book about inanimate objects as *Earth*

Angels (1995). Jung, the son of a minister, valued the spiritual elements in psychoanalysis, whereas Freud, the rationalist, was determined to prove the scientific nature of the new depth psychology.

Ironically, both polarities are more important in the mental health domain than ever before. *Psychobiological* approaches currently dominate the field of psychiatry, while *neuroscience* and *cognitive-behavioral therapy* dominate contemporary psychology. At the same time, in a technological world where human values often seem to have been lost, the hunger for meaning has been intensified. One reflection of this longing is the popularity of spiritual approaches in mental health, as in the many kinds of treatment programs based upon the *twelve-step* method of overcoming addiction, which has been adopted by art therapists as well (Chickerneo, 1993; Waller & Mahony, 1999).

Art therapy, drawing as art has from time immemorial on the human spirit, offers a most appealing avenue for authentic expressions of the soul. Even the most rational among us knows of the deep inner well from which we draw when we express ourselves. While I have found a psychoanalytic orientation most useful in my own work, it does not seem incompatible with the title I used for a book addressed to the general public: *Soul Prints* **(DVD 5.6)**.

Even though art therapists operate from a number of different perspectives, one that cuts across all of our theoretical differences is that of the human spirit, which is so essential to our creative capacity. The philosophy of *anthroposophy*, which underlies the work of Rudolf Steiner and his followers, while primarily expressed in the educational arena of the Waldorf Schools, has also spawned a somewhat mystical approach to *color therapy* (Collot d'Herbois, 1993) and *painting therapy* (Hauschka, 1985). It remains extremely popular in Germany.

Spirituality is a strong element in Bruce Moon's work, for example, *Art & Soul* (1996), and Ellen Horovitz **(Figure 5.13)** has published a series of books with titles like *Spiritual Art Therapy* (2002b), *A Leap of Faith* (1999), *Art Therapy as Witness: A Sacred Guide* (2005), and has created the *Belief Art Therapy Assessment* (2002a**) (A)**. Spirituality is also central in *transpersonal* approaches to art therapy, so it is not surprising that Pat Allen has also written a book called *Art as a Spiritual Path* (2005). And Lynn Kapitan **(B)** has addressed a need

Figure 5.13 Ellen Horovitz, spiritual art therapy.

she has called *The Re-Enchantment of Art Therapy* (2003), which has a similar kind of plea for poetry.

The most multifaceted compendium of such approaches is found in Mimi Farrelly-Hansen's (2001) edited book, *Spirituality & Art Therapy.* David Henley (2002) subtitled his book on using clay *Plying the Sacred Circle,* and Paolo Knill and his colleagues (2004) called their most recent explanation of an intermodal approach *Minstrels of the Soul.* Just as humanistic approaches were a reaction to the dominance of psychodynamic ones, so the move toward both studio and spiritual approaches is in part a reaction to what Allen (1995) called the "clinification of art therapy."

Integrative Approaches to Art Therapy

In the 2001 revision of *Approaches to Art Therapy* I grouped approaches that integrated one or more theoretical perspectives **(DVD 5.7)**. Two chapters from the first edition dealt honestly with the many determinants of theoretical positions and technical decisions, each articulating a rationale for adopting more than one model to guide work in art therapy. Ulman **(A)** explained how and why she ended up working with some patients in *art as therapy* (Kramer) and with some using *art psychotherapy* (Naumburg). Wadeson **(B)** described her *Eclectic* approach, how it evolved, and how she used it over the course of a long career **(Figure 5.14)**. Both offered intelligent considerations of how to be open-minded without being sloppy.

By the time the second edition was published, *Multimodal* theorizing as well as methods had become much more common, so two new chapters were added to this section. One is by Shaun McNiff (**C**) (1986), who had founded a training program in *expressive therapies* in 1974 at Lesley (**Figure 5.15**). McNiff's chapter dealt with a way of working with groups in art using the imagination as well as multiple modalities (McNiff, 1998b, 2003). The other,

Figure 5.14 Harriet Wadeson, eclectic art therapy.

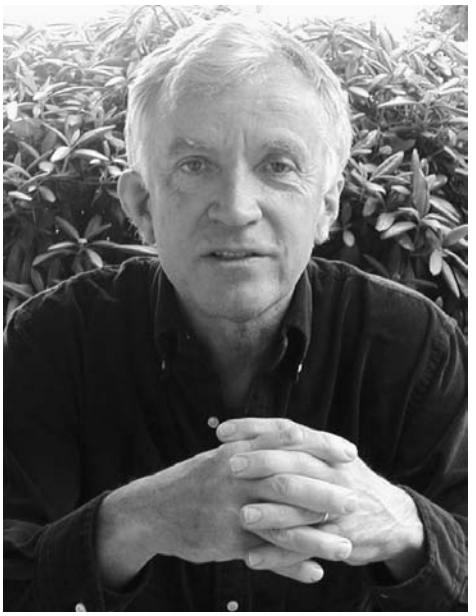

Figure 5.15 Shaun McNiff, expressive therapies.

by David Henley (**D**) (2002), described work in a class of disturbed adolescents not only in more than one art form, but also integrating psychoanalytic concepts with cognitive and behavioral ones. Natalie Rogers's (**E**) chapter integrating person-centered therapy with different art modalities in the humanistic section could equally well have been in the integrative one.

All of the chapters in this section of *Approaches* exemplify what I believe Bernard Levy meant when he wrote, "While divergent viewpoints can be 'integrated' as a conceptual act and even rationalized with an eclectic philosophy, the rationale must not be so broad as to espouse laissez-faire. Integration of divergence need not mean that 'anything goes.'"

Theory, Technique, and Art Therapy

Art Therapists as Theorists

Art therapists are attracted to the field because they like both art and people, and they tend to be curious as well as compassionate and creative. For some, the curiosity extends beyond wanting to understand the people they see and the art that is created, to the creative process that seems to work so well in psychotherapy. This very combination can make theory building endlessly fascinating. Since in many ways art therapy is "a technique in search of a theory" (Rubin, 2005a), it has been fortunate for the field that these restless minds loved to explore new ideas in relation to art therapy **(DVD 5.8)**.

Thus, Margaret Naumburg (1966) in her later years was busy reading *archeologist* Siegfried Gideon and applying his findings to art therapy **(A)**. Edith Kramer (2000) wrote extensively about the implications of Konrad Lorenz's work in *ethology* for art therapy **(B)**. Joy Schaverien (1995) used *anthropology* to amplify her understanding, offering us new ways to think about familiar phenomena, like the art as a *talisman* or a *scapegoat*. All art therapists who have worked out ways of applying different theoretical constructs have done so by

synthesizing what they knew about the therapeutic power of art with what they understood about one or more theories of psychotherapy.

The Unspoken Perspective

Theoretical ideas and the techniques that follow therefrom continually evolve and change in all forms of treatment, including art therapy. As with clinicians who help through words, the majority of art therapists don't think of themselves as following any particular theoretical model. Yet like talk therapists, all art therapists have some notions of what is amiss and how to help people to get better. These ideas necessarily underlie what they do and the way they do it. Though it may remain unarticulated, there is always some kind of unspoken theory behind any art therapist's technique.

Any clinician's preferred theoretical approach is likely to be chosen for largely personal reasons. These include those by whom she has been trained and with whom she has identified, as well as those with whom she works. In addition to experiential variables, temperament is another reason for choosing a preferred framework. The approach selected may be pure or mixed, rigid or flexible. Hopefully, it is both clear and consistent.

Selective Eclecticism

Although it is essential to have a solid grounding in some coherent notion of how people function and how to help them to get better, most clinicians are not purists. In fact, most art therapists are probably mainly *pragmatic,* selecting the approach that best fits the particular situation. Robert Ault (1986), who wrote the commentary on the integrative section for the revision of *Approaches,* described three different approaches, each one to be utilized depending on the needs of the patient(s). He called them *person-, process-, and product-centered art therapy* **(C)** (Ault, 1986).

As Helen Landgarten said, "The truth of the matter is that art therapy is not a discipline, it's … a modality. Art therapy is a way of getting there. *It operates as a modality because you can adapt it to any theory.*[4]

Is Theory Really Necessary?

But what about the art therapist who rejects theory? Isn't it possible to simply be a sensitive person and to be a good therapist as well? There is a difference of opinion in art therapy, as in other clinical disciplines. An *intuitive* approach is probably more acceptable in art therapy, because artists pride themselves on their innate sensitivities, and tend to be anti-authoritarian and anti-theoretical. It seems a logical continuation of the romantic, bohemian tradition, which is appealing to creative people.

Art therapists, however, usually do their work not in artists' lofts, but in offices and institutions run by others. The art therapist is responsible for meeting the goals for which she is being paid, whether she is employed by educators, health professionals, or patients. For an art therapist in private practice, there is an even greater sense of responsibility, because, in truth, the patient's life is in her hands.

Art is a wonderful modality. It has the power to cut through defenses and to uncover unconscious material quite rapidly. It is also a very exciting modality, with the power to stimulate a regression which—in those whose defenses are too fragile—may need to be contained. An art therapist needs to know what she is doing, especially when people are in a vulnerable state.

Most people who come to art therapy, even the "worried well" who are not grossly disturbed, can still be injured by naive or tactless work. Without some understanding of human

frailties and the terrific complexity of mental functioning, as well as the delicacy of healing, I believe that even the most well-intentioned artist is in danger of violating the oath taken by physician healers, which is to *do no harm*.

For this reason, art therapists in training are familiarized with many theories of psychology, psychopathology, and psychotherapy. And they are required to work under close supervision for a substantial period of time before being eligible for registration, in order to be sure that they have assistance in the difficult task of translating theory into practice.

Theory is what enables any therapist to make sense of the data being received, and to be thoughtful about technique. Only with a coherent perspective on what she does can the art therapist make fully available the healing powers of art. In fact, it is only when she has truly mastered some theory of psychological functioning and of psychotherapy, when it is "in her bones," that she can use her intuition in the most helpful way. Theory helps an art therapist to sharpen both her thinking and her clinical skills.

Since art therapy does have connections with other disciplines, it makes sense in theory, as elsewhere, to utilize any relevant insights to understand why and how art therapy works. It seems as unnecessary to throw the baby out with the bathwater as it would be to reinvent the wheel. Just as those metaphors remind art therapists that they can learn from others, so the notion that "a picture is worth a thousand words" is one of the reasons art therapy works. Effectively integrating the synthesis of art and therapy requires an internalized frame of reference.

The more extensive an art therapist's understanding of different approaches, the more clinical lenses she has with which to see (Hedges, 1983). Like a stain on a microscopic slide, a theory can enable a therapist to literally *see* something that would otherwise be invisible. And if she can look at a problem from a different angle, she is often able to view possible solutions from a new perspective. It is a kind of *reframing* for the therapist, for whom a cup can look either half-empty or half-full, just as it can for the patient. That is probably why so many have struggled with the difficult questions of how to view, understand, and do art therapy—in order to help the people they serve as much as possible through art.

Endnotes

1. Harms, E. (1973). "Editorial: Provinces and Boundaries of Art Psychotherapy." *Art Psychotherapy,* Vol. 1, No. 2, p. 1.
2. Maslow, A. "Creativity in Self-Actualizing People." In *Creativity and its Cultivation*, edited by H. H. Anderson. New York: Harper and Row, 1959, pp. 83–95.
3. The reader should not assume that an interest in mental imagery is restricted to those favoring cognitive therapies. My analytic institute graduation paper dealt with spontaneous visual imagery in adult and child analysis, and I included a chapter about its use in *Artful Therapy* (Rubin, 2005b).
4. From "An Interview: Helen B. Landgarten, by L. A. Warren, 1995, *American Journal of Art Therapy, 34*, p. 36, emphasis added.

CHAPTER 6
Assessment

The use of any combination of verbal, written, and art tasks chosen by the professional art therapist to assess the individual's level of functioning, problem areas, strengths, and treatment objectives.

American Art Therapy Association, *General Standards of Practice*

Art and Diagnosis

It has already been noted that some of the threads that became part of the fabric of art therapy came from wanting to understand people through their art expression. The goal may be to identify exactly what is wrong, or to get to know the person better in a more general way. Even when a diagnostic label is not the purpose of an assessment, finding out where an individual is on any dimension relevant to treatment can be extremely helpful. Just as there are many different ways of classifying the information obtained, so there are also multiple methods of gathering data using visual means. This chapter will offer an overview of the many ways of understanding people through art as they have evolved over time.

Projective Techniques

As noted in Chapter 3, *projective testing*—both responsive and expressive—flowered in clinical psychology for several decades, especially during the 20th century. Although no longer as widely used, its history is relevant because the many variations developed over the years greatly influenced the training and work of art therapists. Like most early theories underlying art therapy, it was based on the work of analysts regarding the universal human need to project (or find) meaning in the world.

The assumption behind all such approaches is that the individual is revealing important information that—because it is unconscious and therefore unknown—is not accessible in more direct ways. This is true whether a person is responding to some kind of visual stimulus with his ideas, or is creating something himself using art materials. Psychologist Lawrence Frank termed this the "projective hypothesis."[1] On the **DVD (6.1)**, psychologist

Bernard I. Levy is teaching an art therapy class and then a group of psychiatry residents at Walter Reed about projective techniques.

Responding to Visual Stimuli

In some approaches, the individual is asked to give meaning to a series of stimuli. They may be abstract, like the famous inkblots introduced by psychoanalyst Hermann Rorschach in 1921 (cf. Exner, 2002) or the molded shapes of Twitchell-Allen's (1958) Three-Dimensional Apperception Test. They may also be representational, like the drawings of people in Murray's Thematic Apperception Test (TAT), or of animals in Bellak's version for children, the Children's Apperception Test (CAT). Some tools are specific to the problem, like the *Storytelling Card Game* (R. Gardner, 1988).

Preference Tests

In these, the person chooses from among visual stimuli. Some involve color, as in the Luscher Color Test (Luscher, 1969). Others involve design, like the Welsh Figure Preference Test (Welsh, 1959), which asked people to select preferred line drawings. This test included the *Barron-Welsh Art Scale* developed with Frank Barron, a psychologist specializing in creativity who later advised art therapist Janie Rhyne on her doctoral dissertation. Rhyne (1995) asked individuals not to *respond* to, but to *create* line drawings representing a series of affective states.

Art therapist Joan Kellogg's **(Figure 6.1)** studies of recurring patterns in mandala drawings were the basis for her selection procedure, the *MARI Card Test*, which involves both color and design (Kellogg, 1980). For her doctoral research, art therapist Doris Arrington **(Figure 6.2)** (2005) created a *Visual Preference Test*, in which participants select and rank line drawings. Like the images seen in inkblots or stories told about drawings, such choices are assumed to reflect fairly stable aspects of personality. On the **DVD (6.2)**, art therapist Carol Cox, one of Kellogg's colleagues, administers a MARI test, which includes both the creation of a mandala and an active response to a set of carefully designed cards.

Figure 6.1 Joan Kellogg, MARI Card Test.

Figure 6.2 Doris Arrington, Visual Preference Test (VPT).

Copying and Completion

Used in art education for centuries, copying has also been helpful in the psychological assessment of organic impairment, as in the *Bender Visual-Motor Gestalt Test* (Bender, 1952). Completion procedures are another popular approach. In the *Kinget Drawing Completion Test*, for example, each of the eight sections on the test blank contains a dot or a line, which the subject is invited to develop into a picture (Kinget, 1952). This kind of standardized ambiguous stimulus is similar to the chosen or created stimuli suggested by art therapists as "starters," and is used in treatment as well as in assessment.

The Scribble Drawing

At about the same time, a playful British analyst named Winnicott **(Figure 6.3)** and an inspired American art teacher named Cane independently came up with the notion of using a scribble as a visual starter; that is, developing a picture from a self-made scribble. For Winnicott, it provided a rapid and nonthreatening way to get to know a child he was assessing; and because his interest was in communication rather than composition, a pencil and a small piece of paper suited his *Squiggle Game* (Winnicott, 1964–68; 1971b). Cane, on the other hand, wanted to stimulate freedom and spontaneity in art expression, so her *scribble* technique included preparatory breathing and movement exercises (**Figure 6.4**), and was done on large drawing paper with colored pastels (Cane, 1951). On the **DVD** you will see Elinor Ulman demonstrating the technique as part of an assessment (**DVD 6.3**).

Taught by Cane's sister Margaret Naumburg (1966), the scribble remains extremely popular among art therapists. It was incorporated into the first formally designed art therapy assessment batteries for both individuals (Ulman & Dachinger, 1975) and families (Kwiatkowska, 1978). Since young children have difficulty with the task, Ron Hays proposed a Dot-to-Dot drawing as an alternative for them (AATA *Conference Proceedings,* 1979). Many other "visual starter" approaches are used in treatment as well as diagnosis, some of which are noted in the following chapter.

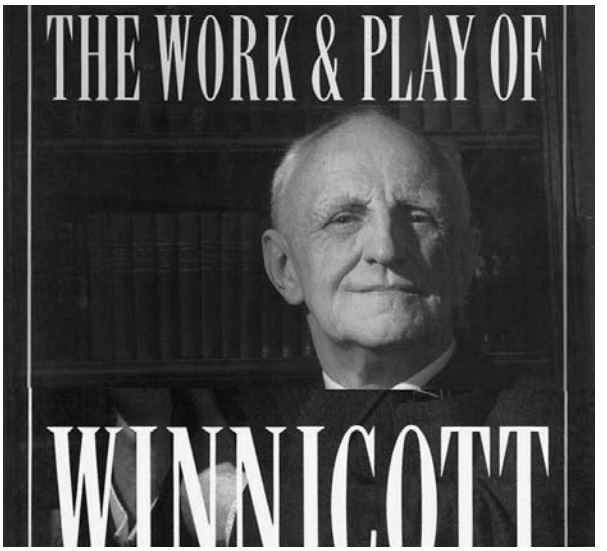

Figure 6.3 Donald W. Winnicott, Squiggle Game.

Projective Drawings

The first individual to standardize procedures for using drawing tests with patients was a German psychiatrist named Fritz Mohr in 1906 (Malchiodi, 1998). Using children's drawings of a person to measure intellectual development was pioneered by a child psychologist in 1926 as the *Draw-a-Man Test* (Goodenough, 1926). In 1931, a psychiatrist named Kenneth Appel[2] (who commented on one of Naumburg's early published cases) described an extensive "drawing battery" he was using in his initial interviews with children, which included drawing human figures.

Clinical psychologist Karen Machover noticed that many features of person drawings seemed to be dynamically significant, so she included the task in her assessments. In 1949 she published a book describing a number of "signs" and their presumed meaning in her *Draw-a-Person Test* (DAP) (Machover, 1949). Psychologist John Buck also saw meanings in the drawings on IQ tests, and in 1948 he introduced his House-Tree-Person Test (H-T-P),[3] in which all three topics were part of the task. His hypothesis was that the house and tree drawings were also self-projections, but less obvious and therefore potentially more revealing.

Central to projective drawing analysis is the assumption that formal elements—like placement, line quality, or shading—are as significant as subject matter. Since many early art therapists were trained by clinical psychologists during the heyday of projective drawings, they incorporated them into their own work and taught their students (Drachnik, 1995). Most art therapists no longer rely on the projective drawing tasks still used by some clinical psychologists, due to a literature that has demonstrated their lack of validity. In learning from people's artwork, however, art therapists also consider form as well as content.

An emphasis on form is the basis for art therapist Linda Gantt's development of the *Formal Elements Art Therapy Scale,* a rating manual for drawings of a *Person Picking an Apple From a Tree (PPAT),* a topic first used by art educator Viktor Lowenfeld (1957) to stimulate the child's identification with the activity being represented **(DVD 6.4)**. Indeed, most art therapy assessments have incorporated psychological testing's demand for standardized

Figure 6.4 Florence Cane teaching a class.

administration of tasks (including the materials being offered) and for scales that result in inter-rater reliability.

In 1958, when projective techniques were being used and created by many, clinical psychologist Emanuel Hammer (1958) edited *Projective Drawings,* in which Naumburg described the history of art therapy and presented a case study. She also noted some of the similarities and differences between prompted, standardized, projective drawings, and the spontaneous work created in art therapy that are still valid (cf. also Hammer, 1997).

Despite numerous research studies, in which most of the common assumptions about the meanings of various "signs" could not be validated, projective drawings have remained popular among some clinical psychologists (Liebowitz, 1999; Oster & Crone, 2004; Oster & Montgomery, 1996) and some art therapists (Brooke, 2004). This is probably due to their ease of administration, as well as the richness of material obtained. Many inventive ideas have been proposed by individual clinicians over the years.

Some involved alterations of some sort (Hammer, 1958). Rosenberg, for example, offered the freedom to *change* completed drawings (of a man and a woman) in any way, using a carbon copy for comparison. Caligor went further with the Eight-Figure Redrawing Test,

in which the person made a *series of eight drawings* of the human figure, each one based on the previous one—as seen through a sheet of onionskin. The instructions were: "Change it in any way you like."

Perhaps inspired by such tasks, art therapist Harriet Wadeson used a similar technique with couples. She invited both members of the pair to draw a portrait of the other, after which each had an opportunity to modify their partner's picture as they wished (Wadeson, 1980). Robert Ault also included such a task in his assessment battery for couples, to be described later. On the **DVD** you can observe Wadeson instructing a couple in how to do this task **(DVD 6.5)**.

Variations on drawing themes have been extensive. These include other self-representations, like a tree, a house, or animals. Sometimes the topic is designed to evaluate the person's ability to cope with stress, such as drawing "a person in the rain" or the Most Unpleasant Concept Test—"draw the most unpleasant thing imaginable." References to such efforts can be found in the books by clinical psychologists (Hammer, 1958, 1997; Oster & Montgomery, 1996; Oster & Crone, 2004) and by art therapists (Brooke, 2004; Malchiodi, 1998a; Rubin, 2005b).

Though many other topics have been proposed, the drawing of the *Human Figure*—or its symbolic extension in the *House-Tree-Person* test—remain the most popular themes with the majority of clinicians, including many art therapists. The H-T-P is either done with a pencil (achromatic) or a set of eight crayons (chromatic). Along with the hypothesis that an individual projects core personality traits in drawing behavior, there is also the related assumption of an internal schema, the *body image*. This idea, originated by psychiatrist Paul Schilder (1950), is one reason for the continuing popularity of the person drawing and other themes that, like the tree or house, are assumed to also represent an individual's sense of himself.

Its only close competitor, clearly superior for getting a picture of the interpersonal situation, is the *Family Drawing*, described in 1931 by psychiatrist Kenneth Appel (see footnote 2, this chapter). Appel suggested adding activity, an idea later popularized by Burns and Kaufman (1970) in the widely used *Kinetic Family Drawing* (KFD). The instructions are: "Draw a picture of everyone in your family, including you, doing something." Burns went on to suggest other ideas, like the Kinetic House-Tree-Person Drawing (Burns, 1987) and the Family-Centered Circle Drawing (Burns, 1990).

One of the variations on the family drawing theme proposed in Burns's 1990 book was called the *Parents' Self-Centered Circle Drawing*. In 1970, art therapists Selwyn and Irene Dewdney asked some of their patients to draw a *mother and child* (Ulman & Levy, 1981). In 1994, psychologist Jacqueline Gillespie suggested the diagnostic use of *Mother-and-Child Drawings*. Since I had been asked to review that book, I tried the task with several adult patients, whose mother-and-child representations were surprisingly helpful in their therapy.

Although the family is the first and most dynamically significant group, others become increasingly important in the course of normal development. In the 1940s the inventor of psychodrama, Jacob Moreno, suggested making pictorial diagrams of interpersonal relationships, with names like *Social Atom* and *Sociogram*.

The latter is used in teaching art therapists by Charles Anderson, who was trained during an era when projective drawings were extremely popular. In his classes, Anderson advised the use of such techniques because, given the time pressures in contemporary mental health, they are very rapid ways of gathering useful information (Anderson, 2000, 2003). These methods are quite similar to the *Genogram*, which is popular among family therapists (McGoldrick & Gerson, 1985; Kerr et al., 2008). Anderson can be seen on the **DVD**, teaching the *Sociogram* to his students **(DVD 6.6)**.

In 1974 Prout and Phillips[4] proposed a *Kinetic School Drawing* (KSD), to be done following a KFD. Klepsch asked children to draw a classroom and to do portraits of authority figures—teacher, doctor, policeman—to assess a youngster's sense of himself in relation to others. Following in the footsteps of Wayne Dennis, who studied *group values through children's drawings*, he reviewed other such studies (Klepsch & Logie, 1982).

Standardization in Drawing Tasks

Most projective drawing tasks developed by psychologists use standardized materials—usually 8" x 11" paper, a No. 2 pencil, and when "chromatic," specific colors and types of crayons. Instructions for each of the drawings are also clearly specified, as are the guidelines for any post-drawing interrogation (PDI). Such standardization is needed to establish group norms, to which clinicians can then relate individual performance. Like norms, precise scoring methods are also needed. For example, one version of the Draw-a-Person Test used *templates*, in an attempt to more objectively measure size and placement.

A systematic approach to test administration, clear identification of items to be scored, and the creation of rating manuals are tedious but necessary steps on the road to *reliability*. One aspect is *test-retest reliability*—how consistent anyone's performance is on a particular instrument. The other is *inter-rater reliability*—how similar raters' judgments are with any specific scale. Whether the instrument measures what it is supposed to—*validity*—is another heavily debated issue. It is the source of most of the criticism leveled at all projective techniques, especially drawings.

Nevertheless, despite negative findings in all of the experimental research, projective drawings did and still do appeal to clinicians from many disciplines. One of the most prolific writers in this area was a pediatrician named Joseph Di Leo, who published a series of books on children's drawings (1970, 1974, 1977, 1983). Di Leo's goal was a differential diagnosis of "the unusual and the deviant" in the context of "the usual and the normative." His diagnostic battery included both copying tasks and specific topics and was popular among some art therapists working with children, as he published during a period of rapid growth in the profession.

Art and Psychopathology

In the early 1970s, a group of clinicians published *Human Figure Drawings in Adolescence*, using pictures collected at a medical clinic (Schildkrout, Shenker, & Sonnenblick, 1972). The idea was that drawings could be efficient screening devices for potential psychiatric problems. Considerable attention was given to signs of emotional disturbance, of organicity, and of danger, that is, "acting-out" of any sort, especially suicide or homicide. The search for warning signs in artwork, whether in a prescribed task or in spontaneous products, can be critical, especially in acute psychiatric settings or in the criminal justice system. Art therapists and others have long sought to identify graphic clues to a variety of diagnostic puzzles (Cohen & Cox, 1995; Gantt & Tabone, 1998).

Most of the early projective drawing literature—like art therapist Brown's (1967) *Psycho-Iconography* or psychologist McElhaney's (1969) book on human figure drawings (HFDs)—was an attempt to familiarize clinicians with typical drawing signs in patients with different disorders. "Art as a Reflection of Mental Status" was the title of psychiatrist Paul Fink's contribution to the first issue of *Art Psychotherapy* in 1973. In fact, there are many ways in which art products can help in differential diagnosis. But it is far from simple, as experienced art therapists, psychologists, and psychiatrists know. Research attempts to validate the meanings of individual drawing *signs*—like shading indicating anxiety—have found them to be less successful than *global ratings*.

Two psychologist/art therapist teams designed similar studies in the late 1960s, independent of one another. Each asked the simple question of whether individuals could judge psychopathology from spontaneous art. Could they tell which picture was done by a patient and which was done by a nonpatient? The judges in a study using adult paintings (Ulman & Dachinger, 1975) were more successful than those in one using child art products (Rubin, 2005a). Although in neither case was success related to years of clinical experience, a subsequent study suggested that training art therapists to assess artwork by adult patients could increase their accuracy (Ulman & Levy, 1981).

Art therapist researchers have questioned most generalizations about patient art. Even though art therapists consult that literature, they tend to be nondogmatic, largely because of the impact of their direct experience. Wadeson, working at the National Institutes of Mental Health (NIMH), designed a series of studies to identify the characteristics of pictures by people with various disorders, which she summarized in her first book (1980). In addition to trying to be precise and descriptive, Wadeson sought a *phenomenological* understanding of a patient's experience. She asked for drawings such as: a self-portrait, what it was like to be depressed **(Figure 6.5)**, to have delusions or hallucinations, or to be in a locked space. Like many art therapists, she often included a free drawing in her assessment battery.

Figure 6.5 "Corridor of Loneliness" by a depressed patient.

Studies of Artistic Development

In the area of developmental psychology, interest in children's drawings waxed and waned in the course of the 20th century. During the child study movement at the turn of the century, drawing studies tended to be either collections of work done by large numbers of youngsters, or detailed longitudinal observations of an individual child, sometimes including the drawing process as well as the products. (See Rubin, 2005a for references.)

However, during the last quarter of the 20th century, developmental psychologists were busy once again studying children's spontaneous art expression. This is due not to a fascination with art, but to an interest in the growth of cognition—and an awareness that drawing behavior is a useful index. That focus on the study of children's drawing behavior was inspired in part by the work of psychologist Rudolf Arnheim (1954), an early supporter of art therapy.

One of Arnheim's students, Claire Golomb, did some of the best research on the development of children's art. In 1974 she published inventive studies of young children's development in both sculpture and drawing. In 1992 she summarized further research, including two chapters of particular interest to art therapists: "Color, Affect, & Expression" and "Art, Personality, & Diagnostics." Though critical of poorly designed studies and skeptical about finding group differences, Golomb is a believer in the overall diagnostic and therapeutic potential of art. Her recent work (Golomb, 2002) is an attempt to put children's art in a cultural context.

Some of the best investigations using naturalistic observation of creative behavior came from an interdisciplinary series of studies done at Harvard called *Project Zero*, which began in 1967 (www.pz.harvard.edu/index.cfm). That project was the basis for Howard Gardner's work (1980, 1982), and for Ellen Winner's (1982) book on the psychology of the arts—which included chapters on drawing development, brain damage, and mental illness.

There is also a fine chapter by Wolf in Gardner's 1982 book about stylistic differences among preschoolers, which is reminiscent of what Viktor Lowenfeld (1952, 1957) discovered about perceptual styles (visual and haptic) in his work with blind and partially sighted youngsters. The presence of such normal stylistic differences, and of intra-individual variability (Rubin, 2005b), make the diagnostic use of any single artwork or group of products exceedingly complicated. There are also a great many uncontrollable variables, like culture or hairstyle, making most diagnostic generalizations about art extremely uncertain.

Other observers of normal art activity and products included Rhoda Kellogg (1959, 1969), who found patterns in her large collection of art by normal preschoolers. *Understanding Children's Play* (Hartley, Frank, & Goldenson, 1952) described not only normal behavior, but also the therapeutic benefits of clay, graphic materials, and finger paints. One of the authors was Lawrence Frank, who had written the first book called *Projective Methods* (Frank, 1948).

Art therapists working with children were greatly influenced by such careful observational studies, including the classic investigation by Alschuler and Hattwick (1947/1969) of the relationship between *Painting & Personality* in normal preschool youngsters. The psychologist who invited me to do art therapy with schizophrenic children in 1963, Dr. Margaret McFarland, was one of the teachers participating in that study, no doubt contributing to her interest.

The hope of finding useful information in children's artwork was high during this period, resulting in rating scales for spontaneous drawings and paintings, like those developed by child psychologists Paula Elkisch[5] and Trude Schmidl-Waehner.[6] Peter Napoli's[7] diagnostic

use of finger painting, inspired by the work of Ruth Shaw (1938), was later used and amplified by others, like my college psychology professor Thelma Alper, whose excitement about a study relating finger paintings to socioeconomic level was contagious. Similarly, the *Easel Age Scale* was designed by psychologist Beatrice Lantz (1955) to study the growth and adjustment of normal young children through their spontaneous paintings.

Other well-designed investigations by developmental psychologists of relevance to art therapists were done by Cox (1992, 1997), Gardner (1980), Goodnow (1977), and Thomas and Silk (1990). Some of the research they report seems to validate at least some common projective hypotheses, like the symbolic significance of size or color. Their skeptical observations on the diagnostic use of art, however, are useful reminders of the nebulous state of this field of study.

While correlations between artwork and personality remain doubtful, drawing assessment of development levels has been shown to have somewhat greater validity. In 1963, Dale Harris revised and extended Goodenough's Draw-a-Man Test as a measure of "intellectual maturity" in children. In 1968, Elizabeth Koppitz refined procedures for the use of *Human Figure Drawings* (HFDs) by elementary school children to measure developmental level, as well as to assess adjustment via "emotional indicators" (cf. also Koppitz, 1984).

Art Therapists as Diagnosticians

Art Therapists and Projective Drawings

When art therapists seeing children were informally surveyed by the American Art Therapy Association (AATA) in 1991, it was found that they were almost as familiar with the DAP, H-T-P, and KFD as they were with the art therapy techniques on the list. Indeed, because of waning interest in projective drawings, Klepsch and Logie (1982) concluded "that people other than psychologists, professionals who work with children, should be prepared to acquaint themselves with what drawings have to say." It would appear that many art therapists have done just that.

Cay Drachnik's 1995 manual on the interpretation of children's drawings includes descriptions of the most common projective drawing tests, along with many traditional assumptions of the meaning of various aspects of both form and content. Stephanie Brooke's 2004 revision of her 1996 *Guide to Art Therapy Assessment* reflects art therapists' continued interest in the drawing tasks developed by clinical psychologists (6 chapters), while including more procedures devised by art therapists (10) than the first edition.

Like many art therapists, I have sometimes suggested themes used in projective drawing tasks for the simple reason that they are central to understanding individuals' perceptions of self and others—like the "Person" and "Self-Portrait" done by Jimmy in the following vignette. I was supervising a student who wanted to do an informal research study in the setting where I had just started an art program. Comparing self and person drawings seemed like a good and potentially revealing set of tasks, given the subjects.

Draw-a-Person and Self-Portrait in Assessment: JIMMY (5)

Jimmy was a five-year-old boy who was a residential student at the Home for Crippled Children in 1967 **(DVD 6.7)**. He was first asked to "draw a person," and proceeded to produce a picture of a clown **(A)**. This drawing was in fact rather advanced for his chronological age level, apparent immediately **(Figure 6.6)** without needing to score it on the Goodenough-Harris Scale (Harris, 1963).

He was then asked to make a self-portrait, and on the other side of the same paper he drew a human figure typical not of a five-year-old, but rather of a two- or three-year-old at a

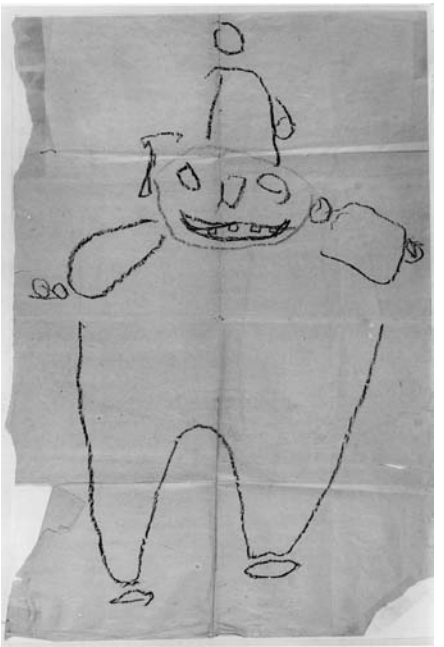

Figure 6.6 "Person" by Jimmy.

pre-figurative stage of development—a crude enclosure with rough indications of limbs and features **(B)**. When asked about his picture of himself **(Figure 6.7)**, Jimmy explained: "The legs got lost in the grass." It was a poignant statement of how damaged he felt, for Jimmy's legs were indeed lifeless: he was able to move only in a wheelchair.

His picture of the clown, on the other hand, showed how bright he was, since it was a superior human figure drawing for a child his age. The massive difference in the developmental level of his self-portrait indicated not only Jimmy's "body image" (Schilder, 1950), but also his rage and helplessness about his disorganized physical state. The self-drawing is particularly poignant in contrast to his choice of a clown, who can not only walk, but who can also jump and hop—and perhaps even "fly" on a trapeze.

Rating Scales by Art Therapists

Before describing how art therapists conduct assessments using creative media, we will note some of the work done by art therapist researchers in the development of rating scales for both artwork and art behaviors.

Rating Scales for Art Products

Art therapists working in research settings often collaborate with other professionals in developing more sensitive rating scales for spontaneous and directed art. The most extensive early studies were done by Hanna Kwiatkowska (1978) and Harriet Wadeson (1980) at NIMH, where they were able to construct imaginative tasks to study patient art. With the help of colleagues in psychiatry and psychology, they also developed scoring methods and rating manuals, the most elaborate one being the *Dent-Kwiatkowska Rating Manual*.

Figure 6.7 "Self-Portrait" by Jimmy.

Inspired by her studies with Kwiatkowska, Linda Gantt **(Figure 6.8)** has developed and refined the *Formal Elements Art Therapy Scale (FEATS)* (Gantt & Tabone, 1998), designed to measure variables in patients' drawings of A *Person Picking an Apple from a Tree (PPAT)* **(DVD 6.4E)** (cf. V. Lowenfeld, 1957). A similar effort has been under way since 1988 to rate drawings elicited in the *Diagnostic Drawing Series* developed and administered on the **DVD (6.14)** by Barry Cohen[8] **(Figure 6.9)**.

In both instances, the art therapist researchers have invited participation by colleagues in the collection and analysis of data, as has Rawley Silver, who has developed and refined rating scales for her drawing tests over a 30-year period (Silver, 1978, 2002, 2007).

Rating Scales for Art Behaviors

While not as common as drawing assessments, rating scales for art behaviors represent one of the ways in which art therapists attempt to assess the effectiveness of their interventions. Such approaches began in the 1960s, when behavioral objectives were introduced in education, and continue to be important, since accountability and evidence-based practices have become necessary for reimbursement and funding in many settings.

Behavioral assessments now characterize most evaluations in education, mental health, and rehabilitation and are used by art therapists to assess patient progress in a variety of settings, although there is no standardized format (Frostig & Essex, 1998).

For her doctoral research, Troeger created an art skills assessment for special education students, using a developmental scale to rate behaviors while working with art materials—drawing, painting, cutting paper, and using clay (Wadeson, 1992). When Fugaro (1985) adapted the *Silver Drawing Test* (Silver, 1978) for assessment with neurologically and emotionally impaired children, he included many behavioral measures as well as the drawing scales of the original instrument.

Figure 6.8 Linda Gantt, PPAT & FEATS.

Figure 6.9 Barry Cohen, DDS.

Figure 6.10 Pre-program art interview with blind child.

The following vignette from the 1970s illustrates such an approach. In order to assess change in a group of blind children with multiple disabilities, I designed a scale that rated behaviors and attitudes during the artistic process, and in relation to others.

Assessing Change After Seven Weeks of Group Art Therapy

In an exploratory art program with thirteen multiply-disabled youngsters at the Western Pennsylvania School for Blind Children in 1970, the children were first interviewed individually in order to be able to group them most effectively. Because of their disability, they were offered a wide range of sensory stimuli, as well as a choice of art materials **(Figure 6.10).**

Two observers using a 24-item, 9-point rating scale were asked to note where each child was on each behavioral dimension. Some items were descriptive of overall behavior, such as passive/active, tense/relaxed, distractible/involved, and depressed/alert. Others referred to the children's interaction with the therapist, like dependent/independent, suspicious/trusting, and withdrawn/outgoing.

Some items related to their use of the art materials, such as awkward/coordinated, impulsive/deliberate, stereotyped/original, or to their attitude toward their work, like critical/pleased. Yet others were about the nature of their creative process, for example, barren/fluent, rigid/flexible. An average of the two observers' ratings on each dimension was used. They agreed almost 90 percent of the time. In other words, the scale had high *inter-rater reliability.*

After seven weeks of group art sessions, we repeated the individual interviews with each child, again using the mean of two observers' ratings on each dimension **(Figure 6.11)**. The differences between the pre- and post-program scores were all in the desired direction. They were *statistically significant (beyond chance expectation)* on the following five dimensions: relaxation, involvement, independence, originality, and flexibility. These objective assessments confirmed our subjective sense of individual and group gains. Jimmy, for example, who had been so shy and lacking in self-confidence that at first he declined art altogether, had become comfortable with drawing, and more important, proud of his work **(Figure 6.12)**.

Figure 6.11 Post-program interview with partially sighted child.

Figure 6.12 Jimmy's pride in his drawings.

On the **DVD (6.8)**, you can see still photographs as well as excerpts from two of the post-program evaluation sessions, which were filmed because by then we had received a grant to record the program. There is no question that the growth indicated by the observers' ratings was evident to me and, I think, to the children as well, who were quite pleased with themselves. Because they had multiple disabilities, they had not been in any sort of art program at the school and were delighted with their accomplishments.

Art Therapy Assessments

Overview

Linda Gantt's chapter in *A Guide to Conducting Art Therapy Research* (Wadeson, 1992) was an excellent "description and history of art therapy assessment" 15 years ago. The next two chapters described a number of drawing batteries and art-based assessment procedures and instruments, including some unpublished materials.

Stephanie Brooke's recent revision of her book (2004) on that topic includes not only more art therapy assessments, but also references to material on the Internet. In a book addressed to non–art therapists (Rubin, 2005a), I included two chapters on the use of art in assessment, because I believe that art therapists' greater knowledge and flexibility about possible materials, themes, and ways of working can enrich other professionals' use of drawings to get to know the people they see.

There is no standardized or commonly accepted approach to diagnostic art interviews, any more than there is a universally accepted way of doing art therapy. A great many different and varied approaches are used by art therapists today. In the responses to a 1991 survey of those who work with children, many different art assessment tasks and batteries were described, in addition to the nine that were listed.

It seemed that art therapists at all levels of experience had modified existing techniques and created new ones, rather than relying on published tools. Perhaps because of this inventiveness, art therapists have typically contributed their own ideas to the evaluation so critical to effective treatment.

Unstructured Approaches

Some approaches to art therapy assessment are unstructured, like my own free choice procedure, for which I have also described ways of "decoding symbolic messages" in art and behavior (Rubin, 2005b). Edith Kramer (2000) suggested a series of art activities—drawing, painting, and working with clay—the sequence of which can be varied, and outlined "observational considerations" (**DVD 6.9**; cf. also **DVD 3.11H**).

Neither of these interviews specifies subject matter. In Bruce Moon's (1992) chapter, "The Role of Assessment," he proposed a wide range of choices of media and topic. He also noted the importance of attending closely to the individual's mode of working with the art materials.

I was surprised when I came across my original proposal for an art evaluation, which was dated April 1969. Although I had first suggested that a free choice be followed by offering a different art medium (like Kramer) and, if time permitted, requesting a self or family portrait (like many assessment batteries), I ended up finding the open-ended approach to be the most fruitful (**DVD 6.10**).

The following vignettes illustrate its power. For Evelyn, free art expression was able to provide evidence not available elsewhere. For Melanie, she needed the help of a "scribble" drawing to be able to create an image, from which she and I were then able to learn a good deal.

Art Assessment Reveals Depth of Pathology: EVELYN (16)

Sometimes an art interview is a peculiarly sensitive instrument where other assessment tools are not. Evelyn, a painfully shy adolescent of sixteen, was thought by the referring psychiatrist to be "mildly inhibited" but not "grossly disturbed." He referred her for an art evaluation because it was so hard for her to talk to him.

Her first production in a diagnostic art evaluation, however, was a painting on the largest size of paper available (18" x 24") of a stark purple "Tree" **(A)**. Asked what sort of place it was, she said it was "nice" and that she would like to be there, right *next* to the tree. Evelyn then paused and said instead that she would *be the tree itself.*

Her next drawing was a bizarre figure named "Fred" **(B)**, who she described as "an eighteen-year-old girl." She said that "Fred" was called "crazy" by the kids, and talked to herself because it was better than talking to others.

Although the referring psychiatrist remarked that the girl's art looked "sicker" than anything else, it was her subsequent suicide attempt that validated the confusion and withdrawal evident in her art work and her verbal associations to the imagery.

She was able to be treated through adjunctive art therapy while hospitalized, which was especially helpful during a period when she became mute. Retrospectively, the glove on Fred's hand and the denial of the body in that drawing, as well as the vaginal "split" in the tree, were clues not only to the depth, but also to the nature of her pathology, which became more apparent in her therapy over time. In addition to art therapy, Evelyn was also able to benefit from dance/movement therapy while in the hospital.

A Scribble Drawing Helps a Sullen Adolescent: MELANIE (15)

Melanie, age fifteen, had been referred to the clinic because of her oppositional behavior. Her rebelliousness had already caused her aunt, who had cared for her since her mother's abandonment in early childhood, to kick her out of the house. She was living with her older brother, but did not feel happy or accepted in his home.

Like many adolescents, Melanie was reluctant to draw spontaneously, since she was "no good" at art. So I suggested that she make a "scribble" drawing, a technique used by art therapists to help people get started. She was able to "find" an image in her scribble, and to develop it (**C**).

At first she said it was an "Eagle," then she changed her mind. "I think it's a 'Hawk' or something." Melanie went on to say that she would like either to *be* the bird or to *take care* of it, eventually deciding that she would rather be a caretaker. She went on to explain that eagles were in danger of becoming extinct—through people's neglect—and that she would like to work for the preservation of the species.

Much to my surprise, Melanie was then able to connect these ideas about her drawing to her own strong and unmet dependency needs. The Eagle/Hawk expressed her loneliness, as well as her hunger for love, acceptance, and family. The sharp beak expressed her biting rage, which was directed at those who had abandoned and rejected her, which was also reflected in the explosive, sullen, angry quality of her speech.

On the **DVD** you can view excerpts from two individual art evaluations—one with a 10-year-old girl (**D**) and one with a 17-year-old boy (**E**), both seen as outpatients.

Structured Approaches: Themes

Other art assessments specify subject matter, like the drawing of a *bridge* suggested by Ron Hays.[9] Like the human figure or the family, such topics are not chosen at random, but

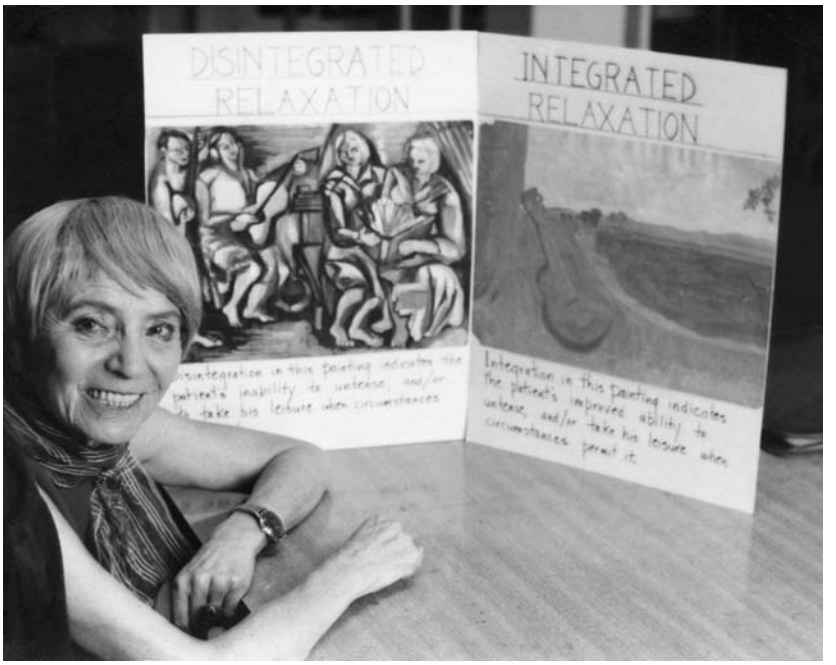

Figure 6.13 Edith Zierer, creative analysis.

rather because they are assumed to tap significant symbolic issues. A bridge, for example, can represent connections and transitions. The added instructions to indicate the direction of travel by an *arrow*, and to show where the artist might be with a *dot*, further amplify the information.

Many projective themes have been proposed by art therapists, such as a rainbow (Shoemaker), a rosebush (Allan, 1988), or a road (Hanes, 1997)—each with a rationale. Noting that abused children often drew inclement weather, Trudy Manning[10] theorized that drawing *A Favorite Kind of Day* (*AFKD*) would reflect how a child viewed his interpersonal environment. She also designed and validated rating scales, using measures of weather, size, and movement.

Creative Analysis, the elaborate system developed by psychologist Ernest Zierer and his art therapist wife Edith **(Figure 6.13)**, was practiced at Hillside Hospital from 1943 to 1967. For assessment, they used "a battery of therapeutic painting tests which are structured but not explicitly directive of the patient's painting activity."[11] The sequence was flexible and determined by each individual's needs. The initial diagnosis was arrived at by making a record of specific elements in the artwork, and creating what they called a "psychogram." They devised a similarly visual way to represent progress over time, measuring the degree of *color integration* in a patient's artwork, and then recording their observations in what they called an "integration graph" **(DVD 6.11)**.

Art Assessment Batteries: Individuals

A battery—a series of tasks in a prescribed order—is the norm for diagnostic interviews in psychology. Hammer, the most vocal proponent of projective drawings, recommends a drawing battery. Indeed, most experienced clinicians agree that a single product—like a

single act or thought—cannot possibly be a valid sample for anyone being assessed, whether the focus is on their potential or their problems.

Thus, both structured and unstructured assessment batteries designed by art therapists usually encourage or specify multiple products. The first was proposed by Elinor Ulman in 1965 (Ulman & Dachinger, 1975), and is now known as the *Ulman Personality Assessment Procedure* (*UPAP*). The sequence of four chalk drawings on 18" x 24" paper is: (1) Free Drawing, (2) Draw Movements (following directed "drawing" in the air), (3) Rhythmic Scribble, and (4) Choice: Free or Scribble Drawing. On the **DVD (6.12)**, you can observe Elinor Ulman conducting a UPAP with two young adult inpatients **(A)** and two adolescent outpatients **(B)**. Her colleague, Gladys Agell, is shown conducting a UPAP with an adult **(C)**.

In 1988 art therapist Barry Cohen designed a three-picture tool, the *Diagnostic Drawing Series* (DDS). The pictures, done on 18" x 24" white drawing paper with 12 pastels, are: (1) Free Drawing, (2) Tree Drawing, and (3) Feeling Drawing (lines, shapes, colors). Modifications for children have also been developed. Many art therapists have contributed data to ongoing studies of the DDS, coordinated by Anne Mills. On the **DVD** you can see Barry Cohen working with one patient **(D)** and Anne **(E)** with another.

Mala Betensky, an art therapist also trained in clinical psychology, designed several different combinations of tasks as *art therapy diagnostics* for different age groups, which she described in her 1995 book with clear rationales for each: For ages 3–7: (l) Exploring Materials, (2) Free Drawing & Painting, (3) Clay, (4) Dollhouse Play & Story, (5) Family Drawing (crayons). For ages 7–10: (1) Free Media Experimentation, (2) Free Picture, (3) Scribble Drawing, (4) Family Picture, (5a) Work with Pipe Cleaners, (5b) Free Clay Modeling, (6) H-T-P (pencil & crayons), (7) 'Grouping Game.' For Pre-Adolescents, Adolescents & Adults: (l) Color-Form Blocks, (2) Poster Paints, (3) Free Picture, (4) Free Clay Sculpture, (5) H-T-P (pencil & crayons), (6) 'Self-in-the-World' Scribble, (7a) Adolescent Window Triptych, (7b) Family (realistic), (8) Family (abstract), (9) Colored Sociogram (You & Your Friends), (10) Free Picture.

Though Betensky incorporated projective drawing tasks, her modifications are those of an art therapist, like large paper for family drawings, or using color for a sociogram. She also designed original tasks, like the *Adolescent Window Triptych* (pictures of *Past, Present, and Future*).

While there is no videotaped record of Betensky administering any of these, on the **DVD (F)** you can see her doing part of an assessment of an adolescent who had returned to her for further individual art therapy. In asking Luis to identify objects using only tactile perception, it is likely that she was assessing his cognitive functioning.

Myra Levick's doctoral work on defense mechanisms in children's drawings (Levick, 1983) led to the development of the Levick Emotional & Cognitive Art Therapy Evaluation & Assessment or LECATA (Levick, 2001). The six tasks, done on 12" x 18" paper with 16 oil crayons are: (1) Free, (2) Self, (3) Scribble, (4) Developed Scribble, (5) Place, and (6) Family. The scoring is based on cognitive stages in graphic development, as well as emotional stages in the use of defense mechanisms. Craig Siegel, a colleague of Levick's, is shown on the **DVD (G)** working with a boy doing all of the tasks.

Art Assessments for Specific Purposes

Just as certain approaches might be especially appropriate for different age groups, so particular sets of tasks may be used for specific purposes or populations. In order to assess the *extent of stroke damage*, art therapist Drew Conger (1978, AATA Conference Proceedings) described using six tasks: (l) Build with Blocks, (2) Draw Around a Block, (3) Copy the

Shape Around a Block, (4) Draw a Clock, (5) Draw a House and a Tree, and (6) Match Colors (using chalk).

Patricia St. John described a similarly well-designed task battery for *children with neurological impairment,* which included copying, drawing from memory, a Human-Figure-in-Action Drawing (someone doing something), a Story-Sequence Drawing (draw a story with a beginning, a middle, and an end), and a Clay Human or Animal.[12] Both Conger and St. John had given serious thought to the individuals whose cognitive ability they wanted to assess, and had come up with tasks that would be both appealing and feasible.

With the emphasis on shortening hospital stays and using time efficiently, art therapists can contribute a good deal to triage (screening) for psychiatric emergencies. The pressure to gather diagnostic data as rapidly as possible has resulted in many creative ideas by art therapists, like Nancy Gerber's *Brief Art Therapy Screening Evaluation* or BATSE (1996). The patient is asked to draw "a picture of two people doing something in a place" in five minutes on small white paper using 8 fine-tip colored markers without using stick figures.

As in psychologist-designed projective drawing tasks, Gerber specifies the questions to ask and what to look for. Since it is so efficient and rich, it is now a routine part of the intake process at Friends Hospital. This has often happened with art therapy evaluations, even those that take more than the 30 minutes of the BATSE, because such a wealth of information can be gleaned in a very short time. The **DVD (H)** shows Gerber demonstrating the procedure with a volunteer graduate student.

Assessing Sexual Abuse Through Art

Art therapists have played an important role in trying to assess possible molestation, but are still looking for the answer to the question that pioneer Clara Jo Stember asked in 1977 (AATA *Conference Proceedings)* about art therapy and child abuse: "Are there graphic clues?" Many have looked for patterns in the drawings and paintings done by abused children (Brooke, 1997, 2007; Drachnik, 1995; Kaufman & Wohl, 1992; Malchiodi, 1997, 1998a, 2008; Murphy, 2001; Wohl & Kaufman, 1985).

Despite the wish to be able to protect children by finding reliable "graphic clues," whether by anecdotal observation or through experimental research, one art therapist concluded after twenty years of work with "child and adult survivors of sexual abuse" (including reviewing the literature in this area) that "At the present time, it has been consistently demonstrated that drawings alone cannot be used as evidence that sexual abuse has occurred" (Hagood, 2000, p. 246).

As for adults, Dee Spring (1993) collected her observations about graphic signs of sexual trauma in art by abused women in and described her *art therapy assessment* with rape victims: (l) This is Me, I Am, (2) My Space, (3) My Life's Road, and (4) My Family and Me. The topics would seem to be useful ones for any adult a therapist wants to get to know through art expression.

Assessing Spiritual Development Through Art

Ellen Horovitz (2002) created the *Belief Art Therapy Assessment* (BATA). Offered a choice of media and surfaces for drawing, painting, or sculpting, the person is asked: 1. "If you have a belief in God, draw, paint, or sculpt … what God means to you." 2. "If you believe there is an opposite force … draw, paint, or sculpt the meaning of that." Horovitz also suggested how to ask questions and what to observe in the person's attitude and artwork. The goal is not to assess cognitive or emotional states, but rather spiritual development or "stage of faith." On the **DVD (I)**, you can see Horovitz conducting part of such an assessment.

Art Assessment Batteries: Families

There are many possible variations in assessment batteries for families as well as in those for individuals, depending on the age and setting of those involved as well as the art therapist's preferences and style of working. In 1967 Hanna Kwiatkowska, inspired by the family therapy that was happening on her inpatient unit at NIMH, as well as by Elinor Ulman's UPAP series, designed the first *Family Art Evaluation* (Ulman & Dachinger, 1975; Kwiatkowska, 1978) **(DVD 6.13)**.

The idea had come to her serendipitously when visiting family members arrived during an individual art therapy session she was having with an adolescent, and she realized that important interpersonal information was revealed when they were invited to use art. For the evaluation, which was conducted with each family member standing at an easel, Kwiatkowska requested six tasks: (l) Free Picture, (2) Picture of Your Family, (3) Abstract Family Portrait, (4) Scribble Drawing, (5) Joint Family Scribble, and (6) Free. Tasks 2, 3, and 5 are demonstrated on the **DVD (A)** by Patti Rossiter and Mari Fleming.

In 1974 Rubin and Magnussen (Rubin, 2005a) adapted the idea to an outpatient clinic with younger children, using three tasks: (1) Scribble Drawings, (2) Family Portraits—abstract or realistic, choice of media and location, and (3) Family Mural. On the **DVD (B)** of our *Family Art Evaluation* you can observe the introduction of each task, as well as portions of the working and discussion time with one family.

In 1987, Helen Landgarten developed her *Family Art Diagnostic*: (1) Nonverbal Team Art Task (pairs of family members, each using one marker color on the same paper), (2) Nonverbal Family Art Task (whole family working on the same paper), and (3) Verbal Family Art Task (deciding and working together). The **DVD (C)** shows her working with a father and his daughter, requesting a task that requires that each make something individually and then put them together.

Parenthetically, a three-dimensional procedure was proposed in 1974 by Margaret Frings Keyes, the *Family Clay Sculpture*. No doubt there are many creative variations in this area.

Art Assessment Batteries: Couples

In 1971 Harriet Wadeson developed an *art evaluation battery for couples* as part of a research project at NIMH. She used four tasks: (l) Family Portrait, (2) Abstract Picture of the Marital Relationship, (3) Joint Scribble, and (4) Self-Portrait Given to Spouse—to "do anything you want to him or her." On the **DVD (D)** you can observe Wadeson inviting a volunteer couple to first create a picture together without talking **(1)**, then to draw self-portraits **(DVD 6.5)**, and after modifying each other's drawings, to discuss the changes **(2)**.

In 1984 the *Menninger Perspective* described Robert Ault's diagnostic drawing series for couples: (1) Free, (2) Family, (3) Joint Picture of Doing Something Together, (4) Individual Abstracts of the Marital Relationship, and (5) Self-Portrait Given to Spouse. Just as Kwiatkowska was inspired by Ulman, so did Ault borrow from Wadeson. There is much cross-fertilization in the still relatively small field of art therapy. In fact, a survey of assessment in art therapy with children commented on the apparent existence of "an oral tradition," in which techniques were passed on to students.

Selection/Creation Art Assessment Batteries

Silver Drawing Test of Cognition & Emotion

One of the most unusual approaches to assessment in art therapy grew out of research by Rawley Silver **(Figure 6.14)**. Inspired by her discovery in their art of untapped capacities in

Figure 6.14 Rawley Silver, Silver Drawing Test.

deaf children (Silver, 1978), she looked for ways to assess competencies through art. Silver used her own artistry to create the 50 pictorial *Stimulus Drawing Cards* that serve as stimuli for the *Silver Drawing Test* (Silver, 2001).

There are three tasks: (l) Draw from Imagination, (2) Draw from Observation, and (3) Predictive Drawing. The first involves selecting two images from the cards and combining them in a drawing that tells a story. In the years since the test was first developed, it has been continually revised, and it has been used with a wide range of people, including elderly stroke patients and at-risk adolescents (Silver, 2002, 2007). The three-task battery is now called the *Silver Drawing Test of Cognition & Emotion* (SDT) (Silver, 2002, 2007).

Although the test was originally designed to measure "cognitive and creative skills," like the psychologists who saw more in person drawings than IQ scores, Silver soon realized that feelings were being expressed too. She therefore published the *Draw-A-Story* test, using the first task of the battery, to screen "for depression and emotional needs."

Indeed, for many years the art therapists of the Miami-Dade public schools have been using her instrument as a screening device and to assess the effectiveness of their work (Silver, 2005). On the **DVD (6.14)**, you can observe Ellen Horovitz conducting the SDT with a deaf adolescent **(A)** and Peg Dunn-Snow conducting one with a young boy **(B)**.

Magazine Photo Collage

The Magazine Photo Collage was elaborated by Helen Landgarten in a 1993 book. Pointing out that the technique is relatively unthreatening and accessible to people of any ethnic background, she outlined an assessment protocol. Given a box of People Pictures and one of Miscellaneous Items, the client is asked to: (l) Select pictures that catch your attention, paste them on paper, and write or tell what comes to mind. (2) Pick out 4–6 pictures of people, paste on another paper, and write or tell what you imagine each person is THINKING and what he/she is SAYING, (3) Pick out 4–6 pictures that stand for something GOOD and something BAD, paste down and tell what they mean. (4) Pick out ONE picture from the People Box, paste down, and write or tell what is HAPPENING to that person. Ask "Do you

think the situation will CHANGE?" IF THE ANSWER IS YES, then ask the client to find a picture illustrating the change or tell WHAT will make it change.

The rationale for the series as well as for each task is clearly delineated. One advantage of the approach is that people of all cultures can easily find photographic images with which they can identify.

Face Stimulus Assessment

As part of her doctoral dissertation,[13] Donna Betts developed a projective drawing assessment that was initially designed for multicultural and disabled youngsters. The task ultimately involves selection, completion, and creation of a face using crayons on 8.5" x 11" paper aspect of the task. Like most art therapist–designed assessments, it is highly inventive, but, as Betts notes, it is not yet tested for reliability and validity (www.art-therapy.us/FSA.htm).

Finally, a fairly comprehensive review of evaluation in and through each of the creative arts therapies was published by Feder and Feder in 1998. It covers many areas, including projective techniques and art therapist assessments.

Concluding Thoughts

By now it should be clear to the reader that many varied approaches to understanding human beings through their art are alive and well in art therapy of the 21st century. While art therapists continue to probe and to work to refine their "third eye" (Kramer, 2000) in becoming even more sensitized to graphic language, they are also striving to be more objective. There has been a consistent attempt over time to be more systematic in the presentation of tasks as well as in the evaluation of data.

Although art therapists are sometimes the only clinicians with whom a regressed patient can "speak," the language of color and form is, like poetry, very difficult to quantify. And even if that can be accomplished, the whole is still greater, deeper, and much more meaningful than the sum of its graphic parts. Messages contained in artwork are received in the context of all associated behavior—before, during, after, and in response to images.

Despite the popular myth that art therapists can "see through" people by looking at their creations, the majority view the artist as the most knowledgeable expert about his or her own symbols. Most art therapists question formulaic approaches to understanding, and resist the temptation to be clever interpreters. They see patients as complex human beings, and many have trouble with the kind of labeling involved in psychiatric diagnosis. Nevertheless, art therapists are often called upon to assist in such tasks, and do have some unique tools.

Any time an art therapist can tell something from artwork that is not available in other ways it is potentially useful. For example, Rawley Silver (1978) saw a gifted artist in a deaf boy called Charlie. Edith Kramer (1958) found artistic talent in a delinquent named Angel (Ulman & Levy, 1981). I discovered that a deaf-mute named Claire was not profoundly retarded (Rubin, 2005b). Similarly, the DDS, a popular art therapy drawing battery, is said to help in predicting treatment course—like identifying the prefusion of "alters" in dissociative identity disorder (Kluft, 1993).

As part of the process of developing the certification examination, the Art Therapy Credentials Board (ATCB) surveyed registered art therapists. While agreement about most areas was impressive, there was so little consensus about assessment that a separate commentary was published in the AATA Journal:

> Although the general public often views art therapy as dealing with the use of drawings in a diagnostic manner … within the field of art therapy little consensus has

> developed over the years as to what types of assessments are legitimate and which ones (if any) should be taught to students of art therapy. There was much disagreement and ambiguity in the findings of the Art Therapy Practice Analysis Survey regarding this area.[14]

There is no question that the use of art for the purpose of assessment and diagnosis is extremely complex, which is reflected in the title of a panel of experienced art therapists at the 1995 conference—"Art-Based Diagnosis: Fact or Fantasy?"—a discussion published in the *American Journal of Art Therapy* (1996, p. 9). Despite the discomfort of art therapists with simplistic approaches to the topic, current trends in mental health and special education require that serious attention be paid to this area.

The assessment of individuals and families through art can contribute a great deal to such diverse areas as: differential diagnosis, clarifying family dynamics, the evaluation of medication effects, or the prediction of dangerous behavior. Moreover, art can enable people to reveal both hidden conflicts and *potential capacities.* Assessing strengths is at least as vital to helping someone as assessing weaknesses.

Art is very rapid and extremely rich, both of which are relevant in times of shrinking resources. A sophisticated art therapist is aware of the hazards as well as the potential in understanding others through their creative work. Used with respect as well as restraint, art can be a powerful tool in diagnosis and assessment. As David Henley wrote:

> We attempt to confirm, moderate and predict the outcome of our treatment process through the fervent study of client artwork. Yet we must do so cautiously and in reverence to the artwork, which tells us so much more than we can describe.[15]

I couldn't agree with him more.

Endnotes

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CHAPTER 7

Technique(s)

The only technique of art therapy is the technique of relating to a patient through art.

Hanna Kwiatkowska

We experience it [a dream] predominantly in visual images; feelings may be present too, and thoughts interwoven in it as well; the other senses may also experience something, but nonetheless it is predominantly a question of images. Part of the difficulty of giving an account of dreams is due to our having to translate these images into words. "I could draw it," a dreamer often says to us, "but I don't know how to say it."

Sigmund Freud, quoted by Margaret Naumburg

Introduction

As Margaret Naumburg often pointed out, "Although Freud made the modern world aware that the unconscious speaks in images, he did not follow the suggestion of his patients that they be permitted to draw their dreams rather than to tell them. Art therapy, however, encourages just such an expression of inner experience" (1966, p. 2). This was the basis for Naumburg's conception of *Dynamic Art Therapy*; that is, promoting the release of spontaneous imagery. But it is not the only way to proceed.

In fact, one of the most pleasurable aspects of art therapy is the creative challenge of deciding what to do and how to do it. As you have seen, there are many different ways of using art to achieve some kind of understanding in assessment. Similarly, there are many different ways of using art as a therapeutic modality. The specific approach chosen depends upon the *goals* of the particular intervention, the context in which it occurs, and the range of what is possible. Art is used *in, as*, and *for* therapy in a variety of ways.

Regardless of what is done, there is a series of necessary steps noted earlier. They begin with setting the stage, a major element in promoting expression in art therapy. A well-prepared environment can inspire creativity, whereas a confusing or uncomfortable one can have a most inhibiting effect. Introducing the task, whether free or specified, is also critical, since instructions need to be both clear and inviting. This is all part of the art therapist's

special area of expertise, evoking expression. Another element central to art therapy is facilitating that expression once it has begun, which requires sensitivity as well as skill.

After the work is completed, the art therapist turns her energies to helping the artist to learn from expression—from the process of creating and from the art product that is made. At each step of the process, art therapists use what they know about art and therapy to make the experience as helpful as possible for the person(s) involved.

This work, like all therapy, is most effective when it is done *artistically*, with tact, sensitivity, and a well-integrated *technique*. Although I added the optional "s" to this chapter title, I have been concerned, as was Hanna Kwiatkowska quoted above, about the apparently insatiable hunger among beginners for lists of *techniques*. I suspect Kwiatkowska would have agreed with dancer Rudolf Nureyev, who said "the reason for technique is to have something to fall back on when you lose your inspiration." Despite those insecure practitioners who want to be told what to do, most art therapists value individual creativity, including their own.

Evolution of Art Therapy Technique

Because of its historic roots in psychoanalysis, free art, like free association, was initially the most common method in art therapy. Although some of us still feel most comfortable with that approach, there is much to be said for a thoughtful consideration and selection of specific tasks, especially under circumstances such as time-limited therapy or work with certain groups.

Ernest Harms long ago called for art therapists to "design specific art interventions to address specific psychopathology."[1] Aina Nucho's (2003) book, which has been thoroughly revised since the first edition of this book, contains a thoughtful discussion about what an art therapist might do during each phase of the therapeutic process. The names she coined are useful too: *Unfreezing, Doing, Dialoguing, Ending*, and *Integrating*. Dr. Nucho articulated many of the considerations that go into decisions about what to offer, how to offer it, and how to behave during each phase of a session and of a course of art therapy. This chapter will offer just a sampling of the many ways art therapists work.

Evoking Expression (DVD 7.1)

Warming Up

Aina Nucho gave considerable attention to the idea of what she called *Unfreezing*. Overcoming natural resistances and blocks to creativity is often called *Warming Up*. All art therapists are concerned with helping individuals of any age who are uneasy about using art media. From Florence Cane's (1951) use of rhythmic body movements before a scribble drawing, to the recent popularity of guided imagery, art therapists have always looked for methods of releasing the creative stream. For they are confident that such a force flows in all human beings, even though it may be temporarily dammed up and therefore inaccessible.

Several popular techniques for loosening inhibitions use some kind of *stimulus,* like music, stories, or fantasy. It may be active and focused, as in a planned sequence of activities, or it may be background and subliminal, as in the soft lighting and music provided by art therapist Bernard Stone to enhance the dreamy atmosphere of his hospital studio, a place I visited 20 years ago but have never forgotten. I have found that by modifying the light—by using candles, flashlights, or projectors and shadows—I can also promote an altered state of mind. On the **DVD (A),** you can see Janie Rhyne motivating an intellectual group of adults

by suggesting body movements and sound making, as well as translating their impulses onto the paper with crayons.

Pictorial Stimuli

Stimulus drawings **(B)** were originally created by art therapist Rawley Silver for assessment. Although her initial purpose was diagnostic, she and others have reported that the set of 50 line drawings can be helpful in art therapy with people who have cognitive impairment, such as chronic schizophrenics or stroke patients (Silver, 2001). They are also useful in overcoming resistances, as with suspicious adolescents. First, the pictures—of people, animals, places, and things—are presented. Next, the person chooses some, imagines something happening, and shows it in a drawing.

Another easily available and frequently used source of visual stimulation are *photographs,* which can become all or part of the final product, as in Helen Landgarten's *Magazine Photo Collage*. On the **DVD (C)**, you can see Landgarten's colleagues, Shirley Riley **(1)** and Maxine Junge **(2)**, using photographs to help families to create.

Many art therapists have also used *art reproductions* in varying forms—from postcards that can be handled and sorted, to slides that are projected and magnified. On the **DVD (D)** you can see Trude Wertheim-Cahen, an art therapist from the Netherlands, describing her way of using reproductions with her clients.

Visual Starters

These are especially popular with art therapists of all persuasions, since they act as a stimulus for the person's own creative ideas. Both Prinzhorn (1922) and Cane (1951) referred to the Renaissance painter, Leonardo da Vinci. His sources of inspiration were ambiguous visual forms, such as the variegated colors and cracks on stones and walls, or on wet, crumpled-up paper. The *scribble,* used interactively by Winnicott (1964–68, 1971b) and after body movement by Cane (1951), is a similar ambiguous stimulus. In fact, it is probably the most widely used *visual prompt* in art therapy, and there are many variations on the theme.

Aina Nucho (2003) described several examples of what she called the *Free Flow Technique*. Art therapist Evelyn Virshup (1978) invited her patients to drag a kite string soaked in ink across the paper, then to develop the abstraction into an image. On the **DVD (E)**, she is doing that with a group of patients in a drug rehabilitation program.

I often suggest "fooling around" with paints on wet paper as a way of getting ideas for pictures. Brown (1967) "drew out" schizophrenic patients by placing a *dot* on the paper, Hays used a *dot-to-dot* exercise with children too young to use a scribble as a way of developing an image, and Vick suggested *Prestructured Elements*[2] for teenagers.

Using the Nondominant Hemisphere

There are other kinds of loosening up or unfreezing techniques, which are thought to depend on accessing the nondominant hemisphere of the brain. One involves drawing with the opposite of the preferred hand. On the **DVD (F)**, expressive arts therapist Natalie Rogers suggests that to Robin, who she is seeing for the first time. Another requires copying a picture viewed upside down (Edwards, 1979).

Rapidly executed *gesture drawings* were first suggested by Kimon Nicolaides (1941) in *The Natural Way to Draw*. Another of his ideas, *contour drawing*, was instrumental in curing Elizabeth "Grandma" Layton's lifelong depression (Lambert, 1995; Nichols & Garrett, 1995).

Art therapist Robert Ault (1986), who brought Layton's story to the professional community, reported that doing regular contour drawing seems to have an antidepressant effect. He

tried the method on himself, students, and patients, to surprisingly good effect. He hypothesized that there was a neurological effect that was salutary (Ault, 1996). On the **DVD (G)**, you will see Layton's story **(1)**, as well as a therapy group where Ault used contour drawing **(2)** and the book he wrote about it **(3)**.

Stimulating Materials and Methods

Using the element of speed, psychiatrist Wilhelm Luthe (1976) suggested a structured approach based on what he called "autogenics." His *Creativity Mobilization Technique* consisted of producing a series of 15 painting exercises in a 30-minute period—four times a week for six weeks.

Sometimes stimulating media are used deliberately, as in the treatment of Gloria, a young widow in her twenties who came for weekly art therapy.

Regressive Media Help in Dealing with Shame: GLORIA (29)

Gloria had vocally expressed her disgust at the finger paints, always noticing but never using them. I had asked if she could describe her feeling of revulsion, but she found it hard to define. I then wondered if we might not find out more if she were to try the paints, despite her negative response. She was willing to do so in an openly experimental way; and it was quite a powerful session, referred to many times in succeeding months.

She began by feeling and expressing disgust, but gradually got more and more into it, exclaiming with glee, "Ooh! What a pretty mess!" After a tentative beginning, she took large gobs of paint, and eventually used both hands and fingers with a high degree of freedom **DVD (H)**. Her unexpected discovery was that she liked it, that it was not unpleasant as she had anticipated, but that it was actually fun. She related this surprise to her initial anxiety about getting her daughter out of school for morning appointments, and her discovery that it was neither uncomfortable nor harmful as she had feared.

Her associations to the first painting **(1)** were that it was a series of "Roads" that led to various places, and that she had to decide where she was going, a fairly accurate description of where she was in her life at that time. The second she described as "like Hell, a Storm with Lightning and Turmoil," **(2)** and ended up talking about her own feelings of sinfulness and guilt over sleeping with a man to whom she was not married. The shame she felt about being "dirty" was stimulated by the medium itself, as well as by the images she projected onto her finger paintings, which were nonrepresentational.

Mental Imagery

The evocation of visual imagery has been used by many clinicians, beginning with Freud, to stimulate memory, fantasy, and awareness of feelings. It has also been used to facilitate art activity. I became interested in spontaneous mental imagery during my psychoanalytic training, and began reading the rapidly mushrooming literature on the topic.

As with studies of drawing development, imagery was long dormant in psychology, largely because it is so introspective and hard to quantify. Due to its frequent use in behavior therapy techniques like desensitization, however, during the last quarter of the 20th century the study of mental imagery once again became a lively arena (Watkins, 1984). This interest is reflected in the existence of the International Imagery Association (*Journal of Mental Imagery*) and the American Association for the Study of Mental Imagery (*Imagination, Cognition, & Personality*). Clinicians who use mental imagery in therapy sometimes invite people to draw what they have seen in the mind's eye, like psychiatrist Mardi Horowitz (1983).

Figure 7.1 James Consoli, *Psychimagery.*

Working at the Menninger Foundation, Don Jones developed an assessment (the *Don Jones Assessment*), which combined guided imagery with drawing. The patients, in a relaxed state, are invited to imagine a journey, stopping at four key points. At each point, they are asked how they would proceed, and are told that they will be drawing a picture of their answer. Each situation is carefully designed to represent a different kind of universally stressful problem. They are then asked to draw a picture of what they imagined. Both exercises are followed by a series of structured questions. Like Jones, most clinicians using mental imagery along with art request drawing or painting an image after it has been "seen." Jones and his colleagues, who studied the protocol, found it to be as useful in treatment as in assessment.[3]

Art therapist Vija Lusebrink (1990) discussed the relationship between art therapy and mental imagery, and Aina Nucho (1995) devoted an entire book to the topic of mental imagery. Art therapist James Consoli **(Figure 7.1)** used a combination of hypnosis and mental and graphic imagery to help a survivor of childhood sexual abuse recover and work through her traumatic memories. On the **DVD (I)**, you can see excerpts from the videotape he made about his approach, which he called *psychimagery* (Consoli, 1991).

A Series of Images

Making a series of images is another evocative technique, one used by art therapists in a variety of ways. Bernard Stone, who worked with hospitalized adults, reported on a *sequential graphic Gestalt,* where the client was asked to rapidly draw a series of pictures in response to his own painting (Jakab, 1975). Psychiatrist Mardi Horowitz (1983) invited patients to do a series of six drawings, beginning each time by staring at a dot in the middle of the page until they saw an image. On the **DVD**, art therapist Trude Wertheim-Cahen **(D)** demonstrates how a series of drawings beginning with a scribble helped one of her patients.

Stimulated by my analytic training, I experimented with a similar idea using various media, which I called *free association in art imagery* (1981 AATA *Conference Proceedings*). On the **DVD (J)**, you can see some workshop participants doing this exercise, and then exploring together the ideas stimulated by the sequence of images each has created.

These approaches using art materials resemble free association in mental imagery, which in some ways is what happens in psychoanalysis, but which has also been requested at times by clinicians. They also resemble *Active Imagination* as practiced by Jungian analysts (Chodorow, 1997), who encourage not only mental imagery, but also art, movement, and drama as ways to enhance the associative process. On the **DVD (K)**, you can see Jungian expressive arts therapist Carolyn Grant Fay inviting her client to move in response to a drawing.

A *series of cartoon drawings* was proposed by Crowley and Mills, Ericksonian child therapists. Using children's natural fascination with cartoon characters, they suggested various exercises to parents and teachers as a way of helping children to deal creatively with stressful situations in their book, *Cartoon Magic* (1989).

Facilitating Expression (DVD 7.2)

Motivational Techniques

Although young children are less likely to be inhibited about using art materials than adolescents or adults, they may still have difficulty creating authentically. Edith Kramer has proposed a classification of *ways of using art materials* that is relevant for all age levels: (1) Precursory Activities, (2) Chaotic Discharge, (3) Art in the Service of Defense (stereotypes or copying), (4) Pictographs, and (5) Formed Expression.

Such an analysis is useful not only in understanding what is produced, but also in thinking of ways to motivate people to achieve a higher level of artistic expression. Stereotyped work, for example, is common during what Viktor Lowenfeld (1957) called the "schematic" stage in normal artistic development, for which he suggested various motivational techniques.

One of his central ideas was the importance of what he called the child's "self-identification" with whatever was being represented. Lowenfeld recommended that children not only *imagine* doing the activity to be drawn (like brushing teeth), but *enact* it as well, thus activating the child's sensory awareness. He also proposed the respectful notion of "extending the frame of reference"—working within and with the child's imagery, rather than trying to suppress even bizarre ideas.

Artistic Interventions

Another set of Lowenfeld techniques involved the use of the worker's "auxiliary ego" to assist the child when his own resources are not sufficient to function autonomously. That is one way to think about *closure,* which means starting a clay modeling or drawing for the child to finish. David Henley (1992, 2002) has used Lowenfeld's ideas in art therapy. He also noted that pictorial interventions—which Edith Kramer called "using the art therapist's *third hand*"—are compatible, as long as they do not distort. On the **DVD (A)**, you see Shirley Riley starting a drawing so that a patient with Alzheimer's disease, who had been unable to begin drawing, can finish it.

One clinician who used his own drawing and associative processes in order to relate to children was British psychoanalyst D.W. Winnicott, who took turns making and developing a series of pencil "squiggles" into pictures. Although playful, the technique penetrates deeply, and requires considerable expertise on the part of the therapist. It is particularly effective where time is of the essence, as it often was for Winnicott **(Figure 7.2)**, who might have only one consultation with a child brought to see him from a great distance (Winnicott, 1964–68, 1971b).

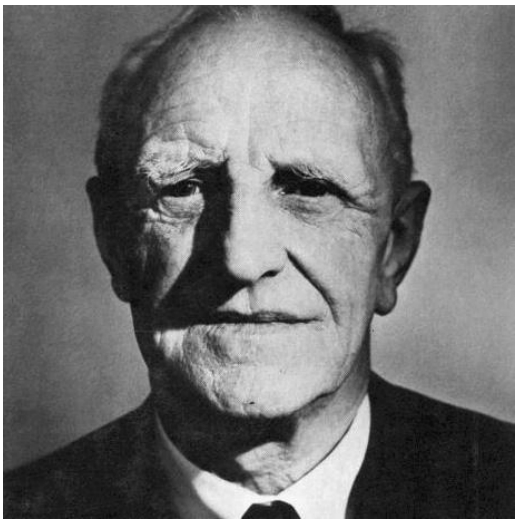

Figure 7.2 D. W. Winnicott, squiggle game.

Like any other activity by the therapist, doing art can be harmful as well as helpful to the patient. Frances Kaplan's *Drawing Together* is a thoughtful discussion of working along with a patient in art, noting those for whom it is beneficial, as well as those for whom it might be disruptive.[4]

Many art therapists have reported working along with a patient, group, or family (Kapitan, 2003; McNiff, 1981; B. Moon, 1995, 2006, 2007; C. Moon, 2002). My own concern is that the art therapist has sufficient self-awareness, so that what she creates does not impinge on the patient's creativity. On the **DVD (B)**, you can see Bruce Moon working alongside a student during their final supervision session.

Another use of the art therapist's artist-self is to *draw a portrait of a patient,* perhaps while he is creating. On the **DVD (C)**, both Vera Zilzer and Alice Karamanol are seen doing this in groups. With her schizophrenic patients in a partial program, Zilzer gives her portrait as a gift to the model **(1)**. With her adolescents in a special school, Karamanol does an outline and invites the student to complete it **(2)**. She comments in the excerpt that drawing someone's portrait is a very intimate kind of attention, "a way that I get to touch them without touching them."

Many of us have done this, as in my own experience of drawing and painting **(Figure 7.3)** Ellen, an elective mute, when she was acting especially hostile. This same girl also stimulated me to invite her to work together on a *joint nonverbal drawing.* Her story is told in Chapter 9. Other clinicians have reported doing this with withdrawn patients of all ages, like Mardi Horowitz (1983), who drew and painted with regressed schizophrenics. *Drawing dialogues* have also been used as a way of "breaking the ice" (Landgarten, 1981).

Many of us have also found ourselves drawing "on demand" with the patient giving instructions, like Irene Rosner did for Eddie, a quadriplegic who told her what and how to create. On the **DVD (D)**, you can see Irene doing this for him in the early part of his treatment **(1)**. Later, Eddie was able to hold a brush in his mouth and create his own drawings and paintings **(2)**.

Having developed a *Boss-Slave game* to deal with authority issues in work with mothers and children (Rubin, 2005a), I have found it useful at times to "follow orders" with patients

Figure 7.3 My painting of Ellen, an elective mute.

of all ages. One art therapist reported acting as *graphic secretary* for the child, and another used the similarly playful traditional *fold-over* drawing game (Wadeson et al., 1989).

Although the use of one's artist-self is probably quite common in the work of art therapists, there may be reticence in reporting it because of the obvious counter-transference hazards. It is indeed possible that an art therapist's own exhibitionism, competitiveness, or lack of sensitivity to the patient's defenses might cause such an experience to be disruptive. Another reason for the selective use of this tool is that it can absorb too much of the artist clinician's attention.

Nevertheless, most art therapists have worked with materials alongside patients in a variety of ways, and for a great many possible reasons. One is to model behavior, as in the "Pied Piper" effect I described in Chapter 4; another is to defuse anxiety about using materials and being observed, which I did in a family art evaluation that is seen on the **DVD (E)**. Yet another is to convey an idea graphically, a useful form of *interpretation*.

An original method of mutual communication has been described by art therapist Mildred Lachman Chapin (Rubin, 2001). After first talking with the patient about current concerns, both draw simultaneously, neither one seeing the other's image **(Figure 7.4)**.

Figure 7.4 Mildred Lachman Chapin drawing with a client.

After creating the drawings, both parties share their pictures and thoughts about each of them. In my opinion, this very powerful technique is appropriate—like Winnicott's—only for experienced practitioners. You can see Lachman-Chapin doing this with a patient on the **DVD (F)**.

An art therapist might use her artist-self either *simultaneously* or *in turn*. Her creation might be a reflection *of* or *to* the patient. The art therapist's ability to use visual language expands her clinical repertoire, just as art enlarges expressive possibilities for the individual(s) hoping to grow through treatment. As with any intervention, the injunction to do no harm applies; when the art therapist uses herself as artist it should be with thoughtfulness and care and an awareness of its impact on the patient—and, of course, in that person's interest.

Drawing Workbooks and Guides

Like fairy tales and art in therapy, the cartoon story drawings proposed by Crowley and Mills in *Cartoon Magic* (1989) offer both disguise and distance, enabling loaded themes to be dealt with more comfortably. The popularity of such *self-help materials*, for both adults and children, has not been lost on art therapists.

Some have developed *creative workbooks* **(G)** that suggest various drawing and writing activities. The pioneer in this area was Lucia Capacchione **(1)** (2001), whose *Creative Journal* **(2)** was the first of her many drawing workbooks (www.luciac.com).

Barry Cohen and his colleagues published a creative workbook for those suffering from posttraumatic stress disorder (Cohen, Barnes, & Rankin, 1995) **(3)**. Graves (1994) created one for those who have been bereaved **(4)**, and Nichols and Garrett (1995) wrote one for those who are depressed **(5)**.

Heegaard's series of 18 workbooks for children, some to be used with parents, and her guide for facilitators (Heegaard, 1996) deal with specific problems, like adoption, illness, death **(6)**, and self-control.

Figure 7.5 A child drawing in the hospital.

While working at a child guidance center, I tried out a variety of *drawing books* with children, including one on reality testing ("Make-Believe Drawing Book"), one on self-concept ("My Book About Me"), and a "Hospital Drawing Book" for children in a medical hospital **(Figure 7.5)**. My young subjects' responses were uniformly positive, confirming the need for such tools. In 2002 the American Psychological Association published one I designed for children whose parents are separated or divorced, *My Mom and Dad Don't Live Together Anymore* **(7)** (Rubin, 2002). I suppose it is meeting a need, since I was recently told that it had been translated into Italian and has sold well in Italy.

Closely related to drawing workbooks are books that encourage readers to explore their own creativity, some of which have been created by artists like Julia Cameron, whose *The Artist's Way* (2002) has a parallel workbook (Cameron, 2007). Janie Rhyne (1995), an art therapist who began her work in the human potential movement, devoted a large part of her book to helping readers gain access to their own creativity. On the **DVD (H)**, you can see Rhyne inviting members of a workshop group to get in touch with theirs by working with clay with their eyes closed, in order to stimulate both relaxation and imagery.

Art therapists have also contributed to this literature, and are now including more exercises in their own books, with directions to the reader for ways of implementing their suggestions (Allen, 1995, 2005; Fincher, 1991; Malchiodi, 1998, 2002; B. Moon, 2006).

Deciding What to Do and Why

There are a number of books by art therapists for those who want ideas about what to do, primarily with groups, though many can be used with individuals as well. Most cover a wide range of materials and processes and are organized according to such categories as goals, media, or themes (Buchalter, 2004; Campbell, 1993; Liebmann, 2004; Makin, 1999). Some are based on, and especially applicable to, particular settings, such as schools (Ross, 1997) or hospitals (Darley & Heath, 2008).

Being inventive, art therapists have come up with a great variety of intriguing and idiosyncratic ways of working. There is usually some kind of systematic deliberation behind

choice of media, degree of task structure, and the nature of the task itself. The goal was central in an early attempt to classify *Techniques for Individual and Group Art Therapy* (Ulman and Dachinger, 1975), whether for: exploration, rapport building, expression of inner feelings, self-perception, interpersonal relations, or the individual's place in the world (cf. Robbins, 1994).

Thinking clearly about the *goal* of an art activity makes it easier for the therapist to decide what to do. If it is *diagnostic,* to *assess* someone's perception of their family, requesting a family drawing would clearly be in order. If the wish is to see how someone sees himself, a self-portrait might be in order. If the goal is to ascertain a patient's ability to function independently, then a free choice procedure would make sense.

On the other hand, the goal might be primarily *therapeutic*, such as helping a constricted individual to become freer. In that case, activities like developing an image from a scribble, or closing eyes and reporting whatever imagery arises might make sense. If the goal is to increase self-esteem, an activity with a high potential for success would be in order, such as modeling with colored plasticine clay or creating a torn tissue-paper collage with thinned white glue and brush on white drawing paper, both of which result in attractive products. On the other hand, if the aim is to help a couple to become aware of their interaction patterns, working together without talking might be indicated. These are just a few examples of ways to use goal setting to decide what to do and how to do it.

In deciding how to proceed, art therapists have three main elements at their disposal, which can have varying degrees of structure or specificity: *media*, *theme,* and *manner of working*. Regarding media, people can be offered an open choice from among two or more alternatives (e.g., drawing or painting), the specified use of a class (e.g., drawing materials), or a request to use a specific material (e.g., pastels).

Knowing the characteristics of different materials helps art therapists greatly. To assess the degree of elaboration in someone's drawing, for example, it is necessary to offer only easily controllable media like drawing pens, colored pencils, or fine felt tip markers, which will allow them to represent details. On the other hand, if people need to cover a large area rapidly, a medium like thick poster chalks is more appropriate.

Art therapists Sandra Kagin Graves **(Figure 7.6)**, who conceptualized *media dimensions variables,* and Vija Lusebrink **(Figure 7.7)** (1990) together elaborated the *Expressive Therapies Continuum* (ETC) model. It postulates four levels of image formation and information processing, in a developmental sequence from *kinesthetic/sensory* (K/S) to *perceptual/affective* (P/A) to *cognitive/symbolic* (C/S). *The creative level* (CR) can be present at any and may be a synthesis of all. This model offers a way to think about media and activities according to specific objectives for people at different levels of functioning. Lusebrink gives a number of examples of how to use it in decision making. Lisa Hinz (2009) has recently elaborated this model in a new book on the ETC.

Another area where art therapists have options is the *theme,* which can be open-ended, such as "Do what you want," or more or less specific, as in "Draw a feeling" or "Represent anger." When in doubt, it is safest to stay at a more symbolic level, since art allows for a substantial degree of disguise. For example, if the goal is to help someone to become aware of anger at their mother without risking resistance, a request to draw a witch might be more fruitful than asking for a picture of the parent herself.

The third element art therapists have at their disposal in deciding what to do is the *manner* in which the task is to be accomplished. It can relate to the *interaction*, as in "Choose a partner and draw each other," the *time*, as in "Do a one-minute gesture drawing," or the *method*, as in "Model a piece of clay with your eyes closed." A central variable is the degree

Figure 7.6 Sandra Kagin Graves, media dimension variables.

Figure 7.7 Vija Lusebrink, Expressive Therapies Continuum.

of structure in the task itself, a topic that has yet to be systematically investigated, but about which art therapists have reported impressions.

Wadeson et al. (1989) described work with two retarded young people, who required different approaches because of their different levels of functioning. One therapist found that a nondirective approach with hospitalized depressed patients resulted in defensively cheerful images, whereas specific themes, like "Barrier Drawings," helped patients to express the pain and anguish they were actually feeling (Wadeson et al., 1989). Conversely, McNeilly (2006) reported that he had "abandoned the directive approach in favor of the non-directive" with an outpatient art therapy group.

The advantages and disadvantages of directive and non-directive approaches have yet to be evaluated in a systematic fashion. What seems evident is that the more non-directive approaches are more likely to be successful with high functioning clients, whereas the more impaired recipients of art therapists' services often seem to require more structured approaches. As Waller (1993) noted, even those favoring open approaches have needed to modify them for patients who function better with clear external structure, such as psychotics, individuals who are cognitively challenged, or children with attention deficit disorder (cf. Paraskevas, 1979).

What is evident in reviewing the literature is the creativity in the field. An experienced art therapist is familiar with a wide variety of media and processes. She also has in her armamentarium many different ways to offer materials, and tasks can range from unstructured to highly specific. The following vignette describes the thinking behind designing some tasks in family art therapy.

Specific Tasks Help a Family to "See" Problems

A psychologist and I worked as co-therapists with a family on a weekly basis for 32 sessions over the course of a year. We recommended this modality on the basis of their response to a family art evaluation; and the fact that the boy Tim's stuttering, which was virtually absent in the children's group he had attended at the clinic and at school, was still evident at home and a source of distress for the parents (Rubin, 2005a).

Most of the time, the family members were free to use whatever they wanted, and to make whatever they wished. Tim and his sister enjoyed using the art materials as did the parents who were bright and articulate. With two therapists in a large space, we were able to conduct some individual and couple therapy, as well as talking with the family as a whole in the sharing time at the end of each session. In addition to free choice, we also assigned certain topics based on our weekly post-session collaborations **(DVD 7.3)**.

The first topic we assigned was "the Main Problem in the Family that you would like to work on," asking that they not look at each other's drawings until the sharing time. Father drew Mother abandoning him with the two screaming kids at the supper table, complaining that "She never joins us" **(A)**. Mother drew him reading, while the kids argue and she wearily does the dishes, begging him to intervene in the children's fight **(B)**. Both were shocked by the similarity in their feelings of abandonment and mutual resentment.

Several months later, feeling the continuing tension between the two, we asked them to "draw things the *way you wish they were*." Mother made a picture in which a maid is cooking a meal in the kitchen, while she and her husband have a drink on the sofa. They are romantically planning a trip to Africa, as she thanks him for the beautiful flowers he has sent her. The children are notably absent **(C)**. Father, however, had a very different wishful image. In his picture, his wife is happily cooking the meal, both children at her side. On the other side of his drawing she is sending him to work with a kiss, while the angelic youngsters—complete with halos—wave goodbye from their windows **(D)**. Their conflicting images of perfection and their mutual dissatisfaction, poignantly evident in these drawings, became an increasingly open topic for discussion.

Despite their ability to express how they felt, my co-therapist and I became increasingly frustrated by how effectively this family could rationalize. One day we suggested that they try to draw on the same sheet of paper without talking, a helpful task for highly verbal families. They worked on the drawing for 45 minutes, Mother "taking over" almost half of the space, even adding to the others' pictures. Tim began by drawing a house in the center, but soon gave up and left to work alone with clay at another table **(E)**. He tried to get his father

to join him, and his dad did so for a while **(F)**, but then went back to the table where his wife and daughter were still at work **(G)**.

When all were seated, it was safe for Tim to go up and add some more details to his house **(H)**. For the first time, Mother understood what the others had been trying to tell her about how intrusive and controlling she could be, albeit with loving intentions. The picture—because it so vividly recalled the process—was used by the family, posted on the wall at their request, as a dramatic reminder for many months. It was a visual record of some of the interaction patterns causing stress in the family system.

Family art therapy continued. By the latter part of the work, the focus had shifted from the boy and his now-absent symptom to stresses in the marriage. When it ended, the parents agreed to our recommendation of individual and/or couples therapy, both of which they pursued with positive results. The parents' marriage continued and each of the children went on to become successful adults, earning advanced degrees and functioning at high levels both professionally and personally.

Selecting the best option(s) for any particular therapeutic situation is not that difficult—as long as the clinician's imagination is unclogged, her repertoire is broad, and the purpose is clear. A critical variable in effective therapy is the worker's ability to be open-minded and flexible. For art therapists, this means being sympathetic to a wide range of approaches and materials. The most common modalities in art therapy are the fine arts of drawing, painting, modeling, and constructing—in both two and three dimensions. Since these are well known, the rest of this chapter is devoted to descriptions of several of the many possible variations on the visual arts.

Variations on the Visual Arts

Sandplay

For generations, children have played with *miniature life toys,* and people of all ages have built castles in the sand. Since I always had a sand table in my playroom, the idea of *sandplay* (Kalff, 1980; M. Lowenfeld, 1971, 1979) seemed natural. And although the majority of sand tray devotees are Jungian analysts, the technique itself is used by a variety of practitioners (Bradway et al., 1990; Bradway & McCoard, 1997; Carey, 1999; Homeyer & Sweeney, 1998; Labovitz & Goodwin, 2000; Markell, 2000; McNally, 2001; Mitchell & Friedman, 1994; Ryce-Menuhin, 1992).

Many art therapists, such as Zweig and Caprio (Virshup, 1993), Lusebrink (1990), and Steinhardt (2000), have also found the *sandtray* to be a useful adjunct to their work. On the **DVD (7.4)** you can see Kalff doing sandplay with a child **(A)**, Carolyn Grant Fay doing it with an adult **(B)**, and both talking about the procedure.

Hypnosis and Guided Imagery

One aspect of sandplay is that doing it usually creates a dreamy state of mind. Like most art therapists, I am not trained in clinical hypnosis. But reading fascinating work about painting and modeling while hypnotized (Meares, 1957, 1958, 1960) long ago impressed me with the potential value of creating in an altered state of consciousness. Watkins (1992) devoted a book chapter to what he called "hypnography and sensory hypnoplasty." On the **DVD (7.5)**, Karen Clark-Shock is shown describing her use of both hypnosis and art in what she calls *Hypno-Art Therapy* **(A)** (cf. also Jim Consoli's use of hypnosis in his technique, *Psychimagery* (**DVD 7.1) (I)**.

Approaches to art therapy that use meditation, relaxation, or imagery are closely related, such as the *Guided Imagery in Music* (GIM) technique developed by music therapist Helen Bonny (Bonny & Summer, 2002) and art therapist Joan Kellogg (2002). On the **DVD** Natalie Rogers is shown beginning a session with a new patient by asking her to close her eyes and relax before creating **(B)**.

Phototherapy, Videotherapy, and Computers

Using modern technology, the visual worlds of *Phototherapy* and *Videotherapy* are extensions of the artist's eye, with the camera as the medium. As photographer Alfred Eisenstadt said in a televised interview, "I'd have liked to paint, but I can't paint. I have to paint with my camera!"

Many clinicians have asked patients to bring in *family photographs* (Akeret, 1973). Among them are practitioners such as psychologist and art therapist Judy Weiser (1993) who uses personal snapshots and family albums. On the **DVD (7.6)**, an AIDS patient is seen sharing a photograph of his cats with his art therapist, Ellen Hiltebrand **(A)**.

Robert Wolf[5] **(B)** incorporated *Polaroid photography* in his art therapy with adolescents, who were invited to make cartoon drawings using photographs of themselves and the therapist **(C)**. Two other art therapists introduced what they called *Photo-Art Therapy* (Fryrear & Corbit, 1992a, 1992b), in which they use instant photographs in collage creations. On the **DVD** you can see such a group **(D)**.

From the brief existence of the *International Phototherapy Association* and its newsletter during the 1970s, one might conclude that this visual treatment modality is a form of art therapy, since many of its practitioners ended up settling in AATA. Most prominent is Judy Weiser (1993), director of the PhotoTherapy Centre (**Figure 7.8)**, who has facilitated training and communication **(E)** (www.phototherapy-centre.com). Ellen Horovitz uses photography as well, and has produced a **DVD** about some of the techniques she uses in her work (www.arttxfilms.com).

Figure 7.8 Judy Weiser, PhotoTherapy Centre. © Judy Weiser. Reprinted with permission.

Figure 7.9 Filming for animation.

Film animation, while more complicated, involves art in a very direct way **(DVD 7.7)**. During the 1960s at a hospital in Lausanne, Switzerland, two psychiatrists invited a group of inpatients to make *animated cartoons* using a 16-mm camera. During the 1970s, I became fascinated with simple animation techniques using a Super 8mm camera. I tried them out with several individual children in art therapy at a clinic, as well as with some youngsters who were in "art-awareness" groups in preschools and in a summer program at an elementary school **(Figure 7.9)**. During the 1980s, art therapist Judith Rothschild worked with a group of outpatient adults with chronic mental illness to draw on 16mm film and create animated stories.

On the **DVD** you can see some students setting up **(A)**, doing **(B)**, and filming **(C)** animation. In addition, there is an excerpt from "Dreams So Real" **(D)**, made by filmmaker Oren Rudavsky while he was a student at Oberlin College, about an animation program for patients at an Ohio mental hospital.

Shaun McNiff was one of the first art therapists to explore the usefulness of *videotaping* group art therapy sessions and playing them back to the group. Jerry Fryrear pioneered as well in bringing *media arts* like *videotherapy* (Fryrear & Fleshman, 1981) and *phototherapy* (Krauss & Fryrear, 1983) to the attention of art therapists.

As with viewing the art created in therapy, photography is another way for a person to gain both aesthetic and psychological distance. In *art–drama therapy* groups at the Pittsburgh Child Guidance Center, we often used *slides and films* taken by ourselves or the members **(Figure 7.10)** as a way to re-view and reconsider **(E)**. A film about an adolescent group, *The Green Creature Within* (Irwin & Rubin, 2008), is composed of such photographic records **(F)**. They were also used in the therapy, viewed and discussed like the art, and film was especially useful for recording dramas. But the film needed to be developed, so the visual feedback was necessarily delayed for a week.

Figure 7.10 Filming in an art–drama therapy group.

Video technology, on the other hand, allows instant replay, and is helpful for training and supervision as well as therapy. A combination of art and video therapy is indeed remarkably powerful, as Irene Jakab and I discovered when we conducted some video art therapy family evaluations in the 1980s at a psychiatric hospital. Recent papers and presentations describe using the medium not only for recording and playback, but also as an expressive tool. On the **DVD** you can see some scenes **(DVD 7.8)** from the edited videotape (Jakab, 1982).

For a boy named Isaac, both art and film were central to his therapy as a young child, as an adolescent, as a young adult, and eventually to his life.

Art and Film Therapy Help a Young Man Grow Up: ISAAC (**DVD 7.9**)

I had seen Isaac for five years in child analysis. He was a sad and preoccupied little boy, but took to the use of expressive media with enthusiasm **(Figure 7.11)**. Art and drama were his prime modes of communication throughout his treatment **(A)**. One of his favorite activities was the making of animated films using clay, where the stories he often enacted with his artwork could come alive **(B)**. He made slow and steady progress, but had a hard time ending therapy and saying goodbye when he was 11.

Three years later, Isaac returned for two months of art therapy, saying that he was depressed because he felt rejected by other kids. When he began to express suicidal thoughts, I referred him to a psychiatrist, and we all agreed on hospitalization and a trial of medication. After leaving the hospital, he enrolled in a creative arts high school, where he did a lot of acting and began to make films and videos.

Toward the end of his senior year, Isaac returned once more for art therapy. Deeply discouraged, he had been rejected from all of the colleges to which he had applied. Although he blamed his guidance counselor, he had not applied to a "safety school" as he had been advised. I thought he was probably having a hard time leaving his parents, who were not only angry at him, but also loving and very needy.

Since Isaac was still deeply attached to me as a parental figure, I suggested that he work with an art therapy intern I was supervising at the time. With her assistance, Isaac was able

Figure 7.11 Isaac dramatizing in art therapy.

to overcome his lethargy, find a job, and apply to schools where he had a reasonable chance of being accepted. His dream of becoming a filmmaker helped him to manage the stresses of working and waiting. He also took courses in filmmaking, and began to feel generally more hopeful.

Having made progress in dealing with the outside world, Isaac was then able to use art therapy to deal with his inner world. In his twice-weekly sessions, he was able to get in touch with more of the rage that he had repressed when he was younger. This rage, turned on himself, had been a significant factor in his depression and feelings of worthlessness.

Isaac spent many months working on what he called his "statement." He first sculpted a massive clay head, then covered it with gesso, so that it was literally whitewashed. He displayed it, along with sculptures by other patients, on a round table in my office. Its most outstanding feature was a wide-open mouth, full of carefully sharpened teeth. At one point, he picked up a bloody-looking sculpture by another patient, and placed it inside the devouring mouth, instantly creating a drama **(C)**.

The head was an eloquent symbol of the fears Isaac needed to work through, in order to separate and become a truly autonomous young adult **(Figure 7.12).** He left it as a memento for both of his art therapists, and kept in touch as he made his way through college as a filmmaking major.

At one point he sent me a film he had made and asked for reactions. While it wasn't explicitly autobiographical, Isaac was aware that the drama reflected continuing work on his own wishes and fears. Parts of the film used clay animation, reminding me of his earlier dramas. It seems clear that the arts—in one form or another—will always be Isaac's mode of coping with and contributing to the world. On the **DVD** there is a claymation segment from that film **(D)**.

Computers, like video, are also extremely versatile. They have the ability to do all sorts of creative and colorful things with all kinds of visual elements, both still and in motion. If my experience with a computer-literate intern is any indication, the future holds exciting possibilities for expression. In fact, things are moving so rapidly in that area that a book called *Art Therapy & Computer Technology* is already out of date (Malchiodi, 2000) and is soon to be revised.

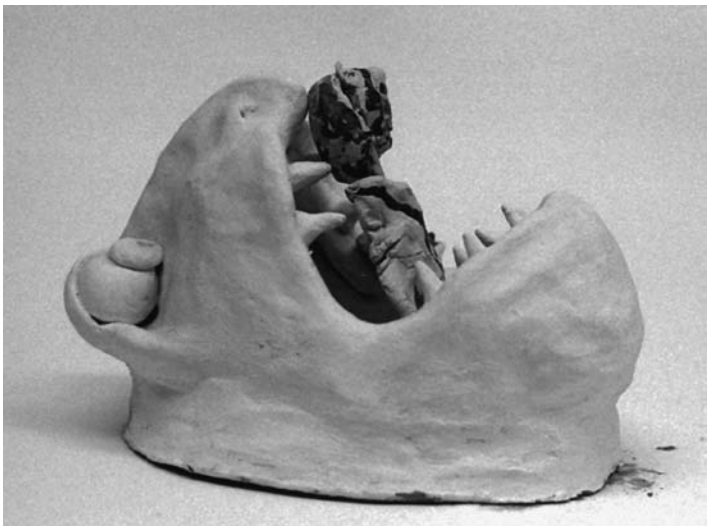

Figure 7.12 Isaac's "Sculpted Head with Victim."

Multimodal Expressive Arts Therapy

The notion that individuals need to find the materials that suit them best is one to which many art therapists subscribe. The related idea—that some media serve certain expressive purposes better than others—is also one with which most art therapists would agree. Since film, video, and animation involve action as well as imagery, they are excellent for the telling of stories. Because they can incorporate art, movement, music, and drama, they lend themselves well to *expressive therapy* (**DVD 7.10**).

Although there are some practitioners who are fluent in several modalities, most art therapists aren't equally facile in other art forms. A few have been trained in two expressive therapies, like Suzanne Lovell who found a deep compatibility between art therapy and the kind of dance therapy called *Authentic Movement* (Virshup, 1993). Lovell's sense of conviction was especially strong, since a combination of the two helped her to successfully combat her own illness (Lovell, 1990). Gong Shu (2004) has similarly integrated her training in psychodrama and art therapy with traditional Chinese healing techniques. On the **DVD** is an art therapy/psychodrama workshop she led **(A)**.

Sometimes two expressive therapists work together, like Norwegian art therapist Ase Minde and British drama therapist Sue Jennings, whose book on *Art Therapy & Dramatherapy* (1993) reflects a respectful collaboration. Although one motivation is the practitioners' interest in learning from one another, it also seems as if more than one modality can sometimes better meet patient needs.

Drama therapist Ellie Irwin **(Figure 7.13)** and I have collaborated on art–drama groups, **(B)** parent play groups, **(C)** and a study comparing responses of the same individuals to art and drama diagnostic interviews. In that research, we found that some themes were more easily expressed in art, and some were more easily expressed in drama—another asset of a multimodal approach (Rubin, 2005a).

Just as it seems to help patients when art therapists are open to collaborating with other clinicians, it also helps when therapists are open-minded, albeit not naively so. Fads and techniques come and go rapidly in the lively world of psychotherapy. All therapists need to

Figure 7.13 Eleanor Irwin, drama therapist.

examine new and potentially helpful adjuncts, especially if they have primary responsibility for treatment.

Linda Cohn's combination of "Art Psychotherapy and Eye Movement Desensitization" (EMDR), which has grown in popularity since she published her chapter, is one such example (Virshup, 1993). Art therapists seem less rigid and doctrinaire as a group than others, perhaps because of the openness that is necessary for a genuine creative process.

I once had the fascinating experience of putting together what I know about art therapy with what Dr. Louis Tinnin was finding out about using video in what he called "Time-Limited Trauma Therapy." Tinnin, a psychiatrist who is also a true believer in art therapy, was using videotaped feedback with clients who had dissociative identity (multiple personality) disorder.

Thanks to his generous sharing of ideas and procedures, I was able to help one of my patients to get to know a number of her *alters* who had so far eluded co-consciousness. She first viewed a videotape of herself in each personality state, made while she was in the hospital. Since she was also taped while watching the first video, she was then able to watch the second tape as well. When we later videotaped the alters drawing and painting as well as talking, the recognition and acceptance of her "parts" was greatly accelerated for the patient. This was a truly multimodal approach, most useful for this hard-to-treat condition. (See the story of Elaine in Chapter 9.)

Concluding Thoughts

I could go on and on, and that in and of itself is the most wonderful thing about technique(s) in art therapy. There are so many different ways of using art to help people. Sometimes they offer possibilities that would be impossible in any other way. For example, time can be collapsed. A *Life Line* of colors and shapes can tell a person's story, and a *Life Space* picture can show how things are at any moment in time.

A *Journal* can be kept in color and line as well as in words, as in a *Doodle Diary*. Relationships can be depicted in three dimensions, as in a *Family Sculpture*. And because you can move three-dimensional forms in space, their dramatized action can further enhance awareness. There is probably no limit to what can be explored and expressed through the rich, wordless medium of art.

And there is similarly no limit to what can be imagined as an approach to helping people through art by the therapist. The source of artistic technique, as noted earlier, is for the art therapist to have digested and assimilated a theory so well that she is then able to respond with disciplined spontaneity. Similarly, the more media and technique(s) she knows about, the greater the menu from which she can choose, as she seeks to provide the most nourishing and most digestible treatment for those she serves.

Deciding how to go about either assessing or treating through art requires a thorough familiarity with artistic resources, as well as with ways of understanding and helping people in pain. The specific fashion in which any art therapist puts them together is the artistry of this work, a source of deep pleasure and continual satisfaction.

Robert Ault cited a metaphoric image of an "*ice skater* … one skate representing art understanding and involvement, the other … representing psychological understanding as well as interpersonal skills."[6] In order to get anywhere, you have *to shift your weight* from one to the other, sometimes pushing off with one and sometimes gliding with both. As Bob wrote, "the skill of the therapist is in the timing, and knowing when to use one or both."

I have often thought of *sailing* as a good metaphor for doing art therapy, since the clinician needs to "catch the wind" when it comes up, often with little notice. There may be long periods of waiting for wind and tides to shift, so that the course of the art therapy voyage can be a safe one. It takes alertness to sense when the patient is ready to move in a new direction—whether in the creative process or in self-understanding.

An art therapist tunes in to multiple frequencies for evidence of readiness to go deeper: artwork, dreams, mood, attitude, and behavior in and out of the sessions. As is true when sailing, there are inevitably rough as well as smooth periods, during which the therapist must hold firm to the rudder, in order to keep the boat of treatment as steady as possible.

Whether the art therapist is seeing an individual, a couple, a family, or a group, whether the goal is assessment or treatment, whatever the age and wherever the setting, the creative challenge of this work consists in deciding what to offer and how to do it. The artistry of the work lies in helping people to become engaged in the creative process in ways that enhance their personal growth.

A good art therapist is selective and sensitive, trying to accomplish the goals of any particular intervention within whatever constraints are present. This may involve using one or another technical approach, but always doing so with the deepest respect for both the materials and the human being(s) involved. Effective and thoughtful art therapy is at least as much an art as it is a science. As in other art forms, only practice can help the practitioner to develop both skill and spontaneity.

As with knowing theory, well-developed technique is not so much a collection of ideas, as it is deeply ingrained and easily available. Elinor Ulman made this point when she wrote that "a little learning may be worse than none. Our understanding must be well digested if it is to inform lightning decisions" (Ulman & Dachinger, 1975, p. 28). A good art therapist, like the gifted and creative psychoanalyst Donald Winnicott (1971a, 1971b), has both theory and technique "in her bones."

Endnotes

1. "Introduction" to the first issue of *Art Psychotherapy*, by E. Harms, 1973.
2. "Utilizing Prestructured Art Elements in Brief Group Art Therapy With Adolescents," by R. Vick, 1999, *Art Therapy, 16*(2), 68–77.
3. Three Perspectives: Framing the Don Jones Assessment (DJA), by D. Jones, M. Vinton, and W. Wernick, 1999, Panel presentation, American Art Therapy Association Conference, Orlando, FL, November 21, 1999.
4. "Drawing Together: Therapeutic Use of the Wish to Merge," by F. F. Kaplan, 1983, *American Journal of Art Therapy, 22*, 79–85.
5. "Art Therapy in a Public School," by R. Wolf, 1973, *American Journal of Art Therapy*, *12*(2), 119–127.
6. Ault, R. E. (1983). Unpublished manuscript.

CHAPTER 8
People We Serve

Just as art therapy can be done in an endless variety of ways for the purpose of diagnosis or treatment, so too there seems to be no limit to those who can be served. Art therapy can indeed be helpful to people of any age level, and with any degree of health or handicap. Its uniqueness, however, lies in its ability to reach people who do not find other forms of help accessible. Whether the condition is temporary, extended, or permanent, there are times when art expression seems to best fill a need.

Art Therapy Is Especially Good For …

Those Who Have No Words

Art may be the only communicative channel for those who cannot speak, whether because of autism, deafness, retardation, brain damage, or dementia. Claire, a deaf-mute girl whose story is told in Chapter 11, could only talk through her drawings. She was eventually able to learn sign language, but never speech. Individuals who do not know the therapist's language—like recent immigrants—can always speak the universal language of color and form.

One of the roots of art therapy, you may recall, was the spontaneous art done by people with incurable mental disorders, whose paintings and drawings were sometimes their only intelligible communications (Prinzhorn, 1922). In a wonderful account of a long treatment, the psychiatrist and the patient describe how art helped Mary Barnes **(Figure 8.1)** to express what she was going through during a massive psychotic regression (Barnes & Berke, 1971; cf. also Barnes & Scott, 1989). Those suffering from chronic mental illness are still well served by art therapy, though they are now more likely to be seen in partial or day treatment programs than in long-term psychiatric settings (Schaverien & Killick, 1997). As one artist eloquently told her interviewer, "art is all the feelings trapped inside."[1]

When I was co-director of a Creative & Expressive Arts Therapy (CEAT) program in a psychiatric hospital, I was impressed by how successful the art therapists were with patients who were admitted in acutely psychotic states. I think there are several reasons for this. One is that creative individuals are likely to think in a more fluid rather than linear fashion. Freud theorized that this was due to a "flexibility of repression,"[2] while more recent thinking has emphasized a reliance on the right (holistic) rather than the left (linear) hemisphere of the brain. Whatever the reason, art therapists are more likely than other mental health

Figure 8.1 Mary Barnes working on a painting.

professionals to be comfortable with the illogical world in which a psychotic person finds himself, as in schizophrenia.

One of the most successful art therapy programs in the CEAT department is a group run by Mary Ann Hayden-Shaughnessy, who has helped those with chronic schizophrenia for many years (**Figure 8.2**). The patients who attend regularly seem to be more compliant in taking medication and in attending psycho-educational groups, both of which allow them to remain more stable. Perhaps Mary Ann's success is due not only to the creative activity itself or the fact that she is an experienced and sensitive therapist, but also to the fact that she herself is an artist.

Artists not only can "understand" primary-process image-talk as noted earlier, but as a group they are more rebellious than conforming, and more isolated than socialized. Art therapists working with colleagues in bureaucratic institutions, however, have had to find sufficient ways of adapting to survive. Therefore, art therapists may be especially able to help those who are atypical to find ways to relate to and live with others, while preserving their individuality and authenticity.

In any case, even highly verbal people of all ages often find that they have no words for certain experiences, especially those that elicit overwhelming feelings. Like Mrs. Lord, who was in such a state of "shock" that she could not talk (Chapter 1), or the family whose fluency masked their feelings (Chapter 7), there are many times when creating visual imagery is far more effective than anything a person might say.

Figure 8.2 Mary Ann Hayden-Shaughnessy.

Those Who Are Resistant

Those who are able to talk, but are resistant to verbal therapy, may be more accessible through art, especially if other avenues have been tried and failed. Despite the anxiety of most adolescents and adults about their artistic abilities, even wary and hostile patients can become engaged if the art activity is presented in a nonthreatening way. Those who are suspicious of verbal therapy and fear that a therapist will "play with their minds," may be more willing to use paint or clay than to talk. Like all elective mutes, Ellen refused to speak, but art was an open avenue of expression. As you will see in the following vignette, it proved to be the key that unlocked her ability to reconnect with her family and eventually to recover.

Art Therapy With an Elective Mute: ELLEN (11)

Ellen had seemed quite normal until the day she got mad at her deaf older sister and stopped talking to her. Shortly after that, she stopped speaking to her alcoholic mother, then to her father, and then to her best friends. By the time she was admitted to Children's Hospital of Pittsburgh for a month of observation, her selective silences had been going on for almost two years. When Ellen refused to return home, she was sent to live with her grandmother, one of the few people to whom she still spoke, on the condition that she come to the Child Guidance Center for psychotherapy.

She had refused to enter the building or to talk to the child psychiatrist assigned to her case, even when he went to her grandmother's car. Ellen was therefore referred for the only nonverbal treatment available—art therapy. I was relieved that she was willing to come to my office, to use some clay (albeit with her back to me), and to draw, facing me as she did so **(DVD 8.1)**.

But when I requested, at the end of her first session, that she leave her picture on a shelf reserved for her, like the others in art therapy, Ellen got very upset. When I asked if we could photocopy it before she left the clinic, she refused, angrily blurting out "You didn't *tell* me!" She walked out rapidly, clutching the drawing tightly to her chest.

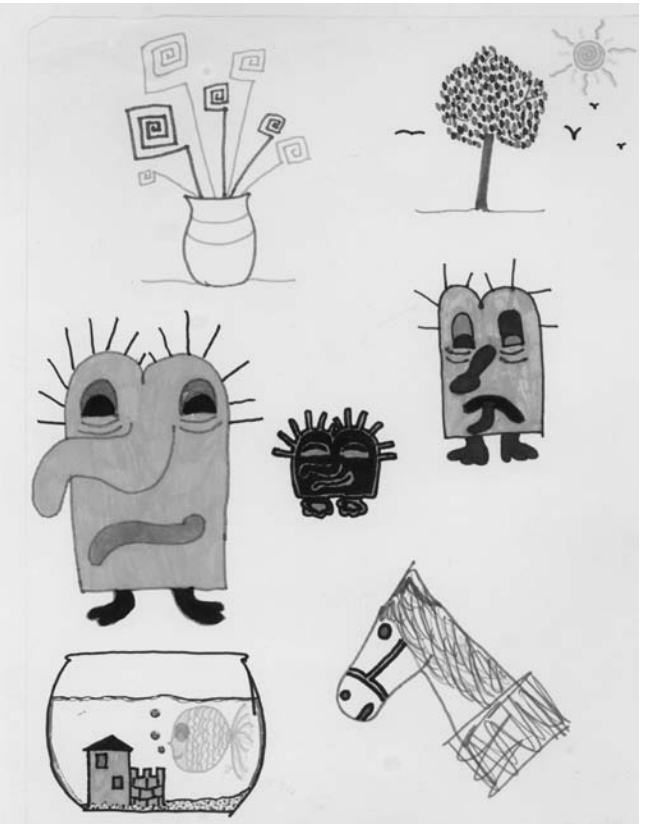

Figure 8.3 Ellen's first drawings of her creature.

Despite this uncomfortable beginning, Ellen seemed to loosen up a bit during the next four sessions. She was interested in my portraits of her doing artwork **(A)**, and was willing to engage in a nonverbal "drawing dialogue," which became fairly intense **(B)**. She even whispered responses to some of my questions about her drawings. I thought we were getting somewhere.

After a six-week interruption—due to vacations and scheduling problems in the Fall—Ellen returned, and created the first versions of what eventually became a rigidly repetitive visual theme. She began her marker drawing with several tight, geometric, linear designs, and then continued on the same paper with a fishbowl, a horse's head, a tree, a geometric flower pot, and finally three creatures in the center, the last with an angry tongue sticking out of a twisted mouth **(C)**. I noted with relief that her posture was more relaxed while she was drawing the creatures (**Figure 8.3**).

In response to my questions, she told me that all three were female. The one on the left was older, the one in the middle was younger, and the one on the right was very angry. Asked who *she* might be in the drawing, Ellen pointed to the fishbowl, then to the horse. I was thrilled that her repressed anger—which is usually behind the stubborn symptom of "elective mutism"—was beginning to emerge.

Ellen spent the following session drawing an enlargement of her odd cephalopod (head-foot) creature **(D)**, while I drew a sad–angry girl with a long nose and prominent eyes, similar to but different from Ellen's creation **(E)**. She said that the girl in her drawing was both happy and sad. The girl in my drawing, Ellen said, was "sick because she's going to the

Figure 8.4 A later drawing by Ellen of her creature.

doctor [who will make her] worse and sicker." She was clearly afraid of this process we had begun, but how fearful I had yet to discover.

From then on, Ellen was stuck on her theme, drawing only variations of it and turning her back to me more and more. Her whispered answers stopped, replaced by head nodding, then silence. As the same creature was drawn week after week **(F)**, month after month **(G)**, Ellen seemed more and more frozen (**Figure 8.4**). Having unsuccessfully tried music, silence, and other maneuvers throughout the Fall and Winter, in mid-February I began to wonder aloud about what was going on, empathizing with her anger and anxiety.

In mid-March, though her therapy-hour behavior was unchanged, her grandmother brought in a book Ellen had made entitled "From Isolation to Involvement." With photographs and poetic text, it seemed a statement of intent. It also included many of the things I had said in our one-way communication system, leading me to hope that perhaps I was getting through after all. Nevertheless, Ellen continued to face me with her back, and to draw the same rigid creature for five more sessions, avoiding eye contact more than ever **(H)**.

The last session in late April began like all the others, but at one point in her drawing Ellen stopped as if immobilized, seeming more openly fearful than usual. I first spoke of, then acted on, an impulse to put my hand on her shoulder. It was close to the end of the hour, and Ellen did not respond. She remained tense and frozen, went on with the picture, and walked out, more rapidly than usual. She went back to her grandmother's and, for the first time in almost a year, telephoned her mother. The purpose of the call was to tell her that she didn't want to come to the clinic anymore "because I don't like Mrs. Rubin."

Although she never opened the note I sent her, and returned no more, Ellen gradually proceeded to go home—first for weekends, and in a few months for good. When I called her mother two and a half years later to follow up, she told me that Ellen had come home warmer and more open than ever in the past, and had done well in school. Most delightful was the fact that this teenager, who had been so frightened of how dangerous her words might be, had become a high school *cheerleader* (!)

Art Therapy Is for All Ages

This chapter is a very general overview of work with people at different age levels, with brief clinical vignettes like the one about Ellen to give the reader a flavor of how art

therapy can work. In addition, the edited video clips on the **DVD** will bring it even more alive for the reader.

Children

There is a widespread notion that art therapy must be used mostly with children, since most adults have more verbal facility and can discuss what's bothering them. There is, of course, some truth in the title of a book about children's art, *They Could Not Talk and So They Drew* (Levick, 1983). But art therapy is actually used more often with adolescents and adults. One of art therapy's greatest assets is that making art comes naturally to youngsters (**Figure 8.5)** and can be helpful in therapy even before a child can work representationally, as in the following example.

Art and Sandplay Help a Grieving Toddler: BILLY (2)

Billy was a two-year-old whose young father had suddenly disappeared. Because he had committed suicide, the family had a harder time than usual dealing with the death, and an even harder time helping poor little puzzled Billy.

As this formerly cheerful, independent boy became increasingly depressed, clingy, and oppositional, his distraught young mother found herself unable to comfort or to control him. Her sister, a therapist, suggested that maybe Billy needed to see someone outside the family, in order to work on his confused feelings and fantasies about his father's death. So he came to see me **(DVD 8.2)**.

Figure 8.5 A preschool child absorbed in creating.

In the beginning Billy spent most of his time at the easel, not speaking and with his back to me. He would paint a blob of color, and then angrily cover it over—compulsively repeating this ritual for many weeks.

Next he turned his attention to the sand table. First he played silently with water and sand, digging, filling, and in general enjoying the sensory experience. Soon, however, he was bringing plastic animals to the sand table, which he would engage in fierce battles with lots of noisy growling **(A)**.

After a few weeks, Billy began to bring rubber human figures to the sand—a boy and a man. They too would fight, and Billy would furiously bury the father figure in the sand, while I would talk about how *angry* he was at his dad for leaving him and his mom so suddenly.

This drama, played and replayed for several months during his weekly sessions, was interspersed with quiet times of painting shapes that were no longer obliterated. Over time, Billy was able to put his feelings into words in the sand stories.

I met several times with Billy's mother, mainly to help her with management issues. As often happens when a parent feels sorry for a child, she was having a hard time setting limits or being consistent. Since Billy already felt some guilt and worry about his anger at his dad and his dad's death, his "power" to intimidate his mother was making him more anxious.

As his mom felt freer to assert her authority, and as Billy became less scared of his powers, she reported that he was no longer oppositional or clingy, but was his old cheerful, agreeable self, coping with his loss by pretending to "be a Daddy" **(B)**.

Art therapy can be helpful at all stages of development. Both Alan (Chapter 1) and Isaac (Chapter 7) were able to use it in early childhood and come back to it later. Paradoxically, art therapy seems to be especially helpful to children at each extreme of the behavioral continuum. A tightly constricted child like Linda (Chapter 5) can become freer, and a chaotic child like Randy (Chapter 1) can become more organized. An oppositional child like Jack (Chapter 1) can sublimate his aggression in clay, and a timid child like Don (Chapter 5) can explore freer behavior by using fluid media, then by safely expressing his "scary mad wishes" in sculptures that cannot hurt.

All kinds of children can be helped because the process of creating with art materials requires both spontaneity and control. Thus, children who are treated with art therapy not only span a wide age range, but also an even wider range of problems. A boy with a developmental or cognitive disorder like Randy (Chapter 1) can use art to organize his thoughts as well as to express them. An anxious child like Carla (Chapter 2) can picture her fears and end her nightmares. A depressed child like Lori (Chapter 1) can work through her feelings about loss through art and play. Parents and children who are having problems can see interaction patterns more easily on a piece of paper than in words, like John and his mother in Chapter 5 or the family in Chapter 7.

As you just saw with Billy, even a two-year-old can benefit from expressive therapy. He of course had suffered a sudden and traumatic loss, and his father's suicide no doubt made it hard for his mother to help him. It was good for both of them that she sought treatment.

In contrast, in the vignette below, Amy's parents were both warm and loving, and she had been developing smoothly until age three, when, with no major trauma like a death, she suddenly started to have nightmares and to wet her bed. Her mother knew the parent of another child I had seen when he was four (Alan, in Chapter 1), and after assessing the situation I recommended art and play therapy, which proved to work well and quickly. Here is a summary of her story.

Figure 8.6 Amy in art and play therapy.

Art and Play Therapy for an Anxious Little Girl: AMY (3) (**DVD 8.10**)

Amy was an adorable little girl who had been quite cheerful and well-adjusted until she started to wet her bed and to have scary dreams. Her mom had recently gone back to work, and worried that Amy was missing her. Her separation anxiety had indeed escalated, but behind it were very mixed-up feelings, because when Mommy went on business trips, Amy got to be alone with Daddy, which felt both good and bad. In fact, it felt great to pretend to be the mommy, but it frightened Amy that her scary-mad wish (to "get rid" of her mother) seemed to have come true.

She was very bossy and competitive with me, often reversing our roles in dramatic play. She liked both dramatic play **(A)** and art **(B)**. But the biggest breakthrough came after she drew what she called her "favorite picture" **(C)**.

When Amy made the drawing, her mom had just returned from a trip, and Amy was mighty relieved. The picture was of a king and a queen, happily beaming at their little girl, the princess. Amy announced that the princess was going to a ball, where she would meet a man named Prince Charming, that they would soon be getting married, and that they would live in their own castle **(Figure 8.6)**. Her symptoms gradually subsided, and she was soon able to finish her therapy. The pivotal drawing represented her acceptance that her father's mate was her mother, even if when she traveled Amy had Dad all to herself. In psychoanalytic terms, she had resolved the Oedipus complex.

Many different approaches (Rosal, 1996) are used in art therapy with children, including Freudian psychoanalytic (Case & Dalley, 1990, 2008; Kramer, 1958, 1971, 1979, 2000; Naumburg, 1947; Rubin, 2000b), Jungian (Allan, 1988; Furth, 2002; Jeffrey, 1995), Gestalt (Oaklander, 1988), solution-oriented (Gat, 2003), and phenomenological (Betensky, 1973, 1995). There are also therapists who use psycho-educational approaches, though because these tend to be more common with children who have disabilities, they will be described in the next chapter.

Adolescents

Teenagers, who are normally narcissistic, tend to be extremely interested in themselves and, by extension, their creations (**Figure 8.7**). Although it is usually necessary to deal with their

Figure 8.7 An adolescent doing rug hooking.

anxieties about performance and about the therapist "seeing through" them, art therapy is a fine avenue for the developmental task of identity formation.

Art is also one way to make relatively uncensored self-statements, since every creation is a self-representation, even when it is not so identified. Exploring media, finding out what you like and what you don't, what is comfortable and what is not, are all fairly nonthreatening forms of self-definition. Developing a personal style, so important to adolescents in dress and grooming, can be explored without embarrassment in the area of artistic style.

Normal adolescence is a period of rapid physiological change, creating confusion and concern about body image. Overwhelming and sometimes disorganizing feelings, along with sudden mood shifts, are also characteristic of this hormonally fluid period of life. Art offers a safe way to deal with such transformations, as was true for Betty Jane whose story you heard in Chapter 1.

Defining the self in relation to the peer group is another major developmental task. Creating alongside other teenagers about common themes like friends, or working together on art projects like murals, are some of the many ways to deal with relationships through art therapy. Adolescence is also a time to redefine one's role in the family, and family art therapy can help all members adjust to the changing equilibrium.

Most books about art therapy with children also include work with preadolescent and adolescent youngsters. In addition, adolescent art therapy per se has been the focus of several books written or edited by those who treat teenagers (Camilleri, 2007; Linesch, 1988; Moon, 1998; Stepney, 2001; Riley, 1999).

There are also some detailed case studies, like Margaret Naumburg's (1950) work with Harriet or Helen Landgarten's (1981) with Lori. As is true for young children, adolescents seen in art therapy suffer from a wide variety of disorders—including depression, phobias, eating disorders, addictions, other problems with impulse control, and conflicts with authority.

Because adolescents are in the process of separating from their parents, they are often more resistant to therapy than other age groups, unless they themselves have requested it. For that reason, art may be more acceptable than verbal therapy, since the demand to talk about problems is reduced and there can be pleasure and discharge in using materials once anxieties about performance are overcome.

Adolescents are more inhibited about using art media and talking about their work than younger children, because unless they have continued to study art, they feel inadequate as artists. Like reluctant adults, they need to be helped by the therapist to understand why and how using art can help them to understand their problems more rapidly.

Art Therapy for a Painfully Shy Adolescent: LUCY (13)

From the time of her parents' divorce when she was three, Lucy had been a terribly timid child. Forced by a judge to move to her father's after a traumatic custody battle at age 12, she became increasingly withdrawn and depressed. By the time she was brought for the therapy that had also been ordered by the court, Lucy was justifiably suspicious because the psychologist with whom she had met for the custody evaluation had not honored her stated wish to remain at home with her mother and brother.

Since she was so reluctant to speak, it was fortunate for both of us that Lucy was willing to try using art materials and that she liked doing so **(DVD 8.4)**. She began by carefully modeling tiny clay creatures, just a few inches high **(A)**. Though she worked in silence, Lucy was willing to talk for the figures in response to my questions, as if they were puppets. The little figures began to softly voice the angry feelings she had turned on herself, causing her depression.

After a few months, Lucy began to experiment with other media, like chalk, crayons, and all kinds of paints **(B)**. She told me a great deal about her fantasy life in powerfully poignant paintings and poetry, long before she was able to speak freely and directly about her feelings.

She gradually adjusted to her new school, and became involved with a group of giggly girlfriends. After a year of weekly art therapy, Lucy was less depressed and more assertive—no longer terrified of her intense feelings—no longer frozen in silence. Although her father thought that she was so much better that therapy was no longer necessary, Lucy—who had been too afraid of her dad's temper to oppose him in the past—was able to speak up and to say that she wasn't ready to stop. She came for another year, and began to confront her more deeply buried fears and fantasies.

The Story of Sam: A Schizoid Teenager (18)

Sam, oversized (six feet nine inches tall), overweight, and extremely bright, had dropped out of school, and had literally locked himself in his room before coming to the clinic. He had been in individual and family therapy for several months, and was referred to an adolescent art–drama group, partly because he was talented in art (Rubin, 2005b). After seeing Sam for individual drama and art assessment interviews, Dr. Irwin and I thought that this kind of group might be especially appropriate for Sam. He had withdrawn completely from peers, and we felt he would only be able to tolerate a kind of group therapy where he could work individually until he was ready to interact with other members. This, in fact, is exactly what happened **(DVD 8.5)**.

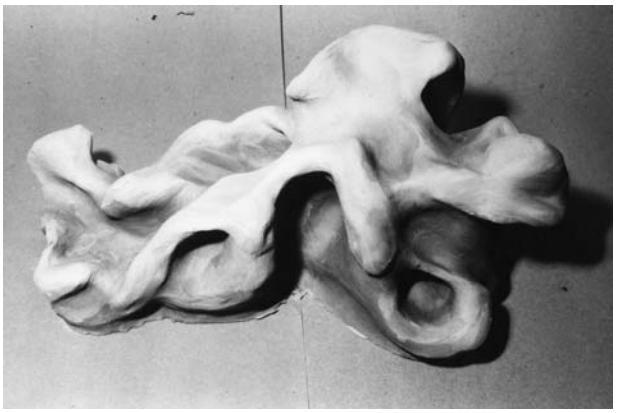

Figure 8.8 One of Sam's abstract sculptures.

In the group, he began by isolating himself behind an easel in a corner and working on a series of brightly colored, organic, curvy, voluptuous paintings. During those early months, his work in clay was equally soft, undulating and fluid **(Figure 8.8)**. But in the fourth month, for the first time he played a role in a drama—that of a defense attorney, where his debating experience enabled him to be verbally aggressive and competitive.

His artwork around this time started to gradually change, extensions emerging from the clay, projections thrusting out from the flowing masses. In his paintings, too, there were more often clearly separated parts, shapes, and colors, becoming more varied and differentiated. Gradually he began to try other media, like wood, which gave his creations even more form, stability and power.

As though a structure was forming internally as well, Sam began in minute, playful ways to display some of the anger he had always repressed. After about a year of group therapy, he spontaneously created a vivid, powerful drama that seemed to represent the psychic awakening he was experiencing.

Saying that he was playing a "crazy person," Sam cowered fearfully, retreated inside a womblike enclosure (a large wooden box), and pulled it out the door. Opening the door brusquely, he walked back in, appearing to be a totally different person, stomping and speaking loudly, angrily, and strongly: "Where is that fellow? That other fellow who is so scared all the time? If you see him again, tell him to get out of here!"

He repeated the drama the following week, after proudly reporting the sale of one of his paintings for $25 to a local bank. This time he involved the other two leaders in the story but had some difficulty being assertive with them. He dressed Dr. Irwin as a witch and Dr. Borrero as a king, then struggled in pantomime with these powerful parent figures. He was able to win out with the witch-mother but often weakened in his battle with the king-father.

Since Sam was unable to use words to express his anger at the male leader, we suggested he try numbers. He was then able to carry on an intense, angry dialogue, with dramatic intonation and affect. The outcome was a compromise, in which a third Sam finally emerged, not the violently angry one or the fearful cowering one, but a strong, reasonable (integrated) self.

Simultaneously, his artwork began to change dramatically. He began to move from abstraction to representation, sometimes even making people—faces that were often

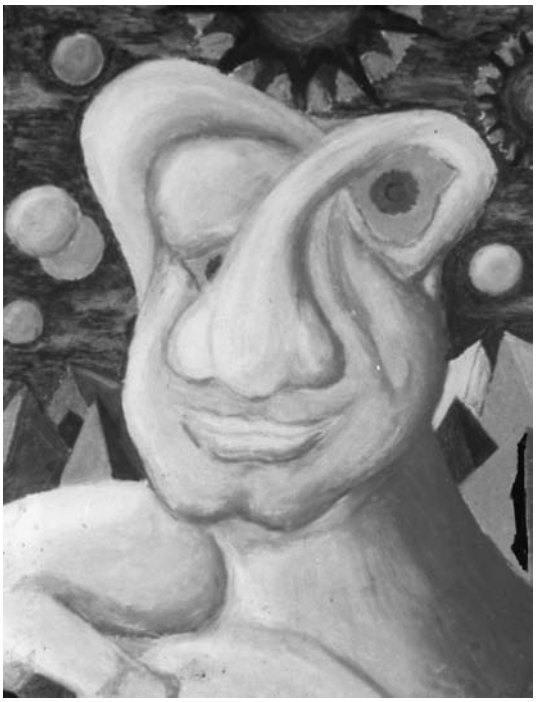

Figure 8.9 One of Sam's figurative paintings.

distorted and grotesque **(Figure 8.9)**, perhaps representing some of those long-repressed inner feelings **(A)**. The same damaged self was in a story Sam had told several months earlier, after a brief hospitalization and some regression. He described a Martian invasion and an Earthling, clearly a self-image, about whom he then felt almost hopeless:

"About this time, one of the most primitive of the Earthling creatures wanders to the far side of the ship, and is immediately stranded, unable to get back. The Martian scanner analyzer at this time determines that the earth creature doesn't have enough life support system. The Earthling creature will die. The Martians will have to intervene to save his life … The elevator hydraulic on the lift is raised, and three Martians go out to rescue the primitive Earthling, who is now dying.

"This is a great victory for the Martians, as they can now examine an Earthling, and now they can condition it, and can observe very closely its behavior patterns. The only disadvantage for the Earthling is that he'll find out … Another disadvantage for the Earthling is that there is intense physical pain in the cranial brain area … The Earthlings are very weak creatures. The Earthlings must realize that the Martians are omnipotent. They are not only superior but omnipotent. However, the Martians respect the Earthlings for their ability to grasp *some* information, and find that the Earthlings could no doubt be developed into an intelligent lifelike form. The end."

Dr. Irwin, to whom he told the story, asked: "You mean there's some hope for the Earthlings?" Sam replied slowly, "Well, some hope … rather remote. At times it seems nonexistent, but there is *some* hope." His characterizations of himself and the leaders reflected both his fears and his hopes for change through therapy.

Change for Sam, as for all, was often slow, with regression as well as progression over time. Becoming aware of all of his feelings, happy as well as sad ones, he struggled to integrate

this newfound awareness of his inner life. As he became stronger, he related more and more to the others, developing genuine friendships such as those he later formed in college. One of his favorite creations was a powerful phallic head of a king, symbolizing perhaps the strength he was beginning to realize in himself. On the **DVD** you can see Sam's story from the film about the group, *The Green Creature Within* **(B)**.

Through the leaders and the other group members, Sam was able to grow in remarkable ways. When the group ended after two years, Sam continued in individual art therapy until shortly before he left for college. His letters from school were full of humor, and sometimes included drawings, like a view from his window **(C)**, which were far more realistic than what he had done in group. In college Sam was not only academically successful, but went on to a highly responsible international position where he could comfortably use his extensive linguistic knowledge.

Adults

While most adults are reluctant to use art materials at first, many can be helped to do so when the activity is explained as another way to work on their problems, and one that may speed up the process (**Figure 8.10**). Art therapy is also appealing to normal adults who want to improve the quality of their lives, whose goal is not so much symptom relief as it is personal growth. Identity formation is a task that continues as people go through the life cycle, as in the story of Laurie in Chapter 4 or Gloria in Chapter 7.

Using art materials, parents can draw about their children, and couples can deal with their relationships—like Mr. and Mrs. T. in Chapter 1. In fact, people can represent practically

Figure 8.10 A woman beginning a self-portrait.

Figure 8.11 A man working with clay.

anything in art—from abstract ideas like freedom to feeling-states like panic. Art therapists treat adults with a wide range of problems, including personality disorders, anxiety disorders, and problems in adjustment (**Figure 8.11**). Because images can bypass verbal censorship, art therapy is especially helpful for those who use words defensively, like Laurie in Chapter 4 and the family in Chapter 7.

While the majority of art therapists see adults, and much of the literature describes work with people in the middle phase of life, only one book deals specifically with *Adult Art Therapy* (Landgarten & Lubbers, 1991). Pioneer Margaret Naumburg's seminal books that followed her early work with children (1950, 1953, 1966) all include detailed case studies of individuals in both young and middle adulthood. Like Freud, Naumburg was a good writer, and these stories still read so well that they remind me of the title of a book by a Gestalt therapist, *Every Person's Life Is Worth a Novel* (Polster, 1990).

Other fascinating stories of people whose art was central to their therapy are told by Baynes (1961), Harding (1965), Meares (1957), and Milner (1969). Like the account of a woman who emerged from a psychotic regression in part via art (Barnes & Berke, 1971), there is another fascinating story told by both the patient and the therapist (Dalley, Rifkind, & Terry, 1993; Cf. Also Naevestad, 1979).

Art in Diagnosis and Therapy with a Young Adult: SALLY (22)

Sally was a graduate student in musicology and had always been an outstanding performer. But when she confessed to her advisor that she was having a very hard time getting her work

Figure 8.12 One of Sally's powerful paintings.

done, he suggested that she see a therapist. Because Sally was articulate and very high functioning in both her academic work and her part-time job singing at a church, my first impression was that she was having an adjustment reaction to being so far away from home. After several months of therapy, however, she was still quite depressed and behind in her studies.

She was so full of things that pressed to be conveyed, I simply let her words flow to relieve the pressure. Being in my space, however, she was aware of the art materials and the table with others' sculptures on it and had commented on some of the pieces. One day I wondered if she had ever tried painting or drawing, and Sally said that she had loved art when she was little, but that she was sure she was "no good" at it now. Assured that the art was for therapy and not for show, she was able to start experimenting at home, a suggestion I sometimes made for those who were inhibited about creating in front of me. When she brought in her first drawings and paintings **(Figure 8.12)**, I was astonished **(DVD 8.6)**.

Not only were they beautiful, they also revealed the extent of her well-masked pathology, which included occasional paranoid delusions **(A)**. Thanks to the clues in her artwork **(B)**, Sally was able to be placed on medication for her mood disorder before she had any psychotic episodes. Thanks to her hard work in therapy, accelerated by what she learned from her artwork, she was able to finish her degree program. Sally's art became a welcome outlet at times of stress. When she left for a job in another city, her parting gifts were framed paintings and permission to tell her story.

Unresolved Grief Finally Faced: OLIVER (36)

Although Oliver lost his mother when he was only six, his aloof and grief-stricken father was unaware of his son's withdrawal. Because of this early loss, Oliver's problems as an adult brought him to a series of therapists, as he struggled to work through all of the confused feelings within. Only then could he give up self-destructive behaviors, which he had tried to use, in vain, to cope with his pain.

In his thirties, Oliver sought therapy for his pervasive depression and persistent problems with women **(DVD 8.7)**. After several months, he shared with me his adolescent sketchbooks, in which he had continued to grapple with his mother's death. His drawing of a lonely

Figure 8.13 A lonely boy looking out a window.

young man—feeling alienated and staring sadly out the window—(**Figure 8.13)** showed his inner state of painful isolation **(A)**.

The one genuine human bond Oliver had—with his mother—was repeatedly torn, first by the birth of his sister when he was four, then by his mother's illness, which led to many separations, and finally by her death from cancer. His last memories of her were of her face framed in a hospital window, echoing his self-portrait.

Death was present on many pages of his sketchbook, even in otherwise peaceful scenes. Oliver searched vainly for a passionate, instant "love at first sight"—the adult equivalent of mother–infant bonding.

He looked for a woman so strong that he could never be hurt, like an aloof "superwoman" (**Figure 8.14)** he drew early in treatment **(B)**. Sadly, because of the "repetition compulsion," he was attracted to distant, unavailable women—far away like his dad and cold like his mom. The end of a relationship with one such "Snow Queen" plunged him into the despair for which he sought therapy. Significantly, he did not return to the male therapist he had seen some years before, but sought a woman, going first to his lover's analyst who then referred him to me.

Though not consciously planned, the transfer involved a reliving of the same loss he had felt as a child when his mother died, to be replaced first by his grandmother, then by a stepmother when his father remarried eight years later. It was only when Oliver returned for

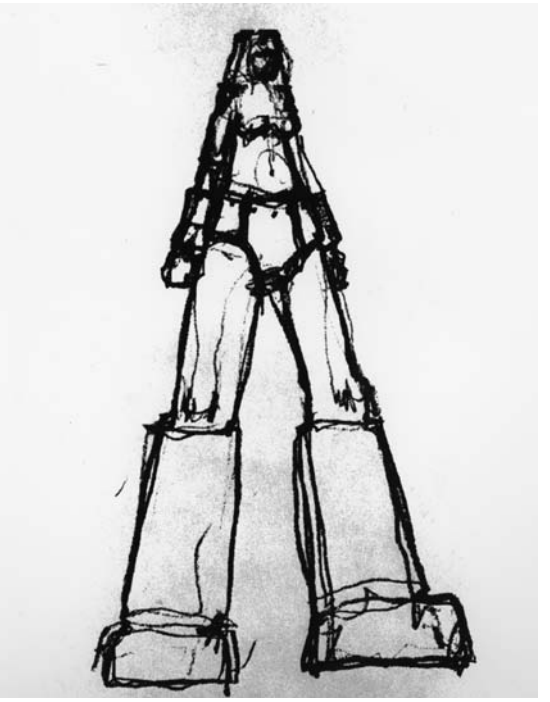

Figure 8.14 A superwoman.

further work later on that we could begin to deal with his hurt by the analyst and his rage at me for not being her.

It was only then that he could tell me how angry he was that I had not realized the extent of his alcoholism, which he had minimized, just as he had hidden his pain from his father. Fortunately, he had met a woman shortly after his first two-year period of therapy whose concern helped him to finally go into rehabilitation.

After completing the program, becoming a father, and marrying the woman, Oliver returned for further therapy. This time he was able to express feelings he had hidden from me, especially hurt and anger. On many levels, it was clear that along with his physiological vulnerability, his addiction had been a classic instance of the search for "mommy in a bottle."

Art Therapy for Artists

You might wonder whether art is an especially appropriate form of therapy for artists. Most artists feel that their own art has been therapeutic for them, especially at times of stress (Birkhauser, 1991; Sherman, 1994; Spencer, 1997). Many individuals have decided to become art therapists because making art helped them to get through some serious crisis in their own lives.

Some artists fear that any kind of psychotherapy will rob them of inspiration, but the evidence is to the contrary (Kubie, 1958). Jackson Pollock's drawings and paintings were used extensively in his analysis, and may have accelerated the treatment (Wysuph, 1970). Many art therapists have treated artists through art, like Josef Garai who helped a painter to resolve "identity conflicts" (Ulman & Dachinger, 1975). Dissolving creative work blocks, a subject often mentioned by Margaret Naumburg, is sometimes the goal of art therapy (Landgarten, 1981).

The Elderly

The focus of most art therapy literature about work with adults is not on developmental issues, but rather on specific conditions. Conversely, art therapy with the elderly, an area that has grown in recent years along with the changing demographics of our population, tends to focus on aspects of aging, per se, a normal condition for all human beings. As I discovered in my own life, aging truly creeps up on you. The changes are for the most part gradual and subtle. At around the time I was writing the first edition of this book, I had been invited to deliver a presentation at a university conference on the elderly. My assigned topic was art therapy for older adults.

While I was thinking about preparing for that lecture, I was on a sightseeing boat in the San Francisco harbor with my grandson Ben who was then five years old. I watched him interact with a family on the other side of the deck, and with a startle, listened to him say as he pointed to me, "See that old lady? That's my Nana."

The truth is that I hadn't thought of myself as an "old lady," but Ben was a more objective judge than I. I was already a member of AARP and within a few years of being on Medicare. Despite the fact that I had taken up tap dancing at age 62, my body had in truth developed a number of new "conditions," with ominous names like hypertension, atrial fibrillation, spinal stenosis, and emphysema. So despite my denial of being "old," I have, like all of my friends, had to learn about the importance of acknowledging the changes and challenges of getting older. As Bette Davis said, it's "not for sissies."

People are living longer lives these days, and despite those who want to look only on the bright side, aging carries with it inevitable and potentially painful losses—of people, position, role, resources, and faculties. Depression is common, and art therapy can be a powerful modality for *Railing Against the Rush of Years* (Ridker & Savage, 1996). In fact, the power of creative activities to enhance and improve our lives is finally being confirmed by well-designed studies (Cohen, 2001, 2007).

It was not always so. When I first consulted to nursing homes in the 1960s, if there was any art at all for their elderly occupants it was limited to such impersonal tasks as making pot holders or filling in paint-by-number pictures. Like the long-term state hospital patients I watched pouring clay into molds, the elderly were thought to be incapable of creating personally meaningful art (**Figure 8.15)**. While preformed approaches may indeed guarantee "successful" products, they do so at the expense of personal expression. Worse, they do not permit an authentic experience of mastery, which is especially vital when so many formerly intact faculties are ebbing.

Although some prejudices still exist, they have been successfully challenged by those art educators and art therapists who have seen beyond the limitations of older adults to their capacity for genuinely creative work (**Figure 8.16)**. Whether to touch the past in "life review," or as a way to find order in the changing present—art can be a veritable lifeline for those whose world has shrunk, and whose days have become heavy with empty time. The sensory aspects of art materials provide pleasure in contact. There is also a sense of pride in having formed something new and beautiful. Art is one way to fill the need for "vital involvement in old age" (Erikson et al., 1986).

A few art educators pioneered in bringing art to the elderly (Greenberg, 1987; Hoffman et al., 1980). Art therapy pioneers included Dewdney (Ulman & Levy, 1981) and Zeiger, who used the technique of *Life Review* (Ulman & Dachinger, 1975). Weiss (1984) published an eloquent pictorial essay, and later a book. And Jungels described her work on film (1980) and in writing. Wald wrote about art therapy with those suffering organic impairment (Wadeson

Figure 8.15 An elderly woman painting in a nursing home.

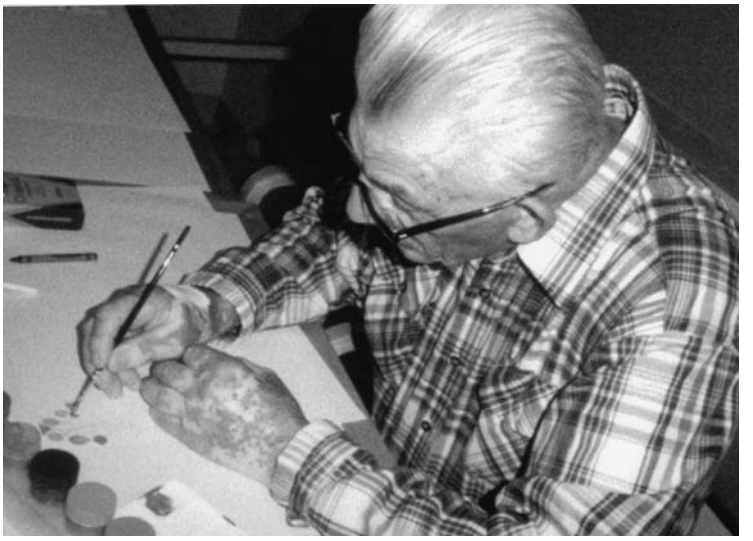

Figure 8.16 An older man painting in a hospital.

et al., 1989) and two other art therapists published a guide to drawing and writing for older adults (Rugh & Ringold, 1989; cf. also Fausek, 1997).

About 10 years before Ben helped me to acknowledge my own aging process, I worked with a woman in her early sixties. The psychiatrist who had referred her expressed the then-common concern that a person her age might not be flexible enough to change in psychotherapy, but that it was worth a try. It turned out to be surprisingly successful. While I was finishing this revision, almost 20 years after our work together, I ran into her at a play, and she introduced me to her husband as "the woman who helped me so much in therapy." Now

81, despite some significant health problems, she seemed genuinely optimistic about herself and life, and clearly enjoyed the chance encounter.

It's Never Too Late: HANNAH (64)

For Hannah, a woman in her sixties who had been sexually abused by a family friend as a little girl, and who had been subtly rejected by her mother, her first foray into therapy was an anxiety-provoking event. She had come because one of her sons had gotten into drugs, and seemed to be on a self-destructive collision course. Like many mothers, she worried that she herself had been the cause.

Hannah was also restless, now that her children had left home and she was alone with her workaholic husband. She was unhappy about herself and with her own lack of direction, feeling that she had played roles defined by others all of her life. Although she couldn't say it, Hannah was really yearning for a sense of Self, wanting to find her inner voice **(DVD 8.8)**.

Frustrated by the short time span of a regular session (45 minutes), since it took her the better part of it to "warm up," she had asked for a double session, which had worked out well. Invited to use art materials, she made a powerful clay head of a dog, and said it looked "very sad" to her **(A)**. We both saw it as a self-portrait, reflecting her discouraged state. Then, using a scribble as a "starter," she drew a pained head, mouth wide open **(B)**. It conveyed how "hungry" she was, not so much for the extra time she had requested, but for what it symbolized—maternal love.

After a year of such weekly meetings, Hannah announced with pride that she thought she was ready to leave. She kept in touch for a time, with cards and the gift of a book about a talented child artist from another country. In therapy, she had what she experienced as a new beginning, in which my nonjudgmental acceptance of her and pleasure in her timid steps toward self-definition—which included trying art materials—enabled her to grow, at a point in her life where she had almost lost hope.

Elizabeth "Grandma" Layton's story shows that it is never too late for art, and that it can have amazing healing powers. This Kansas housewife overcame a lifelong depression at age 68—by making contour drawings of herself and her concerns—a technique she learned in an art class (**DVD 8.9**).

The 82-year-old artist testified on a videotape played at Senate hearings on the *Older Americans Act* in 1992, while her drawings were on exhibit at the Smithsonian Museum (cf. Lambert, 1995; Nichols & Garrett, 1995). Her story was also told at the hearings by art therapist Robert Ault (1986), and it was so moving that art therapy was included in the regulations as a supportive service (**Figure 8.17**). Four years later, successful lobbying led to the inclusion of the arts therapies in the regulations for *Day Treatment Programs*, which often serve the elderly.

Beyond Words: Art Therapy for Older Adults (Rubin, 2008a) was first made to promote art therapy to legislators in 2004. It has been revised, and is now available with added features. These include an introduction to the film as well as excerpts from two other films on art therapy with older adults: *Make Your Mark With Art* (about *Wheel Art,* done using wheelchairs) and *Portrait of Pleasure Endeavors,* about a program at a California hospital. In addition, *Anna Shafer & Her Art,* a charming film based on an interview with an 85-year-old artist (Jungels, 1980), is also on the **DVD** available from EMI (www.expressivemedia.org). A three-minute excerpt from *Beyond Words* is included on the **DVD** that comes with this book (**DVD 8.10**).

One of the most promising developments has come from a well-designed study by Gene Cohen, a psychiatrist and gerontologist who is director of the Center on Aging, Health, &

Figure 8.17 "I'm Into Art Therapy" by Elizabeth Layton.

Humanities at the George Washington University Medical Center (Cohen, 2001, 2007). The therapeutic power of the arts has been dramatically demonstrated by the Creativity and Aging Study, which has examined "the influence of participatory art programs on the general health, mental health, and social activities of older people."[3]

Only a year into the two-year study in which matched groups of elders were assessed on a variety of measures, it was clear that those involved in the arts programs were benefiting. They had better overall health, fewer doctor visits, lower medication usage, fewer falls, less loneliness, better morale, and were involved in more activities.[4] The data confirm what artists, art educators, and art therapists have known for so long: that being involved in the exciting and rewarding activity of making art improves health and prevents illness.

Parenthetically, art can help in assessment too, since drawings may show the extent and nature of organic impairment. Both the diagnostic and the therapeutic value of art therapy for older adults are described by a group of experienced authors who have worked with this population (Magniant, 2004). *When Words Have Lost Their Meaning* (Abraham, 2004) is by an Israeli art therapist who worked with those suffering from Alzheimer's disease, a loss of the self that is painful for both individuals and their families.

But even when there are no more words, there is still the capacity to respond to one of the nonverbal art forms, music. Mala Betensky, a brilliant art therapist who wrote two wonderful books about her work with children (1973, 1995) ended her life in a residence for those with Alzheimer's. A proud woman, she was aware of her deteriorating condition when the disease began, and would not let me come to visit because she was ashamed. Her daughter, however, visited until the end. At the funeral she spoke with warmth of how the activity that most calmed her mother in her final days was listening to Yiddish lullabies that she had sung to Aya when she was a little girl.

In another interesting story reported in the press, residents of a nursing home were taken to a museum to look at the artwork. The docents explained, as usual, things about the history and the artists. What was unexpected, however, was that some of the elderly viewers

began to talk about their responses to the paintings in language that was more extensive and more coherent than they were usually capable of using.[5]

Although the explanation for this phenomenon will no doubt someday be found in brain imaging studies as increasingly sophisticated technology becomes available, something quite amazing happened when these presumably regressed elders looked at art. As with Mala Betensky, the power of the arts to calm and to stimulate the older mind is not limited to producing but also to receiving. According to a 2005 article in the *New York Times*, short focused tours for Alzheimer's patients were being offered at the Museum of Modern Art in New York City, the Museum of Fine Arts in Boston, and others.

The Hebrew Home and Hospital for the Aged in Riverdale, New York, has long known about the value of seeing as well as creating, and has had a curator of art, which is exhibited on its walls, as well as an art therapist. On the **DVD (8.11)**, you can see an excerpt from a television program about that two-faceted involvement in the visual arts.

Parenthetically, you may remember that art therapy always involves both doing and reflecting, perhaps intuitively tapping into the value of both expression and perception for the human psyche.

One more story … Margaret Naumburg, the grandmother of art therapy, and a brilliant woman like Mala Betensky, ultimately lived a very long life. Toward the end, she too began to lose her mental faculties. It was a blessing, however, that she did not seem to be aware of the decline. In my last visits to her, in connection with interviewing her for a film on art therapy pioneers, she asked me to look over a manuscript she had been working on. When I read it, I realized that it was actually a fairly jumbled version of her first book. Not only was she unaware, but what was also impressive to me is that part of what she was doing instinctively to cope with being confused, and by then in her nineties, was to create, as best she could.

That drive to express and externalize the self, whether in words or sounds or images, is so strong in human beings that it seems quite primal as well as quite powerful. As I was rewriting this book, a gentleman in his nineties, whose art I had long admired, died. Jimmy Lee Sudduth was a farmer who created art from natural materials, using mud and water to make paint and leaves and berries to add color **(DVD 8.12)**. Although he became quite well known as an "outsider" or self-taught artist during the 1980s when that kind of art began to be popular, he created not in order to sell or to exhibit, but rather because it was a compelling urge **(A)**.

Like Howard Finster **(B)**, another self-taught artist who was profiled in a book and film entitled *Passionate Visions* (Yelen, 1995), Jimmy Lee Sudduth found painting to be a powerfully engrossing and deeply fulfilling activity. It is probably not accidental that many such folk artists are in their later years. Some of the recent research cited by Gene Cohen (2001, 2007) suggests that the very fact of a dementia in old age frees the capacity to create. Willem de Kooning, for example, became even more productive as an artist when he developed Alzheimer's disease.

In fact, I can think of no better words than Jimmy Lee's with which to close this chapter: "When I first started I was three years old. If I couldn't paint I'd just be lost! I don't believe I'd live long. I believe I'd just die. If I couldn't paint nothing—I just got to be where I can paint something! I paint something all the time."

Endnotes

1. "Art is all the feelings trapped inside: An interview with Marilyn McKeown," by S. Spaniol, 1995, *Art Therapy, 12*, 227.
2. Freud, S. (1908) "Creative Writers and Day-Dreaming," *Standard Edition*, Vol. 9, 1908, 141–156.
3. "Research on Creativity and Aging: The Positive Impact of the Arts on Health and Illness," by G. D. Cohen, 2006, *Generations, 30*(1), 10.
4. "The Impact of Professionally Conducted Cultural Programs on the Physical Health, Mental Health, and Social Functioning of Older Adults," by G. D. Cohn et al., 2006, *The Gerontologist, 46* (6), 726–734.
5. Kennedy, R. "The Pablo Picasso Alzheimer's Therapy, by R. Kennedy, 2005, *New York Times.* October 30, http://www.nytimes.com/2005/10/30/arts/design/30kenn.html#.

CHAPTER 9

Problems We Address

Wherever there is a spark of human spirit—no matter how dim it may be—it is our sacred responsibility as humans, teachers, and [therapists] to fan it into whatever flame it conceivably may develop… .We are all by nature more or less endowed with intrinsic qualities, and no one has the right to draw a demarcation line which divides human beings into those who should receive all possible attention in their development and those who are not worth all our efforts. One of these intrinsic qualities is that every human being is endowed with a creative spirit.

Viktor Lowenfeld

Living With Mental Illness

Introduction

Art therapy cannot *cure* psychotic disorders. If they are chronic, the person is fortunate to find a medication that helps to keep the condition under control. As noted earlier, those with chronic mental illness were the first to "speak" through art, alerting psychiatrists to what was going on inside them (Prinzhorn, 1922). If the breakdown is temporary, like the experience of Canadian artist William Kurelek, then the story can have a happy ending (Adamson, 1984). Kurelek ended up in one of the first art therapy studios, that of Edward Adamson at Netherne Hospital in England. He found his way out of madness through painting, and his story was told in the film *The Maze*. On the **DVD (9.1)**, you can hear about some of what happened from Kurelek himself, as he discusses one of the many powerful paintings he created during his illness.

A Story of Bravery and Creative Coping: KAREN

While I was working on the adolescent unit at Western Psychiatric Institute and Clinic (WPIC) in the early 1980s, a depressed girl named Karen was admitted after a suicide gesture. She was unwilling to talk to anyone, although she was not mute. She came to an art therapy group and discovered that art allowed her to say things she couldn't put into words. She asked the physician in charge of her treatment if she could have individual art therapy as well and he agreed **(DVD 9.2)**.

We met several times a week and Karen began to warm up to me, as well as to art. We discovered a lively side of her that she had never known, which I at first thought was a good sign, though as her story unfolded it turned out to be a clue to her underlying bipolar disorder. When she was discharged from the hospital she was not allowed to return for outpatient art therapy, even though that is what she requested, but was required to attend a clinic near her home since she was on Medicaid.

A few months later I got a call from a nurse at WPIC telling me that Karen had made a serious suicide attempt but had failed because a sister rushed her to the hospital where the blood flow from the razor cuts on her wrists could be stanched. Even though she was in her teens, she couldn't be admitted to the Adolescent Unit where she knew the staff, but was sent instead to the Geriatric Unit, the only one that had a bed. I was called to come up there, and was shocked to see how regressed she was—almost catatonic.

I was asked to come to that unit to work with her, but for many visits I could only sit and talk softly, since Karen was mute. Finally, she began to respond not to my words but to some drawings I had made, so that our first communications were graphic ones. Although she was moving enough to draw and to look at me off and on, for the most part she remained locked in her rigid mental prison.

After trying many medications, which had no effect except to make her more groggy, the doctor in charge decided to try lithium. It worked miraculously and was the clue to the diagnosis of manic-depressive (bipolar) disorder. Ever so slowly, Karen emerged from the space in which she was trapped and began to talk as well as to draw, though I did not see the cheerful hypo-manic side I had glimpsed during her earlier hospitalization, only her sadness and paranoid suspiciousness.

Art was her salvation, allowing her to express feelings and fantasies that she could not put into words even when she was willing to speak, because they were so confusing. Eventually Karen was able to leave the unit for individual art therapy sessions in my office in the hospital **(A)**, and when she was finally released she was allowed to continue. I found it fascinating that during this period she was spontaneously making mandalas **(B)**, confirming the function of the circle as a holding space, an emblem of the wholeness for which she longed so intensely.

After I left the hospital to go into private practice, I continued to see Karen on a *pro bono* basis. I greatly admired her pluck, as she became the first member of her family to go on to college; first a community college and later the university, majoring in Child Development and Child Care. She was able to do the schoolwork with effort, though it was not always easy for her to concentrate. After more than the usual number of years, Karen proudly graduated and got a job in a Day Care Center.

Like many, she did not like taking her medication and would periodically go off it to prove to herself that nothing was wrong with her. Alas, that didn't work, and while she was not on medication her performance on the job and with people suffered. Her third psychotic break became obvious to me the day she visited me in my office. In fact, she was so disoriented and at risk that I took her over to the hospital and had her admitted against her will. She trusted me, but it was still painful for both of us.

Just as art and writing (especially poetry) had helped Karen, so writing helped *me* when I left on a plane trip the same night I had hospitalized her. I reflected on the terror of psychosis, and this is what I wrote as I flew across the country:

> Tragically, such a break is not only with the reality of the world outside; there is also a rupture within. And only time—and often drugs—can help the individual to

> reconnect with the personality which is the healthy self … the Self that lives and learns and loves with determination and vigor. I suppose we ought to be grateful that such ruptures with reality are now rarely permanent, that the world within and without can be regained, and that genuine living is possible for the majority of the time.
>
> Nevertheless, it still seems unfair, and it is my fervent wish that some day, when we understand much more than we do now of the biology and chemistry and electricity of that delicate thing called the mind, we will be able to eradicate these scourges of mankind forever. Although this may sound callous, it seems to me that an illness affecting the body is somehow less fearsome than one afflicting the mind, which distorts the only thing we have to orient ourselves within our constantly shifting universe.
>
> If the Self cannot be felt as a constant, through all the inevitable vicissitudes of existence, that seems to me to be the worst possible deprivation. For with a stable, ongoing sense of Self one can be centered, despite adversity and pain and loss. But to be disoriented, to be cut off from *who* we are—even more than where and when and how we are—must be an experience of such terror that 'nightmare' is a pallid way to speak of it.

After that experience Karen reluctantly decided that medication compliance was worth it, and she was able to forestall further psychotic breaks. But she was not able to maintain enough consistency in her behavior to keep a job, and finally ended up living on disability payments from Social Security, for which I helped her to apply. When I knew I was going to retire from practice, because of the strength of her attachment to me **(C)**, it was important to be sure that Karen was connected to a mental health center where her medication and living situation could be monitored regularly.

Both of us were disappointed that she was unable to accomplish so much that she had seemed close to, such as working with children or getting married. She had a wonderful spirit that I found quite inspiring, especially since her mother (who probably had an untreated mood/personality disorder) was so rejecting of her.

Karen was eventually able, despite her very meager income, to move out of her mother's house, to furnish her own apartment, and to find pleasure in her creative pursuits. Painting and making all sorts of things continued to be important to her, and when she would come into my office it was almost always with something she had created **(Figure 9.1)**—a photograph of her living space, her artwork **(D)**, and sometimes even the cats who were her steady companions.

Because she functioned at a high level when taking her medication, Karen tried and rejected outpatient art groups for those with chronic mental illness. Instead, she preferred to go the Pittsburgh Center for the Arts, where she took classes in art forms she had never explored before, thanks to their scholarship fund. One of the classes she loved was dance with an instructor named Phoebe, from whom I took tap after retirement and who remembered her well. Karen had always liked to dance, even though she had only a few years of ballet lessons as a child. One of her favorite self-soothing activities was to put a record on the phonograph and dance to it in her apartment. When the landlord complained, she had to turn down the volume, but she didn't stop.

Every year at Christmastime she would have a friend film her with a video camera doing a series of dances, for which she designed the set and costumes. She was very serious about this annual ritual, since it allowed her to give a copy of the video as a gift to each of the adults who had supported her in her struggle to stand upright. In addition to me, there was her grandmother and the only African American faculty member of the Child Development Department at that time, who had become a good friend.

Figure 9.1 One of Karen's self-portraits.

On the **DVD** you can see Karen doing one of her dances **(E)**. It is such a powerful testament to the human spirit, which though battered, remained unbowed. Even more impressive, although she was not able to hold a job, Karen volunteered whenever possible with elders and children with multiple disabilities at the School for the Blind. I am convinced that without her creative outlets, she would not have been able to do all that she did and to remain a solid citizen of her community as well. For Karen, the arts offered a lifeline on many levels and in many ways. To call them "therapy" seems almost too limiting, since they enabled and sustained both her spirit and her soul.

Children with Psychotic Disorders

My very first work as an art therapist was with a group of children who were diagnosed with *childhood schizophrenia*. Sometimes the professionals referred to them as suffering from *early infantile autism*. While they would probably be given different diagnostic labels today, most likely as having an *autistic spectrum disorder,* they would still be struggling with trying to stay afloat in a world that for them is more confusing than for children without problems in reality testing.

Art for many of them was, and still is, often as indispensable a language as it was for Aloise Korbaz, Adolf Wolffli, or my patient, Karen. I will first tell the story of Dorothy, whose art was her only intelligible speech, and who grew in remarkable ways from just seven months of weekly individual art therapy.

A Youngster with Childhood Schizophrenia: DOROTHY (10)

Many years ago I worked with Dorothy, a seriously disturbed, brain-damaged girl suffering from some loss of vision and hearing and from childhood schizophrenia. Adjunctive art therapy sessions were made available to Dorothy, as they were to all ten children on her residential treatment unit. She came every week from November through March and usually stayed for about one hour.

At first, her teacher having introduced me as an "art teacher," Dorothy wanted and expected some instruction in art. Rather quickly, however, she accepted the open-ended nature of the sessions, soon overcame her quiet reserve and initial disappointment, and began to relate in a warm and trusting way. Although she could speak, she did so rarely, since her speech was so distorted that it was very hard to understand. She was a most articulate draftsman, however, and from the first, was able to express her fantasies and ideas quite clearly through pencil and paintbrush **(DVD 9.3)**.

During her first three sessions, Dorothy concentrated on the drawing **(A)** and painting **(B)** of birds **(C)**, an animal she often pretended to *be*, making birdlike noises and flapping movements with her arms. She seemed "stuck" on a rather compulsive and careful way of doing this repetitive subject, always drawing the birds first in pencil **(D)**.

So, during the fourth session, after her attempt to paint a large bird with tempera led to frustration due to the lack of small brushes, I suggested that Dorothy try just using the paints without planning in advance. She did so, and became quite excited by her new freedom, literally dancing and yelping with glee as she let loose, slopping on one bright color after another, delighted even when they became muddy **(E)**.

When finished with her first such effort, she asked for the largest size of paper (18" x 24") and announced, with considerable excitement, "I'll make a monster!" She then did a rather fanciful and colorful painting of a multilimbed creature **(F)**, and followed this by saying, "I want to make another monster," this time drawing a birdlike creature saying "Growl!"

The following week, Dorothy began with one of her careful birds, an eagle, first drawn and then painted. She then drew at the right what she later called a "dummy," a crayon figure of a boy with strings like a marionette standing on a ladder, with his arm in the eagle's mouth **(G)**.

"I want to do another one!" she said, after naming the first "The Dummy and the Eagle." Her second drawing, in pencil, was an even more graphic picture of the destructive effects of the eagle's rage **(H)**. The figure, called both man and dummy, had a chewed-off arm, bandaged eyes, and had been violently injured. There was a narrator at the upper left saying, "Egles. Egles are mad. They want to kill man and eat them" (**Figure 9.2**).

Perhaps for the first time, the aggressive aspects of Dorothy's bird fantasy were clarified for those who worked with her, and maybe for Dorothy, too. The following week, emphasizing the flight aspects, she drew a saucy bird, then covered it over with dark paint, saying frequently, "Go home!" a commonly verbalized wish. A girl was then drawn in a cage (the hospital ward as she experienced it?) saying, "Boo hoo!" with a large monster-like creature at the right saying "Ha ha!"

This was followed by the drawing and painting of a large and a small bird, along with arm-flapping and repeated rhythmic chanting of the words "Go home! Go home! Go home!" Her final product in this emotion-filled session was a rather lovely, carefully painted, large and majestic bird **(I)**.

At her ninth session Dorothy shifted gears in her imagery, and began a long period of representing the children on the ward **(J)**, first in rows, later involved in typical activities **(K)**. Her perception of them was so accurate that it was possible for anyone who knew them to identify the figures **(L)**. These drawings were done mostly in marker, along with much verbalization about the children and her relationship to them.

This subject matter occupied her for the next six weeks, with increasing action and drama in the pictures. While she was always careful to include each of the others, she never drew herself. After what turned out to be the last one, I asked where *she* was, and with a grin she pointed to the bird flying overhead **(M)**.

Figure 9.2 Dorothy's angry eagle drawing.

At her fifteenth session, Dorothy again shifted symbols, carefully drawing a pictorial "list" of clothes, later identifying them as all belonging to the youngest child on the unit, a boy of five of whom she was jealous. She said she wished she had clothes as pretty as his, and complained that hers were so ugly.

The following week the clothes were drawn first, then a picture of an older boy and the younger one, in which the older one has thrown away the little one's doll and he is crying—perhaps her jealous wish as well as empathic fear **(N)**.

In the next session, she began her "cat phase," and for seven weeks made pictorial "catalogs" of cats **(O)**, pictures of cat families **(P)**, and of her fantasy wish of being dressed in a cat *costume* **(Q)**—a bit more realistic than actually *becoming* a bird **(R)**.

At her twenty-fourth session, the next to the last we were to have, Dorothy drew a picture of the young boy and many articles of his clothing, afterward circling those that she also possessed. She was talking much more by then, having improved considerably in intelligibility through intensive speech therapy, and had many questions about "endings."

At the last session, we reviewed the artwork in her folder, a useful way to help a patient to get closure during termination. She was very interested, studying the pictures quietly and closely, with little verbalization. The most potent pictures, those dealing openly with hostility, were passed over rapidly, and the greatest time was spent looking at those of the children on the ward.

She looked longingly at her portrait of the "Tortoise Shell Family," remarking that the mommy and daddy weren't there, though previously she had identified the larger ones as parents, and that the cats want to cuddle up to people (**Figure 9.3**). No doubt the perceived loss of parents was related to the impending loss of her art times and art therapist (**S**), to whom she had grown attached. She did one more drawing of clothing, an item or two belonging to each boy on the ward, then put her arms around me, saying, "I like you," and said a rather clingy goodbye.

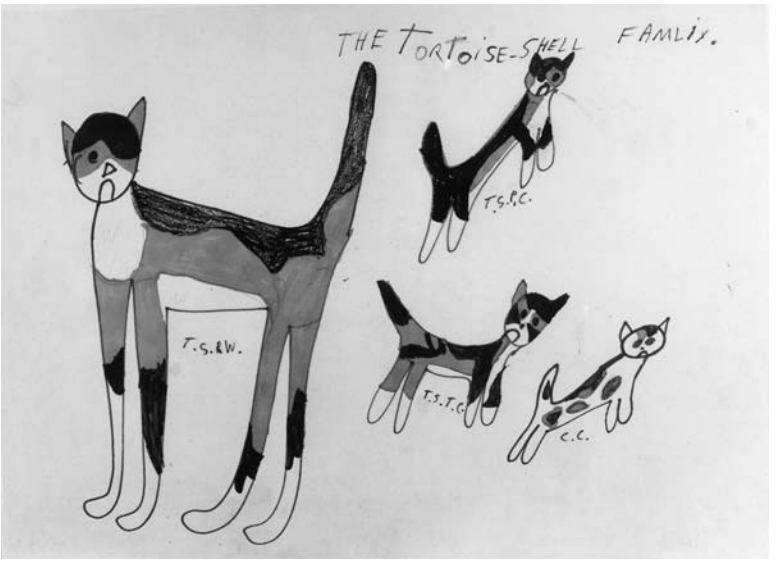

Figure 9.3 "The Tortoise Shell Family" by Dorothy.

Dorothy's therapy was ending prematurely, not because she was ready, but because I was pregnant, and in the early 1960s you couldn't teach or work in a child psychiatric unit for long after a pregnancy was visible. Although Dorothy was not able to express her anger at me then for leaving her, when I visited the craft class on the ward a month later, she showed me drawings of "Mrs. Rubin Having a Baby" **(T)** and "Mrs. Rubin being Attacked by Soldiers for Being Bad" **(U)**.

Twenty-five years later, despite having had considerable supervision and training in the interim, including a PhD in counseling psychology and completing the program in both adult and child psychoanalysis, I was confronted with a child in my private practice who proved to be even more of a challenge to work with than Dorothy.

Such children can often be helped through art therapy when other methods fail (Evans & Dubowsky, 2001; Rutten-Sarris, 2005). On the **DVD (9.4)**, you can see Marijke Rutten-Sarris, an art therapist from the Netherlands, working with two such children, using movement and mirroring as well as drawing. She calls her approach "Emerging Body Language (EBL) Therapy." I got to know Marijke when serving on her doctoral dissertation committee. As so often happens, I learned much more than I taught.

The little girl who was referred to me, however, would not let me get as close as the boys in the video of Rutten-Sarris's work. I am still not certain what would be the best diagnosis for my patient, though I suspect it would be what is now known as *autistic spectrum disorders*. Whatever her diagnostic label, and although Kitty functioned on a much higher level than Dorothy, she forced me to use all of my resources just to connect with her. Here is her story.

A Girl Who Spoke by Shutting Me Out: KITTY (4)

Kitty was a beautiful girl who had attended a progressive preschool for years but had no interest in other children. Instead, she would play out stories by herself and would sometimes do odd things, like flapping her hands or jumping up and down and twirling. At the

repeated urging of her teachers, her parents reluctantly brought her for treatment, choosing an art therapist because Kitty loved to draw **(DVD 9.5)**.

Her fluid and fluent drawings, which her mother gave me in abundance, reminded me of those by Nadia, a British girl with autism who had become famous for her remarkably detailed drawings (Selfe, 1977). Indeed, Kitty was a fine artist.

I felt concerned when I first saw Kitty's bizarre behaviors, fearing that she had *early infantile autism, pervasive developmental disorder,* or a *neurological impairment.* I soon referred her to a child psychologist for diagnostic testing, but Kitty was so oppositional that the findings were inconclusive.

At that point, I met with her parents again to try to get more of a developmental history, which would be especially important in trying to understand the nature of her difficulties. However, as had been true in our earlier meetings, their memories of Kitty's early years continued to be both inconsistent and vague. Since this was in the 1990s, I finally asked if they had videotaped her when she was little. They had, and were more than willing for me to look at their home videos.

The tapes were startling. While Kitty seemed like a pretty normal baby and toddler, her mother, the main videographer, was so intrusive that it stood out as the most significant feature. Mother's narration, which was constant while she was filming, as well as her boundary-less interaction with Kitty, introduced another possible motive for the child's puzzling symptoms and for her behavior with me, which had been evolving during the months I had seen her before viewing the videos.

In the beginning, Kitty had enacted her solitary dramas at a distance—as far away as she could get with her back to me in the large former living room of my office suite. After a few sessions, she began to use the smaller adjacent playroom (the former kitchen).

She would usually grab drawing paper and markers and quickly produce pictorial storybooks. She would tell me what to write on each page, but Kitty would not respond to any of my questions or comments. On the **DVD (9.5)**, you can see the cover and inside pages from one about "Wonder Woman" **(A)** and her adventures **(B)**, and another about being "In the Bubble" **(C)** and popping it to escape **(D)**.

Finally, she began to involve me in her dramas. Her favorite thing was to shut me out of the playroom space by literally shutting the door. Kitty would then gleefully control when and how she would *let me in*. Sometimes she would *shut me in,* being equally bossy about how and when she would *let me out*.

It was clear that she was trying to tell me something. But her message wasn't so easy to grasp. At first I thought she was telling me—by making me feel *left out*—that she was feeling excluded from the closeness between her younger brother and her mother, which I had observed and which was unusually intimate.

After viewing the videotapes of Kitty's early years, however, I realized that her primary need was to *create a boundary between us.* Her withdrawal from me and from other children was not simply an avoidance of people. It was also a way of *separating* from her loving but anxiously overinvolved mother, who was still having a very difficult time differentiating Kitty's needs from her own. She gave me permission to share my observations with her own therapist, who had referred Kitty to me.

The information contained in the videos helped her mother's therapist to help *her* to separate, thus giving Kitty the space she needed to grow more autonomously. As Kitty worked through her problems in therapy using both art and drama, she became more sociable at home and at preschool. Much to my surprise, when it was time to enroll in a kindergarten

she was even able to handle a public school (with good supports), which I could never have imagined when I first met her.

When I was getting ready to retire from clinical practice, I referred Kitty to a child psychiatrist. Her assessment was that the child was suffering from *Asperger's syndrome* at the high-functioning end of the autistic spectrum. Because Kitty was so distant and uncommunicative, I doubt that she would have been accessible to therapy at age 4 without the creative modalities of art and drama.

A Teenager With Asperger's Syndrome Uses Puppets: EMILY (16)

Many years after I saw Kitty, an adolescent I knew who had *Asperger's syndrome* was in the hospital for a bone marrow transplant because of her leukemia. Although she was already 16, Emily functioned in many ways like a younger child. I brought in art supplies as well as puppets, in my attempts to help Emily to express her feelings about what was happening to her, which she was unable to verbalize comfortably.

Although the art supplies held no interest for her, she was able to work through a good deal of the fear and rage she was experiencing by using the puppets, as did I in order to interact with her in a nonthreatening fashion. Emily began to request that I come more often, even though she had many loving visitors. It was clear that this adolescent needed the symbolic distance provided by the puppets to be able to cope with her terrifying illness and the effects of the treatment.

Four years later, after an almost miraculous recovery, I attended her graduation party from the special high school she had attended. Much to my surprise, the first question Emily asked me was whether I still had the puppets. She remembered the names she had given them, as well as many of the dramas she had created.

That experience with Emily reminded me of a paper written years earlier by a colleague about work with a retarded adult and how the symbolic function had been activated through art making (Wilson, in Ulman & Levy, 1981). Whatever the explanation, there is no question that individuals of all ages whose cognitive abilities are challenged in any fashion are often able to use the symbolic avenues of the arts more successfully than ordinary verbal language.

Living With Disabilities

Art therapy cannot give a retarded person comprehension, a blind person sight, or a person who is crippled mobility. But art can and does give those with disabilities a stimulating and pleasurable way to enjoy and to explore the sensory world. It gives them a way to be in charge in a limited sphere, to master tools and processes within their reach, and to savor the pleasure of skills honed through practice.

Art gives those with disabilities a way to "map out" a confusing sense of the body and the world. It gives them a way to define themselves through choices and decisions, and creations that are uniquely theirs. It gives them a way to create products of which they can be proud, which can add beauty to the world and meaning to their lives. Through art, a person can both escape symbolically, and come to grips with feelings—especially those about the disability itself, as Jimmy did in his Person and Self drawings (**DVD 6.7**).

While these benefits are available to all human beings, they have special value to the disabled, for whom—like the elderly—there are many more problems and many fewer avenues of expression. The same medical progress that extends more lives also saves more premature babies, who are at greater risk for having multiple disabilities.

Art gives people with disabilities a way to safely smear and pound, and to symbolically express feelings like anger—which is especially hard to do because they are necessarily so dependent on others. This was poignantly clear for Jane, a girl I met when I did a demonstration program at the Western Pennsylvania School for Blind Children in 1970.

A Therapeutic Art Program Helps a Partially Sighted Girl: JANE (11)

Jane was legally blind, although she had more useful vision than most of her schoolmates. Still, like them, she was angry about being blind, and resentful of the sighted adults on whom she was dependent. Jane didn't know the intensity of her retaliatory rage, but was able to express it symbolically in a story about her painting (**Figure 9.4**).

"This is a building which is a hospital, and in this hospital—there's just one patient in this hospital … The one patient is Mrs. Rubin … She had an accident. She bumped into another lady's car and … she punctured her eye." When asked what would happen, Jane said with a grin, "It's going to blind her!" She went on to explain how Mrs. Rubin would then be unable to work with children in art **(DVD 9.6)**.

When asked how she herself felt about it, she asserted with a sly smile, "I don't feel anything. My sight's coming back!" Having verbalized this wish, she went on to deny her disability completely, a fairly common phenomenon. "I can see just like a regular person!" In the course of group art therapy, Jane was eventually able to accept her disability—as well as her feelings about it—a necessary task for every blind individual.

Figure 9.4 Jane describes her painting.

Another child in Jane's group was more seriously disturbed. At first, because of the extent of his rocking and his chaotic behavior and self-talk, Larry was thought to be possibly psychotic. He came to the Child Guidance Center for 6 years of twice-weekly therapy while I consulted to the school and a blind social worker met with his parents. He used art and drama therapy to master repeated traumatic experiences, and to come to terms with the blindness caused by his congenital glaucoma.

Expressive Arts Therapy Helps a Blind Boy: LARRY (8)

Larry was an eight-year-old who had everybody worried about him. He looked and acted "crazy," and was always threatening to smash things or people. Sometimes he withdrew into a private world where he would sit in a closet and make up stories, playing all the characters using different voices. He was finally brought to a clinic for therapy, because the teachers and house parents at his residential school were unwilling to let him remain there without some kind of treatment. His parents reluctantly agreed to try the Pittsburgh Child Guidance Center **(DVD 9.7)**.

So Larry came to the clinic for weekly individual therapy, while his parents saw a (blind) social worker. Although it may seem strange that a boy with two artificial eyes was referred for art therapy, he enjoyed the sensory pleasure of squeaky markers and smooth wet clay **(A)**. At first, Larry made clay "rockets" in which he imagined himself as an astronaut, who would explore outer space **(B)**. The playroom was a safe "closet," where he could share his fantasies with an accepting adult (**Figure 9.5**).

Art materials often became props in his dramas, and these stories helped us to figure out why he was acting so "crazy" or—as he would say—"mental." Many of his early stories were about a boy getting lost, sometimes on a clay "planet." Then, for almost a year, he played and replayed scenes of doctor **(C)** /dentist (**D**) /nurse/patient. Though I was often assigned a role,

Figure 9.5 Larry and the art therapist.

sometimes he was both doctor and patient, doing things like examining himself or giving himself a shot, as on the **DVD (E).**

In fact, Larry had fifty operations for congenital glaucoma before his eyes had been removed at age five. To make matters worse, he had been jealous of his baby sister, and she had died of cystic fibrosis just before the operation. His repeated dramas were related not only to the trauma itself, but also to his unconscious guilt about his sister's death. He thought his blindness was a punishment for his badness.

With his dramatic flair, usually using art materials as props, Larry went on to create a series of dramas about a "Good Larry" and a "Bad Larry." He played both parts, and I was myself/parent/teacher according to his instructions **(F)**.

The struggle went on for many months, and included both repeated injuries and symbolic replacements for his lost eyes **(G)**, but finally the "Good Larry" was victorious. He ended up taming the "Bad Larry" so that he could stay at the School for the Blind, where the *real* Larry was starting to make friends and to enjoy learning. He left after six years of therapy, announcing his "resignation" from the Child Guidance Center. He had come out of his closet of fantasy and was warmly regarded by others.

Fifteen years after he terminated, I ran into Larry on the street. He recognized my voice immediately, and greeted me warmly. He told me proudly about the life he had made for himself: his friends, his job at the Guild for the Blind, and his performances at a local Comedy Club. The latter was no surprise, since he had always done wonderful vocal imitations and musical improvisations **(H)**. He recalled our times together fondly and grinned as he announced that he was no longer "mental!"

Probably ten years after that meeting, I got a phone call from Larry, telling me sadly that his mother **(I)**—his best friend in the world—had died and asking if he could come in to meet with me. Even though I had by then retired I agreed, because he sounded so forlorn.

He had two requests: for a copy of the film I had made about the art program at his school, which he remembered remarkably well, and for some of the tape recordings from our sessions **(J)**. We had used the microphone of the tape recorder extensively so that he could replay what had gone on in his many dramas. Months after that, he called to say that he had copied all of the tapes, and wanted to meet again to return the originals.

Larry's struggle to stay sane in a very confusing world was one of the more dramatic in my own early years as a psychotherapist. It was moving that he remembered the details of our work so well **(K)** and that the sound recordings of the sessions and on the film sound track were so meaningful and comforting to him. Art can also function as such a *transitional object,* allowing separation to happen more comfortably.

History of Art Therapy for Those With Disabilities (**DVD 9.8**)

When I began working with Larry in 1969, blind adults were making brooms, not expressing themselves creatively. Like the elderly, individuals with disabilities were most often seen as incapable of genuinely creative work. In 1967, when I started an art program (**Figure 9.6)** at the *Home for Crippled Children* **(A)** (now the Children's Institute), I found only one project, reported in the News section of the *Bulletin of Art Therapy* in 1964 (p. 66), which promoted authentic work with those with disabilities.

A New York artist had started a program in 1958 with cerebral palsied adults. He had noticed something I also observed, which looked miraculous—that when a person with involuntary muscle spasms is absorbed in a painting process, like mixing colors, he often achieves a degree of relaxation that allows him to actually control the brush!