otherwise destructive urges and experiencing a safe altered sense of reality, of aliveness. On the **DVD** an adolescent puts this quite eloquently **(L)**.

As Elinor Ulman said years ago, being deeply involved in a creative process is "a momentary sample of living at its best." The sensory and spiritual pleasures of art-making are profound, enriching lives already full, and brightening those that are far too dim. Most art therapists see art not only as a form of "symbolic speech" that augments verbal ways of knowing, but as a deeply healing activity.

Ulman thought that one reason for its power to help was that "art is the meeting ground of the inner and outer world" (1971). Ten years earlier (Ulman, 1961, in Ulman & Dachinger, 1975), she had also written about art:

> Its motive power comes from within the personality: it is a way of bringing order out of chaos—chaotic feelings and impulses within, the bewildering mass of impressions from without. It is a means to discover both the self and the world, and to establish a relation between the two. In the complete creative process, inner and outer realities are fused into a new entity.

In addition, because art-making involves the whole body and is both sensory and kinesthetic, the very act of touching, shaping, and manipulating materials can be a source of deep pleasure. And, when the process has come to an end, viewing and showing the finished product(s) can be a wonderful source of pride and enhanced self-esteem **(Figure 4.10)**.

Creating something unique with materials facilitates much more, however, than a sense of accomplishment. Having an effect on even a small piece of material reality is a powerful antidote for feelings of shame and helplessness. Without a sense of efficacy of agency, it is very hard—if not impossible—to feel hopeful about life. For those who are isolated or gravely impaired, making art can truly enhance the quality of life **(Figure 4.11)**.

Figure 4.10 Pride in one's product is highly therapeutic.

Figure 4.11 A nursing home patient engaged in creating.

Why Art?

When we ask, "Why art therapy?" it implies another question: "Why art?" It has been said that "Art is a way of making ordinary experience extraordinary," or as Dissanayake (1995) wrote, of "making special." This idea returns us to the roots of art therapy, which are deep and ancient, and to its branches, which are able to flower in so many different ways.

I think the titles of two books by a poetic art therapist say it well: that *Art Is a Way of Knowing* (Allen, 1995) and *Art Is a Spiritual Path* (Allen, 2005). I also believe that artists and clinicians alike make use of *Art as Medicine* (McNiff, 1994). If therapy means to heal, and hopefully to cure, then art may really be the ideal medicine for the human soul, the best way for the Spirit to know and to actualize the Self.

There are many ways to think about why art is therapeutic. One was beautifully articulated by a psychologist named Ley (1979): "One cannot use a left hemispheric key to open a right hemispheric lock." Another was written by a psychiatrist named Jakab: "The nonverbal aspect of art psychotherapy holds an important and unique position in the realm of mental health work, for it gives the clients an opportunity to listen with their eyes."

Another eloquent statement of why and how art is therapeutic was written by art therapist Edith Kramer (2000): "Since human society has existed the arts have helped man to reconcile the eternal conflict between the individual's instinctual urges and the demands of society. Thus, all art is therapeutic in the broadest sense of the word" **(Figure 4.12)**.

Perhaps my favorite, however, was said by a patient in a mental hospital to E. M. Lyddiatt (1971), a British art therapist: "In the Art Therapy room my sick self found my whole self and the therapist, by total, unquestioning acceptance of me and the things that I painted, encouraged me to believe in myself as a valid person."

Back to Basics

The most recent trend in the field of art therapy in the United States has been a return to the art studio (C. H. Moon, 2002). The concept of the open studio articulated by Pat Allen in Chicago and offered to homeless individuals by Janis Timm-Bottos in New Mexico has

Figure 4.12 A person can create only when safely "held."

become hugely popular among art therapists. AATA now has an Art Committee, originally ad hoc but now standing, which sees to it that art is central to the annual conference, which always has an open studio space where attendees can go to create throughout the meeting. Each day's presentations begin with a slide show of art submitted by AATA members.

A similar kind of development, beginning in 1999, was what is known as QuickDraw, during which well-known art therapists create in a specified space and time where they can be observed by conference participants. Not only do they often answer questions informally during the process of creating, they also respond to queries using a microphone in a discussion that is uniformly stimulating and enlightening. On the **DVD** you can see and hear Shaun McNiff first drawing and then reflecting on the experience **(DVD 4.7)**.

As artists become involved in using the arts in healing, most evident in arts medicine, this trend is likely to continue within the world of art therapy as well. There has always been a tension between artist and therapist-self for many individual art therapists, some of whom have continued parallel careers as active, exhibiting artists (Kramer, 2000; Lachman-Chapin, 1994).

Having needed to prove our credentials as therapists in the early days of the field of art therapy, we also ran the risk of clinification and of forgetting our roots in art. The back to basics movement reaffirms that which is unique to art therapy: Art. The challenge for the 21st century is to demonstrate that art therapy can provide for human beings what is missing in the technology and accelerated pace that now dominate our way of life, to satisfy what many believe to be a basic need to create—in order to feel and to be fully alive.

Endnote

1. From "The Effectiveness of Psychotherapy: The *Consumer Reports* Study, by M. P. Seligman, M. P., 1995, *American Psychologist, 12(5*), 965–974.

CHAPTER 5

Approaches

As a psychotherapist I found it particularly heartening that the use of art in therapy seems to have the effect of reducing the differences between Freudians, Jungians, Kleinians, and adherents of other schools … Art not only bridges the gap between the inner and outer worlds but also seems to span the gulf between different theoretical positions.

Anthony Storr

Multiple Paths: Multiple Perspectives

The reader will recall that there were a number of individuals from different fields who, in one way or another, pioneered the use of art in therapy. Each of them had a primary identity in another discipline, whether it was art, education, or mental health. It was natural, therefore, that their ways of understanding art therapy were disparate, influenced as they were by their personal histories.

Founding editor Ernest Harms (1973) expressed his concern about this variety in the second issue of *Art Psychotherapy*: "What we find designated today as art therapy or art psychotherapy presents a conglomerate of undertakings with little coherence."[1] Indeed, it would probably be accurate to say that if truth be told, there have always been as many different approaches as there are art therapists.

Nevertheless, it would be inaccurate to suggest that each one is completely idiosyncratic, having nothing in common but a shared basis in art and therapy. While every art therapist's way of working is stylistically unique, it is still possible to talk about different perspectives. Just like practitioners of verbal therapy, art therapists have grounded their work in a variety of theoretical frameworks that have expanded as the profession has developed.

In 1983, I invited some individuals who practiced art therapy from different points of view to write chapters on how they had translated a particular theory into technique. The book that resulted, *Approaches to Art Therapy* (Rubin, 1987/2001), contained descriptions of a number of orientations; and because new approaches have since evolved, there is a second edition with six new chapters on even more particular ways of thinking and working.

To grasp any one of them requires extensive study and close supervision by an experienced clinician. This chapter offers a broad overview of different ways to view, to understand,

and to do art therapy. These multiple perspectives define the discipline as much as do its common underpinnings.

Psychodynamic Approaches to Art Therapy

Historically, art therapy's roots were in the then-dominant mode of understanding, psychoanalytic theory. Psychoanalysis is only one of many ways of trying to understand how and why people function as they do. But it is the oldest and most elaborate among modern therapeutic approaches, and has influenced all of the others, which are either modifications of or reactions to it. Both *Freudian Psychoanalysis* and *Jungian Analytical Psychology* are based on an understanding of the dynamics of the patient's internal world. They are called *psychodynamic* because they assume that unresolved issues cause unconscious conflict, exerting tremendous power and resulting in painful symptoms. Because they have been repressed as too distressing, they are often unconscious and need to be discovered through bypassing defenses, as in art.

There are a variety of approaches within both analysis and analytic psychotherapy. Many emphasize developmental as well as interpersonal phenomena, exemplified by the studies of "attachment" (Wallin, 2007) as well as "relational" approaches (Mitchell & Aron, 1999). Contrary to popular misconceptions, psychoanalytic therapy deals with the present as well as the past, has educational as well as cognitive components, relies heavily on empathy, and builds on strengths.

Despite rumors of its demise, contemporary psychoanalysis is alive and well. In fact, it is extremely fertile, teeming with new ideas about both theory and technique, many of them relevant to art therapy. In the second edition of *Approaches*, I invited individuals to comment on the group of chapters in each section. Joy Schaverien, an art therapist from Great Britain—where analytic modes of thinking and working are still dominant—wrote a thoughtful commentary.

Freudian Psychoanalysis

The two main pioneer art therapists each based their approach on the theory developed and modified by Sigmund Freud. Naumburg emphasized *insight,* uncovering unconscious forces through images and associations to them. Kramer focused on *sublimation* through the creative process, a form of ego mastery. Many art therapists have followed in their footsteps, like myself (Rubin, 2001) in the Naumburg tradition or Lani Gerity (1999) in the Kramer tradition.

Most art therapists who think analytically have emphasized one or another component of Freudian theory. Some examples are: Margaret Naumburg's (1966) stress on the *dynamic unconscious,* Edith Kramer's (2000) on *sublimation*, Laurie Wilson's (Rubin, 2001) on *symbolism,* Arthur Robbins's (1997; Rubin, 2001) on *object relations*, Mildred Lachman Chapin's (Rubin, 2001) on *self-psychology*, and Myra Levick's (1983) on *defense mechanisms*. All analytically based approaches value and foster free expression of the person's own imagery. Some emphasize spontaneity, while others stress the achievement of formed expression.

Psychoanalysts—both medical, like D. W. Winnicott (1971b) and Nolan D. C. Lewis, and nonmedical, like Madeleine Rambert (1949) and Marion Milner (1969)—were among the first to use drawing and painting, especially with regressed or resistant patients. On the **DVD (5.1)** you can hear Marion Milner talking about a patient whose treatment she described in *Hands of the Living God* (1969) **(A)**. Many other clinicians were influenced by analytic thinking about the role of the unconscious in mental distress and its tendency

to speak in images. Several pioneered in doing such work, like Ainslie Meares **(B)** (1957, 1958, 1960) in Australia, Ralph W. Pickford (1967) in Scotland, Irene Jakab (1956/1998) in Hungary, and Mardi Horowitz (1983) in America.

Melanie Klein (1932), who used drawing as one of many modalities in child analysis, was a disciple of Freud who developed her own unique ideas. Her theories have been applied to art therapy by Weir, (Dalley et al., 1987). Indeed, the dominance of analytic thought among British art therapists is in striking contrast to recent developments in the United States, where it was originally most the most common orientation.

Margaret Naumburg called her approach "dynamically oriented art therapy," relying on patient associations to images illustrated by Judy Rubin on the **DVD (C).** Edith Kramer called hers "art as therapy" **(D)**, relying on the ego-building potential of sublimation, a psychoanalytic defense mechanism. Laurie Wilson stressed the value of art in promoting symbolization **(E)**. Arthur Robbins focused on the importance of internalized images in the psyche, what Freud called "object relations" **(F)**. Mildred Lachman Chapin highlighted the value of Self Psychology, an analytic orientation developed by Heinz Kohut, and developed a technique of mirroring what the patient was concerned with by drawing with him **(G)**.

In addition to the approaches outlined in this chapter, some art therapists—like Shirley Riley—have been very enthusiastic about other ways of conceptualizing the treatment relationship, such as narrative therapy, postmodernism, and social constructionism (Riley, 1999, 2001). My own sense is that these terms have to do with working in a more egalitarian way, which is not so different from what is currently known as "relational psychoanalysis" (Mitchell & Aron, 1999).

Analytic therapy, whether through art or words, relies on the method of *free association,* which is illustrated in the following vignette.

Free Association in Art Imagery: LINDA (8)

Linda was a sad, inhibited eight-year-old who had come for several assessment sessions before she and her parents agreed to child analysis (four sessions per week). In her first analytic hour, she worked with soft-colored wax, creating in rapid succession a series of three-dimensional images, which were later made into candles by the insertion of wicks.

Although Linda thought of making a turkey for the first, she decided on an "Orange … because a turkey is too hard." She bragged that she would make "a whole bunch." She then pressed the round piece of wax on the table saying she had to make it "square," and talked about her older sister coming home from college for Thanksgiving "tonight or tomorrow." She added dots to the square, and called it a "Dice." She then reiterated the concern she had voiced in the beginning of the hour: "I'm wondering if—if—who's your favorite person that goes with you?"

Linda's second product was a roundish piece of yellow clay on which she put "gold dust," calling it "A Gold Lump." Her third was a red "Apple," copied from a picture on a box. She complained about how hard it was to shape the wax, saying, "I'm gettin' tired of it. I thought it was pretty at first sight, but I didn't know it was so much trouble!" She made a leaf for her apple, and told me that she was missing a party but didn't mind. She then joked about her friend's mother being "a wicked witch."

Her next effort was called "An Eiffel Tower"… "very tall, one of the tallest!" Linda told a story about "a giant magnet and it was sucking everything up and it sucked the Eiffel Tower." She told me I was "a funny person." She then decided she would give away all her candles ("They're just candles") as gifts, saying , "I love giving things. I really want the Eiffel Tower because it isn't so pretty … I think I'll keep that." In response to my questions about

Figure 5.1 Linda welcoming the next patient.

what she had created, Linda imagined that the dice belonged to "a famous game-player" and that the apple was owned by "the best person in the world—the King!"

What is striking is how very much Linda was able to tell about herself through free association with art media in this relatively brief segment from her first analytic hour—about her hunger for attention (supplies), her jealousy of siblings (my other patients), her difficulty with anger toward her mother (her friend's mother is a "wicked witch"), and her defense of reaction-formation … whereby this hungry, needy child who wants to suck up everything like a giant magnet, ends up deciding to give all of her creations to others as gifts. In a later version of this defense, Linda would welcome the next child analytic patient, of whom she was really quite jealous, by writing cheerful greetings **(Figure 5.1)** on the floor **(H)**.

Jungian Analytic Therapy

Margaret Naumburg was analyzed not only by a Freudian, A. A. Brill, but also by a Jungian, Beatrice Hinkley—who analyzed her sister Florence Cane as well. Some of Jung's ideas about symbolism and imagery were incorporated into her formulation of what she called "Dynamically-Oriented Art Therapy" (Naumburg, 1966). Jung's thinking has gradually become popular among American art therapists, and has remained appealing in Great Britain, where one of the first books on art therapy was by a Jungian (Lyddiatt, 1971).

Jung believed that all human beings were born with a *collective unconscious,* and that there were universal *archetypes* common to all cultures. The similarity of visual symbolism in widely separated artistic traditions was part of the evidence for this hypothesis. Jung's notions about *symbolization* were quite different from Freud's. Jung emphasized the capacity of symbols to *reveal* hidden ideas, while Freud stressed their ability to *conceal* unconscious feelings and fantasies. Jung himself had found that building with natural materials and painting mandalas were helpful in his own self-analysis.

Because he felt that there were messages to be "heard" in visual symbols, Jung's approach to mental and artistic imagery was respectful and intuitive—much less analytical and deductive than Freud's. He advocated the use of movement, drama, and visual imagery in the technique he called "active imagination," which was a creative way of amplifying ideas and feelings in

Figure 5.2 Edith Wallace, Jungian analytical art therapy.

therapy (Chodorow, 1997; Fay, 1994). He wrote: "An emotional disturbance can also be dealt with in another way, not by clarifying it intellectually, but by giving it visible shape" (Jung, 1916/1952). Some art therapists, while they are not Jungian analysts, have been attracted to the notion that images "speak" to the artist and have developed methods that enhance the likelihood of learning from such messages (Allen, 1995, 2005; Kapitan, 2003; McNiff, 1995).

Jungians are more likely than Freudians to promote art activity as part of analytic therapy, making Jungian analysis attractive to artists like Jackson Pollack (Wysuph, 1970) and Peter Birkhauser (1991). Several analytical psychologists have published book-length case studies (Baynes, 1961; Harding, 1965; Wallace, 1990; Weaver 1973). Jungian analyst Edith Wallace **(Figure 5.2)**, a psychiatrist and psychologist, also contributed a chapter to *Approaches* (Rubin, 2001).

The arts played a central role at Withymead Centre, a unique therapeutic community run by a British Jungian analyst named H. Irene Champernowne (Stevens, 1986). Michael Edwards, one of the art therapists who worked there, later pursued Jungian training and contributed another Jungian chapter to *Approaches* (Rubin, 2001). In 1992, Joy Schaverien published *Analytical Art Psychotherapy in Theory & Practice* (1995) and later extended her theoretical framework to include ideas from other psychoanalysts like Bion (1991), Winnicott (1971a, 1971b), and Lacan (2007). A recent book from Great Britain includes chapters by Schaverien and other art and drama therapists with an analytical psychotherapy orientation (Searle & Streng, 2001).

As a group, analytical psychologists are less likely to work with children, perhaps because Jung never articulated a fully developed theory of human development. A few, however, used art extensively (Allan, 1988; Fordham, 1944; Jeffrey, 1995). Furth, like his mentor Bach (1990), helped sick children through art. Dora Kalff (1980) was inspired by Margaret Lowenfeld's "World Technique" (Lowenfeld, M., 1971, 1979) to invent what she called "sandplay," a technique used with patients of all ages (Bradway & McCoard, 1997; Carey, 1999; Homeyer & Sweeney, 1998; Labovitz Boik & Goodwin, 2000; McNally, 2001).

Although her early training was in *Freudian object relations theory*, movement therapist Penny Lewis's *Creative Transformation* (1993) reflected her *Jungian* studies as well. Jungian

psychiatrist David Rosen, like Lewis, embraced a multimodality method in his treatment of depression. It is no accident that the word *transformation* is in the titles of both of their books (Rosen, 2002). Jungian approaches often include a strong mystical and spiritual component.

Several art therapists have used Jung's thinking as one component of their conceptual foundation. When Keyes's 1974 book was reprinted (1992), a supplement entitled "On Active Imagination" was added. Indeed, the best collection of Jung's own writing on that topic was compiled by a dance therapist (Chodorow, 1977), and the explanation by movement therapist Carolyn Grant Fay (1994) is also excellent **(I)**.

As for art therapists, Lusebrink (1990) incorporated the idea of *archetypes* and the method of *active imagination* into her work. Kellogg (1980, 2002) spent many years exploring the use of the *mandala* for both diagnosis and therapy, a technique also embraced by others (Fincher, 1991). And Corbit and Fryrear's 1992 book on *Photo-Art Therapy* was subtitled *A Jungian Perspective*. And, as Jung's ideas have been "re-visioned" by contemporary analytical psychologist James Hillman (1977), they have become even more attractive to art therapists.

Humanistic Approaches to Art Therapy

Another major group of therapies developed in reaction to the psychoanalytic focus on the past, on the unconscious, and on conflict. These are the humanistic approaches, which emphasize the acceptance and development of individuals in the present **(DVD 5.2)**. Such approaches were very popular in the 1960s during the flowering of the *human potential movement*. Humanistic psychology offered a *wellness* model of change, as opposed to a medical model of *illness*. Josef Garai, who wrote that chapter in *Approaches* (Rubin, 2001), also included "Holistic" in the title **(A)**.

Holistic ideas about healing are an outgrowth of humanistic ones, as are those in what is known as *transpersonal* psychology and psychotherapy. Abraham Maslow,[2] an early humanistic psychologist, emphasized "self actualization," or the fulfillment of the individual's innate potential for growth. He also described "peak experiences," similar to Ulman's characterization of art-making as "a momentary sample of living at its best" (Ulman & Dachinger, 1975).

Person-Centered Approach

This approach, developed by Carl Rogers, was originally called the *client-centered* approach. It is based on the therapist's *unconditional positive regard* for the patient, and the powerful effect of *empathy* (feeling with) as a way of fully responding to the person in pain. His daughter, Natalie (Rogers, 1993) was taught by Maslow. Initially trained as a play therapist and a dancer, she used art along with movement, music, and drama in what she called "Person-Centered Expressive Therapy" **(B)**. A recent methodological contribution to this orientation is Laury Rappaport's adaptation of the work of Carl Rogers's colleague Eugene Gendlin in *Focusing-Oriented Art Therapy* **(C)** (Rappaport, 2009).

In Great Britain, Silverstone (1997) developed a training course called *Art Therapy: The Person-Centred Way*. A recent publication from the United Kingdom contains papers on the arts therapies in "person-centered dementia care" (Innes & Hatfield, 2001).

Adlerian

Alfred Adler, a former colleague of Freud's who created *Individual Psychology,* inspired several American art therapists. One was Rose Garlock, who led groups at an Adlerian social club in New York for many years and contributed a chapter to the first edition of *Approaches*

to Art Therapy (Rubin, 2001). Another was Sadie Dreikurs (1986), wife of Adler's best-known American disciple, Rudolf Dreikurs. She began her work in a Chicago hospital in 1962, and taught her approach in Adlerian institutes. Although Adlerian approaches to therapy are much less common than they were 20 years ago, there is an art therapy training program at the Adler School of Professional Psychology founded by Judy Sutherland (Cf. Kerr et al., 2007).

Gestalt

Like many other humanistic approaches, *Gestalt therapy* also involved modifications of psychoanalytic theory and technique. Like Rogerian therapy, it emphasized the here-and-now. Unlike that approach, it required a more active role by the therapist. Gestalt therapy was the creation of an analytically trained psychiatrist, Fritz Perls, who integrated his dynamic understandings with the findings of Gestalt psychology. The latter was an experimental approach that focused on sensation and perception. A major area of interest was *visual* perception, as in the work of Rudolf Arnheim (1954, 1967, 1969), who influenced many art therapists, including his student, Shaun McNiff (1988).

Joseph Zinker (1977), a Gestalt therapist and sculptor, wrote about his multimodal use of expression. Violet Oaklander, (1988) another Gestalt therapist, described her use of art and other expressive modalities in therapy with children, adolescents, and families. On the **DVD (D)**, you can see her working with an angry boy (www.violetoaklander.org).

One art therapy pioneer trained by Perls also participated with him in the human potential movement. Janie Rhyne **(Figure 5.3)** called her 1973 book *The Gestalt Art Experience*, and led workshops in that approach **(E)**. Later in her career, Janie Rhyne became interested in George Kelly's *Personal Construct* theory of personality. She explored what she called "mind-state drawings" for her doctoral research. Rhyne described her findings and their application in her clinical work, elaborating these ideas in her chapter for *Approaches* (Rubin, 2001). Her later thinking is in the Foreword and Afterword to the 1995 revision of her book, whose new subtitle—*Patterns That*

Figure 5.3 Janie Rhyne, Gestalt art therapy.

Connect—reflects her growing interest in both personal constructs and *cybernetics* (the study of feedback systems).

Ericksonian

Milton Erickson was a psychiatrist who created his own personal synthesis of various philosophies and techniques into a highly inventive approach. Like other humanistic therapists, he emphasized human potential, and advocated a collaborative versus an authoritarian model of psychotherapy. He pioneered in many techniques, such as the clinical use of hypnosis and what he called "creative reframing."

In a 1940 case study with analyst Lawrence Kubie (1958), Erickson described using "Automatic Drawing" to treat a case of "Acute Obsessional Depression"—an early instance of art therapy. Although art therapists have not been notably involved in Ericksonian therapy, both rely heavily on *metaphor,* as in the use of art by Mills and Crowley (1989).

Phenomenological

A strong current, with its roots in 19th-century philosophy, also had a profound impact on 20th-century psychology. Known as *phenomenology,* the essence of the theory is the uniqueness of each individual's experience of reality at each moment in time. In psychotherapy, the clinician concentrates on helping the patient to focus keenly and intensely on each moment, to fully know the phenomenon of *being-in-the-world* (existing). Art therapy pioneer Mala Betensky **(Figure 5.4)** developed an approach based mainly on phenomenology, into which she integrated elements of Gestalt psychology as well. She wrote two books describing her work (Betensky, 1973, 1995) and contributed a chapter to *Approache*s (Rubin, 2001). On the **DVD** you can see her working with an adolescent girl whose art she discussed in her second book **(F)**.

Existential

Existentialism also began in philosophy and was then embraced by a number of psychologists and psychiatrists. A strong element was the centrality of *meaning*, a key factor in art therapist Bruce Moon's work with adults, described in his book *Existential Art Therapy* (1995). Moon has continued to write about his practice which is, like most humanistic

Figure 5.4 Mala Betensky, phenomenological art therapy.

Figure 5.5 Pat Allen, the open studio approach.

approaches, profoundly client centered (Moon, 1992, 1994, 1996, 1998, 2007). Moon contributed a *Commentary* to the section on humanistic approaches in the second edition of *Approaches* (Rubin, 2001). On the **DVD** he can be seen working alongside a supervisee **(G)**.

Although both were psychologists and not art therapists, Clark Moustakas (1953, 1959), who worked with children in play therapy, and Rollo May (1975), who saw adults, described *existential therapy* in which *creativity* was synonymous with *mental health.* All humanistic approaches emphasize man's capacity to take charge of his life, to use *free will* and to exercise *intentionality.* In contrast, psychoanalytic approaches stress unconscious dynamics and the power of the *repetition compulsion* to affect even presumably "free" choices (Freud, 1900, 1916–1917, 1923).

"Intentionality" is highlighted in Pat Allen's **(Figure 5.5)** chapter in the second edition of *Approaches* (Rubin, 2001), in which she described its function in the *open studio*—an idea that is further defined and delineated in her books (Allen, 1995, 2005). On the **DVD** you can see a young person following her creative experience in an open studio with *witness writing* in response to the image **(DVD 7.2B)**.

Psycho-Educational Approaches to Art Therapy (DVD 5.3)

Behavioral

Experimental psychologists focus on what can be measured; that is, overt behavior. They have greatly enhanced our comprehension of how learning takes place. We know, for

Figure 5.6 Ellen Roth, behavioral art therapy.

example, that if a behavior is reinforced or rewarded in some way, it will tend to be repeated. We also know that if a behavior is ignored or punished, it is less likely to recur, and that it will eventually "extinguish," or disappear.

This understanding is the basis for techniques that have gained in popularity among clinicians during recent years. *Behavior Therapy* and *Behavior Modification* are approaches in which a systematic description of appropriate and inappropriate behaviors provides the basis for therapeutic intervention. All therapies provide reinforcement for some behaviors and not for others, but except for behavioral and cognitive-behavioral approaches, it is rarely the primary instrument of change.

These approaches have not been especially popular among art therapists, since at first glance they appear antithetical to a genuine creative process. They are not really incompatible, but require—as do all theories—a deep understanding in order to be able to be meaningfully integrated with art therapy.

Behavioral approaches have been used most often with children with disabilities, as in Ellen Roth's **(Figure 5.6)** use of *reality shaping* with emotionally disturbed children who were also cognitively challenged. Her chapter in *Approaches* (Rubin, 2001) outlines a history of behavior therapy, as well as Roth's rationale for her adaptation of its principles to art therapy with these youngsters. The combination of behavioral and cognitive approaches has been used by some art therapists, including Marcia Rosal, who contributed a chapter on its application to her work with a disturbed adult to the second edition of *Approaches* (Rubin, 2001).

Cognitive

Cognitive therapies focus on habitual distorted thought processes, which are thought to underlie maladaptive feelings and behaviors. The therapeutic approach is largely an *educational* one, in which the task is first to identify the patterns of misperception or thought

Figure 5.7 Rawley Silver, cognitive art therapy.

causing the persistence of symptoms. Patients are then taught new and more adaptive ways to think and to behave, using cognitive strategies. While there is an educational element in all therapies, it is not usually the primary mode of treatment.

One of the first to espouse a cognitive approach to therapy was psychologist Albert Ellis, who developed what he called *rational-emotive therapy* (RET) in the 1960s. At the 1982 American Art Therapy Association (AATA) conference, art therapist Sondra Geller and a colleague described how they could "unblock the creative process" for students unable to complete theses who were seen in the George Washington University Counseling Center. They felt that the effectiveness of art therapy was enhanced when combined with the cognitive-behavioral strategies of RET (AATA, 1982 *Proceedings*).

Many art therapists of varied theoretical persuasion have considered the cognitive aspects of art activity to be *central* to its therapeutic power, including people as different in orientation as Edith Kramer (2000) and Janie Rhyne (1995). Shaun McNiff (1986, 1988) developed his ideas about the therapeutic action of art, paying tribute to his mentor, Rudolf Arnheim—the author of *Visual Thinking* (1969). Other cognitive psychologists, like Howard Gardner (1980, 1982) and the Kreitlers (1972), have also been appealing to art therapists because they clarify and value the cognitive operations involved in making art.

Rawley Silver **(A)**, who contributed a chapter to *Approaches* (Rubin, 2001), titled her book *Developing Cognitive & Creative Skills through Art* (1978). Silver **(Figure 5.7)** applied the cognitive psychology of Jean Piaget and others to art therapy with the disabled. In 1987, Aina Nucho **(B)** conceptualized a *Psychocybernetic Model of Art Therapy* in which she synthesized cybernetic (feedback) theory with art therapy **(Figure 5.8)** (Nucho, 2003).

Nucho (1995), an art therapist, also wrote a book about *Mental Imagery*,[3] which was an active area in cognitive psychology off and on throughout the 20th century. During the 1970s and 1980s, there were two active national organizations—the American Association for the Study of Mental Imagery whose *Proceedings* are listed in the section titled "Resources" at the back of this book, and the International Imagery Association, which publishes the *Journal*

Figure 5.8 Aina Nucho, psychocybernetic art therapy.

of Mental Imagery. Lusebrink (1990) is another art therapist whose work includes the use of imagery, reflecting her application of such cognitive elements as *information processing* to art therapy.

All of these cognitively based theories of art therapy are, however, quite different from what is currently known as *Cognitive Therapy*. Rosal **(Figure 5.9)** described a *Cognitive-Behavioral* approach, which is more similar to current trends in treatment, in her book (Rosal, 1996) and in a chapter she contributed to the second edition of *Approaches* (Rubin, 2001). Like Rhyne (1995), Rosal **(C)** was also attracted to George Kelly's cognitively based *Personal Construct* theory, using it as a basis for her work in both assessment and therapy.

Figure 5.9 Marcia Rosal, cognitive-behavioral art therapy.

A cognitive approach that has promise for art therapy is that known as the *Solution-Focused* approach, which originated in family therapy based on a *constructivist* approach to therapy (Riley, 1999, 2001; Riley & Malchiodi, 2004). Gilat Gat demonstrated the approach with individual children on a **DVD** (Gat, 2003).

Although she doesn't use that term, the problem-solving approach to nightmares demonstrated by Ann Wiseman with children on the **DVD** is based on a similar kind of thinking **(D)**. The child first draws the nightmare, then tries to think of how it might come out differently, and then redraws it. Her approach to *Nightmare Help* (Wiseman, 1989) is reminiscent of child psychiatrist Richard Gardner's method, the *Mutual Storytelling Technique* (1971), in which the therapist proposes an alternative ending to the story.

Developmental

Closely related to cognitive and behavioral approaches, and often a major component, are approaches that are based on an understanding of growth itself. *Developmental* approaches originated in the work of Viktor Lowenfeld **(E)**, whose *Creative & Mental Growth* has been in print for 60 years (Lowenfeld & Brittain, 1987). Uhlin (1972), a student of Lowenfeld's, based his approach to helping children with disabilities through art therapy largely on what he knew of normal development **(F)**.

Developmental therapy was invented by a special educator whose ideas were combined with those of an art therapist in *Developmental Art Therapy* (Williams & Wood, 1977). Doing art therapy with children who were blind, deaf, and developmentally challenged, led Susan Aach-Feldman **(G)** and Carole Kunkle-Miller **(H)** to adopt a *developmental* orientation, which they described in their chapter in *Approaches* (Rubin, 2001).

Adaptive

The *Adaptive* approach, which works toward *normalization,* was first articulated by Lowenfeld (1957), and was then amplified by Frances Anderson (1992, 1994), an art therapist who has contributed several books on art therapy for youngsters with disabilities and who wrote the commentary on *Psycho-Educational* approaches in the revision of *Approaches* (Rubin, 2001) **(I)**.

Robert Ault (1986) defined two similar orientations as *Process-Centered Art Therapy* and *Product-Centered Art Therapy*, where the focus is on achieving specific goals leading to better and more adaptive functioning. On the **DVD (J)**, you can see and hear Ault's **(Figure 5.10)** brief descriptions of these approaches to art therapy.

In contrast to psychodynamic (analytic) or humanistic approaches to art therapy, those stemming from behavioral, cognitive, or developmental orientations are more likely to offer *prescribed* art activities. While themes or tasks are also offered at times by psychodynamic or humanistic art therapists, they are even more consistently used with behavioral, cognitive, developmental, adaptive, and functional models of treatment. These approaches are also used more frequently in the treatment of individuals with disabilities, who are more likely to require a *remedial* approach.

Systemic Approaches to Art Therapy

Although I had not included group or family art therapy in the first edition of *Approaches to Art Therapy* (because they can be done from so many different theoretical positions), I did decide to add them to the second. This revision (Rubin, 2001) includes a chapter by Katherine Williams (Group) and Barbara Sobol (Family), as well as a commentary by Shirley Riley **(Figure 5.11)**, who did a good deal of work in both family (Riley & Malchiodi, 2004)

Figure 5.10 Robert Ault, process/product-centered art therapy.

Figure 5.11 Shirley Riley, solution-focused art therapy.

and group art therapy (Riley, 1999). Indeed, there are many different schools of thought in both areas.

Most early art therapists were influenced by the dominant psychodynamic thinking about groups, including families. Since then, however, the developing fields of *group dynamics, cybernetics*, and *systems theory* have spawned a whole new set of conceptualizations about people in plural. These ideas have greatly affected contemporary art therapists who work with families (Goldenberg & Goldenberg, 2007) and groups (Yalom & Leszcz, 2005).

Family Art Therapy

One of the most influential art therapy pioneers was Hanna Kwiatkowska, who worked on an inpatient unit for adolescents with schizophrenia at the National Institutes of Mental Health (NIMH), one of the key centers for the development of family therapy itself during the middle of the 20th century. Although other art therapists were seeing families too, this gifted therapist was the undisputed pioneer of *Family Therapy & Evaluation Through Art* (Kwiatkowska, 1978). On the **DVD (5.4)**, you can observe her **(A)** conducting an early **(B)** and a later family art evaluation **(C)**.

Many followed in her footsteps, often learning by observing and consulting with her, like Helen Landgarten **(Figure 5.12)**, who worked in an outpatient clinic for children and families **(D)**. She described work with families in her first book (Landgarten, 1981), and later devoted an entire book to the topic (Landgarten, 1987). Sobol, who was trained by Kwiatkowska at George Washington University, wrote the part of the chapter on family art therapy in the second edition of *Approaches to Art Therapy.* (Rubin, 2001).

Riley **(E)**, who commented on that chapter in *Approaches,* studied art therapy with Landgarten, and later wrote a book titled *Integrative Approaches to Family Art Therapy* (Riley & Malchiodi, 1994). Linesch, a student of both Landgarten and Riley, also edited a book that included a variety of approaches to family art therapy titled *Art Therapy with Families in Crisis* (Linesch, 1993).

Figure 5.12 Helen Landgarten, family art psychotherapy.

As with behavioral and cognitive approaches to art therapy, it would appear that strategic and structural family therapy are not as incompatible with art therapy as they may look at first. What is essential is that—as with any approach to individual art therapy—the clinician needs to have thoroughly mastered the theory, in order to be true to it, as well as to art.

Because of its versatility, art therapy has also been used with many of the possible variations on the family theme, such as couples, multiple family groups, mothers and children, and siblings. Harriet Wadeson (1980), who was trained by Kwiatkowska at NIMH, pioneered in work with couples **(F)** and with groups of families, doing what she called "multi-family art therapy."

Since then, many art therapists have described their work with family groupings of one sort or another (Arrington, 2001; Rubin, 2005a). Lucille Proulx (2002) developed an unusual variation on this theme, inviting parents and their toddlers or preschoolers to work together in groups doing what she called "parent-child dyad art therapy." On the **DVD** you can see her working with one of those groups **(G)**.

Images Illuminate Important Issues—John and His Mother After Father's Death

The following vignette describes work with a 13-year-old boy and his mother at an outpatient clinic where they came for help following his father's death. The mother initiated the referral because, as she said, John had become "unmanageable." In order to assess what was going on and to advise the best modality for treatment, they were first seen individually. Because they had each described problems between them, I suggested that they come in for a joint art session.

I first asked John and his mom to draw a picture together. Although they discussed it in advance, and tried at first to create a joint picture, they ended up dividing the paper in half, each drawing his or her own version of their jointly selected theme: "Our House" **(H)**. When they were done, they were astonished at how different their representations of that same home were. John's house had "dark clouds over it," while his mother's looked quite cheerful. They decided that they often perceived the same thing quite differently, and agreed that this was one of their main problems in communication and in getting along. John then became tearful about how he felt his mom not only misunderstood, but also rejected him. I observed that his mother had as hard a time hearing what he was saying as she had in seeing what he had drawn.

At a second joint session, I asked each to draw a portrait of the other, on opposite sides of the table easel, which each individual then "corrected" **(I)**. John felt that his mother had portrayed him as older than he really was, sensing her very real wish to have him replace his father—to be "the man of the house"—while at the same time complaining about his assuming an adult role. Mother thought John had made her eyes and mouth "too large and sexy" **(J)**. After modifying the features, she added a "more attractive" hairstyle and more appropriate earrings. In fact, she had made the drawing even more seductive, while at the same time speaking to John in a critical, distancing fashion.

This confusing message, echoing her adolescent son's own (normal) revived oedipal wishes, was causing tremendous anxiety in both. Mother described John as "putting up a wall" between them, while he felt that she was "holding me on a leash" and treating him "like a baby" **(K)**. Both were eventually treated in family art therapy, which turned out to be a modality that helped them to see and hear each other better.

Two recent publications on work with families in art offer a good overview of some of the different approaches developed by early workers in this area. The first (Arrington, 2001) has useful charts comparing family art evaluations. The second is a multi-authored volume

by members of the next generation of art therapists, who explain the various systems and schools of family therapy, providing a useful overview of this domain (Kerr, Hoshino, Sutherland, Parashak, & McCarley, 2008).

Group Art Therapy

There is a similar variety of theories and techniques in group art therapy, but no individual has had a dominant role comparable to Kwiatkowska's with families. It is likely that more patients experience art therapy in a group than in any other context, which has probably been true from the inception of the discipline.

A truly *open* studio in the literal sense of a place that patients could visit when they wished was initially most common in the 1940s for people like Mary Huntoon at the Winter Park Veterans Administration Hospital in Topeka, Kansas, Edward Adamson at the Netherne Hospital in Surrey, England **(L)**, and E. M. Lyddiatt at a number of British hospitals. Although there was more than one person in the room at a time, each worked quite independently.

As time went on, with the growing understanding of group dynamics (Bion, 1991), the trend has been toward approaches that more consciously utilize the power of the group in conjunction with the power of art. Art therapy students often learn about *group dynamics* and *group process* through participating in art groups themselves (Ulman & Dachinger, 1975). Over time, many approaches to group art therapy have been described by different clinicians, working with both children and adults.

One of the first books on the topic, by art therapist Cliff Joseph **(M)** and psychiatrist Jay Harris, was *Murals of the Mind* (Harris & Joseph, 1973). Like most early publications, it was psychoanalytic in orientation. Because of the method (all patients working together on a mural), it is a fascinating study of an inpatient group's development over the course of a year, by analyzing the form and content of weekly murals.

Though the practice of group art therapy gradually expanded during the growth of the field in the 1960s and 1970s, there were few publications. They more than doubled, however, between 1975 and 1980. Gestalt and humanistic approaches became increasingly common. Janie Rhyne's book, first published in 1974, devoted an entire section to work with groups, and several others included chapters on that modality (Landgarten, 1981; Rubin, 2005b; Wadeson, 1980). The work described by Xenia Lucas in her 1980 book was typical of early group art therapy. Although group process was acknowledged, the primary focus was on individuals and their artistic and psychological development.

When Kathleen Hanes compiled an annotated bibliography called *Art Therapy & Group Work* in 1982, she noted that art was being offered in groups that ranged from unstructured "open studio" situations to theme-centered ones and those using interactional tasks. She also reported that the emphasis was intrapsychic as often as it was interpersonal, but that interventions based upon group dynamics were increasing.

Meanwhile, our art therapy colleagues in Great Britain also found themselves often working with groups. In 1941 Dr. Joshua Bierer, who developed *Adlerian social clubs* in London, invited artist Rita Simon to work with his patients in groups, initiating her long career in art therapy. In 1986, Marian Liebmann published a survey of techniques used in group art therapy, which offered practical advice along with many exercises. Others have continued that tradition, proposing group art activities with some sort of structure (Campbell, 1993; Fausek, 1997; Furrer, 1982; Makin, 1999).

Liebmann's book provoked a debate in the United Kingdom regarding the wisdom of structured as opposed to unstructured approaches. It seems to have been especially