

THIRD EDITION

A large, circular abstract artwork composed of various colors including green, blue, purple, yellow, red, and brown, blended together in a textured, watercolor-like style. The colors are layered and blended, creating a sense of depth and movement. The overall effect is a vibrant, multi-colored sphere.

APPROACHES TO
ART
THERAPY

THEORY AND TECHNIQUE

EDITED BY JUDITH ARON RUBIN

Approaches to Art Therapy

The third edition of *Approaches to Art Therapy* brings together varied theoretical approaches and provides a variety of solutions to the challenge of translating theory to technique. In each chapter, the field's most eminent scholars provide a definition of and orientation to the specific theory or area of emphasis, showing its relevance to art therapy. The third edition includes many new chapters with material on a wide variety of topics including contemplative approaches, DBT, neuroscience, and mentalization, while also retaining important and timeless contributions from the pioneers of art therapy. Clinical case examples and over 100 illustrations of patient artwork vividly demonstrate the techniques in practice. *Approaches to Art Therapy, Third Edition*, is an essential resource in the assembly of any clinician's theoretical and technical toolbox, and in the formulation of each individual's own approach to art therapy.

Judith Aron Rubin, Ph.D., ATR-BC, is a licensed psychologist, a child and adult psychoanalyst, and a past president and honorary life member of the American Art Therapy Association. She is also co-founder and president of Expressive Media and has practiced art therapy since 1963. The creator of seven books and thirteen films, she serves on the faculties of the psychiatry department at the University of Pittsburgh and the Pittsburgh Psychoanalytic Center in Pennsylvania.

APPROACHES TO ART THERAPY

Theory and Technique

Third Edition

Edited by Judith Aron Rubin

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Contents

[Contributors](#)

[Acknowledgments](#)

[Introduction](#)

Judith Rubin

[Part I](#)

[Foundations](#)

[1 Art is the Therapy](#)

[Symbolizing](#)

Laurie Wilson

[Seeing](#)

Mala Betensky

[2 The Therapist as Artist](#)

Mildred Chapin

Barbara Fish

[3 Relational Aesthetics and Art Therapy](#)

Catherine Hyland Moon

[Part II](#)

[Psychodynamic Approaches](#)

[Psychoanalysis \(Freudian\)](#)

[4 Discovery and Insight in Art Therapy](#)

Judith Rubin

[5 Sublimation and Art Therapy](#)

Edith Kramer

[Addendum—Sublimation](#)

Elizabeth Stone

[6 Variations on a Freudian Theme](#)

Elinor Ulman

[7 Object Relations and Art Therapy](#)

Arthur Robbins

[Addendum—Object Relations](#)

Eleanor Irwin

- [8 Mentalization-Based Art Psychotherapy](#)
Dominik Havsteen-Franklin

Analytical Psychology (Jungian)

- [9 Jungian Art Therapy](#)
Nora Swan-Foster

[Addendum—Jung as an Artist](#)
Michael Edwards
[Addendum—Active Imagination](#)
Edith Wallace

Part III

Humanistic Approaches

- [10 Art Therapy: Humanism in Action](#)
Bruce Moon
- [11 Gestalt Art Therapy](#)
Janie Rhyne
- [12 Person-Centered Expressive Arts Therapy](#)
Natalie Rogers
- [13 Positive Art Therapy](#)
Gioia Chilton and Rebecca Wilkinson

Part IV

Contemplative Approaches

- [14 Art Making as Spiritual Path](#)
Pat Allen
- [15 Focusing-Oriented Art Therapy](#)
Laury Rappaport
- [16 Contemplative Wisdom Traditions in Art Therapy](#)
Michael Franklin

Part V

Cognitive and Neuroscience Approaches

- [17 Cognitive-Behavioral Art Therapy](#)
Marcia Rosal
- [18 Narrative Art Therapy in Trauma Treatment](#)
Linda Gantt and Laura Greenstone
- [19 CREATE: Art Therapy Relational Neuroscience](#)

Noah Hass-Cohen and Joanna Clyde Findlay

Part VI

Systemic Approaches

20 Family Art Therapy

Barbara Sobol and Paula Howie

21 Group Art Therapy

Katherine Williams and Tally Tripp

Part VII

Integrative Approaches

22 Developmental Art Therapy

Susan Aach-Feldman and Carole Kunkle-Miller

23 Lessons in the Images

David Henley

24 Pandora's Gifts

Shaun McNiff

25 An Eclectic Approach to Art Therapy

Harriet Wadeson

Conclusion

Judith Rubin

Index

Contributors

*Deceased.

Susan Aach-Feldman, M.Ed., ATR*

Expressive Arts Therapist, Western Pennsylvania School for Blind Children; Adjunct Faculty, Art Therapy Program, Carlow College, Pittsburgh, PA; Consultant, Arts in Special Education Project of Pennsylvania.

Pat Allen, Ph.D., ATR, HLM

Co-founder and Former Co-director, Open Studio Project, Chicago, IL; formerly Adjunct Professor, School of the Art Institute of Chicago; Director, Virtual Studio Pardes, Ojai, CA; Author, *Art Is a Way of Knowing, Art Is a Spiritual Path*.

Mala Betensky, Ph.D., ATR*

Psychologist and Art Therapist in Private Practice, Washington, DC; Author, *Self-Discovery Through Self-Expression; What Do You See?*.

Mildred Chapin, M.Ed., ATR, HLM

Painter, Poet and Art Therapist, Tucson, AZ; Formerly Director, Adjunctive Therapies, Barclay & Pritzker Hospitals, Chicago, IL; Author and Illustrator, *Reverberations: Mothers & Daughters* and *Haiku, Painted and Written*.

Gioia Chilton, Ph.D., ATR-BC

Creative Director of Creative Wellbeing Workshops, LLC; Associate Editor, *Art/Research International: A Transdisciplinary Journal*; 2014 Torrance Award, American Creativity Association.

Michael Edwards, R.A.Th., H.L.M. *

Jungian Analyst and Art Therapist in Private Practice, Cornwall, England; formerly Director, Graduate Art Therapy Program, Concordia University, Montreal, Canada and Honorary Curator, The C. G. Jung Picture Archives.

Joanna Clyde Findlay, M.A., ATR

Adjunct Faculty, California School of Professional Psychology, Alliant International University, Phillips Graduate Institute, Los Angeles, CA; Co-author, *Art Therapy and the Neuroscience of Relationships, Creativity, and Resiliency: Skills and Practices*.

Barbara Fish, Ph.D., ATR-BC

Faculty, University of Illinois at Chicago and the School of the Art Institute of Chicago; Author, *Art-Based Supervision: Cultivating Therapeutic Insight through Imagery*.

Michael Franklin, Ph.D., ATR-BC

Coordinator, Art Therapy program, Naropa University; formerly Director of Training Programs, Bowling-Green-State University; College-of-Saint-Teresa. Author, *Art as Contemplative Practice: Expressive Pathways to the Self*.

Linda Gantt, Ph.D., ATR-BC, HLM

Owner, West Virginia Trauma Consultants, *Intensive Trauma Therapy*, ITT Training Institute; Co-developer with Louis Tinnin, *The Instinctual Trauma Response and Dual Brain Dynamics*; Co-developer, *Formal Elements Art Therapy Scale* (FEATS); Past President, American Art Therapy Association.

Laura Greenstone, M.S, LPC, ATR-BC

Co-creator, *Arts Based Approach to "Psychological First Aid"*; Past Chair, National Coalition of Creative Arts Therapies Associations; New Jersey Certified Disaster Response Crisis Counselor.

Noah Hass-Cohen, M.A., Psy.D., ATR-BC

Faculty, California School of Professional Psychology, Alliant International University; Founder and former Director, Art Therapy Program Phillips Graduate Institute; Co-editor, *Art Therapy and Clinical Neuroscience*; Co-author, *Art Therapy and the Neuroscience of Relationships, Creativity, and Resiliency: Skills and Practices*.

Dominik Havsteen-Franklin, Ph.D., R.A.Th.

Consultant in Arts Psychotherapies, NHS (National Health Service); Art Psychotherapist in Private Practice, London, UK.

David Henley, Ph.D., ATR

Professor and Director, Art Therapy Programs, C.W. Post Campus, Long Island University, Brookville, NY; Author, *Exceptional Children: Exceptional Art and Clayworks in Art Therapy: Plying the Sacred Circle*. Retired, he now divides his time between Denver and Boulder, CO.

Paula Howie, M.A., ATR-BC, LPC, LCPAT, HLM

Former Activities Therapy Director, Walter Reed Army Medical Center; Faculty, George Washington University, Vermont College of Norwich University, Washington School of Psychiatry; Private Practice, Washington, DC; Trauma Therapy Consultant; Co-editor, *Art Therapy with Diverse Populations: Crossing Cultures and Abilities*.

Eleanor Irwin, Ph.D., RDT

Clinical Assistant Professor, Department of Psychiatry, University of Pittsburgh; Faculty and former Director, Pittsburgh Psychoanalytic Center; Licensed Psychologist, Drama Therapist, Psychodramatist and Psychoanalyst in Private Practice, Pittsburgh, PA.

Edith Kramer, D.A.T. (Honorary), ATR-BC, HLM*

Adjunct Professor of Art Therapy, New York University and George Washington University; Author, *Art Therapy in a Children's Community, Art as Therapy with Children, Childhood and Art Therapy, Art as Therapy: Collected Papers*.

Carole Kunkle-Miller, Ph.D., ATR

Formerly Art Therapist, Western Psychiatric Institute & Clinic and Western Pennsylvania School for Blind Children; currently Art Therapist and Psychologist in private practice, Pittsburgh, PA; Personal Coach at www.LifelineCoach.com.

Shaun McNiff, Ph.D., ATR, HLM

Provost and Dean, Endicott College, Beverly, MA; Founder and former Director, Expressive Therapies Program, Lesley University, Cambridge, MA; Author, *Imagination in Action, Art as Research, Integrating the Arts in Therapy, Art Heals, Trust the Process, Art as Medicine*, and other books.

Bruce Moon, Ph.D., ATR-BC, HLM

Professor and Co-founder, Doctor of Art Therapy Program, Mount Mary University; Author, *Existential Art Therapy: The Canvas Mirror, Introduction to Art Therapy: Faith in the Product, Art-Based Group Therapy*, and many other art therapy texts.

Catherine Hyland Moon, M.A., ATR-BC

Professor and Chair, Art Therapy Department, School of the Art Institute of Chicago; Author, *Studio Art Therapy*; Editor, *Materials and Media in Art Therapy*, Co-developing a community studio in Chicago and therapeutic art programs for children in East Africa.

Laury Rappaport, Ph.D., MFT, ATR-BC, REAT

Founder and Director, Focusing and Expressive Arts Institute, Santa Rosa, CA. Author, *Focusing-Oriented Art Therapy: Accessing the Body's Wisdom and Creative Intelligence*; Editor, *Mindfulness and the Arts Therapies: Theory and Practice*; Faculty, Lesley University, Expressive Therapies Division, Notre Dame de Namur University.

Janie Rhyne, Ph.D., ATR-BC, HLM*

Assistant Professor of Art Therapy, Vermont College of Norwich University; Adjunct Professor, Graduate School of Social Work, University of Iowa; private practice, Iowa City, IA; Author, *The Gestalt Art Experience*.

Shirley Riley, M.F.T., ATR*

Faculty, Phillips Graduate Institute; Art Therapist in private practice; Co-author, *Integrative Approaches to Family Art Therapy, Supervision & Related Issues* (1996); Author, *Contemporary Art Therapy with Adolescents* (1999), *Group Process Made Visible: The Use of Art in Group Therapy* (2000).

Arthur Robbins, Ed.D., ATR, HLM

Professor, Art Therapy, Pratt Institute, Brooklyn, NY; Founding Director, Institute for Expressive Analysis, NY; Faculty, National Psychological Association for Psychoanalysis; private practice of art therapy and psychoanalysis, NYC; Author, *The Artist as Therapist, A Multi-Modal Approach to Creative Art Therapy*, and other books on art and therapy.

Natalie Rogers, Ph.D., REAT*

Author, *Emerging Woman: A Decade of Midlife Transitions*, *The Creative Connection: Expressive Arts as Healing*, *The Creative Connection for Groups: Person-Centered Expressive Arts for Healing and Social Change*; Lifetime Achievement Award, IEATA; Founder, Certificate program: Expressive Arts for Healing & Social Change: A Person-Centered Approach. www.nrogers.com

Marcia L. Rosal, Ph.D., ATR-BC, HLM

Professor and Director of the Florida State University Art Therapy Program; Past-president of the American Art Therapy Association; Author, *Approaches to Art Therapy with Children*; Co-editor, *The Wiley-Blackwell Handbook of Art Therapy*.

Judith A. Rubin, Ph.D., ATR-BC, HLM

Faculty, Psychiatry, University of Pittsburgh and Pittsburgh Psychoanalytic Center; Licensed Psychologist; Author, *Child Art Therapy*, *The Art of Art Therapy*, *Art Therapy: An Introduction*, *Artful Therapy*, *Introduction to Art Therapy: Sources & Resources*; Director of 13 films on art therapy and related areas.

Barbara Sobol, M.A., ATR, LPC, CTT

Child and Family Art Therapist, Prince George's County, MD, and Clinical Case Coordinator, Montgomery County Department of Health and Human Services, MD; Faculty, George Washington University, Vermont College, NYU; Director, Washington Art Therapy Studio; Consultant, D.C. Rape Crisis Center.

Elizabeth Stone, M.A., ATR-BC, LCAT

Faculty member, Ecole de Psychologues Praticiens of the Catholic University of Lyon/Paris; Art Therapist, Association À la Recherche en Oncologie Grenobloise; psychoanalytic psychotherapy and art therapy, private practice.

Nora Swan-Foster, M.A., ATR-BC, LPC, NCPsyA

Diplomate Jungian Analyst in private practice in Boulder, CO. Published author, supervisor, lecturer at Naropa University and member of the Inter-Regional Society of Jungian Analysts (IRSJA).

Tally Tripp, M.A., MSW, LICSW, ATR-BC, CTT

Assistant Professor and Clinic Director, George Washington University, Art Therapy Program; Private Practice Art Therapy and Psychotherapy, Washington, DC; graduate, Washington School of Psychiatry Group Training Institute.

Elinor Ulman, D.A.T. (Honorary), ATR-BC, HLM*

Founder and Former Executive Editor, *American Journal of Art Therapy*; Founder and Adjunct Professor of Art Therapy, George Washington University, Washington, DC; Co-editor, *Art Therapy in Theory and Practice, Art Therapy Viewpoints*.

Harriet Wadeson, Ph.D., LCSW, ATR-BC, HLM

Author, *The Dynamics of Art Psychotherapy, Art Therapy Practice, Art Psychotherapy, Journaling Cancer in Words and Images*; Editor, *Advances in Art Therapy*; Editor, *A Guide to Conducting Art Therapy Research*; Co-editor, *Architects of Art Therapy*.

Edith Wallace, M.D., Ph.D.*

Jungian Analyst and Psychiatrist in private practice, Santa Fe, NM; Workshop Leader, "Opening Channels to the Creative"; Faculty, C. G. Jung Foundation & Institute for Expressive Analysis, NY; Author, *A Queen's Quest*.

Rebecca Wilkinson, M.A., ATR-BC, LCPAT

Executive Director, Creative Wellbeing Workshops; Co-author: *Positive Art Therapy: Linking Positive Psychology to Art Theory, Practice and Research*; Artist/Author: *Miraval Mandalas for Meditation*.

Katherine Williams, Ph.D., ATR-BC

Associate Professor Emerita and Former Director, Art Therapy Program, George Washington University; graduate, Washington School of Psychiatry Group Training Institute; Art Therapist and Psychologist in Private Practice, Washington, DC.

Laurie Wilson, Ph.D., ATR-BC, HLM

Art Therapist and Psychoanalyst in private practice, New York City; formerly Director, Graduate Art Therapy Program, New York University; Faculty, NYU Psychoanalytic Institute; Sculptor; Author, *Alberto Giacometti: Myth, Magic, and the Man, Louise Nevelson: A Life in Art*.

Key

ATR	Registered Art Therapist, Art Therapy Credentials Board
BC	Board Certified, Art Therapy Credentials Board
HLM	Honorary Life Member, American Art Therapy Association
H.L.M.	Honorary Life Member, British Association of Art Therapists
R.A.Th.	Registered Art Therapist, British Association of Art Therapists
REAT	Registered Expressive Arts Therapist, International Expressive Arts Therapy Association
RDT	Registered Drama Therapist, National Association for Drama Therapy
CTT	Certified Trauma Therapist, Intensive Trauma Therapy
LCAT	Licensed Creative Arts Therapist
LCPAT	Licensed Clinical Professional Art Therapist
LICSW	Licensed Independent Clinical Social Worker
LPC	Licensed Professional Counselor
NCPsyA	Nationally Certified Psychoanalyst

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There are always many who have helped directly and indirectly with a project as complex as this book. An edited volume is a special challenge, and I confess I have sometimes felt like I was “herding cats,” while communicating with all of the authors who either revised their earlier chapters or wrote new ones. However, I am indebted to all of them for agreeing to contribute a new chapter, to revise an earlier one, to update their Contributor Information, and to be generally pleasant and responsive to my requests. Some chapters have been written or revised by two authors, adding yet another perspective to the text. In all, this revision has been a pleasure to put together, and I hope it will be helpful to art therapists now and in the future.

Book production has come a long way in the 30 years since putting together the first edition, which began as an idea in 1983 and was published in 1987. Thanks to email and the ability to send both text and images through the *ether* (which is how I naively think of the Internet), it has been remarkably efficient. The first edition was typed on something called a *word processor*, a piece of equipment that was used between the manual and electric typewriter of earlier books and the computer of the present, and each technological advance has indeed seemed quite miraculous at the time.

Many of the illustrations for the new chapters and even those for revised chapters were photographed by the authors themselves, thanks to a significant improvement in digital cameras. In the second edition, there were many lovely photographs, by photographers Susan Aach-Feldman and Lynn Johnson. Jim Burke of the Center for Instructional Development and Distance Education of the University of Pittsburgh took the vast majority of the photographs of artwork sent by contributors for the second edition, and his digital files are found throughout the book. Some of the new contributors also turned out to be excellent photographers, such as Michael Franklin. My deepest gratitude to John Mittner, whose magical skills in Photoshop and other imaging programs have made the illustrations for this third edition as good as they could be. I am also grateful to Barry Cohen and Janice Rose for their assistance with the cover design.

This book has been my only attempt at an edited volume, which seems to be the norm nowadays, but was not at the time it was first published. Most of the authors in the first edition were visionaries and pioneers—and were both generous and generative in being willing to contribute. They didn’t always agree with each other, but they were very agreeable as collaborators. The second edition, in which there were several new sections and to which 13 new authors contributed, was also a pleasure to put together. For that one I rewrote the Introductions to each section, and added Commentaries, as well as a number of new chapters.

To decide how best to revise this book for the rapidly changing art therapy world of the 21st century, I turned to my colleagues who have used it in teaching over the years. A number of them responded to my request for honest feedback, thanks to the cooperation of the Coalition of Art Therapy Educators (CATE) and its then-coordinator, Juliet King. Many offered informal suggestions, but some generously spent a considerable amount of time, having used the book as a text for many years.

My deepest thanks go to Randy Vick for his detailed and thoughtful comments and suggestions. Others whose candid responses were especially helpful were: Marie Wilson, Maxine Junge, Barbara Fish, Patricia St. John, Elizabeth Stone Matho, Judy Sutherland, Olena Darewych, Robyn Cruz, Marygrace Berberian, Erica Curtis, Arnell Etherington Reader, Geri Hurlbut, Lariza Fenner, and Renee Obstfeld. As I searched for people in the next generation of practitioners and teachers to rethink earlier orientations or write about new ones, I was assisted by many, including Diane Waller and Sondra Geller.

They were all immensely helpful in telling me, not only which chapters they were actually assigning and which they were not, but also what new material should be included. I thank them for their generosity in answering my questions with clarity. The authors invited to write new chapters have generally been prompt and agreeable, even when the changes I suggested in their first drafts were more than minimal. My deepest thanks, then, to each and every one, for writing a chapter, and for making my editorial job so pleasant and rewarding.

To those authors who agreed to update and revise their original chapters my deepest thanks as well. Thanks too to colleagues who graciously sent me copies of relevant talks, articles, or illustrations: Mimi Farrelly-Hansen, Michael Franklin, Irene Jakab, Frances Kaplan, Anne Mills, Marcia Rosal, Irene David, Judy Sutherland, and Elizabeth Stone. Finally, my deepest thanks to my husband, children, and grandchildren, whose patience and understanding allowed me to complete this work.

Introduction

Judith Rubin

In order to decide how best to revise this book—first published in the penultimate decade of the twentieth century and later revised at its denouement—for the rapidly changing art therapy world of the twenty-first century, I turned to my colleagues who have used it in teaching over the years. Many of them generously responded to my request for candid feedback. They were helpful in telling me not only which chapters they were actually assigning, and which they were not, but also what new approaches should be added, along with recommendations of possible authors.

To include new material without changing the length of the book as requested by the publisher, it has been necessary to omit some of the earlier chapters. For myself, there is considerable sadness and a feeling of loss in leaving out writing I had not only solicited, but had also grown to love. Some of the authors have departed this world; some have not. But the field of art therapy has evolved significantly in the 30 years since I first imagined this text, and it is only right that the book reflects the reality of today, in order to be useful for students of tomorrow.

Actually, thanks to the stimulating ideas of my consulting colleagues, I have been able to re-imagine the book, something I dared not contemplate initially. Paradoxically, this third edition in some ways comes full circle historically, reaffirming the origins of art therapy in the studio and the community. The first edition of *Approaches* (1987) reflected the state of a discipline that was, in the mid-1980s, struggling for recognition as a legitimate profession. In addition to starting mainly in psychiatry, most art therapists were then employed in mental health settings. For that reason, most of the theories in the first edition were those that were prominent in psychology and psychiatry, because that is where art therapy was practiced, and where it was actively seeking acceptance as an equal player on the treatment team.

Over the years since 1987, however, a number of developments, both within the profession and in the larger world, have dramatically altered the theoretical landscape. Perhaps the most important one is that *art therapy*, which was little known when I began to practice in 1963, is now a familiar and accepted term. One of the salutary effects of this enhanced public profile is that the Art Part can truly be viewed as forming, not only the synergistic companion of the Therapy Part—the core of the second edition of *The Art of Art Therapy* (Rubin, 2011)—but as its equal.

Despite the fact that art therapy is often misrepresented and misunderstood—an inevitable effect of it being a hybrid—there is now relatively more security among practitioners and relatively greater awareness in the public about art therapy. For that reason, the field has been able to return to its roots with *art* as the *core*—the uniquely distinguishing aspect of what art therapists do—whether credentialed as counselors, psychologists, educators, and/or board-certified art therapists.

In other words, I believe that this synergistic discipline has developed sufficiently over the last three decades for its most sophisticated practitioners to be as secure in their *artist* identity as in their *therapist* persona. Because of that enhanced pride, there has also been a shift in perspective, which has allowed me to literally re-imagine this volume in a number of ways. It has also mitigated my sadness about omitting earlier chapters, since many of them contained wonderful sections that deal with the *art* part of our profession, and which I have been able to include in a new initial section on Foundations. For in truth, without *art* as the foundation, none of the theoretical or technical approaches described in any edition of this book would have been or would ever be possible.

It is also exciting that the meanings of both *art* and *therapy* have evolved in recent decades, particularly among educators and practitioners. Art originally meant the visual arts, even though some of the earliest treatment programs included other art forms, like the one at Withymead in the United Kingdom in the 1940s

(Hogan, 2001; Stevens, 1986). Over time, more art therapists have begun to include other modalities in their work (E. Levine, 2015), a development also reflected in the chapters by David Henley and Shaun McNiff.

Moreover, the terms *expressive therapies* and *expressive arts therapies*, while still evolving (Atkins, 2002; Eberhart & Atkins, 2014; Knill, 2004; Kossak, 2015; Levine & Levine, 1999; Malchiodi, 2005), have gained much greater acceptance in recent years, illustrated in Natalie Rogers' chapter. They are used in a growing number of training programs, like the one at Lesley University, and are evident not only in academia, but also in organizations like the International Expressive Arts Therapy Association (www.ieata.org) and events like the Expressive Therapies Summit (www.summit.expressivemedia.org). As one who has always believed in offering people a range of expressive modalities, I am delighted to see this development, which I believe is not only healthy for all of the arts therapies, but even more important, for those we serve.

A related development in art therapy over the last few decades has been an increasing level of comfort with the idea of *play*. In the effort to be taken seriously, there was a period of time when we were not so ready to emphasize the playful aspects of this work. But the truth is that for any creative process to occur, one must engage in a truly free kind of improvisational play (cf. Nachmanovich, 1990). Winnicott, a psychoanalyst, proposed that both healthy growth and effective therapy take place in what he called the *play space*— that between a child and its mother, as well as that between patient and therapist. As he wrote in *Playing and Reality* (1971), "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self" (pp. 72–73).

Jungian analyst Edith Wallace put it beautifully in her chapter for the first edition:

Letting be, allowing, can best be achieved in a playful way, and the joy of a playful way is felt. We can go by the motto: "All art is meditation." Once one takes brush in hand a calm descends, a concentration ensues, which makes the "listening" possible. *Play* has been described as a "non-purposive state" (Winnicott, 1971, p. 55). By adulthood, we are so conditioned that we have to trick ourselves into being open. One trick is to play, and that means: *Play seriously and work playfully*. We must step aside to allow the depth, the unconditioned, to speak. For Jung, play was a necessity. He (1923) states, "It is serious play...it is play from inner necessity. The creative mind plays with the object it loves" (CW 6, pp. 154–155).

The colleagues who gave feedback on what they were asking students to read told me that the Introductions and Commentaries in the second edition were rarely assigned; so they have been omitted, as well as the chapters no longer required by most instructors. As noted earlier, however, I have made an effort to include excerpts from those earlier chapters that are clear, vivid, and relevant, like the one quoted above. Selecting excerpts from footage for teaching films during the past 15 years has no doubt had a significant impact on how I've approached choosing gems from past editions to include in this new one.

The Egalitarian (R)evolution

Historically, psychoanalytic theory was dominant in art therapy, as it was in American psychiatry, during the early years of its development. In psychology, there was a heated debate between those espousing psychodynamic approaches and those enamored of behaviorism, which, like analysis, was born in the beginning of the twentieth century. In response to the determinism inherent in both, a variety of other approaches were proposed, which became known as “humanistic,” or a “third force” in psychology. Most stressed positive, “self-actualizing” elements in human nature, as well as the ability to take charge of one’s fate, and not be at the mercy of either the invisible unconscious or learning experiences.

Characteristic of all humanistic therapists is a belief in the individual’s ability to be not only in charge of his or her own life, but also to be a *partner* in his or her therapy. Over time, the notion of a *more egalitarian relationship between patient and therapist* has grown considerably stronger in all of the approaches in this book. This is a reflection of a major shift in the larger field of psychotherapy—from the therapist as the *expert*—a shift sometimes referred to as *postmodern* (Burt, 2012). The humility of not knowing has been brewing for some time, including within psychoanalysis (Casement, 2013), and has finally become mainstream.

Shirley Riley, in her Commentary on Systemic Approaches in the second edition, wrote eloquently about this changing position:

Although art therapy has always used externalized images and invited changes based on the knowledge emerging from these images; few of us have felt comfortable giving up the position of “knowing.” In 1988 Anderson and Goolishian proposed a therapeutic stance of “not knowing.” This was named the “social constructionist” view. They believed that too often the therapist’s belief system is imposed on the clients, albeit unconsciously. To be “postmodern” as I see it is to give up programmed knowledge. It is essential to become the student of the client, and to learn from each the meaning of the situation they bring. By “co-constructing” therapy with the client, the therapist becomes a collaborator in the therapeutic conversation. This position required a relinquishing of power and was a creative leap in therapeutic relationships.

The narrative, the story told and believed, became the key to change. The story was accepted as the “truth,” not second-guessed as a “defense” or some other psychological term for not telling the truth. In fact there was no “truth,” only the narrative, and the possibility of finding alternative stories buried in the dominant tale. The therapist became a detective, searching for more satisfactory meanings in the script.

A social constructionist/narrative philosophy is my preferred way of thinking about and conducting art therapy. However, although this is an exciting philosophy, a vital component of storytelling was still missing. The stories needed to be illustrated! Illustrations made the story more “real” for the participants in the therapy. It became more of a “here and now” experience. The pictures broadened and deepened the collaborative exploration for new solutions, within the reality of the storyteller.

For some of us who have been mental health workers for a long time, there is a growing awareness that it is very hard to separate any one school of therapy from others. I believe that therapies grow from and with others, and that there are more changes currently in the position of the therapist vis-à-vis the client than in any other aspect.

Where once we were the “experts,” seeing information in knotholes, and pathology in baselines, now we are collaborators. If we are concerned about a knothole, we explain the reason why others have considered this diagnostic and ask the clients what they think. What they think is what we believe. The discipline is not to impose judgment on the clients. I believe that few art therapists judge their clients, but many judge their artwork. For me, art and artmaker are fused; therefore, I cannot be wise about one and not the other.

Faith in the client is central to postmodern beliefs. Casting out the search for pathology, and looking to the external pressures of society and culture—rather than within the individual psyche—is another keystone. A broad world view is also the core of systemic thinking. None of these beliefs can be pretended in the therapeutic relationship. The contemporary therapist allows a form of transparency that

lets the client into his or her philosophy—of life and of therapy. The two ways of being in the world should not be divided.

Postmodern belief systems are a release for the therapist. Not to be wiser than our clients is more respectful and less stressful. We can look forward to collaborating with individuals, families, or people in group therapy—where that “system” becomes itself a significant treatment tool. We can enjoy the art, as it reflects the process of the therapy, and reveals material that invites an alternative understanding of life events. I confess that I am passionate about having a philosophy that includes as many levels of creativity as I am capable of. My realities at this point in my professional and personal life are in some harmony; I respect and am curious about yours.

The notion of a *narrative*, referred to above by Shirley, is illustrated in the new chapter by Linda Gantt and Laura Greenstone, where a *graphic narrative* helped free a severely traumatized patient from intrusive flashbacks, allowing her to go on with her life unburdened by the lifelong symptoms that brought her into treatment. The theory underlying the approach in that chapter evolved dialectically over time. In fact, regardless of orientation, theory is only meaningful and worthwhile if it helps to explain the phenomena with which it deals in a way that enables us to do our work better. Theory and technique should go hand in hand; the one based on and growing out of the other, each constantly modifying the other over time.

An example of such a long-term evolution of theory in tandem with a continually developing set of treatment innovations is found in the work of psychiatrist Lou Tinnin and art therapist Linda Gantt, which became the basis of their approach using the *graphic narrative*. A team in work as in life, they were constantly adjusting what they were doing with patients while at the same time modifying their theoretical understanding of what was happening. After many years of such clinical research, refining and revising both theory and practice, they developed a magnificently conceptualized method for helping severely traumatized patients, especially those who had developed dissociative identity disorder due to preverbal traumas. It was and is elegant, and is based primarily on their understanding of how the hard wiring of the brain responds to trauma in what they named the *instinctual trauma response* (Tinnin & Gantt, 2014).

The intimate relationship between theory and practice, exemplified in the approach described in that chapter, is the main reason why a book like this one is still needed. As we continue, in this new millennium, to struggle toward greater clarity and more coherent theory in art therapy itself, it is essential that we not abandon the parallel challenge of truly comprehending different theoretical and technical approaches to helping others to grow. It is equally important to continue the debate, and to go on with the attempt to apply ways of thinking about people and change to art therapy, a task begun by the contributors to all editions of this book.

Being familiar with different theories of how and why people develop and grow is essential primarily because it allows us to see the phenomena that confront us as art therapists with a greater variety of lenses, permitting a more thoughtful decision about how best to help whoever we are hoping to assist. In the chapters in this volume, individuals who have studied the original theorists describe aspects of that theory they find relevant to their work. They then present examples of art therapy conducted according to their understanding of the particular model, so the reader can more easily bridge the gap between the original theory and its possible application to our own discipline. The challenge is “to adapt [any] theory to the special needs of the art therapy situation with as minimal a compromise in the integrity of the theory as possible,” while making sure that “the art process remains a ‘full player’ and not just another psychotherapeutic treatment tool” (Stone, 1996, p. 1).

Changes in the Third Edition

Part I. Foundations

As noted earlier, the first section of the book is now about *Foundations*, with the emphasis on *art*. There are three chapters in this section, the first two consisting mainly of a selection of relevant passages from previous editions. Underlying any work that regards visual symbols as carriers of meaning—true for every approach in this book—is the issue of *symbolization*. This was the organizing principle in Laurie Wilson’s chapter in earlier editions on Symbolism and Art Therapy (Wilson, 2001), so it has therefore been extensively excerpted in [Chapter 1](#). Similarly essential to all approaches is the need to find a way of *seeing*, as described in Mala Betensky’s earlier chapter on Phenomenological Art Therapy (Betensky, 2001), also excerpted in the first chapter of this edition, “Art is the Therapy: Symbolizing and Seeing.”

A second chapter in this section deals with the therapist’s use of his or her artistic skills to enhance the experience of those being helped. An early and inspired use of the art therapist’s own artistry is found in Rawley Silver’s creation of *Stimulus Drawings* in order to communicate with the hearing-impaired children she was teaching. As she described in *Art as Language* (2001):

Originally, the stimulus drawings were attempts to communicate with children who had auditory or language disorders. I had volunteered to teach art in a school for deaf children after being temporarily deafened myself in an accident. Painting had been my vocation, and I wanted to share its pleasures with the children. Manual communication was forbidden in most schools for deaf children during the 1960s. Instead, the schools emphasized lip-reading and speech, and provided little or no education in the visual arts. My offer to teach was accepted and I enrolled for a master’s degree, then a doctorate in Fine Arts and Fine Arts Education.

At first, the children and I communicated through pantomime, but when I started sketching messages, communication soared. A sketch of my family prompted sketches of their families, and soon we were sharing other experiences through drawing...offering my own sketches to those who needed help in getting started. The popular sketches became the stimulus drawings presented in the three assessments. (pp. 17–19)

In [Chapter 2](#), “The Therapist as Artist,” I have excerpted sections on both the theory and the visual dialogues between art therapist and client, using drawings from the original chapter on Self Psychology and Art Therapy by Mildred Chapin. I have also added some of Barbara Fish’s recent writing about what she has named “response art,” including a vivid example of her work with a client (Fish, 2012). The use of the art therapist’s artist self with groups and individuals is illustrated in a number of other chapters in this edition, both old and new.

The final chapter in the Foundations section is an art-based approach rooted in “relational aesthetics,” created for this edition by Catharine Moon, author of *Studio Art Therapy* (2001) and editor of *Materials and Media* (2010). Media are the raw materials of art therapy, and as such are common to all theoretical approaches, while constituting the basis of some concepts, such as that of the “expressive therapies continuum.” (Hinz, 2009; Kagin & Lusebrink, 1978)

“Relational aesthetics” is an orientation also referenced by Michael Franklin in his chapter, part of the *Contemplative* section. What both Cathy and Michael reflect, however, is not simply a return to the studio or a preference for a non-hierarchical relationship between therapist and patient—though both are deeply committed to art and to egalitarianism. They also exemplify a passionate desire to use their art therapy in the service of social justice, with a deep and genuine concern for those who are marginalized, oppressed, and less advantaged—a drive, in other words, to change the world through art and empathy.

The desire to go into the wider community, to make art available to many who would never enter the mental health system, is beautifully exemplified in the work of Janis Timm-Bottos, whose community art studios in the United States and Canada have long inspired many. The recent extension of her early storefront studios into what she calls “art hives” (a powerful metaphor) is really exciting, providing not only creative opportunities for community members, but also learning opportunities for university students in a variety of

disciplines, including art therapy. In *La Ruche d'Art aka Art Hive* (<http://www.arthives.org/tags/la-ruche-dart>), Janis describes this model:

The community art studio, aka Art Hive, is an experimental arts-based social inclusion delivery model of nonclinical art therapy that reaches across disciplinary borders, inviting collaboration and unique partnerships between artists, art educators, and other social scientists. Theories based in movement theory, multiple ways of knowing, and Liberation Psychology underpin this strength-based way of working.

Community art studios remind me of those art therapists who worked in Adlerian “social clubs,” like Rita Simon (1992) in the United Kingdom, Rose Garlock (1987) in New York, and Sadie “Tee” Dreikurs (1986) in Chicago. Dreikurs’ orientation is taught and practiced in the training of art therapists by her student Judy Sutherland at the Adler School of Professional Psychology (Personal communication, 2014).

During the late 1960s, following the assassination of Dr. King and subsequent riots in Pittsburgh, a group of arts therapists offered creative activities to children and adults of all races at the “Martin Luther King Freedom School.” In the early 1970s, Georgette Powell founded “Tomorrow’s World Art Center” in Washington, DC, with classes and exhibitions for individuals of all ages (Junge, 2010). In 1972 and 1973, I directed a therapeutic arts program in two “model city” (impoverished) neighborhoods for youngsters and their parents (Rubin, 2008). Working in the community with what Bob Ault called “the unidentified patient” (1989) is not new, but has gained renewed appeal.

Indeed, one of the most prominent developments is the use of art therapy in the service of social action (Kalmanowitz & Lloyd, 2005; Kaplan, 2006; Levine & Levine, 2011). This is not a brand-new idea, but it is enjoying a considerable renaissance in our unstable and troubled times. Taking art therapy on the road, visiting communities around the world that have been devastated by human violence or natural disaster, has also become an increasingly common component of art therapy training. It is being done by people from a wide variety of orientations, but bears mention because, like the return to the studio, it is a major force in the field.

The Organization of the Third Edition

Part II. Psychodynamic Approaches

This section is shorter in this edition, for the simple reason that it is no longer the dominant theory in the helping professions or in art therapy. The two primary original orientations espoused by Naumburg (often called “art psychotherapy”) and Kramer (usually called “art as therapy”) are still important polarities in the work of art therapists, so the chapter on Discovery and Insight as well as the one on Sublimation are included. Elizabeth Stone, who studied and worked with Edith Kramer, has added an Addendum to Kramer’s chapter on Sublimation. And Elinor Ulman’s chapter, “Variations on a Freudian Theme,” now follows the first two, since it deals with the two major orientations and her own attempts to integrate them.

Interpersonal relations have become much more central in psychoanalysis and in psychodynamic art therapy, with a renewed interest in attachment, intersubjective and relational approaches. All of these are based on the original ideas about “object relations” as illustrated by Arthur Robbins in his chapter. To update the reader on recent thought in this area, Eleanor Irwin has revised her Addendum. Finally, there is a new chapter by Dominik Havsteen-Franklin detailing a psychodynamic approach based on what is known as “mentalization” (Bateman & Fonagy, 2011).

This edition also contains a new chapter on Jungian Art Therapy, contributed by Nora Swan-Foster, an art therapist and Jungian analyst. In addition, there is an Addendum with excerpts from the original chapters by Michael Edwards (2001) about Jung as an artist, and by Edith Wallace (2001), where she described a lovely example of Active Imagination.

Part III. Humanistic Approaches

I invited Bruce Moon (who wrote the Commentary for the second edition) to write a new chapter, which is more contemporary in terminology and outlook than those in earlier editions. He called it “Art Therapy: Humanism in Action.” Janie Rhyne’s Gestalt Art Therapy remains, however, as does Natalie Rogers’ Person-Centered Expressive Arts Therapy, which she has revised extensively to reflect her recent work. The current and lively area of Positive Psychology in Art Therapy is represented in a new chapter contributed by Gioia Chilton and Rebecca Wilkinson.

Part IV. Contemplative Approaches

The next Section in this third edition is imperfectly named “Contemplative Approaches.” It flows naturally from Humanistic ones, in that it extends the Transpersonal ideas that dominated later humanistic thought. In it I have included Pat Allen’s chapter on a Spiritual approach, revised for this edition, as well as two new chapters. The first is on Focusing-Oriented Art Therapy, a method developed by Laury Rappaport who not only wrote a book about it (2008), but also recently edited another on the related topic of *Mindfulness and the Arts Therapies* (2014). The other new chapter is by Michael Franklin and is titled “Contemplative Wisdom Traditions in Art Therapy.” It is a mouthful and a mindful, but it reflects what I asked Michael to do, which was to write about how he has integrated Eastern wisdom traditions into his work as an art therapist, both intra- and inter-personally (cf. also Franklin, M., 2016).

Part V. Cognitive and Neuroscience Approaches

The next section of the book features approaches based on cognitive psychology and neuroscience. Marcia Rosal has extensively revised and updated her chapter on Cognitive-Behavioral Art Therapy with recent developments in both cognitive and Dialectical Behavioral therapy. She has also included a description of Ellen Roth’s Behavioral Art Therapy with a retarded, emotionally disturbed boy using Roth’s highly creative adaptation of behavioral therapy to art therapy: *reality shaping*.

Also in this section of the book are methods based on the findings of neuroscience that, as noted earlier, have been enormous in recent decades (cf. also Chapman, 2015; King, 2016). To describe neurologically based art therapy, I invited two colleagues to write about their unique ways of conceptualizing and conducting their

work. As noted earlier, one had worked with her spouse and collaborator to develop not only a theory about the “instinctual trauma response,” but also an amazingly effective short-term method of treatment. Because Lou Tinnin died before he could co-write that chapter, Linda Gantt invited Laura Greenstone, a colleague who has applied these methods to individuals surviving domestic abuse, to collaborate with her. Noah Hass-Cohen, who had co-edited one of the first books about art therapy and neuroscience (Hass-Cohen & Carr, 2008), has also contributed a chapter written with the co-author of her latest book, *Art Therapy and the Neuroscience of Relationships, Creativity, and Resiliency: Skills and Practices*. (Hass-Cohen & Clyde Findlay, 2015). In their chapter, Hass-Cohen and Joanna Clyde Findlay describe their art therapy approach, which is based on interpersonal neurobiology.

Part VI. Systemic Approaches

The section on Systemic approaches to art therapy, introduced in the second edition, has been expanded with separate chapters on Family and Group Art Therapy. The original authors each decided to invite colleagues currently teaching courses in those areas to help them revise and update their contributions. Family art therapy is now a collaboration between Barbara Sobol and Paula Howie, while the group art therapy chapter has been revised by Katherine Williams and Tally Tripp.

Part VII. Integrative Approaches

The final section in the book includes those chapters that might be best described as *integrating* various sources of information around a central theme or topic. They include Developmental Art Therapy, Art Therapy in Creative Education, Imagination and All of the Arts, and an Eclectic Approach. Both David Henley and Shaun McNiff have revised and updated their multimodal chapters, and Harriet Wadeson has noted what she would have added at this time to her earlier eclectic one.

The reader may wonder at the absence of other approaches included in some texts on theories of psychotherapy. Since any selection process is ultimately arbitrary, I apologize to those who feel that important orientations have been overlooked. There is, for example, no chapter on feminist or multicultural art therapy. While there have indeed been books, like Hogan’s on feminist art therapy (Hogan, 1997, 2002), and recent publications about art therapy in different cultures (Kalmanowitz, Potash, & Chan, 2012) and with different groups (Hiscox & Calisch, 1997; Howie, Prasad, & Kristel, 2013), they seem to me to be about *who* or *where* we work, rather than *how*. In that regard, they are parallel to child or geriatric art therapy, or prison or medical art therapy.

Although it would be nice if we were further along in the area of theory development in art therapy, we can take comfort in the knowledge that both art and human beings are wonderfully rich and complex. Thus, it makes sense that our search should be an ongoing and, I suspect, an eternal one. While there are no easy answers, when art therapists can see the intimate relationship between theory and practice, theory becomes a lively area that can greatly empower our work. This volume, with all its imperfections, is meant to be a contribution to greater thoughtfulness and open-mindedness on the part of those who practice the work of healing through art.

Only someone who knows and understands a theory well can teach it to others. While this is true for any kind of therapy, it is especially true when the theory must be modified in some way in order to be applied to a specific form of treatment with its own intrinsic qualities, like art therapy. Contributors were asked to introduce the reader to the orientation, note the particular relevance of the theory or concept to art therapy, and illustrate the approach in practice with one or more brief case examples.

I remind the reader, nevertheless, that the following descriptions—of what is always a heavily nonverbal or paraverbal process—should be understood as mere approximations of therapeutic reality. As John Locke wrote in his *Essay on Human Understanding*, “We should have a great many fewer disputes in the world if words were taken for what they are, the signs of our ideas only, and not for things themselves.” And as far as I am concerned, the last word on that issue was said by Lewis Carroll in *Through the Looking Glass*:

“The question is,” said Alice, “whether you can make words mean so many different things?” “The question is,” said Humpty Dumpty, “which is to be master—that’s all.” Hopefully, this book, though far from perfect, will help the reader to be “master” of his or her work as an art therapist... “that’s all.”

A Note About Pseudonyms and Privacy

All of the chapter authors have disguised the actual names of patients. I have therefore deleted explicit statements to that effect, since they only appeared in a minority of chapters. I want to assure the reader, however, that all names are disguised, with the exception of the people noted in Michael Franklin's description of his community studio who are seen as collaborators, not clients.

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Part I
Foundations

1

Art is the Therapy

Symbolizing

Laurie Wilson

[Seeing](#)

Mala Betensky

Introduction

Judith Rubin

The very foundation of art therapy is *art* itself. Without that basis, there would be no possibility of the discipline, nor any of the theoretical amalgams that comprise this text. The beginnings of the field were in the Art Studio, with artists offering an opportunity for creating to mental patients. As noted in the Introduction, the past several decades have seen a return to the Studio on the part of many who practice art therapy and train others.

Because art in therapy is so very powerful, however, it is really essential that those offering art to people who are in a state of vulnerability be prepared with considerable understanding about human psychology and the process of change over time. The bulk of the chapters in this book address different ways of understanding both human beings and the kinds of transformations for which we aim in art therapy.

Beginning, however, with *art*, there are a number of elements that are equally vital. Fundamental are two we often take for granted, but which are essential to the use of art in therapy, regardless of theoretical orientation. They have to do with what happens when people create art—*symbolizing*— as well as what happens when people perceive art—*seeing*. Both are ways of making and finding meaning through creative expression. Two chapters in earlier editions dealt beautifully with each of these topics, the first from a psychodynamic stance and the second from a humanistic one. While the theoretical basis is quite different, the clarity of thinking and writing in each brings the ideas to life.

The first chapter excerpted here was written by Laurie Wilson for the first edition and was titled “Symbolism and Art Therapy” (Wilson, 2001). As an art therapist and psychoanalyst, Wilson looked at the issue of symbolizing through an analytic lens informed by ego psychology, especially the work of David Beres (1965). Because she explained it so clearly, what follows are excerpts from her original chapter, part of the Psychodynamic Section.

On Symbolism

Laurie Wilson

The capacity to form and to use symbols distinguishes man from other species. "Instead of defining man as an animal rationale, we should define him as an animal symbolicum. By so doing we can designate his specific difference, and we can understand the new way to man—the way to civilization" (Cassirer, 1974, p. 26). Visual imagery—the quintessential stuff of symbolism—is the raw material of art therapy. I shall attempt to demonstrate that, by encouraging production of artwork, we are promoting the development of the capacity to symbolize, and that this capacity is linked to a number of critically important ego functions....

Pathology of the Symbolic Process

Dysfunction in symbol formation characterizes severe disabilities ranging from schizophrenia to aphasia. A brief look at some specific forms of pathology can help in understanding the value of making visual images in treating them. Beres (1965) notes three clinical areas in which pathology of the symbolic process may be seen: retarded ego development, schizophrenia, and organic brain disease. In all, "the essential element is a concurrent disturbance of the reality function of the ego" (p. 16).

Retarded Ego Development

In retarded ego development the child does not develop the capacity to distinguish the representative object from the real object—Linus' blanket *is* mother. We see this clearly with the mentally retarded, whose crippling incapacity in this area (among others) interferes with the normal development of language, thought processes, and object relations.

Elena, a severely retarded, 22-year-old woman with an IQ of 20, had been living in institutions for 18 years (Cf. Wilson, 1977). Her records documented Elena's prolonged fixation at the oral phase. She could not be weaned from a bottle until age five, and shortly thereafter developed a habit of collecting and chewing or swallowing bits of string and buttons. In adolescence Elena still collected such objects, but she no longer put them in her mouth. By age 22 she had abandoned this habit; instead she constantly carried, or wore around her neck on a chain, a ball-like clump of metal jingle bells. Elena herself wove the bells together with wire, and from time to time would increase or decrease the size of the cluster. If the bells were taken from her or she accidentally left them behind, she would cry inconsolably or angrily hit or overturn tables or chairs.

In addition to this fixation, Elena had a repertoire of gestures that included rubbing her hands together, stroking her cheeks, mouth, and nose, and holding and rubbing her breasts. Often she began to make these gestures when distressed, but her pained expression usually gave way to one of pleasure or comfort. Elena appeared to be attempting to comfort herself, with caresses that had in the past been given her by others.

When Elena began art therapy sessions, she was fixated on one image: a circle with a pattern of radial lines imposed on it. She repeated this pattern steadily in her artwork for a year and a half, covering sheet after sheet with numerous examples, almost always using red. Although she willingly varied the medium (using crayon, paint, or chalk), she would rarely alter the image or the color. She was also very clingy, needing constant reassurance and praise.

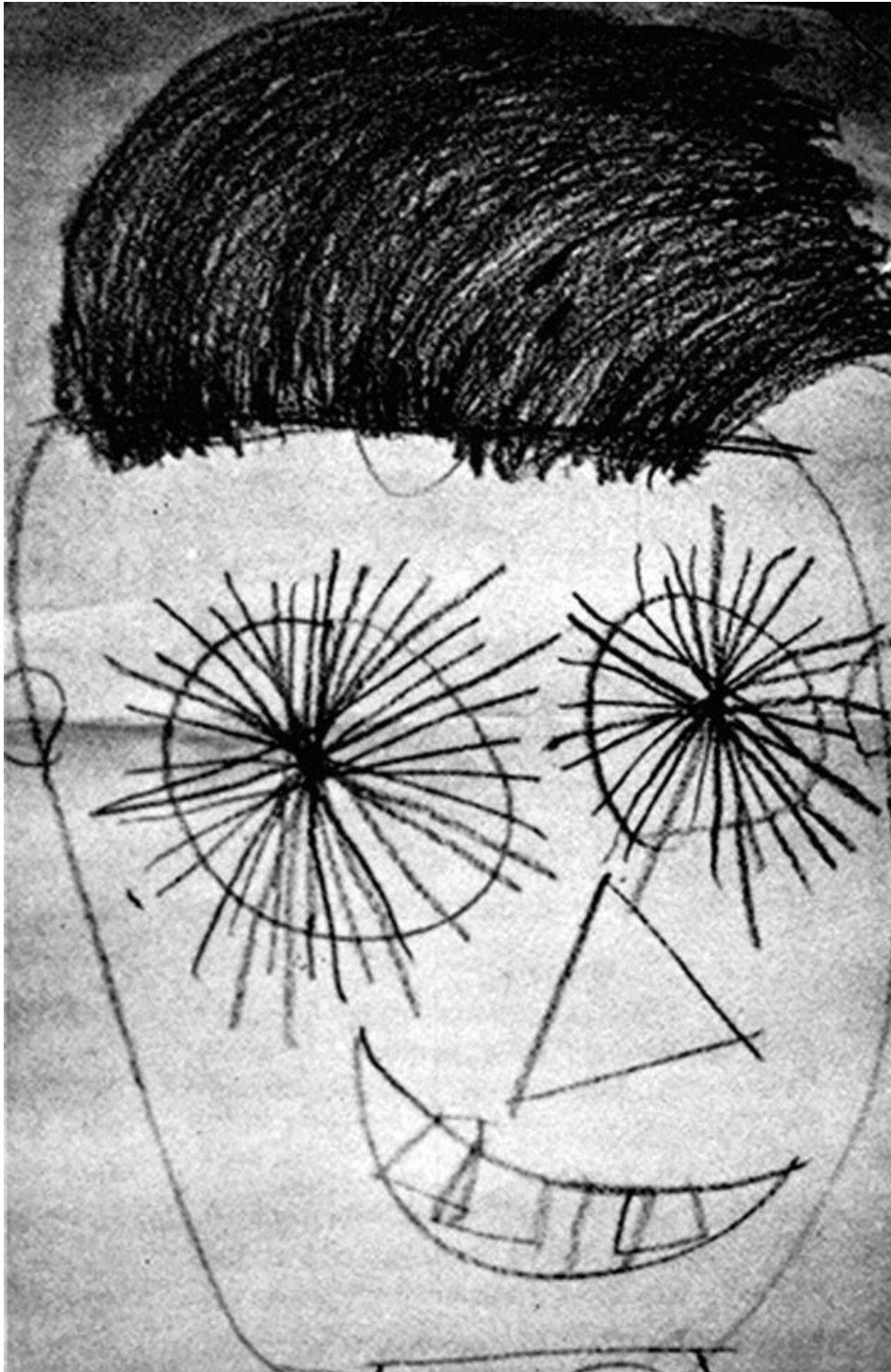
Over the course of two years, Elena gradually progressed, in both her art expression and general behavior, from an infantile dependency to greater maturity. The key to helping was understanding the psychological meaning of her art. By partially satisfying some of her needs, both artistic and personal, and by leading her toward small, but appropriate changes in these two areas, Elena was gradually able to become more flexible and independent, eventually travelling unassisted to the art room.

Her graphic vocabulary also expanded to include concentric circles, images of bodies, squares, and ultimately a rich combination of circles, triangles, squares, and hybrid shapes that she used to draw full figures, clothing, and ornaments. She was able to modify her radial schema, and to include it in different configurations as eyes ([Fig. 1.1](#)) and breast.

As I realized that Elena's perseverative radial schema stood equally for breast, mother, and bell, I understood

the clump of jingle bells to be her transitional object. I now see the desperate attachment to her bells as a *failure of the symbolic function*, since at the start of treatment the bells stood for her as a substitute, not a symbolic object. Elena then developed—through art therapy—a capacity for symbolization, whereby the function of the transitional object shifted from substitute (*standing as equal*) to symbol (*standing as representation*) for the original object—mother.

The persistent making of visual images in art therapy sessions actually seemed to spur the development of her ability to symbolize. As long as the clump of bells and the radial schema functioned as a *substitute* for mother, they were experienced as essential, and could not be given up or altered. When Elena finally developed the capacity to *symbolize* and thereby evoke the absent mother, she was freed to function more flexibly, her security consisting now of symbolic rather than concrete reminders of an absent object. Thus, she was able to leave her bells behind in her room, and to come to sessions unaccompanied either by this transitional object or an actual attendant. We also saw her replace the bells with a pocketbook—another symbolic transformation of the original substitute object....



[Figure 1.1](#)

Organic Brain Disease

Partial or total loss of the ability to articulate ideas through brain damage is known as *aphasia*. David, a 65-year-old man, was seen in art therapy for three months by Irene Rosner, an art therapist who specializes in work with the physically ill and disabled. He had suffered a stroke, causing paralysis on the right side of his body and an inability to speak intelligibly. Retired for three years from his position as a social security examiner, he had maintained a private business in accounting. His wife was disabled with cerebral palsy, as was one of their five children. The family seemed to be supportive and nurturing.

When first admitted to the hospital, David was extremely lethargic. His yes/no responses (head movement) were unreliable, and he was exhausted by any attempts at communication. The psychologist reported that David was only sporadically alert, but when alert did respond to visual stimuli by nodding. Although he seemed to understand some of what was said to him, his attention span was very limited. He emitted a repetitive, grating cry and was demanding.

The treatment plan included daily physical and occupational therapy, speech therapy two or three days a week, and art therapy every other day. Initially art therapy sessions lasted 20 minutes and were increased to between 45 minutes and an hour as he was able to concentrate longer.

David's first drawings in art therapy were similar to a child's early scribbles. Although his marks looked as if they had been placed randomly on the paper, his drawing process reflected a struggle to gain motor control. The paralysis of his right side meant that David had to use his left hand—not his dominant hand—which had been weakened by a bout with polio in childhood. Nevertheless, he was focused and attentive while he drew. Although incomprehensible to an observer, his drawings seemed to have specific meaning for him. So his art therapist focused on attempting to help him to achieve more recognizable forms.

David's progress in art paralleled the development of drawing in young children. In time, his perseverative vocalization decreased, and he slowly regained the ability to say some words; he then reached the stage of naming his scribbles, although they were still unrecognizable. Like a young child, the name David supplied for a given drawing might shift with the associational current. Thus, at one moment he called an early scribble "ice chips" and at another "fish." At this time the psychologist reported that David was more alert and attentive, was communicating his needs with nonverbal cues, and was responding well to directions.

The next stage in David's development marked an advance in two areas. He began to make recognizable forms, to name them appropriately, and was able to place his marks on the paper in a way that indicated his awareness of the entire page. We can easily pick out the tree in [Fig. 1.2](#), titled by David "Fish, Tree, and Amoeba." In contrast to his earlier efforts, David's work now gave evidence of planning and deliberation. He created numerous intentional enclosures: circles of various sizes, elongated triangles, and irregular shapes. Because of the shakiness of his hand, the shapes were barely discernible amid the scribbled lines on the same page, as with young children's drawings.



[Figure 1.2](#)

Nevertheless, on close inspection, forms become apparent in David's drawings from this period—in one a face schema, a crude circular shape with two eyes. Soon after, when asked to draw a person, David combined

his face schema with body parts to create [Fig. 1.3](#).

As he drew, the human figure took on a personal meaning. He began to cry and in response to gentle questioning, said, “My wife—she’s short and fat and ugly and wonderful.” David had been responding without signs of emotion; now he began to register personal involvement. His reaction, stimulated by his own art, seemed a pivotal event in his psychological recovery. He went on to produce better integrated pictures and to invest them with personal meaning, as well as to make further strides in speech and movement.

In view of all of his therapies, it is impossible to say to what extent his work in art precipitated or merely coincided with a longer attention span, more coherent speech, and appropriate affect. But this moving sequence of events suggests that, just as the development of visual images by young children promotes their capacity to engage in symbolic processes, so brain-damaged adults may be helped to recover symbolic functioning in all areas, including language, through a similar development of visual images.



[Figure 1.3](#)

David seemed to reflect progress first in his drawings, and only later in his language and object relations. With each advancing step of visual symbol formation—scribbles, named scribbles, schemas, recognizable images, and human figure drawing—we can postulate the return of impaired ego functions. Perception, memory, conceptualization, reality function, and the organizing function all united to once again permit *mental representations—symbols of absent objects*. With the return of this capacity, feelings (affect) and human (object) relations were reinstated—a lost love took on new life.

Conclusion

The lesson to be learned from these two cases is that patients with an impaired symbolic function (and consequent defective ego functioning) can be helped, by making visual images, to *develop* the ability to symbolize—a capacity fundamental to almost all civilized activity. Elena’s and David’s pathologies resulted from developmental irregularities. Elena, a case of arrested development, was able, by making images to develop the capacity to recall and relate to an absent object. This step, in turn, promoted increased freedom to explore the world and to function autonomously. Severe regression characterized David’s pathology. His production of images promoted higher-level functioning of the capacity to symbolize, and ultimately led to the restoration of object relations.

Language, a shared symbolic system, is central in development and in human experience. When using language is too difficult—or, for those who find using words too frightening—practice in symbolizing, by making visual images, can further development. Developmentally impaired patients, like young children, can be helped by exercising the visual-motor function to achieve higher-level functioning—the capacity to

symbolize in the form of language. As art therapists learn the particulars of symbol formation and their relationship to developing ego functions, we can arrive at better interventions to promote growth in our patients....

Psychoanalytic ego psychology, with its developmental framework, can be most helpful to art therapists. Applying the theoretical formulations of David Beres on symbolism and mental representation, we can better understand some of the ways art therapy works. One is that making visual images helps patients with defective ego functioning and impaired symbolization develop the capacity to symbolize, an ability fundamental to almost all civilized functioning. Another is that, by understanding some of the roles played by symbolic expression in art, we may become even more effective, and know better how to explain the results of our labors.

On Seeing

Mala Betensky

One of Mala Betensky's most powerful suggestions, highlighted in her original chapter for the first edition of Approaches, as well as in the title of her last book, What Do You See? (Betensky, 1995), was her intentional, non-judgmental and receptive way of inviting art therapy clients to look at what they have created. The following excerpts from her chapter, "Phenomenological Art Therapy" (Betensky, 2001), describe her approach, beginning with its basis in phenomenology.

Man in the World—The Subject of Intentionality

Guided by a therapist into the *intentional* perception and study of his art, truly seeing his own painting or sculpture may open new possibilities for [the client].... The act of *seeing* is vital. Perhaps this is one of art therapy's most important contributions to psychotherapy and to phenomenology, because art therapy pays attention to authentic experience in a twofold way. First, clients in art therapy produce a work that is a direct experience. Then, they see its appearance in their eyes and in their immediate consciousness, and this is a second direct experience. In this, they need some help in learning how to look, in order to see all that can be seen in the art production.

When I succeeded in suspending all my a priori judgments and all acquired notions about what I was supposed to see, when I trained my eyes to look with openness and with intention at the art object, I began to see things in that object that I had not seen before. I began to understand the truth in Merleau-Ponty's statement that "to look at an object is to inhabit it and from this habitation to grasp all things" (1962, p. 168). This is a phenomenologist's way of looking in order to see—with intentionality.

Intentionality and Meaning

Intentionality means I am intent on what I am looking at. With my intent look, I make it appear to my consciousness more clearly than before. The object of my attention begins to exist for me more than it did before. It is becoming important to me. Now it *means* something to me. At times, a meaning becomes vital to my existence, to my being. Man is an intentional being, with an intentional consciousness that makes the world actual to him. Intentionality may even help to invent new worlds, and to make the invisible visible, as in the arts and sciences...

It seems to me that art therapy comes closest to fulfilling the task that Heidegger assigned to phenomenology: revealing the hidden aspects of man's being as phenomena accessible to consciousness and to conscious investigation. Art therapy can best achieve this aim phenomenologically by means of a free expressive process, with art materials freely chosen by the client, along with a method in which the client views his art production as a phenomenon within a structured field of vision.

Phenomenological Intuiting

This deals with the client's direct experience of his production, in two phases. Phase 1 facilitates its perception, in three steps. The first step in that phase is *Visual Display* of the art expression. When the client indicates to the therapist that the artwork is completed, both place the sculpture or tape the picture where it can be conveniently viewed. The next step is *Distancing*: The therapist suggests that both of them step back or move their chairs back to gain perspective. The art product is now a phenomenon with an existence of its own. It is now a part of the world, separate from its maker, with its own properties. It can now be examined objectively, from a distance, and without preconceived notions. The powerful emotions contained in the visual product can now be viewed with a certain measure of detachment.

The third step is the process of *Intentional Looking* at the art expression. The therapist now asks the client to take a long look at the picture, sculpture, or collage. S/he may say something like: "Now take a good look at it. First study it and see what you can observe. When the picture is right in front of your eyes, you don't always notice things that you can see later when you have gained some distance from your picture. So, take a long

look and try to see everything that can be seen in your art.”

The client now concentrates and looks, without distractions. S/he is in communication with the phenomenon s/he has produced. The art maker becomes the receiver of messages deposited, half-knowingly, in the artwork. Now, as beholder, s/he receives the messages embedded in the art expression, which has become the phenomenal field. Awareness is now deepened and enriched by new observations, which seem like discoveries.

It is important for the therapist to realize that a great deal of this activity may be taking place in silence. It is therefore essential that the client be given sufficient time to examine the artwork and, most important, that the therapist learn the importance of silence, develop the ease to bear it, and guard against casual comments that might distract the client.

Phase 2. What Do You See?

Now follows the therapist’s invitation to the client to share the results of the three earlier steps: visual display, distancing, and intentional looking. The therapist asks, *What do you see?* This simple question contains two fundamental aspects of the phenomenological approach. One is the importance of individual perception and meaning—what do YOU see? You, the creator, do not need to see the picture the way others do. YOUR way of seeing is essential, and is what we are now interested in. This question underscores the rightness and value of subjective reality. According to the phenomenological view, each person’s inner reality is a fact of paramount importance.

The other notion contained in the question “What do you see?” deals with phenomenological evidence. All that can be SEEN is seen in the art expression itself, not surmised or thought out from a pre-established theory. This is achieved by guiding the client to notice specific structural components in the artwork and the feelings they convey; how certain components relate to one or more others; whether they clash, complement, or coexist; what the organization is; whether the components of the content may be grouped in any way; what these groupings share in common, and whether that is seen in the art itself. Vague feelings slowly reach awareness, and a new ability to identify and name them appears.

Phenomenological Description

Phenomenological seeing is getting the self in touch with the art expression in a very precise way. This is possible by virtue of a kinship and an ongoing interaction between the self and the outer world, the art expression serving as the center. In answer to “What do you see?” the client-turned-beholder gives a *description*, as precisely as he can, of what is in the picture. The art therapist’s guidance may be needed in naming the elements of the art.

Phenomenological Unfolding

The phenomenological discussion of the art expression is the second phase. The therapist helps the client to unfold, as it were, the private meanings contained on various levels in the visual product. As in the previous phase, the therapist merely indicates points for discussion, addressing components and objects *in* the art.

The following excerpt from a 12-year-old girl’s *description* of her picture ([Fig. 1.4](#)) shows how the art therapist’s initiatives are limited to guidance in the naming of elements, and addressing points for discussion about components and objects in the art.

T: What do you see, J?

J: I see a girl playing with her ball in the park.

T: Playing with her ball.

J: Can I say something else I just saw?

T: Of course, just say it.

J: Well, now I see that she doesn’t really care to play with the ball.

T: Mmm...I was wondering about that. What else do you see?

J: Nothing, really. Oh, over there is her dad, in the back, kind of behind.

T: Mm hmm. Her dad.

J: Yeah. And he doesn't care to walk. [sounds angry]

T: What else can you see on your picture?

J: [pointing far up] Oh, oh, see that house? That's our house, and see my mom? She goes back into the house? See, she told my dad to take me to the park and...and now I don't see anything else. [abruptly] [cries, then quiet]

T: [handing a tissue to J] Well, I remember, when I had tears in my eyes I couldn't see well at all, so I will see for you right now. And what I see on your picture has lots of bright colors and is very pleasant to look at.

J: You mean the sun and the trees? The sun, I made it setting. It makes everything in the park so pretty.

J: Yes, that is what I see, and you put it all in the picture. Now, what would you call all these things at sunset on your picture—things that are not people, but that make people feel what you just described? Find a word for it, can you?

J: You mean, the whole park and the sky and the sun? Something like what's around? Or background?

T: That's it, you just said it, background. Now let's go back to the people in the foreground.

J: The girl and her dad.

T: Mmm hmmm. What on the picture shows us that she doesn't really care to play with the ball, and that Dad doesn't really care to walk? Can you take another look and tell us?

J: Well, see, the ball is rolling away, almost to the end of the paper, and she doesn't run after it. She just walks, and her face is, kind of, worried? The mouth...oh, I don't know how to draw what a mouth...looks like. [grimaces]

T: What about the mouth on the picture?

J: It's just a straight line, looks like mad or something.

T: And the father?

J: Oh, he looks like he wasn't there. See, he didn't want to go. He was mad with me. And, oh look, I forgot to fill in his blazer. And I didn't hardly make him a face.



[Figure 1.4](#)

Answers to the question “What do you see?” often act as catalysts, drawing out the essence of the existential dilemma as simply as a client is able to state it. A withdrawn adolescent boy who produced a picture of a fish in a net responded to this question with a reality-oriented description: “I see a fish...caught in a net.” He went on to say, with growing tension in his voice, that the fish “feels sad and mad.”

In the next session the *description* continued, when the boy was able to point to the lines in the picture that

conveyed the “stiffness” of the fish and its immobility, in contrast, the brilliant colors “decorating” the fish. In reply to the therapist’s wonderment about this contrast, the boy said that the fish was “mad...because *he* couldn’t show his colors to all the other fishes in the water.” The pronoun “he” served as a transition to the boy’s subsequent ability to refer directly to himself. This is an example of a process of self-discovery in *becoming*: the pre-intentional level of identifying himself with the fish was becoming intentional.

An adolescent girl responded to the question about her picture (Fig. 1.5): “Well, I see a group of people. They are sort of standing around and they look sort of distressed, and everything.” These first statements are then discussed and further specified, and the girl’s often used “and everything,” for which she had no clear concept (though it meant something to her), is gradually clarified and understood by both client and therapist, as the discussion of the artwork proceeds. The therapist must be a good listener to pick up vague clues from a client’s slow and laborious verbal reflections about art expressions.

The unfolding of the ideas and feelings contained in the art usually proceeds along one of two lines. One starts with the client, and deals with subject matter. The other emphasizes structural properties and the relationships among them. The therapist will usually listen to the client’s description of content and will then turn to structure. With the adolescent girl, the therapist tried to find out: Who might the people be? Why are they all huddled together? Are they trying to protect themselves from the cold or, perhaps, from something else? What is happening to them right now? What might happen in a moment? Much as this approach yields in the client’s interesting observations about subject matter, it is not all.



[Figure 1.5](#)

From a phenomenological perspective, discussions of content are less fruitful than the possibilities offered by the structural components of the artwork. With their ability to convey emotional meanings, they represent the inner reality of the client more accurately and more acutely than the content, which is on a somewhat more disguised level of symbolization.

The following dialogue excerpts and picture are from the author’s videotaped art therapy session with the same girl looking at the same picture (Fig. 1.5)

- T: Now let’s take a look at the placement of the figures. Which figures are placed where on the sheet of paper?
- Cl: Well, the people are all sorta huddled together, and um...they seem like they are all sorta huddled together in little groups...
- T: Which groups are huddled together? Can you make some groupings there?

Cl: This group right here and these three figures...and these three right here and those two...and that one up there....

In a later session, “that one up there” became the center of self-discovery: the girl recognized herself.

Sequence 4—Phenomenological Integration

The last sequence is phenomenological integration, which includes 3 aspects of self-discovery. The first consists of the client’s reflections on the development of the artwork. S/he may comment on the original intentions and on the actual outcomes of those intentions, as seen in the completed work. Although some components of the completed product may have been decided upon and executed deliberately, others may have arisen perchance or as if on their own, without a conscious decision or even with no awareness on the part of the art maker. Here is an example from the same session:

Cl: It looks like this person right here...ummm...is not worried as all the others....

T: Which one?

Cl: This one right here.

T: The one in yellow?

Cl: Uh huh.

T: Is not worried as the others? Uh, huh, uh huh. [long pause] Were you aware of that while you were drawing it? Or do you see it now?

Cl: No, I see it now.

The second aspect of phenomenological integration is the search for similarities and differences in a client’s artwork over time. By looking at current art with previous work, the client discovers certain recurrent components or themes (Betensky, 1973). The adolescent girl noticed how the sense of “heaviness” present in two pictures she selected was handled differently in each. This intra-series comparison leads to a discernment of patterns, first in one’s art, and then in one’s responses to situations in life. Developing an ability to see patterns in the art expressions leads the client to a further recognition of patterns in behavior. A questioning of such patterns by the client then follows, and that eventually leads to change.

The third aspect of phenomenological integration flows naturally: the search for parallels between the client’s struggles with the process of art expression and efforts to cope with real-life experiences. From a discussion of the changes she had made “here on the paper” in an art therapy session, the adolescent proceeded to comment that she was now more able to choose and to make friends, and also to schedule her classes at school—two of her major recent difficulties in life situations.

Conclusion

Through the act of looking at their own art expressions, new facets of themselves become apparent to the art makers, and new communication takes place between the art expression and the subjective experience of the client-turned-beholder. Clients learn to perceive more clearly and more articulately the phenomena of the formal components and their interaction in the artwork. They then connect them with their inner psychological forces, and apply the newly acquired art of looking to phenomena outside and around themselves, in their own world and in that of others.

As they discover facets of themselves in their interactions with others, something else happens: they transcend their self-centeredness and become members of the world—literally—in their everyday life. They assume responsibility for their artwork from the start, and actively participate in the intellectual and artistic process of working through the difficulties that have arisen in interactions between themselves and others. This is the special contribution of the phenomenological approach to art therapy—arrived at by creating art and the subsequent treatment of its organization—from pre-intentional functioning to fully intentional living.

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2

The Therapist as Artist

Mildred Chapin

Barbara Fish

Introduction

Judith Rubin

From the beginning, those who named the field and did the work were primarily artists, like Adrian Hill, who coined the term *art therapy* to describe work that began when he was a patient in a tuberculosis sanatorium (Hill, 1945, 1951). Hill found himself drawing in order to while away the long empty hours, and when Occupational Therapy was introduced into the hospital, he was invited to teach art to the other patients. He also initiated a program of art appreciation, with reproductions ultimately being made available to those in hospitals around the United Kingdom. Hill worked energetically to promote art therapy, eventually becoming president of the British Association of Art Therapists, founded in 1964.

Florence Cane, a psychologically sophisticated artist, taught art at Walden, a progressive school founded by her sister, art therapy pioneer Margaret Naumburg. In 1951 Cane included a section in her book, *The Artist in Each of Us* on “The Healing Quality of Art” with a chapter named “A Modern Psychotherapy” and another that was a moving case study. Artist Edith Kramer began her work at the Wiltwyck School for Boys in 1950, and developed her theories about art therapy during seven years of running the art program, publishing them in her first book *Art Therapy in a Children’s Community* in 1958. As these experiments were evolving, individual artists were invited or volunteered to help mental patients in various locations, like sculptor Hanna Kwiatkowska at the National Institutes of Mental Health in 1951 or painter Elinor Ulman at DC General Hospital in 1953 (Junge, 2010).

Meanwhile, in Topeka, Kansas, artist Mary Huntoon was hired by Dr. Karl Menninger to teach art to psychiatric patients at the Winter VA Hospital in 1946, and published a paper in 1949 on “The Creative Arts as Therapy” in the *Menninger Bulletin* (Junge, 2010). During the Second World War, artist Don Jones was a conscientious objector serving his time at a mental hospital in New Jersey where, deeply moved by the plight of the patients, he used his own art as a form of self-therapy, painting and drawing their portraits. Barbara Fish, whose article on *response art* (Fish, 2012) is excerpted later in this chapter, quoted Jones’ reflections:

It was my previous experience with art that now provided me asylum and a means of survival. I developed a growing awareness that creative expression often serves those who are under severe stress. I found myself painting in the process of working out and living through the human misery that I shared with these patients.

(Jones, 1983, p. 23)

When Jones moved to Kansas after the war, he taught art classes in Topeka that attracted Menninger Foundation staff members, thereby bringing his artwork to the attention of Karl Menninger who wanted it for their museum. Don said he was happy for Dr. Karl to have his paintings, but that he too wanted to be at Menninger’s. In 1951, he became the second art therapist in that renowned institution (following Mary Huntoon), and began his pioneering work, eventually training artist Bob Ault as well.

Although the Menninger Foundation’s treatment was based firmly in psychoanalysis, Jones and Ault were primarily artists, who found ways to synthesize what they were learning from their analytic colleagues and to develop approaches to art therapy clearly based in art. When Jones left to develop a program at Harding Hospital in Worthington, OH, this orientation permeated that department, and when Ault retired, he founded “The Ault Academy of Art,” where he made his own artwork, taught classes, and did what he called “art therapy with the unidentified patient” (Ault, 1989).

Establishing and consolidating a professional identity takes time in any field. It may be especially difficult in art therapy, because of the potential tug-of-war between the clinician’s artist-self and therapist-self. Even if the issue of their relative importance has been settled, there is still the pragmatic problem of finding the time and energy to make art. This has been a source of discontent, personally as well as philosophically, from the inception of the field and was, in fact, the theme of the 1976 AATA conference: “Creativity and the Art Therapist’s Identity.” Bob Ault put it quite simply in a talk at that meeting (1977, p. 53). He had been asked; “If someone shook you awake at 3:00 in the morning and asked ‘Are you an artist or a therapist?’ how would you

answer?" Bob then said that he had found himself deciding in favor of "artist," but that he also resented having to make a choice. The same issue was raised in a series of papers by Mari Fleming (1993) and Mildred Lachman-Chapin (1993) titled *From Clinician to Artist: From Artist to Clinician*. Although both authors were excellent clinicians, after retiring from clinical practice, they each turned enthusiastically to full-time work as producing and exhibiting artists.

One way to bridge the potential conflict while doing clinical work is the use of the therapist's artist self in the process of doing art therapy. In 1986, Edith Kramer had conceptualized using the art therapist's "third hand" as a way of facilitating the patient's art expression (Kramer, 1986). It was similar to therapeutic art educator Viktor Lowenfeld's (1957) idea of "extending the frame of reference," as a way of lending one's auxiliary ego to make possible another's creative expression. However, Mildred Chapin's chapter for *Approaches* presented a radically different idea, involving the art therapist's creation of her own art as a *response* to what the patient presented, in some cases pictorially, and in others verbally. As she acknowledges, it was daring.

I was asked to comment on Millie's first public presentation of these methods and was, frankly, quite concerned about the risks of the intrusion of the therapist's issues into what I thought should remain the patient's uncluttered field...a space I had earlier called a "framework for freedom." Since I was also in orthodox psychoanalytic training at the time I was especially worried that any unrecognized counter-transference issues could seriously impair the most felicitous outcome for the patient.

I had already been favorably impressed by Winnicott's (1971b) "squiggle technique," which was completely interactive, the therapist literally taking turns with the patient in drawing images, but thought that only someone with Winnicott's vast amount of experience and self-knowledge was equipped to use such a method safely. Millie had had a successful analysis and possessed a considerable degree of self-awareness. She was indeed an empathic and attuned therapist, but I worried that suggesting such an approach to others with less self-understanding and sophistication was risky. While I have not fully resolved such concerns, I have definitely evolved in my own thinking about art therapists making art alongside of or in response to their patients. Most important, since such practices are becoming much more common among art therapists of varying theoretical persuasions and degrees of experience, I decided that it would be helpful to excerpt a considerable portion of Millie's original chapter. It was titled "Self Psychology and Art Therapy" (Lachman-Chapin, 2001), and because Kohut (1971) was a psychoanalyst, it was in the section on Psychodynamic Approaches.

Therapist as Artist

Mildred Chapin

Introduction

Judith Rubin

Millie first notes how and why Kohut's ideas about self psychology are especially apt for art therapists, after which she describes ways of using the clinician's artist self to help the client develop healthy rather than pathological narcissism. She begins by describing the longing for what was not available to the growing child from the mother, but that can now be provided by the art therapist as an admiring and approving response to the client's artistic product by what Kohut called a "self-object."...

When the client becomes invested in the product of his or her own action—that is, in his or her own artwork—this is progress...Narcissistic investment in an art product helps the client to individuate, to separate from the need to have his or her exhibitionistic yearnings confirmed in an...infantile fashion. It is most important that, throughout the mirroring process, therapists hold out the promise of ultimate approval for the real accomplishment....

Mirroring was technically described by Kohut as an empathic responsiveness of the "self-object." Kohut's self-object is a person or thing valued for its function in enhancing oneself. This differs from a true object, a person who is valued and related to in his or her own right. In the early developmental stages of narcissism, a self-object is needed by the child and used for the kind of mirroring I have been describing. Failure in empathic response by a self-object can inflict damaging blows on the growing child's sense of self. The therapist functions as a self-object in psychoanalytic therapy with a patient who has a narcissistic personality disorder. The mirror transferences invite the therapist to respond empathically, with a specific kind of nurturing. Ideally, over time the patient will feel the response, will recognize what he or she is asking of the therapist, will reconstruct some personal history, and—most important—will profit by the reparative empathic experience, by beginning to build a cohesive sense of self.

Millie then goes on to describe how she used her own artistic response in the service of what Kohut called "mirroring" with a client named Mary...

An example of this process in art therapy is found in the case below, particularly in the therapeutic sequence represented in [Figures 2.3, 2.4, and 2.5](#). In [Fig. 2.3](#), Mary sees herself as a devouring and destructive person, whose need for control and almost physical possession of the object is global, omnipotent; the object is seen as something or someone who can and *must* be globally possessable and devourable. I contributed [Fig. 2.4](#). She is led to understand her archaic self-object needs from the perspective of an adult looking at a newborn. She then, in producing [Fig. 2.5](#), seems to be seeing herself as still "hungry," but within some kind of structured environment.

This translated into an understanding that her hungers could now be looked at in terms of what they actually were in her present reality. She had been fearful of going on a trip with her newfound boyfriend, afraid she would become like the devouring fish in [Fig. 2.3](#) and ruin everything. She was able, after this interchange, to actually take the trip and enjoy it. She had modulated her initial response, as if needing an archaic self-object, to one in which being with the self-object seemed more manageable.

In the stage of primary narcissism, the infant has no way to relieve inner tension. Only soothing from a "good-enough mother" (Winnicott, 1971a) relieves inner tension. Later, adoption of a transitional object, whereby the absent mother is mentally invoked, allows the child to relieve tension alone. Regulating tension oneself is a basic step in ego structuring.

Kohut, like Winnicott, pointed out that artistic work can be a means of dealing with pain and tension by providing a way of expressing it (rather than keeping it operating *within* the body-mind); and transforming the tension into a self-regulatory mechanism, like the transitional object. The mechanism can be described as recall or imaging of an object when it is not there—a crucial first step; the introjection of the object, taking it in but not yet identifying with it; and then identification with the object to the point where it becomes part of the person. Kohut calls this *transmuting internalization*, or structure building. It means the person has achieved a more independent way of relieving tension. Thus, art and creativity are seen as a way not only to relieve

tension, but also to build ego strength.

As artists we are drawn to an empathic way of relating to the world. We project our subjective state onto our artwork, which objectifies and expresses our introspection in a form outside ourselves, that others can grasp through empathy. We empathically grasp artwork made by others. Thus, we are already attuned to an empathic response; as we help clients to produce expressive works of art, and as we respond to their creations.

We are also very much involved, as artists, in expressing the self. When faced with troubled clients, whatever their pathological label, we may intuitively recognize that these people are troubled in their “selves.” Here too, our qualities as artists equip us to function as therapists. It is also likely that certain unresolved grandiose exhibitionistic stirrings are part of our own makeup. Thus, we can not only mirror and empathically accept these archaic strivings in our clients, but can offer to them a solution we ourselves have found. Art can be used as a form of exhibition, as a way to create, to be magic, to be understood, admired, and affirmed.

I also believe that the artwork itself can become a “self-object.” The client is helped to shift from considering the therapist as sole self-object, to the creation of his or her own self-object. This is a step toward individuation, with the art therapist there to give the longed-for empathic response.

I have also explored another way to provide a kind of mirroring empathic response—by doing art *along with* the client. After we have dialogued for a while, we each set about drawing, usually not looking at the other’s work. I am intensely focused on the client’s concerns, but do not plan what I will do. When finished, we first consider the client’s work; then mine. After the client has responded to my work, I offer my own comments.

This is a response to the client through my preconscious processes, formed by my artistic skills and informed by my clinical judgment. It is a daring procedure. All good therapists use their unconscious responses, but here, there is a *visible* product to be examined by both. It documents the therapist’s response. The client becomes vividly aware of the reality of the person s/he is relating to. The therapist cannot avoid looking at whatever countertransference issues or personal problems appear in the artwork, and must deal with them so as to further the therapeutic relationship. The art therapist has used him/herself as an artist. The client has received a concrete and vivid empathic response from a “real” person.

In the case that follows, Mary had an unmet need for reciprocity, for an empathic response from the external world. I believe this stemmed from her very earliest attempts to bond with her mother. She had not been able to enjoy a healthy symbiosis, where she could learn to soothe herself with the kind of grandiose creativity that Winnicott described. Although this case doesn’t fit Kohut’s formulations (i.e., a patient needing mainly to individuate), it does highlight the need for a response in terms of the development of *self*, no matter what stage. My technique in art therapy would be the same: an empathic art response to the client’s needs *at the level of his/her needs*. Mary’s implicit questions are: What is merging? Is it safe to merge? Will I destroy the person I merge with?

For me, art therapy offers many ways to provide nurturing, empathic responses for the developing self, with the therapist ever aware of the particular step the client is ready and asking for.

Case Example

Mary, a young woman in her early 20’s, who had been taking drugs since early adolescence, was admitted to a psychiatric hospital after a suicide attempt. She had had a number of drug-related hospitalizations and had been in treatment with several therapists who used interpretation and explanation, not empathic attunement. Her family had given up on her; from their viewpoint, this was to be a final attempt to help her.

As part of the treatment team, I provided individual art therapy while she was hospitalized, and continued to see her as an outpatient. She responded very well to the interactive technique I have described; so this was how we worked together most of the time. In the hospital, she would sit in bed, working on a lap board, insisting that the room be dimly lit. I sat beside the bed, using a lap board. When she was an outpatient, we sat at a card table, facing each other. I propped a board up so that she could not see my work, and I rarely looked at hers until she was finished.

Following are two examples of such interchanges, one in the hospital, and one as an outpatient.

Fig. 2.1, “See Me Sometimes,” was drawn in the hospital in anticipation of a visit by a former boyfriend, the first visitor since her admission two months earlier. I asked her to do a picture about what she expected, what her thoughts and feelings were about seeing him again. She refused. Instead, working from a scribble, she produced the head of a man “smoking a reefer.” He had a stitched-up slit across the side of his face, two frontal

eyes on a profile head, the hair standing on end. The person seemed disoriented, possibly drug induced. I referred to her drug episodes with her boyfriend. She denied this interpretation, said she didn't like the picture, quickly turned it over, and produced [Fig. 2.1](#).



[Figure 2.1](#) "See Me Sometime"

She said this was like Mae West who said, "Come up and see me sometime." It was "psychedelic" and "fun." She referred to the brightly colored undulating form flowing out of the left side of the female figure as "psychedelic disco lights." She spoke with a kind of tough disdain, "cool," as if she didn't care. The female figure has red arms and shoulders. The border surrounding the figure is a dark and dull blue-black.

My impressions of the image were that she was referring to the sexy, exciting life she'd had with her boyfriend, now compartmentalized and distant. It was a boxed-in memory, suggesting, by its distinct border, a kind of separation from her real self; just as the sexy-looking figure was self-absorbed, sending out "vibes," but connected to no one. It may also have reflected her pronounced feelings of confinement in the hospital, with no visitation or telephone privileges until then. The picture is bleak, brassy, sad. My associations were to a little girl dressing up in mother's finery, trying to be sexually grown up. I did not voice any of these ideas to her.

Instead I showed her my picture, [Fig. 2.2](#). I worked from a scribble, producing a figure which Mary said looked like a nun. She said it was funny to see a nun all naked and feeding a baby. Then she giggled and talked about stories she'd heard of nuns having sexual intercourse. She seemed fascinated by this image, and titled it "The Naked Nun." We talked about babies and mothers, and she repeated her complaints about her own mother, which had been a primary theme of our work all along.



[Figure 2.2](#) “The Naked Nun”

She had described her mother as cold, demanding, expecting too much of her, demanding support from her child instead of the other way around. Mary had had no contact with her for some time before hospitalization, dealing only with her father when family contact was necessary. And in the picture the nun-mother is not looking at the baby, not even making the visual connection between mother and child that is so elemental.

Mary was an adopted child, her mother a diabetic who couldn't have children. Her pictures had many images and references to oral themes. Her psychiatrist described her as “never having found her mouth.” She'd never had the symbiotic bond that is the precursor to the development of self-soothing capacities. Drug taking was her attempt to soothe herself.

Mary was also fundamentally unattached, as suggested in [Fig. 2.1](#), not having formed the first essential bond

with mother, thus unable to make genuine attachments in later relationships. The sexuality depicted in this picture is false, an imitation of adult activity, but without relationship to another person. It is frantic, narcissistic, and exhibitionistic.

My picture reflected, I believe, my preconscious sense of her strange relationship to mother and birth. I did not think of the mothering figure as a nun. That was *her* association. As a matter of fact, I don't remember having any conscious thoughts about this picture. But as she developed her associations, it became clear to me that what I had depicted in this picture *for her* was an unnatural mother, someone who wasn't supposed to be sexual and therefore to have a child. It condenses in one image the ideas of coldness, chastity, and mothering. The mother's body, as naked, warm flesh, is forbidden to her and felt as prohibited by the child.

The sexual union that produced the child was also forbidden, illegal. This suggests thoughts about her natural mother, who may have given Mary up for adoption because she was illegitimate. It also implies that sexuality is a remote, illicit activity, magically creating a child but having nothing to do with a relationship, either to the partner or the child. Some of these ideas about sexuality are implicit in her picture of herself, [Fig. 2.1](#). My picture presented her with the implications of her own thoughts about her birth, and her fundamental early lack of connection with her mother.

None of this was verbalized between us as interpretations of our pictures. We simply talked about her anger at her mother (in the present) and she made references to lewd nun stories. But, just as my picture had come from my unconscious, mirroring for her what she was saying at a deep level about early, verbally inaccessible experiences; it was, through its image and her associations to it, able to convey to her some of the meaning that I could later articulate for myself.

I believe it was this kind of art dialogue that helped her break out of her psychic cocoon in the hospital. Mary was gradually able to let herself be cared for by various members of the hospital team, to experience some self-soothing, to form some meager relationships, and eventually to leave.

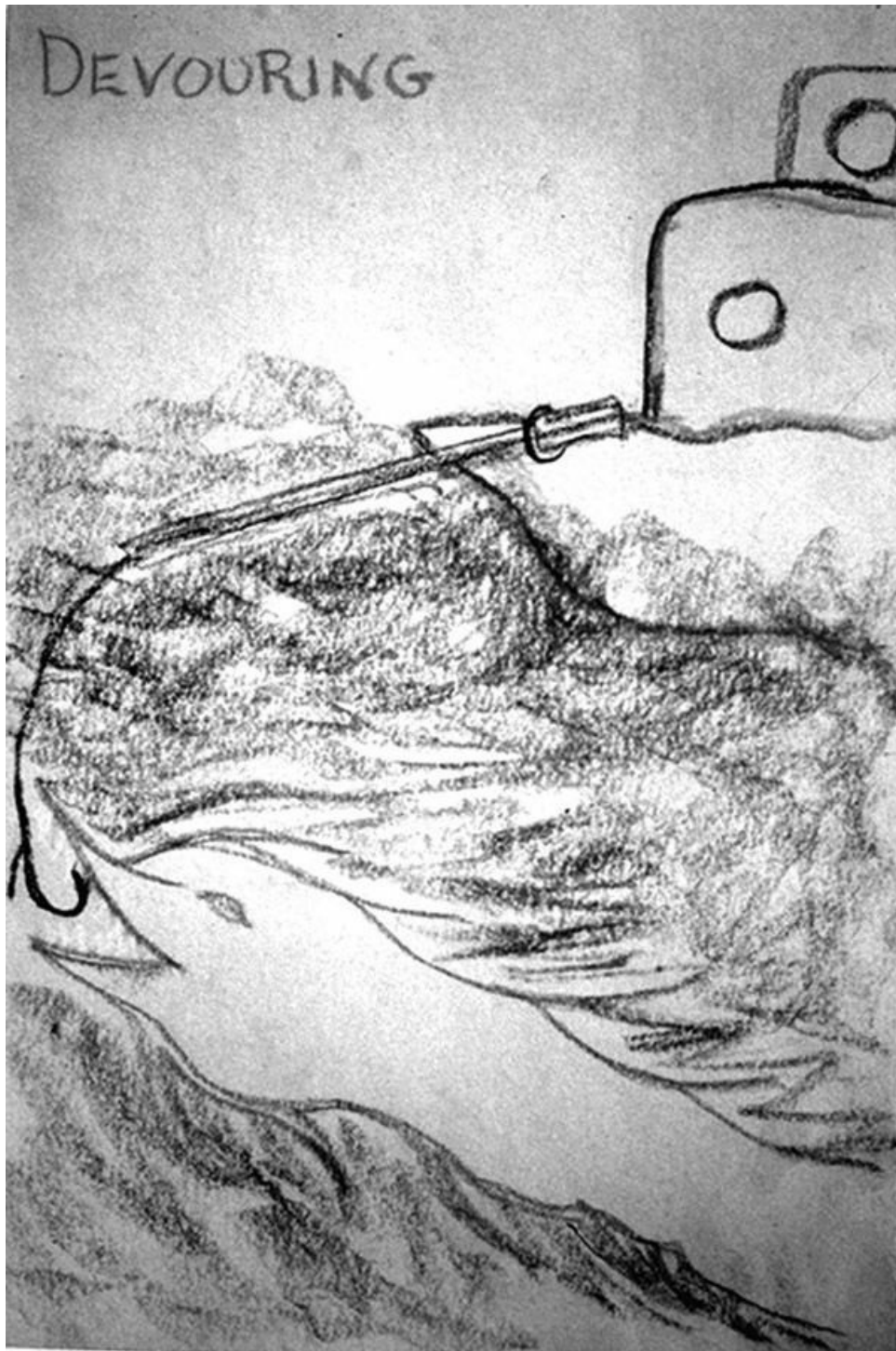
Mary made a remarkably rapid adjustment to life outside the hospital, was able to get and hold a part-time job, and to find a new boyfriend. When that relationship began to deepen, she became afraid. She drew [Fig. 2.3](#), "Devouring," after telling me that her boyfriend had invited her to take a trip to visit some of his friends, and that she was fearful. This picture was a response to my asking her to try to draw her fear. She said the large fish at the bottom was herself, that she was about to bite on the hook, and that once she got the hook in her mouth, she would pull down the whole boat with all the people on it, and they would all drown. Then she spoke about all the relationships that she had ruined, and said she was afraid she would make a mess of this one too.

I showed her my picture, which I had not yet titled ([Fig. 2.4](#)). Mary described what she saw—a mama bird and some eggs in a nest—but had no other thoughts or associations. I then explained that the eggs in the nest would hatch, and hungry little birds would emerge. I said that for newborn animals (and infants), eating was a life and death matter, that they are blindly voracious, needing and wanting only to fill themselves with food. I explained that this thoughtless, all-consuming greed and need may feel frighteningly destructive to the infant.

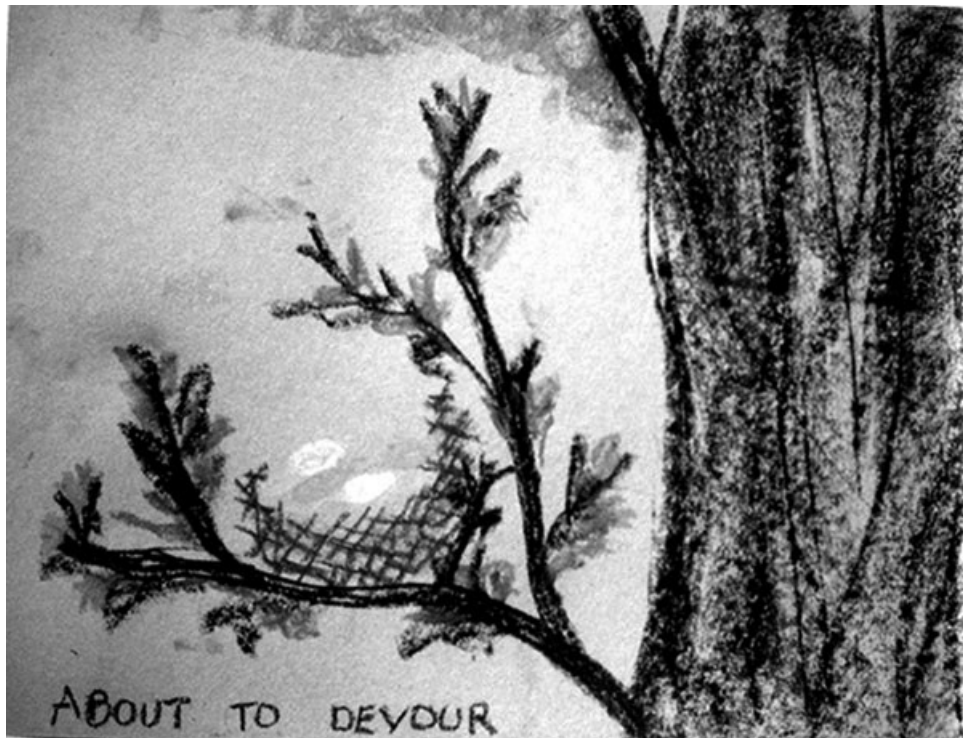
I said that perhaps her present wish to be close to her boyfriend may have that same quality of potentially destructive greed, that sometimes we re-experience later in life the frighteningly devouring nature of this hunger. I suggested that perhaps her own mother bird hadn't brought the worms in a satisfying enough way. She immediately retorted, "So you take it." "Right," I said, "you reach out and devour." She called her picture, then "Devouring;" I called mine "About to Devour." In this interchange, I had seen the sharp, hungry mouth of the fish that she began her picture with before I started. I thought of a newborn chick, so that my picture of the eggs in the nest was a conscious response to her initial image.

"Wish to Survive" ([Fig. 2.5](#)), was done by Mary at the next session. She'd clearly continued to think of her devouring hunger, but had begun to see it not as destructive and frightening, but as expressing her own vital needs. She'd gotten in touch with a primitive sense of self which, in itself, began to give her some psychic structure. The geometrical network that forms the environment for this poignant, animal-like figure suggests such structure.

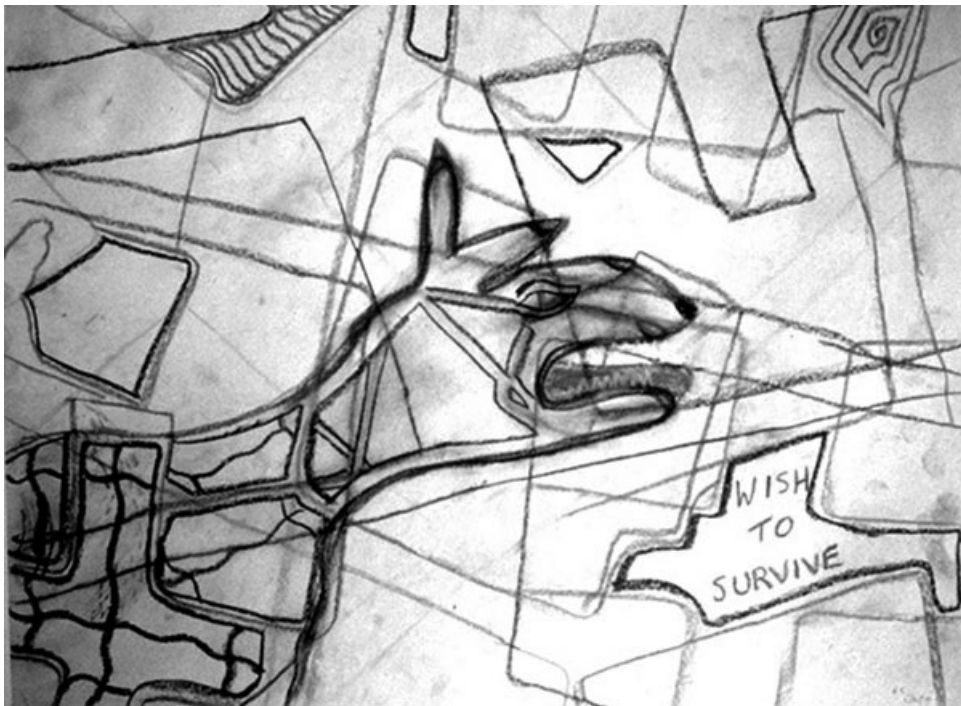
In the first picture dialogue, Mary presents herself as a sexual woman having "fun." Sexuality implies intimate physical contact with someone, yet her picture was lonely, self-absorbed, enclosed, sad. My picture was an empathic response to her essential loneliness and lack of truly satisfying intimate contact at a primary, infantile level. As was evident during her hospitalization, this indeed was the level of her pain.



[Figure 2.3 "Devouring"](#)



[Figure 2.4](#) “About to Devour”



[Figure 2.5](#) “Wish to Survive”

In the second picture dialogue Mary was expressing her fear of the destructiveness of her own insatiable needs. My picture provided a context in which she could understand her needs. It was a way of “reframing” for her what she was at last getting in touch with, but was unable to tolerate.

In both dialogues, through empathic response in my artwork, I could acknowledge her grandiosity (being looked at, [Fig. 2.1](#), and being powerfully destructive, [Fig. 2.3](#)) as well as her feeling of disappointment at a failure of empathy in early maternal response ([Fig. 2.2](#)). I was responding to her very early experiences of the developing self, which cannot be easily expressed in words, having occurred before language. An empathic

verbal response may also not be felt as immediately as this kind of artistic imagery.

This does not mean that to be effective, the dialogue must be in representational imagery. These pictures were chosen for ease of presentation and reproduction. There are just as many instances, in this case and in others, of abstract drawings and sculptures by the client and myself. Formal elements of line, color, and shape are also the expressive language of visual/artistic communication and can be just as powerful as representational pictures or sculptures.

Mary had had a traumatic mothering experience, probably from the beginning of her life. She had not received the kind of maternal empathic responses that provide what Winnicott (1971a) called the “holding environment.” Thus, vital steps in the development of a cohesive self were missing. For such people, working with an artist in this kind of pictorial dialogue can provide a way of experiencing a primal relationship, where the person can engage more successfully in a mutuality that allows him to contribute something—to make reparation, perhaps, for some of the primitive hostility and mortal fears engendered in the infantile dyad.

Therapist as Artist—Response Art

Barbara Fish

Introduction

Judith Rubin

When Barbara Fish invited me to read her doctoral dissertation, in which she described what she called “response art,” I confess that I was as ambivalent as I had been when I first heard Millie’s ideas. But the more I read, the more intriguing and promising the practice became. In a recent publication on the topic (Fish, 2012), she described many potential uses of art made outside the session, like containing one’s anguish (as in Don Jones’ portraits of psychiatric patients), as part of supervision, and in training (cf. Fish, 2016). However, since this book is about ways of working in art therapy, I have chosen to excerpt only the portions of her article that refer to art made in session with the client as a component of the therapeutic encounter. These include a brief literature review, followed by a vivid case example.

Art therapists have used their own art making to understand therapeutic work since the early days of the field.... Moon (1997, 1998) has described his practice of making finished paintings in sessions with his patients... Many art therapists have discussed the use of their own artwork...as part of the relational dialogue in session (Fish, 1989; Franklin, 2010; Moon, 1998).

When made with clients or brought into session, response art can literally show clients how the art therapist understands their experiences, which may deepen the therapeutic exchange (Fish, 1989, 2006; Wadeson, Marano-Geiser, & Ramseyer, 1990). Moon (1998) observed that an art image “brings the art therapist into a deeper understanding of the life of the [client] by intensifying empathy and providing another way for knowing a person” (p. 57). Franklin (2010) has created art images alongside his adolescent clients in group art therapy, asserting that art therapists “are in a unique position to build on intersubjective understanding by mindfully utilizing empathic art to receive, consolidate, and offer back expressions of deflected affect to their clients” (p. 166). In doing so, “potentially disorganized emotions can be responded to with art and skillful verbal and visual listening” (p. 166).

Response Art to Communicate Empathy

I also have made response art during sessions with patients, as was the case with Warren, a 16-year-old patient from a small rural town. Warren became a ward of the state at an early age because of the severity of the abuse he experienced at the hands of his parents. After years of residential and inpatient treatment, the hospital treatment team decided that his parents could no longer have contact with him because their ongoing substance abuse made them unreliable to Warren—a decision that infuriated him. He passionately argued that contact with his family was the only way to work out his problems.

I drew *Home* (Fig. 2.6) while listening to Warren rage about the team’s decision. As he spoke, I picked up colored pencils and drew my representation of the longing and loss that I perceived he covered with anger. He calmed as he watched me draw. When I told him that my piece represented him looking at his home from a distance, he said that he thought I understood how he felt. Studying the image after the session, I recognized my own longing for home. At the time my father was ill and near the end of his life. The image brought powerful feelings about my own childhood home and how it would soon change forever.

Warren’s feelings about being separated from his family did not change the treatment team’s decision. But believing that his feelings were understood did change our relationship. We became allies instead of adversaries. The drawing helped me make sense of multiple points of view. Although I understood Warren’s feelings, at the same time I was part of the team and supported the decision. The image was also helpful to Warren. He knew that I believed family contact harmed him. However, he trusted that I understood how he felt about it because of the drawing.



[Figure 2.6](#) “Home”

Although Warren was more willing to engage in treatment, our relationship continued to be bumpy. I frequently made and shared my artwork with him to show him my understanding, concern, and frustration. He usually responded with images or poetry of his own. Response art helped us navigate difficult interpersonal terrain. Making response art does not ensure positive treatment outcomes; however, it can help both the therapist and client deal with interpersonal challenges, clearing the way for more effective work (Fish, 2012, p. 140).

Conclusion

Judith Rubin

Any good therapist, regardless of orientation, strives to be fully present and empathic. Since it is incumbent upon us to use all of ourselves in the effort to help others, it makes at least conceptual sense that art therapists would want to use their artist-selves as well as their therapist-selves in this demanding and delicate work. Just as our nonverbal behavior with clients has a tremendous impact of which we need to be aware, so do the words we choose to use.

From this point of view, art expression by the therapist as part of the therapy encounter may indeed be not only appropriate but, perhaps at times, the preferred mode. For myself, observing and being open to whatever happens has always felt like the most comfortable and respectful place to be. But I know that there are times I have used my own art, whether to reduce self-consciousness, to demonstrate a process, or to convey a message. Perhaps I was inhibited by my psychoanalytic training not to intrude myself and to maintain “evenly hovering attention.” In any case, art therapists are both artists and therapists, and current trends suggest that many now engage in their own art expression during therapy, including people with a wide variety of theoretical positions.

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3

Relational Aesthetics and Art Therapy

Catherine Hyland Moon

Aesthetic experience is the occasion of an artwork commencing and recommencing its endless work.

(Davey, as cited in MacLagan 2001, p. 14)

Introduction

This chapter describes an approach to art therapy in which art-based ways of thinking and working are in the foreground. Relational aesthetics is offered as a theoretical construct through which to consider art-specific perspectives and ways of being that have broad implications across a range of art therapy practices with diverse client populations and in varied settings. This theoretical construct is not intended to replace transdisciplinary models informed by psychology or other fields, but rather to provide an underlying basis for all art therapy practices. That is, this chapter addresses a core question for the field: What art-based perspectives and expertise does art therapy offer that distinguishes it from related health care disciplines?

Contemporary Art Context

In the present day, the boundaries of “art” have extended far beyond the realm of conventional fine arts to include crafts, architecture, design, indigenous arts, and visual culture, as well as practices in which the making of concrete objects may be of secondary or no concern. The realm of cultural production is no longer the exclusive domain of “artists,” but has become more democratized, due largely to technology, social media, and the DIY (do it yourself) zeitgeist. While painting, drawing, and sculpting are still alive and well, there has been a turn in art—beginning in the 1960s and continuing into the present—toward practices that are dematerialized, performative, collaborative, participatory, and social in nature. Of particular significance to art therapy are the many manifestations of “social practice,” which is generally characterized by community engagement, collaborative production, interdisciplinarity, engagement with social and political concerns, and the aim of real life impact (Kester, 2004; N. Thompson, 2012). In response to this shifting terrain of art forms and aims, art historians and critics have wrestled with how to understand the meaning and function of art and to evaluate its quality.

Concerned about the lack of rigor in art therapy scholarship related to contemporary art theory and criticism (Gilroy, 2014; C. Moon, 2010), I have elected to focus this chapter not on traditional conceptions, but rather on current aesthetic theory. Staying connected with interdisciplinary scholarship about art and aesthetics will help practitioners maintain a strong foothold in the artistic attributes of this hybrid field. While not everything about contemporary art is germane to art therapy, there is much to be gained from an interdisciplinary dialogue about the nature of current art and cultural production (Frostig, 2011; Marxen, 2009, 2011). This is true not only for art therapists practicing in community studio settings, but also for art therapists practicing in *any* setting.

The art therapy profession does not exist within in a vacuum. We are all implicated in what Enwezor (Kester, 2011, p. 4) asserts are the political and social crises that have historically called the identity of the artist into question. What is art therapy’s role in a society in which “personal issues are rarely linked to the greater social context that could help frame them, isolate their origins, and catalyze their resolutions” (Becker 2012, p. 68)? Engaging with contemporary art theory and practice can help us consider both our contributions to addressing social problems, and our culpability in reinforcing them.

Multiple Aesthetics

What constitutes aesthetic experience and “art” is shaped by the lived experiences of individuals and groups whose social, cultural, and political contexts vary widely. For example, the Western assumption that the function of art is to reflect and document experience is contested by practices in non-Western cultures where formative, participatory art experiences are tied to metaphysical transformation and meaning (Crowther, 2009). Stige (2008), a music therapist, proposed the idea of *multiple aesthetics* existing along a continuum, and expressed through a plurality of intersecting localized understandings and formed expressions.

Though I recognize the existence of multiple aesthetics, I am also aware of how influenced I am by my white, middle-class, college-educated, Western exposure to aesthetic thought. When working in diverse social and cultural contexts—whether in the Global South or a Chicago neighborhood—I try to refrain from appropriating or exoticizing the aesthetic thought and art of other cultures. I also attempt to avoid imposing my own, while being open to varied perspectives that enrich my appreciation for the plural nature of aesthetics

(Marchianò, 2009). The focus on collaboration and context-specificity in current art practices is consistent with an intercultural approach to aesthetics.

Aesthetics in Contemporary Art Theory and Criticism

A (Very) Brief History of Art and Aesthetics

Aesthetics, from the Greek word *aisthesis*, refers broadly to sensual and perceptual experiences. Around the end of the 1700s and based primarily on Kant's *Critique of Judgment*, aesthetics came to be more narrowly associated with the philosophy of art and the task of establishing universal criteria for evaluating the quality of art (Welsch, 2009). Over time, aesthetics in art became even more narrowly associated with a particular kind of sensory experience, the perception of beauty (van Maanen, 2009).

By the early 1980s, the term *anti-aesthetic* was used to signify questioning of the validity and relevance of narrowly defined aesthetics. It also denoted cross-disciplinary practices that engaged the political or were rooted in the vernacular and eschewed the concept of a privileged aesthetic realm (Foster, 1982). A false split between aesthetic practices and anti-aesthetic practices remains embedded in art school pedagogy, despite the strong theoretical argument that all art has both political and aesthetic dimensions (Elkins, 2013).

Contemporary Aesthetic Theory

For the purpose of this chapter, aesthetics is defined as “critical reflection on the nature of art.” Given the current pluralism in art materials, methods, and aims, aesthetic criteria are being questioned, employed, and reformulated, based on lived experience and culturally specific processes of meaning making. Aesthetic judgments are no longer seen as neutral and absolute, but rather as contingent, inter-subjective, specific to time and place, and open to debate (Halsall, Jansen, & O’Conner, 2009; Welsch, 2009).

A number of years ago, art therapist Shirley Riley (1996) called for a *pragmatic aesthetic*; one in which creativity was not limited to object making, but was inclusive of finding ways to live successfully amidst pressing social issues. Art theorists have similarly recognized the need to make aesthetics more socially relevant and responsive. Bennett (2012) proposed a “practical aesthetics,” a method of engaging with art by tracing the perceptions, affects, social processes, and web of connections that reveal its meanings and transform experiences. Her approach is responsive to the prevailing social milieu, open to transdisciplinary perspectives, and concerned less with the art object itself than the processes and methods that result in dynamic relationships. These principles resonate with Riley’s call for a pragmatic aesthetic in art therapy, as they propose an approach to aesthetics characterized by an open search for meaning within a socially and materially interconnected existence.

Social practice in art, which intersects with aspects of art therapy practice, is characterized by an emphasis on collaboration, participation, and process. It contests the nature of art and the identity of the artist, and proposes new methods for receiving and analyzing relationally oriented art. Kester (2011) pointed out the need for aesthetic standards that consider the long-term impact of a project and that evaluate its success in relation to challenging preconceptions, catalyzing understanding, mediating exchange, fostering new insights, and sustaining both empathic identification and critical analysis.

Today, “art” is embedded in the world, and consists of the many ways people participate in creating culture through symbolic practices—including those found in pop culture. Cultural studies scholars validate the many modes of seeing and discerning quality that exist beyond those reified by academia, affirming that the average maker or viewer of art is capable of conscious insights (Felski, 2004). Some present-day art educators, influenced by cultural and visual studies, have rejected the teaching of traditional aesthetics in favor of contextual aesthetics. They are interested in students learning to be not only producers of art, but also informed consumers of the visual culture that permeates every facet of contemporary life (Freedman, 2003; Meban, 2009).

Aesthetic Theory in Contemporary Art Therapy

There has been a tendency in the art therapy field to eschew aesthetic theory on the basis of its association with art world elitism and judgments of style and quality, which have seemed at odds with the field's emphasis on art process and therapist neutrality (Maclagan, 2011; B. L. Moon, 2014). However, "rejecting all aesthetic questions as synonymous with the market and cultural hierarchy...self-marginalize to the point of artistic and political disempowerment" (Bishop, 2009). Rather than denying the relationship of aesthetics to art therapy theory and practice, it is imperative that practitioners raise conscious awareness about the values, standards of taste, and techniques of evaluation that circulate within the field. As with any profession, these aesthetic values, tastes, and methods are not innocent, but rather contribute to the perception and molding of art therapy's collective identity (Hamera, 2011).

In *Studio Art Therapy* (2002), I wrote about the many contributions of scholars who described the relationship of aesthetic theory to art therapy. Though I made mention of aesthetic theory arising out of postmodern sensibilities, the primary thrust of that publication was on modernism and the conventional aesthetics associated with it. In this chapter, therefore, I will take up where I left off, by focusing on more recent publications and by considering what they convey about the field's relationship to current aesthetic theory.

In general, recent publications in the arts therapies continue to highlight modernist aesthetic perspectives, though with adaptations to art therapy theory and practice. They address four broad themes: the psychology of aesthetic encounters (S. K. Levine, 2009; Maclagan, 2001; McConeghey, 2003), revised understandings of beauty (for example, Kossak, 2009), practices of viewing art that challenge habituated psychotherapy perspectives (Gilroy, 2014; Henley, 2002, 2004; Huss and Maor, 2014; G. Thompson, 2009), and the role played by aesthetic sensibilities for clients, therapists or both (Aigen, 2007; Franklin, 2010; Marshall-Tierney, 2014; G. Thompson, 2009).

One of the most developed approaches to integrating aesthetic sensibilities into practice was first proposed by Paolo Knill and later expanded upon by Ellen and Steve Levine (Knill, Levine, & Levine, 2005). In their approach the therapist has an "aesthetic responsibility" to move beyond empathic witnessing and take an active role in shaping the session so that an aesthetic response is elicited in the client. This active role includes providing feedback to make concrete the experience as it is happening, offering challenges responsive to the unfolding artistic process that engender curiosity, and providing constructively critical feedback (Knill, 2011; E. G. Levine, 2015; S. K. Levine, 2011). The work is based on a "low skill-high sensitivity" principle whereby the emphasis is on aesthetic satisfaction, and success has its origins more in the emerging work than in competence related to technical skills (Knill, 2011). This approach preserves the integrity of the art experience and doesn't rely on theories foreign to it for interpretation (E. G. Levine, 2015).

In addition to the four themes outlined above, a few authors have broached the topic of contemporary aesthetics in relation to art therapy. Alter-Muri and Klein (2007) note the range of practices considered legitimate within a postmodern art context, and challenged the view of some art therapists that objects made in the context of therapy are graphic images, but not art. Schreiber and Chilton (2012) reflect postmodern sensibilities by characterizing their aesthetic reflections on their supervisory relationship as unconcerned with "facts or resolution, but rather...[with] intersubjective, emotive meanings that are shifting, contingent, and transformative" (p. 190). This same ethos is echoed in Whitaker's (2010) environmental art therapy approach, in which she sets a framework and then encourages clients to work within it in a largely improvisational way. Timm-Bottos (2011) provides an example of engaging with environmental and economic issues through a community-based art therapy practice.

As the field moves forward, art therapy will be best served by an aesthetic theory that encompasses a wide range of art practices, including artwork done on or with the body, time-based art, sound art, and ephemeral, conceptual, collaborative, participatory, or action-based art. In addition, the scope of art therapy will be best supported by a theory that encompasses not simply the processes or products of art making or even the relationship between therapist and client, but the dynamic whole of the conceptual, relational, and meaning-making processes that comprise the practice of art therapy (Abrams, 2011; C. H. Moon, 2002).

Relational Aesthetics

Relational Aesthetics in Art

In 2002, concurrent with the publication of a chapter on “relational aesthetics” in my *Studio Art Therapy* book, Nicolas Bourriaud published the English version of a book titled *Relational Aesthetics*. Bourriaud’s book caused quite a flurry in the art world, receiving mixed reviews from scholars, but much interest on the part of a new generation of artists, critics, and curators for whom it struck a chord (Elkins & Montgomery, 2013).

Bourriaud defined relational art as “taking as its theoretical horizon the realm of human interaction and its social context, rather than the assertion of an independent and *private* symbolic space” (p. 14). His focus was on a specific group of artists whose choreographed work in gallery exhibits was intended to produce relationships rather than “objects.” The book, however, has been appraised within the broader context of art practices in which the relational processes are more improvisational, collaborative, and situationally responsive than those considered by Bourriaud (Doyle, 2013; Kester, 2011).

In addition to critiques about the quality of his scholarship, critics questioned the value Bourriaud ascribed to the artworks under discussion and, by extension, the value of other socially engaged art practices. Such work was criticized for inviting spectators into micro-utopias that fostered complacency, rather than disrupting their habitual reactions and confronting them with contradictory social truths that might provoke action in the real world (Bishop, 2009, 2012; Elkins & Montgomery, 2013). Reviewers also pointed out that attention to the relational impact of social practice typically hasn’t extended to the support and maintenance staff that makes gallery events possible, even in works purportedly confronting labor exploitation (Doyle, 2013; Jackson, 2011). Supporters, on the other hand, perceived the works as critical responses to a collective sense of disconnectedness and as a way of confronting elitism in the art world. They proposed that creating a shared set of assumptions through art might not be simply affirmative, but also provide the affective and relational platform for mobilizing and generating new forms of political response (Elkins & Montgomery, 2013; Jackson, 2011; Kester, 2011).

Relational Aesthetics in Art Therapy

Relational aesthetics in art therapy refers to critical reflection on the nature of artistic practices in which relationships are central. A contemporary perspective on relational aesthetics in art therapy is inclusive of a wide range of art materials, methods, and practices and considers the dynamic whole of the experience of therapy. Its primary concern is to reflect on the nature of art in which relational connections—with the self, others, art process/product, and sociopolitical contexts—are fostered and deepened. It differs from the relational aesthetics proposed by Bourriaud and other social practice theorists in that it identifies inward psychological, imaginative, and affective processes (relationship with oneself) as a necessary and significant aspect of the continuum of relational encounters that can be explored and embodied through art.

In *Studio Art Therapy*, I argued for an insular examination of aesthetic matters and principles, one that mined art therapy’s profession-specific knowledge and experience. This approach no longer seems prudent, given the globally interconnected, socially constructed nature of knowledge production. As a hybrid discipline that has kinship with numerous other professions and practices with intersecting claims on art and relational aesthetics (performance ethnography, social work, community theater, cultural anthropology, activist art, action research, etc.), art therapy can thrive only if we engage in scholarly pursuits in a collaborative and—yes—*relational* fashion.

I have previously provided an in-depth discussion of relational aesthetics, including a series of questions that probe the connective potentials of art therapy practice on multiple fronts. I have also examined the impact of relational aesthetics on many facets of practice, including how art therapists conceive of their work, attempt to understand clients, co-create therapy spaces, relate with clients, engage with artwork, document their work, and communicate with others about the nature of art therapy (C. H. Moon, 2002).

In the final section of this chapter, I offer additional thoughts about the practical implications of relational aesthetics. In particular, I focus on the implications arising from situating art therapy theory and practice within the current discourse on art and aesthetics, which emphasizes collaboration, collectivity, social

awareness, and a definition of art that is wide and inclusive.

Practical Implications of Relational Aesthetics

This section is written in the creative nonfiction form of a letter. In it, I share my approach to relational aesthetics, as applied to recent work at a men's shelter through a project called *ArtWorks*. (For more information about *ArtWorks*, see Moon & Shuman, 2013.)

My dear art therapy colleague,

As you requested, I'm writing to share a bit about the practical application of relational aesthetics. Let me begin with a brief description of a site where I recently did some work:

I go down the basement steps and hear the annoying blare of the television, but at least I don't crinkle up my nose at the smell. I wonder if I have simply gotten used to the odor and no longer notice it. Men of all ages sit around large round tables in the old gymnasium, some reading, others playing cards or simply staring into space, most of them mesmerized by the big screen TV. On the screen I see a promotion for Wheel of Fortune Millionaire Maker Sweepstakes! I can't help but smile a little wryly, hit by the irony of this promotion in the context of a men's homeless shelter.

I find a staff member to unlock the closet and begin to carry bins full of art supplies up to the stage where we set up our small "studio" each Wednesday afternoon. I look around to see who might join us today. Everyone is welcome, but most typically decline. Perhaps they see my art therapy colleagues and I as interlopers and are suspicious of our motivations. Some say they don't have any interest in art and maybe others see it as a "frill" that has no relevance to their current life circumstances. Most of them will not be at the shelter for long—a reality that has made it hard to build relationships or a sense of community support for art making. From week to week, I never know who—or whether anyone—will show up. So on this day I'm pleased when Roger comes up from behind me and says, "Hey Cathy, I have an idea about what I want to make today."

This was a hardscrabble, difficult space to work in, which sometimes made it challenging to keep my aesthetic attunement alive and well. I won't be describing specific procedures and wonderful success stories; instead, I'm going to let you know how—in small, everyday ways—relational aesthetics influenced the way I thought and worked. I'll include a misstep I made and some questions I'm still working over in my mind. That's because learning from mistakes and posing questions helps me to keep my approach a living, creative practice.

The scenario I described above is about an ongoing project called *ArtWorks*, organized by a collective of seven art therapists (including me). We establish free community art studios in Chicago neighborhoods, with the aim of decreasing stigma and increasing understanding among people with social differences (rich and poor, with and without mental illness, housed and homeless, old and young, etc.). We do this by organizing spaces where people have the chance to get to know one another through shared activity that occurs naturally rather than in a contrived way. The studios are based on a concept of radical inclusivity, meaning *everyone* is welcome. One of our stipulations for holding the studio in the men's shelter was that it had to be made available to anyone in the community.

What took place in the men's shelter was not what you would think of as conventional therapy. There were no mental status exams, treatment plans, or progress notes. The overall goals were socially rather than individually oriented, and the focus was on resilience, not pathology. My collaborators and I were facilitators, but also participants. Together with shelter guests and community members, we made art, taught, learned, laughed, listened, talked about challenges, and shared our ideas about overcoming those challenges ([Fig. 3.1](#)).

We weren't ignorant of individual struggles with addiction, mental illness, physical illness, or criminal history, but that's because some of the participants openly and spontaneously shared their struggles. At the same time, we were conscious that these personal struggles intersected with racism, classism, homophobia, and other systemic problems. Much of the critical reflecting my art therapy collaborators and I did was concerned with how our social positions—as cisgender, female, able-bodied, mentally coping, middle-class, college-educated art therapists, all of whom are white and straight except for one multi-racial/Asian-American, one

Latina/Caucasian, and two who identify as queer—impacted our work with mostly men and some women who were poor, mostly people of color, many with physical ailments and/or mental illnesses, and whose education levels ranged from high school dropouts to college graduates. We strived to diminish the power differential as we worked side-by-side with all participants, but we also knew that at a systemic level, the playing field was far from level. Reading and talking about social practice in art helped us to be mindful of these complicated social differences.



[Figure 3.1](#)

These are the topics I want to talk to you about concerning relational aesthetics: conceptualizing the work, considering the context, relating to the clients, and relating with the artwork. I'll provide some examples as I go along, so you can get an idea of how this theory might play out in practice. I'll also occasionally tell you about other art therapists' ideas that I've found helpful.

Okay, first topic: conceptualizing the work. I did my professional "growing up," as an art therapist at a psychiatric hospital where, thanks to my mentor Don Jones, it never even occurred to me to center my practice in anything other than art. Later I was inspired by Millie Lachman-Chapin (2000), who claimed her artist identity with conviction and made art alongside clients.

However, I know there are many art therapists who are not comfortable with the identity of "artist" or feel it has been drained out of them by the demands of their work environments. Maybe you are one of them. This is a problem for our field. I don't say this because I think everyone has to be involved in the gallery scene or make work that would be considered "successful" or "edgy" by art world standards. It's a problem because it undermines the credibility of our field and probably also discourages clients from embracing their own artist identities. By disowning the identity of artist, art therapists trivialize and undercut the progress being made in the wider world by those who challenge art world hierarchies and embrace a more inclusive, accessible, and participatory concept of art and artists.

You are probably wondering what it means to me to claim my identity as an artist. Well, for one thing, I'm clear that I (and the field of art therapy) have a place at the table, the "art world table" that is. I see it as my responsibility to be in conversation with other artists and thinkers who are also committed to art as a means of enhancing healthy interpersonal and collective relationships.

Operating with a core sense of my identity as an artist also helps me perceive everything I do with artistry. It helped me think creatively about how I might transform the men's shelter by making small, temporary changes to the visual environment, by "performing" connectedness instead of isolation in relation to everyone I encountered, and by viewing the staff, guests, and visitors not as stereotypes but as embodied poetics, our criss-crossing lives forming new creations each week. I know this might sound a little sappy, but it's serious

business to me. Staying rooted in my identity as an artist helps me approach my work with empathy, creativity, and a sense of agency.

Let me now say a bit about considering context from the perspective of relational aesthetics. The context for art therapy has traditionally been viewed as the relationship between the therapist and client, contained within the private space of the office or studio. Most of us now know that the relational context is much wider and more complicated. For example, the context at the men's shelter was the open studio space within the former gymnasium where guests, staff, and volunteers conducted the daily business of homelessness. Beyond that, the context was a diverse, mixed income neighborhood that teetered ambivalently on the edge of gentrification. Within and beyond the neighborhood were the multiple social service settings the men encountered, which were themselves embedded in larger systems of oppression, and thus may or may not have been implicated in maintaining the existing structure of inequality. And finally, at a global level, the context for the perpetuation of homelessness was the economic order that ensured an ever-widening disparity between the wealthy and the poor.

Whew! Yes, I agree, that's a lot to think about. Am I going to tell you now how art can save the world? No. Sorry. But I am going to talk to you about small acts of resistance and change.

Patricia Fenner (2012) has written about the "cascading influences" (p. 12) of all the elements contained within a therapy space, and Shelly Goebel-Parker (2012) has suggested that aesthetics in the built environment have to do with being attentive to patterns that create connections. Although I initially thought of lugging art supplies up to the shelter's stage area and setting up tables and chairs as simply a necessary chore, I later came to view this weekly ritual through an aesthetic lens. Some of the men, even those who didn't stick around to make art, would help out with these tasks. I started thinking about this as creating patterns of connection. The same was true of greeting people in the shelter, even the ones who had no interest in art. Of course, setting up a collective space for art making and conversation was also about creating patterns of connection. All these small acts established a pattern that countered the experiences of alienation and economic apartheid common to people who are homeless ([Fig. 3.2](#)).

You might not think that these "small acts of resistance and change" are part of the art of art therapy, but I do. Framing these everyday acts as my artistic practice helps me to see them in a new light and to appreciate their relational value. Subsequently, I enact them with heightened intention; I think about their artistry and how I might involve others and myself in them in more meaningful, relationally enhancing ways. This thinking and acting gives me a sense of agency within oppressive contexts. I am not a victim of circumstances but an artist subtly disrupting habits of power and privilege, challenging them in small, subversive ways.

That doesn't mean my colleagues and I always get it right. Our biggest mess-up at the shelter was how we came to the decision to exit the site after seven months. To put it bluntly, we acted just like the privileged (mostly white, comparatively wealthy, physically able, mentally coping, college-educated) art therapists we were: We made the decision unilaterally to close up shop. We had our reasons. We hadn't been able to fulfill our own mission of working with a diverse group of community participants, because women and children were reluctant to come to a basement-level men's shelter located in a somewhat dicey neighborhood. So we were discouraged, as well as tired from juggling the many responsibilities of our complicated lives. But still! We could have consulted with the guests and staff in the shelter and the few community participants who were our alleged collaborators! That was one of the times we put our blinders on and "forgot" about relational aesthetics. I think deep down we were afraid that one of our collaborators would come up with a great idea for how to diversify our community participants and keep the studio going...and our weary selves were ready for a break.



[Figure 3.2](#)

That leads to the third topic: how relational aesthetics impacts my approach to working with clients. In reflecting on our mistakes in closing the shelter studio, my colleagues and I decided that when we opened our next ArtWorks studio, we would immediately focus on getting community buy-in, developing shared community leadership, and learning from community members what *they* were interested in doing and making. We decided that if none of us could make it to the space on a given evening, the studio should be able to function without us. I realize this might be a radical and unworkable idea in many art therapy settings. But that's not the point. The idea I'm trying to get at is that viewing one's art therapy practice from the vantage point of relational aesthetics leads to working *with* clients or participants, not *on* them or even *for* them. Art therapist and art therapy participants co-create the experience together.

In my *Studio Art Therapy* book, I've written about how relational aesthetics impacts my work with clients. Really, it affects everything I do:

- understanding clients through the poetry of their lives;
- viewing our work together as performance art collaborations;
- discerning and responding to the points of access offered by clients;
- using my aesthetic sensibilities to observe and document sessions;
- making thoughtful choices about therapist transparency through the style and content of the artwork I make in sessions;
- using my aesthetic sensibilities to enhance empathy;
- using my aesthetic understandings to work with resistance and form alliances; and
- determining if and in what way to engage in art making alongside clients.

If I had to sum it up, I would say that relational aesthetics informs every aspect of my work with clients, because the relationship is central to the art making process. The client and I may be creating objects, but we are also involved in intersubjective exchanges that have implications for our ways of being in the world. As a nice bonus, approaching the work from the perspective of relational aesthetics often makes the work more interesting, moving, meaningful, and enjoyable.

And now for my last topic: the impact of relational aesthetics on my approach to artwork. I view artwork in art therapy the same way I view artwork exhibited or performed anywhere else. That is, I don't ascribe a narrow meaning to it or see it only as a window into the maker's psyche. Art can have multiple intentions and meanings, so I tend to approach both the autonomous art object and the relational praxis with openness and curiosity. I might be moved, pleased, tickled, lulled, confounded, or disturbed by the artwork; but in the

therapy context, I try to remain open to being in relationship with it and its continually transforming meanings.

Sometimes the meaning of art is pragmatic, not self-expressive. At the shelter, men often made jewelry, at times to give as gifts, but most often to keep for themselves. This seemed like a sensible art form for people who must carry everything they own from place to place. One man made a cover to protect his Bible and one woman made rugs from discarded plastic bags in the hopes of selling them. Sometimes the meaning of art is just what it appears to be on the surface: a way to pass idle time, to connect with others, to embellish one's life, to make something practical, to experience pleasure, and so on. These too are relational practices of caring for oneself and others ([Fig. 3.3](#)).

Whether the focus is on an autonomous object or relational enactments, perception is a central aspect of relating to artworks. Attentively witnessing artwork is the parallel to listening to another person so that she or he feels seen and heard. It isn't necessarily about viewing a completed art object, but is always about witnessing the process of co-creation. One of the men in the shelter taught a colleague of mine how to create folded paper chains with which he had made some impressively intricate works. As I observed my colleague intently looking and listening, I thought about how his experience of being seen, heard, and valued probably counteracted his typical experiences as a person experiencing homelessness ([Fig. 3.4](#)).



[Figure 3.3](#)

Overall, my approach to artwork is context-specific. In the shelter, all of us who were participating in the experience co-created the aesthetic environment by what we made as well as how we responded to each other and to what was happening around us. In more conventional art therapy settings, where clients are interested in self-exploration and meaning making, I work a little differently. There, we work together to find ways to explore—not explain—artwork. Telling stories, responding with sound or movement, amplifying an image by making another, bringing a static artwork to a performative level...oh, the possibilities are endless!

All in all, it's up to each of us to think about the ways in which we use our art knowledge and aesthetic sensibilities to best serve the needs of participants in our specific art therapy practices. Because I am always challenging myself to sharpen my understanding of relational aesthetics, I'll end this letter with some of the questions I'm pondering about the intersection of today's practice of art therapy with contemporary art and aesthetic theory:



[Figure 3.4](#)

- In conventional art therapy settings, how do we diminish our authorial or directive roles and work more collaboratively with clients?
- Is there an interplay between developing a sense of agency and developing technical skills?
- Do specific clients most need skills related to the handling of tangible art materials or related to the intangibles of social practice? By this I mean such skills as listening, speaking up for oneself, activism, leadership, or even grant writing, project planning, and so on.
- What is lost when the status of a client's intention for his or her artwork is privileged over a discussion of the work's identity and effectiveness as art?
- Are art therapists guilty of engaging in uncritical do-gooder art practices?
- How can art therapy help address the social and political dimensions of problems without jeopardizing vulnerable clients?
- In what ways do we contribute to addressing social problems and in what ways do we contribute to reinforcing them?

Though there is much more I could say—and many more questions I could pose—about the application of relational aesthetics, I think it's time to close this letter. My words provide just a glimpse into how relational aesthetics might shape and inform one's way of working. I hope you take it as such—a few ideas, a bit of inspiration.

With best regards,
Catherine Hyland Moon

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Part II

Psychodynamic Approaches

Psychoanalysis (Freudian)

4

Discovery and Insight in Art Therapy

Judith Rubin

Preface

Were Margaret Naumburg (1947, 1950, 1953, 1966) alive, she would have been the logical choice to write the first chapter, with its emphasis on Freud's early goal of "making the unconscious conscious," leading eventually to insight ("where id is, there shall ego be"). I have written that chapter myself, after considerable internal debate about the propriety of being both editor and author. However, having been trained at an orthodox Freudian institute in classical psychoanalytic technique, which I have applied to art therapy with children and adults, I felt as well qualified as most of my colleagues to speak as a descendant of our first pioneer.

Background

Freud recognized early that many of his patients' communications were descriptions of visual images. In fact, at first he actively requested images, using a "concentration" technique to evoke forgotten memories:

I placed my hand on the patient's forehead or took her head between my hands and said: "You will think of it under the pressure of my hands. At the moment at which I relax my pressure you will see something in front of you or something will come into your head. Catch hold of it. It will be what we are looking for—well, what have you seen or what has occurred to you?"

(Freud & Breuer, 1893–1895, p. 110)

Of one of his analysands he wrote: "It was as though she were reading through a lengthy book of pictures" (Freud & Breuer, 1893–1895, p. 193). Even after he abandoned this method in favor of free association, he couched his instructions in visual terms, asking the patient to "act as though you were a traveler sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside" (Freud, 1913, p. 135).

Several years later, Freud wrote a passage frequently quoted by pioneer art therapist Margaret Naumburg:

We experience it [a dream] predominantly in visual 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."

(Freud, 1916–1917, p. 90)

As Naumburg was fond of pointing out, Freud did not include drawing as part of classical technique, even though "the wolf-man" did draw a dream during his treatment: "He added a drawing of the tree with the wolves, which confirmed his description" (Freud, 1918, p. 30).

Freud also reported a drawing by Little Hans—the first child in analysis. After his father drew a picture of a giraffe, Hans made "a short stroke, and then added a bit more to it, remarking 'Its widdler's longer!'" (1905, p. 13, [Fig. 4.1](#)). Indeed, drawing and painting were, from the first, well accepted as part of child analytic technique. In the words of Anna Freud (1927), "A further technical aid, which besides the use of dreams and daydreams comes very much to the fore in many of my analyses of children, is drawing; in three of my cases this almost took the place of all other communications for some time" (p. 30; Cf. also Rambert, 1949).

Despite the fact that child analysts were comfortable with art, few who treated adults used drawing or painting, although there were exceptions. Marcinowski "studied dreams of his patients in connection with their pictorial representation" (Bychowski, 1947, p. 34). Pfister tried to "psychoanalyze an artist by means of free association to his own pictures, but had little success in treating this patient" (Naumburg, 1950, p. 12). He wrote enthusiastically, however, of his work with an 18-year-old who "presented a number of oil paintings and drawings which I, in accordance with good analytic procedure, had him at once exhibit and explain to me" (Pfister, 1917, p. 390). In fact, the analysis "dealt almost exclusively with drawings and poems" (*Ibid.*, p. 399).

In 1925, Nolan D. C. Lewis noted that "the interpretation of the art productions has long been recognized as part of the psychoanalytic technique" (p. 317). Sometimes drawings or paintings were offered spontaneously by the patient and utilized by the analyst (Bychowski, 1947; Hulse, 1949; Liss, 1936; Milner, 1969; Sechehaye, 1951). In other instances, analysts engaged artists to help patients create art, which they then brought to individual (Naumburg, 1966, p. 14; Spitz, 1954) or group analytic sessions (Schilder & Levine, 1942).

Some analysts even asked adults to work with art media in the treatment setting, like Mosse (1940), who encouraged psychotherapy patients to fingerpaint and then associate to the pictures, or Auerbach (1950), who invited patients on the couch to doodle on a pad. Stern (1952) urged patients to paint freely at home and bring the pictures into their analysis. And chances are that many an analyst has asked "a patient [to] draw a dream detail he is having trouble describing" (Slap, 1976, p. 455).

A genuine integration of Freud's insights about unconscious communication through imagery and the use of art in therapy was brought about, however, largely through the efforts of Margaret Naumburg, who began her long and productive career as an educator. In 1914, she founded Walden, a school based on psychoanalytic

principles and emphasizing the arts (Naumburg, 1928). One of the first Americans to undergo analysis, Naumburg urged all of her teachers to be analyzed as well.

She began her work during the early Freudian era of “id psychology,” when “making the unconscious conscious” was the primary therapeutic goal. The “release” of unconscious imagery through “spontaneous” art expression was therefore central to her approach to education, as well as to her later development of what she called “dynamically oriented art therapy.” (Naumburg, 1966).

Freud’s earliest model of the mind was known as the “topographic” theory. As if the human mind were a geological entity, he postulated layers or levels of consciousness—from the deepest and most inaccessible (the unconscious), to that which is accessible but not in awareness (the preconscious), to that which is “on one’s mind” (consciousness).

Freud soon added the notion of a “tripartite” division of the mind, with the primitive “id” as the source of repressed (forbidden) wishes (impulses, ideas). These impulses (the “instinctual drives”) constantly strive for discharge (satisfaction) and are expressed in a disguised form, because only in that way can they bypass the “censor” (the force serving to keep unwelcome ideas out of awareness). The “compromise” effected by the “ego” consists of finding some way to satisfy or discharge the impulse, without offending either the environment (reality) or the individual’s moral code (“superego”). This theory helped Freud explain compromises found in psychological symptoms, slips of the tongue, and dreams.

The first psychoanalytic therapists modeled their work on Freud’s early treatments, in which he strove for “catharsis,” or for the “abreaction” of “strangled affect.” Uncovering traumatic events that had been repressed (“making the unconscious conscious”) was therefore thought to be the key to recovery from neurotic illness.

Margaret Naumburg, excited by the “spontaneous” art expressions of the children at Walden, also felt liberated by her personal experiences of analysis, which had included making pictures of her dreams and fantasies. She therefore saw “releasing” the repressed (unconscious) through imagery as curative, in a cathartic as well as a communicative sense.

Naumburg shared with many analytic therapists an enthusiasm for the healing potential of symbolic artistic expression, and for the rich projective possibilities of art in assessment. While not alone in her use of art for either diagnosis or therapy, she was unique in stressing its role as a primary agent, rather than an auxiliary tool.

Thanks to a meeting with analyst Dr. Nolan Lewis (Naumburg, 1975), she was able to explore using art with youngsters in a psychiatric hospital. Naumburg (1947) subsequently published a series of case studies, in which she reviewed the literature on art in diagnosis and therapy and presented her work with the children. These were followed by books on art therapy with schizophrenic (1950) and neurotic adolescents and adults (1953, 1966).

Naumburg called her approach “dynamically oriented art therapy,” and thought of it as based primarily on Freudian understandings. She was also sympathetic to Jung’s (1964) notions about universal symbolism (“collective unconscious”) and Sullivan’s (1953) ideas about “interpersonal psychiatry,” both of which she incorporated into her work. As a scholar knowledgeable about many schools of thought regarding symbolism, Naumburg insisted that the only valid meaning of anyone’s art came from the person. She was skeptical about simplistic or rigid approaches to decoding symbolic meaning, a position consistent with Freud’s teachings about dream analysis.

Most analysts agree that the only valid way to understand the latent meaning of a dream is for the dreamer to associate to it as freely as possible (Altman, 1975). Only such idiosyncratic associations to the manifest content can lead to the hidden significance of the dream, disguised by what Freud called the “dream work” (e.g., symbolization, condensation, displacement, reversal, and other mechanisms of defense). As Freud himself pointed out: “Sometimes a cigar is only a cigar,” and all translations of symbolic meaning from manifest content are hypotheses, to be confirmed or refuted by the dreamer’s own associations.

Naumburg modeled her approach to the use of art in therapy largely on what the psychoanalysts did. Technically, she attempted to stimulate free association, the method by which Freud made his discoveries. In her role as a therapist who saw the patient’s art as a form of “symbolic speech,” Naumburg (1955) remained within the communicative framework of her more verbal model.

In psychoanalysis or analytic therapy, the method is, first, for the patient to express him or herself as freely

as possible. Then therapist and patient work together toward understanding what is interfering with the patient's ability to function more effectively, that is, internalized conflicts.

Two important tools are the "transference"—the symbolic ways in which the patient perceives and responds to the therapist—and the "countertransference"—the symbolic ways in which the therapist perceives and responds to the patient. The transference helps to identify distorted perceptions, which are assumed to be based on unresolved conflicts from the past. The countertransference is a clue to what is being evoked in the therapist by the patient. Though both were first seen as interferences, they are now considered valuable sources of information.

In the course of analytic therapy, the therapist helps the patient to understand and gain control over previously unknown sources of distress through questions, clarifications, confrontations, and other forms of intervention—especially interpretations, in which possible connections may be tactfully proposed. Contrary to the popular caricature of the analytic art therapist arbitrarily imposing meaning on the patient or the art, the method is in fact highly respectful, and the goal is always to help the patient make his or her own discoveries or "interpretations."

Psychoanalytic psychotherapy, then, has as its goals: first, uncovering and thereby discovering repressed material (presumably internalized conflicts that are causing problems), and second, helping the patient to gain insight into the meaning of his behavior in terms of these formerly hidden ideas and feelings. If this process is lived through in a relationship charged with affective as well as cognitive meaning for the patient (the "transference neurosis"), the person can be helped to change considerably, especially when the problem is a neurotic one.

Although I valued and utilized other frames of reference in my work, I found the use of art in a uncovering, insight-oriented approach to be the most powerful and exciting kind of art therapy for myself, as well as for most of my patients. The shock of discovering previously unknown and usually unwanted aspects of the self is often visceral. The excitement of not only seeing—but also feeling—connections between what has been known and what has been hidden is equally powerful. "Insight" in good analytic art therapy is no intellectual matter; it is a vivid awareness, which allows all kinds of things that once seemed inexplicable to make sense. When it is deeply felt, grasped, and accepted, the internal shifts leading to genuine and lasting change can be truly amazing.

I continue to be stimulated by the developments in ego psychology, object relations, and mentalization, as described in the other chapters in this section. But the organizing principles for most of my clinical work remain a psychoanalytic understanding of what is going on in the patient, from the point of view of both development (Colarusso, 1992; Erikson, 1950; A. Freud, 1965) and dynamics (McWilliams, 1994). Although few patients today fit a classical neurotic picture, these concepts are still useful, as in the following illustrations from art therapy with an adult.

Case Example: Mrs. L.

Some years ago, I had the opportunity to work with a young woman of 27 in individual art therapy. A look at her first art session and a later one may illustrate how a psychoanalytic approach can facilitate both understanding material and making technical decisions. Mrs. L. was invited to choose freely from among the available art media and to create whatever she wished. Like free association, this unstructured approach is designed to help patients to express what troubles them as freely as possible (Rubin, 2005). I made few comments during her spontaneous verbalization, primarily to facilitate a comfortable flow of thought in words, as well as a relaxed process of creating with materials.

I listened to her spontaneous remarks and observed her behavior. I asked only for specific “associations” to the art productions themselves, similar to what analysts often do with dreams. And, in making sense of the material, I thought in terms of the kinds of issues highlighted in an analytic assessment “profile” (A. Freud, 1965; Freud, Nagera, & Freud, 1965). This first notes the reason for referral, the history, and possible environmental stressors. The referral of Mrs. L. and her 4 1/2-year-old daughter, Lori, had been prompted by Lori’s depressive symptoms following her parents’ separation. Mrs. L. had become increasingly anxious about her ability to parent either of her two children. The referral for art therapy came after two months of verbal therapy, in which she tended to deny all feelings.

Although Mrs. L.’s depression and anxiety were clearly “reactive” to her situation, her unresolved conflicts and coping mechanisms had to be understood, in order to help her to master the current stress. A psychoanalytic understanding includes not only external “facts,” but also the internal “situation” of the patient: the developmental level of functioning (in terms of libidinal and aggressive drive development and object relations), and whether there are any evident fixation points or regressions.

Since psychoanalysis assumes that unresolved conflict is at the root of neurosis, sources of conflict are also noted. Conflict may be with the external world (other people), “internal” (ambivalence), or “internalized” in a structural sense (between or within one of the metaphorical parts of the mind—id, ego, or superego). To assess a person’s capacity for psychoanalytic therapy, one also notes frustration tolerance, sublimation potential, attitude to anxiety, and progressive vs. regressive tendencies.

A psychoanalytic understanding helps the therapist to know *where* a person is “stuck” (developmentally), *what* is being defended against (feared impulses), and *how* (favored coping and defense mechanisms). We will look at Mrs. L.’s first art session, in order to translate some of this terminology into the clinical “data” of art therapy. As in all dynamic therapy, initial hypotheses need to be continually tested and revised in light of emergent material, as will become apparent when we review a later session.

Mrs. L.’s First Art Session

Mrs. L. nervously selected 12" × 18" white drawing paper and thin chalk, and drew a vase filled with flowers of different colors (Fig. 4.1). While working, she alternated between voicing concern (confessing that she had practiced drawing the picture at home) and noting that her good grades in art were due to the teacher’s clear directions. Though critical, calling the drawing “terrible” and “lopsided,” she was able to look at it on the easel and associate to it, in response to my asking “What comes to mind as you look?” She said she loved flowers, loved both growing and arranging them, and that in this interest as in all ways, she was “just like” her mother. Focusing on the red flowers, she said she liked red roses, but that they gave her a sad feeling because they reminded her of a hospital.



[Figure 4.1](#)

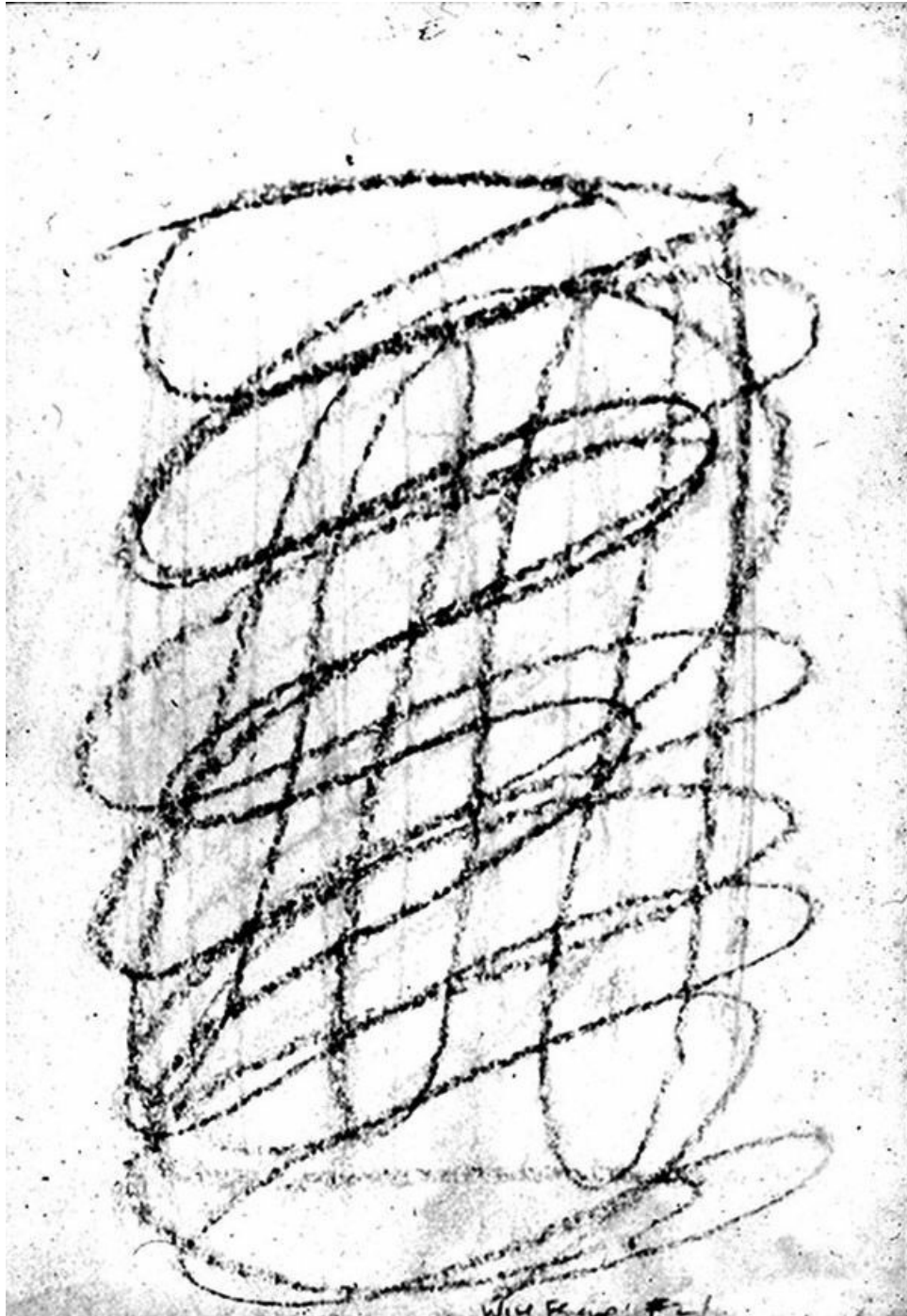
Her second drawing was developed from her own “scribble,” a “starter” suggested by me because of her intense discomfort about what to do in the time remaining. This ([Fig. 4.2](#)) reminded her of a “rolled-up wire fence.” She tearfully recalled the times she had fenced in her children this past summer. She had to, she explained, in order to do all the chores falling on her shoulders since the separation, like mowing and caring for the lawn. She confessed that she had feared my disapproval of the fencing; she was clearly feeling guilty, and worried about having harmed Lori. Mrs. L. was visibly relieved and ready to leave at the end of her first 45-minute art therapy session. She had been controlled throughout, consistent with the referring psychiatrist’s feeling that she was highly defended against any threatening feelings and ideas.

A psychoanalytic understanding of the communications (verbal and nonverbal) of anyone, even in the first

session, involves the notion of *transference*: the projection by the patient onto the therapist of ideas, feelings, and expectations stemming from unresolved past conflicts. I therefore “heard” Mrs. L.’s comments about the art teacher who gave good directions as a rebuke to me for not telling her what to make and thus making her feel inadequate. She let me know what she wanted from me—clear directions about what to do—and also what she expected—criticism. I heard her critical comments about her art as reflecting little healthy narcissism, as well as an index of a severe, punitive superego.

I also examined my responses to her: the *counter-transference*. While that is partly a reflection of my own internal world, which I had better know about so that it doesn’t get in the way of my work; it’s also a clue to things about the patient. I found myself feeling critical of her phony, plastic smile, which I realized reminded me of an aunt whose smile was a thin disguise for her hostility. I also felt controlled by her pre-rehearsed picture, even though I was sympathetic to the anxiety it reflected. I wondered how controlling she was of the little girl for whom she had sought treatment.

Mrs. L.’s initial associations to the superficially pleasant manifest content of her drawing—that she “loved” growing and arranging flowers—paralleled her surface presentation of herself as cheerful, in charge, and pleased with life. Her statement that she was “just like” her mother, suggested possible problems with separation and individuation. The theory of the “repetition-compulsion” also led me to assume that any unresolved problems with her parent would be replayed in some way with her children.



[Figure 4.2](#)

Manifest art content and initial associations are, like the manifest dream, a deceptive disguise for a less obvious (latent) meaning. Mrs. L.'s subsequent associations—to red roses and the sad feeling they gave her, along with her allusion to a hospital—were her first communications of her own depression. It wasn't clear who might be ill, for example, whether this indicated anxiety about her health—now that she had been abandoned—or a worried (disguised) hostility toward someone else (mother? husband? children?). Behind the cheerful smile on her face and the colorful stereotyped flowers in the vase lay a good deal of anxiety, suggesting her use of reaction-formation as a defense.

When Mrs. L. blocked, unable to do a second creation, I understood it in terms of “psychic determinism,” the analytic notion that any series of behaviors (thoughts, words, actions, art) is linked in some meaningful way. Her blocking was similar to a child's “play disruption” (Erikson, 1950), indicating that the anxiety aroused

(presumably by talk of flowers, sadness, and hospitals) was sufficient to interfere with her functioning (e.g., to constitute an unconscious resistance).

I therefore suggested a “scribble drawing,” which offers the patient their own unstructured stimulus upon which to project further imagery, an approach developed independently by a child analyst (Winnicott, 1971) and a creative art teacher (Cane, 1983 [1951]). Margaret Naumburg (1966) welcomed this approach to projection developed by her sister (Cane), since it helped release imagery dormant in the artist’s unconscious.

Mrs. L. labeled her rapidly drawn image a “Rolled-up Wire Fence.” My first thought was of how tightly “wound-up” she herself was, tensely controlling her feelings, which evoked a counter-transferential impulse to tickle her. These ideas, surfacing from my “evenly hovering attention,” seemed related to her subsequent associations to the fencing in of her children during her summer yard work. Her anxiety about my disapproval, and her fear that she was responsible for Lori’s depression, were further indications of a severe superego and a strong sense of guilt. Seeing herself as harmful hinted that her earlier associations—to the roses of sickness and death—may have stemmed from unconscious death wishes toward others, perhaps her mother whom she had described as identical to herself. This suggested that she used identification as a defense, a hypothesis confirmed later in therapy in regard to her hostility toward her daughter.

Despite a defensive idealization of me as a “good mother,” Mrs. L. was able to use weekly art therapy to explore her feelings of rage and hurt toward both her parents and her husband, and to accept her ambivalence toward her children. She soon became able to use her artwork as a valuable source of information about herself. During most sessions, like the one to be described next, she would work almost casually with the materials—preconsciously it seemed—while telling me the important events of the previous week. Then she would put her picture on the easel and look at it with interest, curiosity, and a desire to learn from it, often regarding it with puzzlement, as if it had come from somewhere other than herself.

Mrs. L.’s Penultimate Art Session

(After 10 Months of Weekly Treatment)

Mrs. L. chose acrylic paints, putting them directly onto a small (9" × 12") canvas with a palette knife. Talking of her current concerns, including her sadness about termination, she made a series of oval shapes—some green, some yellow. Regressing to earlier dependent behavior, she asked if it would be “all right to mix the colors together.” Reminded that she could do whatever she wished, she mixed them with the palette knife—first slowly, then vigorously—smearing almost the entire surface, creating a large mass of thick yellow-green paint. She finished by painting a solid white border around the mass, effectively “containing” it ([Fig. 4.3](#)).

As was characteristic by then, Mrs. L. knew that she was finished and placed the painting on the easel where we both regarded it. She first thought of the ocean, titling it “Sea Mist.” Surprised by her association, she went on to say that she doesn’t like the sea, that she’s afraid to go in the water, afraid of fish, a fear she can’t seem to conquer. “Whenever...anything brushes my leg, I really, you know, go crazy! Jellyfish, shark—what is it?” Laughing nervously, she described her fear of horses and of being bitten by a dog, recalling that she’d grown up “in a neighborhood with a lot of vicious dogs,” and reflected that so many problems go back to her childhood.



[Figure 4.3](#)

She returned to her fear of swimming in the sea and being bitten by a shark. When asked how she felt about her art, she called it “a big round blob,” and said—as she often did—“I don’t know how it got like that. I didn’t intend for it to be like that.” The painting reminded her of “ripples in the water,” and “it looks kind of wild, but I don’t think I intended for it to be.” She said she was thinking of “something calmer,” that “the sea is kind of peaceful,” and that she likes wide-open spaces. “I don’t like congestion, you know, or being congested or hindered in any way.”

Mrs. L. then decided to do another picture, this time using her by-then-favorite medium, thick poster chalk, on a 9" × 12" piece of white paper ([Fig. 4.4](#)). While she drew rapidly, she spoke of her plan to take art classes after termination. Looking at her picture on the easel, she first thought that it looked “like something you’d see under a microscope, like an amoeba...It looks like it might just be a watery mass around it, as if you’re taking something out of water and putting it under a microscope, although the water isn’t brown, unless it’s very muddy water.”

Pausing, she seemed blocked, so I asked, “If they were people, who would they be?” She laughed and said, “Here we go—three again! I always end up with three shapes of some kind. I don’t know why that is. I do that very unconsciously, but for some reason or other, it always ends up that way. Oh well, I guess that’s me in the middle again. That always seems to be me in the middle.” She identified the inside shape as Lori and the one on the right as her son, saying that it looked like she was “trying to protect” Lori, probably because “she feels things” more than her brother.



[Figure 4.4](#)

Mrs. L. then spoke of Lori as sensitive and fearful, especially at night. She told how last night Lori couldn't sleep, because "she kept visualizing a man crawlin' up on a ladder to her bedroom, or to my bedroom." She named the picture "Mother Love." She then thought of how Lori would ruminate obsessively about fears, and how she does that too; but "I try to push it out of my mind, like I do anything that I'm afraid of." I wondered if all of this imagery about fear of attack (sharks, dogs, male intruders) was related to the impending termination and her anxiety about being more vulnerable, less "protected" (as she saw herself protecting Lori). Mrs. L. agreed that, although she tends to try to deny or disavow her anxiety, it was heightened by anticipating the separation from her therapist.

Mrs. L.'s artwork in this later session reflects her impulses more than that in the first one—in both the process and her associations. Her surprise in response to pictures and thoughts reflects an enhanced ability to express herself more freely. Her "observing ego" is stronger, enabling her to "see" more frightening imagery; as well as to acknowledge uncomfortable feelings, like sadness and anxiety in response to termination.

Her anger was less accessible to her than in other sessions during this phase, perhaps because hostility toward me was too frightening to contemplate on the next to last session. I had the sense that she was expressing it indirectly through the aggressive smearing of the acrylic paint, which she saw as "breaking" some kind of "rule" (not to mix colors?), as well as in her choice of brown and black chalk for the second picture, first seen as dirty, "muddy water."

Although Mrs. L. rarely worked representationally, she enjoyed projecting images onto her artwork, and was often excited and surprised by what she "saw." This viewing of an image—which she realized came from within herself—had the affectively charged quality of what Ernst Kris (1956) called "id insight." Such discoveries of something about the self are critical in psychoanalytic treatment. Although insight alone is not sufficient, its value in conjunction with affective experiences and a sense of conviction is, as noted, extremely powerful.

Conclusion

Having worked in a variety of modes with a variety of patients over the years—ranging from strictly verbal adult analysis, to using art in adult analysis, to child analysis with art, to psychoanalytic art therapy with adults and children—I am convinced that art can greatly enhance the analytic experience of insight (“seeing in”). This is probably so because art is concrete and visual, in addition to its value in “uncovering” unconscious imagery and discovering unconscious fantasies and impulses.

The psychoanalytic approach to art therapy, in the hands of a trained clinician, offers an extremely rich vehicle for change with many patients. My own conviction, shared by those trained in the Freudian tradition, is that classical analysis is neither appropriate nor necessary for most, but that the theory that informs it is still useful in understanding and guiding all therapeutic work, whether the clinician behaves in a supportive/ego-building or in an interpretive/uncovering manner.

In psychoanalytic art therapy, it is often necessary to shift one’s stance, sometimes supporting defenses, at other times analyzing them. The shifts are often rapid and the relevant cues subtle, so that it is necessary to be flexible, within certain stable conditions—what has been referred to as the “frame” (Langs, 1979; Milner, 1957), or what I have called a “framework for freedom” (Rubin, 1978/2005). However one conceptualizes that constant, dependable “holding environment” (Winnicott, 1971), it does not mean rigidity. Rather, in psychoanalytic art therapy, the clinician shifts his or her stance in accord with what he or she perceives as most needed by that particular patient at that moment in time.

For example, I try to utilize the “least restrictive” (most facilitating, least intrusive) intervention, as a way of helping a patient who, in some way, indicates a need for the activity of the therapist. For a person who is stuck, like Mrs. L. in her first session, I might suggest a “scribble drawing,” or perhaps a series of images, done as freely as possible (Rubin, 1981), thus lending my “auxiliary ego” to the patient’s blocked efforts at expression. On the other hand, when a person can handle a more insight-oriented approach, I might wonder what in the previous image or associations could have led to the current “disruption” (e.g., analyzing the resistance).

Similarly, if someone were producing chaotic imagery, I would probably try to find a way to help them sort out and organize the confused images (e.g., supporting defenses). I might suggest framing and viewing one image at a time, or selecting several to put together in a new picture. If they were generally able to function at a higher level, and the confusion seemed to be a momentary response to stress, I might ask them to stop and consider what in the preceding images or statements had created tension.

In either case, I would be lending my support where it seemed most critical—either intervening constructively in the creative/expressive process or, where appropriate, inviting the patient’s “observing ego” to look with me at what was happening in order to better understand it. In both, I would try to understand the blocking or the regression from an analytic perspective, and would intervene so as to provide what seemed most useful to that patient at that particular moment in time.

In that regard, as in most issues in conducting diagnosis or therapy through art, the psychoanalytic approach to understanding and to intervening has been helpful to me. Although an art therapist cannot possibly behave in the passive, neutral manner of a classical analyst, I have come to feel that in most cases sufficient neutrality for a transference to develop is helpful, whether or not one chooses to analyze it.

And, as psychoanalysts have stressed, an “alliance” with the patient is absolutely essential to effective therapeutic work, something as true for art therapy as for analysis. Both the patient and his or her art have become less mysterious, the more I have understood of psychoanalytic theory over time. I have no question that the training has made me a better art therapist than I would have been without it.

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5

Sublimation and Art Therapy

Edith Kramer

My understanding of sublimation is based on Freudian psychoanalytic thinking, broadened and confirmed by the findings of ethologists, and by clinical observations made in the course of my work as an art therapist.

According to Freudian theory, *sublimation* designates processes whereby primitive urges, emanating from the id, are transformed by the ego into complex acts that do not serve direct instinctual gratification. In the course of this transformation primitive behavior, necessarily asocial, gives way to activities that are ego-syntonic and are as a rule *socially productive*, although they may not always be *socially acceptable*. We need only to recall the fate of Socrates, Rembrandt, Freud, and innumerable others, to realize how frequently achievements that undoubtedly came about through processes of sublimation were rejected by society.

Sublimation is no simple mental act; it embraces a multitude of mechanisms. These include displacement, symbolization, neutralization of drive energy, identification, and integration. Always there is a threefold change: of the object upon which interest centers, of the desired goal, and of the kind of energy through which the new goal is attained. Sublimation invariably implies some element of renunciation. Yet sublimation somehow remains so linked to the urges that set the process in motion, that the individual attains through it at least partial gratification and partial relief from the pressure of these libidinal and aggressive drives. Inasmuch as it involves postponement of instinctual gratification and channeling of drive energy, we can perceive sublimation as one of the mechanisms of defense.

Implied in the concept of sublimation is the awareness that man's instincts are in disarray and can no longer be relied on to safely regulate behavior. We assume that the atrophy of the instinctive programming that regulates the behavior of the lower species occurred as a consequence of the advent of the faculty for conceptual thinking. This enabled man to judge situations on their own merit, rendering the more global dos and don'ts of the ancient instinctual organization obsolete.

Psychoanalytic psychology also assumes that the dissolution of this mindless (yet exquisitely balanced) organization brought into existence an accumulation of unregulated forces—libidinal and aggressive energies pushing toward immediate discharge—oblivious of time, place, and circumstance, in non-rational, potentially lethal behavior. Man's survival as a species thus depended on the development of a new psychic organization holding the key to all goal-directed behavior, capable of taming and directing drive energy. This new organization, the ego, constitutes man's indispensable organ of survival. Infinitely more flexible and efficient, it is also more fragile and less dependable than the ancient instinctive programming it supplanted.

Sublimation entails establishing a *symbolic linkage* between some primitive need and another more complex cluster of ideas and actions. This presupposes the capacity to evoke ideas and perceive analogies, a faculty involving both primary- and secondary-process thinking. The ability to perceive analogies belongs to primary-process thinking. As secondary-process thinking takes over, symbolic representations lose their protean, driven quality, and become stable. Imagination replaces fantasy. We must presume that the faculties of primary-process and secondary-process mental functioning, as well as the capacity for conceptual thinking, evolved simultaneously and interdependently. Evidently, sublimation in the full sense of the word could not occur among any species lacking these mental faculties.

However, we discern among the lower species certain phenomena sufficiently analogous to sublimation to assure us that the process as we conceive of it is not totally without precedent, and does not constitute a biological impossibility. (See pp. 27–29 of the first edition for further discussion of these issues.) It is reasonable to postulate that man's subjective experiences can be linked to the physiological process of tension reduction; that actions that are linked only by a long chain of modification to the gratifications of basic urges can have the power to generate emotions of pleasure and pain, and to reduce tension; and that man's biological heritage

includes the faculty to channel considerable energies into such processes.

Sublimation in Art Therapy

Sublimation is not limited to the arts. A ubiquitous process, it permeates man's entire life. In this chapter, however, our focus is on sublimation as we observe it in the course of art therapy. We must distinguish sublimation from catharsis, from simple displacement, and from the highly sexualized and/or aggressively charged imagery that we encounter in the artwork of psychotics.

Catharsis

When Mrs. Smith, after a day's vacation, found the cottage where she worked as a house parent in an unbelievable mess, she relieved her feelings by covering a white paper entirely with red paint. She then painted a tiny figure with hands upraised in despair on the bottom of the page. After she finished, she had calmed herself sufficiently to resume her duties. Mrs. Smith had found a symbol for her situation: the white sheet of paper upon which she spread the symbol of her all-pervasive rage, the color red. She had experienced the relief that catharsis affords the strong individual who, after such an outburst, is able to return to the task at hand in an invigorated mood.

Failure of Neutralization

When 20-year-old Jim, an ambulatory paranoid psychotic, attempted to draw a tomato using colored pencils, it took on an unmistakably breast-like shape rendered sinister by a dark, blood-red spot that gave the impression of a wound or bruise. The product told of his longing for nurturance, of the pressure of his sexuality, of sadistic perception of the sexual act, and of his anxiety. The picture remained unfinished and appeared misshapen, an unsuccessful attempt at displacement. Sublimation was not attained.

Sublimation Induced and Supported

Sublimation is a complex process requiring a modicum of ego strength and intelligence, yet with some assistance, 18-year-old Jack, an educable retarded man, was able to experience the power of sublimation during a memorable art therapy session. When Jack was informed that his favorite art therapy student would leave the program before his birthday, he stormed out of the art room in a rage. After a little while, he returned and began systematically and angrily to tear up a stack of drawing paper, one by one. Thereupon the chief art therapist took the two halves of a torn sheet and commented, "Now you made two sheets. Will you give me one of them as a present?" Jack was startled. His eyes lit up. He laboriously printed the art therapist's initials on one half of the torn sheet and his initials on the other half, and proffered the half that was inscribed with her initials to the art therapist.

He then began to ask all the people in the room for their initials. He tore paper into even smaller pieces, printed initials onto each of these fragments and proudly went around distributing the many gifts to everyone in sight. His mood had changed dramatically. He had found a way of continuing to give symbolic vent to his pain about being torn from his beloved art therapist. He was still tearing paper; however, he was no longer only destroying it, but was also making more of it. And he was working very hard—as the task of remembering the many initials and of forming the letters was taxing his limited intelligence to the utmost. The episode lasted for approximately 20 minutes, until the end of the session. The next day, however, left to himself, Jack broke a number of clay pieces he had made with the student's help. Without continual support, sublimation could not be maintained.

Sublimation and Other Mechanisms of Defense

Faced with anxiety and emotional turbulence, the ego is likely to mobilize a variety of defenses. Thus, more often than not, sublimation emerges in conjunction with other defensive mechanisms.

Eight-year-old Kenny had sustained second-degree burns on his back, neck, and hands, requiring plastic surgery. A fire had broken out while his mother had absented herself from home for two days, leaving him and his two younger siblings unattended. She was subsequently charged with criminal neglect. After his physical recovery, Kenny was admitted to the child psychiatric ward for observation. An art therapy evaluation session was held as part of the psychological workup.

The session was conducted by the ward's art therapist, whom Kenny had met previously. Also present was an art therapy student, a newcomer. When Kenny perceived a bright-red birthmark on this student's cheek, he was visibly upset and commented on her "ugly scar." When asked to make a drawing, he immediately set out to draw the student's portrait. Observing her intensely, he produced a figure, paying special attention to the detailed rendering of her spectacles and her birthmark. As he drew, he became visibly calmer. Faced with a frightening reminder of his own stigmatized condition, he had at first responded by projection: "Not I, but the *student* is ugly." However, as he began drawing, healthier defenses came into play. Changing passive into active by creating her image, he had also found a way of keeping a watchful eye on this dangerous individual. By keeping himself busy drawing, he managed to look at her without being overwhelmed by anxiety and revulsion. The mature and detailed drawing that resulted testified to considerable ego strength.

However, when Kenny was introduced to clay, he regressed. Smearing and smelling the unfamiliar substance, he dropped it on the floor, yelling: "The floor is bad. It made the doo-doo fall." The intensity and irrationality of his protests signaled the necessity for intervention. Demonstrating that clay had other possibilities, the art therapist attracted Kenny's attention by modeling a clay figure of a little boy. Kenny soon began to play with the figure. Placing him on a clay bed, he declared that the boy was "bad because he peed in bed" (Kenny was enuretic). This led to a discussion of both the clay-boy's and Kenny's own feelings about not being able to control his urination. Hope was expressed that the doctors would be able to help.

The clay-boy safely at rest, Kenny resumed modeling. Pounding out a flat pancake shape and producing a number of clay balls, he discovered that he could make an apple tree by adding a trunk. When he was encouraged to paint his tree with tempera paints,¹ he became deeply concerned about the choice of colors. "Apples are red," he mused, "but aren't they brown sometimes?" Kenny asserted that he would have no brown apples because "it would mean they are wormy." Furthermore, he declared that he would use neither brown nor black paint on his tree because they were "bad" colors. He was overjoyed when he discovered that he could make a brilliantly bright green by mixing turquoise blue and yellow, and he initially painted the whole tree including the trunk with this green, while all the apples were painted red. But the result did not satisfy him. He found that black would be a better color for a realistic trunk. He also discovered that he had forgotten to make stems for his apples. He added stems and painted them brown, declaring, "They can be brown but not the apples." The finished work with the stems not attached to the tree resembled a long-handled frying pan holding apples. Kenny was delighted.

The clay brought forth both Kenny's most disturbed and his most mature and healthy functioning. The material's anal connotations led initially to massive regression and loss of reality testing. But when the possibility of forming the clay into symbolic objects was demonstrated, Kenny could respond to the invitation to enact his trouble in symbolic play rather than via delusional behavior. Symbolic play enabled him to ventilate anxiety and obtain reassurance. This sufficed to inspire him to the creation of a good apple tree. Initially, he attempted to rigidly separate good from bad, rejecting brown and black as "bad" colors. He was about to constrict and impoverish his range of action. However, he transcended the inclination to resort to splitting. Instead, he found a way to integrate the colors in a realistic fashion and still create a good apple tree. Sublimation was attained.

The session, however, did not end with this victory, for Kenny was next asked to use the tempera paints to make a picture. Quickly dipping his brush into the black paint, he produced a simple version of his first pencil portrait of the art therapy student and wrote her name above it. But when he used red paint to fill in her scar, he suddenly burst into tears. Covering up her name, he replaced it with his own, exclaiming, "I am ugly, my

face is ugly, and that's why I want to kill myself." Then, with black paint he added a large stop sign to the picture.

The desperate message naturally required a direct response. Since the art therapist knew of Kenny's ongoing psychotherapy, she could reassure him by reminding him that his doctor was there to help him with his feelings, and by pointing out that he had been able to paint a powerful stop sign, to remind himself that he wanted to get over these dangerous feelings.

The session ended on a hopeful note, as Kenny checked on his apple tree and reassured himself that it would be kept safely—a gesture that confirms that the brief episode of healthy symbolic living had been precious to him, even though sublimation alone had not sufficed to stave off the upsurge of suicidal ideation. Indeed, inasmuch as sublimation tends to reduce the power of rigid defenses, it might have contributed to it. Faced with the full impact of his despair, Kenny had needed to resort to a stark, prohibitive command borrowed from the outside world of law and order. This measure was nevertheless healthier than his initial projection and splitting. Thus, the undisguised communication of his despair opened the way to effective psychotherapy, while the completed apple tree gave hope for continued and fruitful art therapy. More often than not, art therapy and psychotherapy complement each other in such a manner.

Projection, Pornography, and Sublimation

Twelve-year-old Gordon, an ardent and gifted painter, and his friend, John, shared an art therapy session. In the course of the session, the two boys embarked on a bout of so-called slipping or playing the dozens, a ritual of mutual insult where each boy accuses the other's mother and grandmother of every conceivable and inconceivable kind of sexual perversion and promiscuity.

The exchange of vituperation constitutes a conventional social pattern among slum children, whose mothers are in fact promiscuous. It can be embellished with all sorts of colorful inventions, but the crowning insult remains the disdainful declaration "You don't even have no mother." Both partners to the abusive exchange get relief through projection. The child could not possibly accuse his own mother of desertion and immorality, but he can freely accuse another child's mother and have the accusation thrown back at him. Such loaded banter may remain playful among friends, but more often it ends up in a fistfight.

This time peace prevailed. While insults were passed back and forth almost mechanically, Gordon began a large painting of Moby Dick ([Fig. 5.1](#); its actual size is 11 × 4 feet). The subject gave occasion for additional obscenity over the double meaning of the word "dick." One might expect that a painting created while such talk was in the air would at best be crudely obscene. Instead, there emerged a powerful, beautifully executed image of evil, which comes close to embodying the symbolic meaning of Melville's masterpiece.



[Figure 5.1](#)

The white whale is floating on the surface of a light-blue sea, spouting a blue jet of water. The sky is indicated by loose blue brush strokes. The whale's body is painted in subtle shades of gray, with dark-gray accents. The light, silvery atmosphere of the painting contrasts sharply with the whale's evil expression. His mouth is open in a crooked sneer, baring a dark-red cavity surrounded by sharp, white teeth. There is a sly, evil look in his small, black eye. The whole body conveys a feeling of nakedness.

The sexual symbolism of the painting is obvious. We see a composite of male and female elements. The whole whale can be interpreted as one gigantic penis, conceived as a dangerous weapon with teeth. The whale's mouth, on the other hand, can also be interpreted as a vagina dentata, devouring the male organ. The whale as a whole also recalls a woman's body, with the forked tail standing for her thighs and vulva. Most striking are the proportions, roughly 3:8, an unusual, extravagant length suitable for the whale, which indeed fills the paper completely. Equally impressive is the painting's tactile quality. This whale is no decorative symbol; it is a three-dimensional, living thing.

Gordon had been intensely absorbed as he painted the whale's body. Again and again, he brushed over its surface adding more and more subtle shading. Although his way of painting was reminiscent of masturbation, it did not become obsessive or purely repetitive. Gordon never lost command over paint and brush; he knew what he was doing and when to stop. He was proud of the completed painting, and his friend and slipping partner was filled with admiration. The session ended in a spirit of contentment.

If we compare the meaning of the talk that had accompanied the making of Moby Dick with the symbolic meaning of the painting, we find that they both relate to the same painful situation: the boys' unfulfilled longing for mother, their rage over her unfaithfulness, shame over her behavior, and guilt and shame over their

own degraded desires and fantasies.

On the surface this all seems to be expressed more directly in the boys' talk. "Your mother," it implies, "is promiscuous. She is indeed no mother at all; furthermore, you, her son, are ready to degrade her by attacking her sexually." When we listen closely to the merciless words, we find that the abuse is quite impersonal, uttered so mechanically that it becomes meaningless. Talk circles endlessly around the boys' more profound longing and grief, but it brings no insight or relief. The longing for mother is denied, drowned in the flood of mutual abuse.

When Gordon painted a gigantic image, half fish, half mammal, frightening, fascinating, and unfathomable, he created it out of the same ambivalent feelings, the same fears and pressures that drove him and his schoolmates to relentless vituperation, threats, and fights, but he was no longer obsessed, forced to repeat stereotyped behavior with no will of his own. By finding a symbol that transposed his conflicts from the narrow confines of his life into the wider world of imagination and adventure, he freed himself from meaningless repetition. Painting did not alter the nature of his trouble. He was too deeply injured to make an image of goodness. He could only make a monstrous composite of love and hate, male and female, but in making it he had ceased, at least for the duration of the creative act, to be the helpless victim of his conflicts.

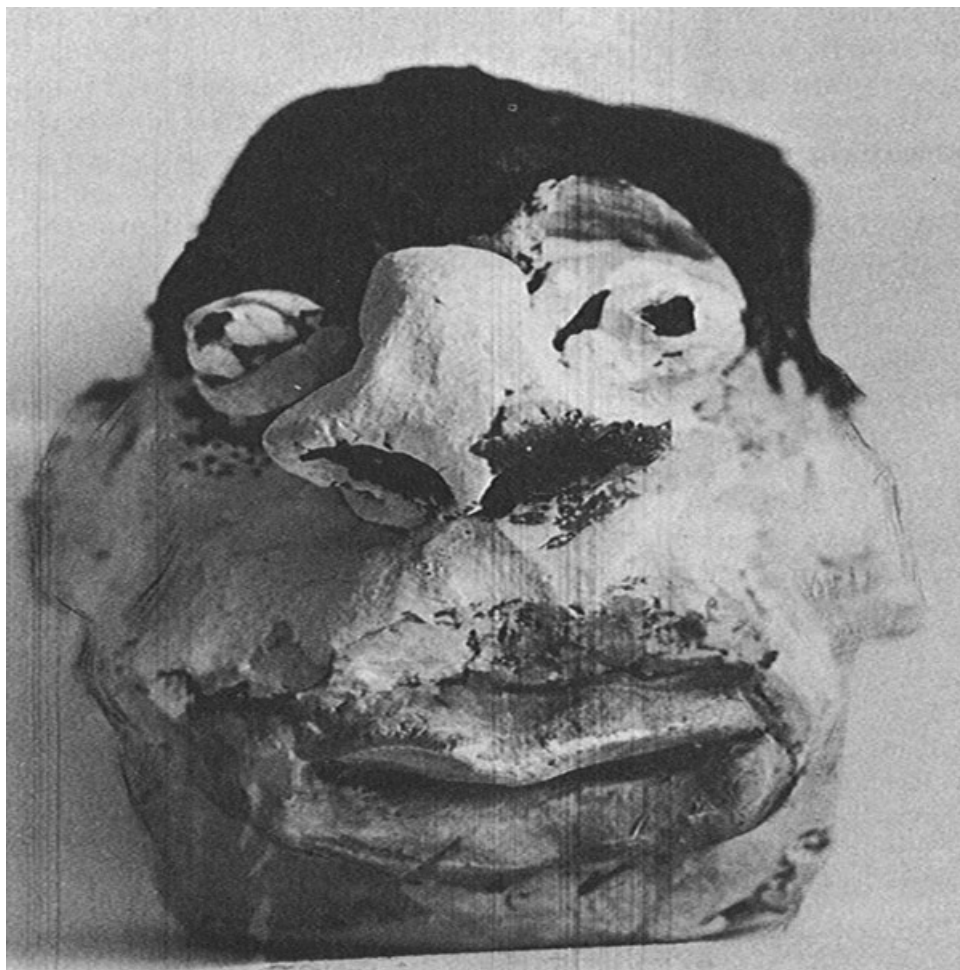
The serendipitous event could not have occurred without the many preceding art therapy sessions during which Gordon discovered his gift and learned to trust himself and to have confidence in the art therapist. During the crucial session the art therapist did not need to intervene. At this juncture her tolerance for the obscene banter and her supportive presence sufficed to establish an atmosphere in which the painting could materialize.

Displacement and Sublimation

In my next example, we can observe the transition from displacement to sublimation. Twelve-year-old Donald, a bright, emotionally troubled child, suffered a psychotic breakdown triggered by a minor operation on his genitals. During one period of his acute illness, he developed an obsessive interest in noses. It became his ambition to learn to sculpt “a perfect human nose.” During many art therapy sessions he modeled nothing but noses.

Later he tried to sculpt human heads. At first they all looked alike, a huge nose dominating a rudimentary face ([Fig. 5.2](#)). He became quite distressed by this repetition. He could see very well that people had different faces and noses, but try as he might, he could only make the same nose and the same face over and over again. Finally, he made up his mind to get out of this impasse by devoting himself seriously to making a self-portrait in a more adult manner.

He was taught how to build an armature of wood and plaster and how to apply the clay systematically around this solid core. Built in this manner, the finished sculpture could be cut into halves, detached from its armature, reassembled, fired in a kiln, and finally painted with poster paint. To look at himself, Donald used a reversible shaving mirror with both an enlarging and reducing side. That by simply reversing the sides he could get very close to his face or move further away was endlessly fascinating to him. It seemed to help him to establish the right distance from himself and to perceive himself as a whole. When the sculpture had been fired, Donald spent much time carefully mixing the colors for skin, hair, eyes, mouth, and sweatshirt to match his own ([Fig. 5.3](#)). The sculpture marked a turning point in both his self-perception and his perception of others. He blossomed into a sensitive portraitist able to produce excellent self-portraits in charcoal. This dramatic increase of energy and heightened productivity constitutes one of the hallmarks of sublimation.



[Figure 5.2](#)

Only a short time before, any complex procedure in making sculpture would have been beyond Donald's capacities. He could have used a shaving mirror only for endlessly repetitive play—casting light reflections on walls or making the world larger or smaller at will. It was essential that material, tools, and instruction in using them were available when Donald emerged from his withdrawn and fragmented state. At this juncture the workmanlike logic of building a substantial sculpture in clay paralleled and confirmed the psychic process of reintegration. Moving further away and closer could be practiced, in order to study detail and totality, with the aim of achieving unity. We see in Donald's story the difference between symptom and sublimation, but we also see how closely linked these two may be, and how inextricably they may at times be intertwined.



[Figure 5.3](#)

Sublimation Achieved

The understanding of the process of sublimation is as important in working with adults as it is in art therapy with children. When Carmine Lombardi, a gifted self-taught artist, had conquered his dependency on drugs and alcohol, he became engrossed in sculpting a huge teardrop in marble. Many mishaps occurred. The stone cracked, the shape had to be modified. Somehow the piece resisted completion.

At this juncture art therapist Vera Zilzer suggested that he go out and draw all the trees of his native South Bronx. A large collection of exquisitely composed drawings resulted. They celebrated the impressive ruins of early twentieth-century architecture as it persisted among the rubble and the irrepressive growth of weeds, flowers, and Ailanthus trees ([Fig. 5.4](#)). Lombardi had neither been encouraged to immerse himself continuously in his grief, nor to escape the tragedy of his environment. Rather, he had been inspired both by works and by example (Vera Zilzer was an excellent artist and thus a suitable object of identification) to integrate his past and present: his inner world and his external situation. Lombardi's work became a source of pride to the community. The process of sublimation initiated in this series of drawings provided energy for artwork of ever broadening scope.

Conclusion

The art therapist's attitude toward the concept of sublimation must fundamentally influence both practice and theoretical outlook. Art therapists who recognize in it a powerful source of energy will approach their task differently from those who perceive it as little more than icing on the cake. Sublimation cannot be planned or plotted. All we can do is establish an atmosphere wherein the group of processes of which it is born can unfold.

The prototype of this situation has been beautifully described by Winnicott (1965) as one in which the child is in contact with a mother who is benignly available but not at all intrusive. Because the child can be calmly certain of her continued availability, the infant reaches a state of relaxed tension. Experiences belonging to the realm of impulsive, instinctual living, or, to use Winnicott's term, *id experiences*, can occur within the framework of a relationship anchored in the ego, rather than arising from the id, serene rather than passionate. Instead of being overwhelmed, the ego is strengthened by the experience.

Such processes are characterized by a benign contact with the primitive mind that enriches and energizes the ego. Repressions are lifted and older modes of functioning activated. Ideas and memories belonging to the ego's realm are briefly subjected to the mechanisms of primary-process thinking. To be beneficial rather than destructive, this dipping into the domain of the id must occur when the individual is able to resist the pull toward permanent regression, so that even though prelogical primary process thinking prevails and ancient libidinal and aggressive strivings are reactivated, the ego continues to function on a mature level. If all goes well, this brings about new maturational spurts. Ernst Kris, who in 1952 described these processes from a psychoanalytic viewpoint, coined the term "regression in the service of the ego," while Silvano Arieti (1976) suggested the term "tertiary process" for this creative synthesis. However, we must be aware of the risk entailed, for if the ego should be unable to withstand the pressures arising from the id, there may be regression in the pathological sense.



[Figure 5.4](#)

Undoubtedly, the companionable solitude that Winnicott describes in terms of psychoanalytic understanding constitutes the ideal situation for producing art or for vicariously experiencing it. In the practice of art therapy, we must frequently be much more active than the mother Winnicott envisions. At times we must directly participate in the patient's creative efforts. At other times, we may be the first to provide the essential catalyst that had been missing in the patients' lives, Kohut's (1966) "gleam in the mother's eye" encouraging ego functioning. As we strive to libidinize the creative process, we must nevertheless maintain a balance between ego support and respect for the patient's need for unmolested introspection. We must remember that only what emerges within an ambience of supportive, but nonintrusive contact can feel real to the person who brings it forth. Enforced productions or information obtained through coercion can rarely be fully assimilated, and has no lasting effect on the individual's life.

Neither intrapsychic conflict nor the conflict between man's drives and the demands of the environment permit final solutions. Sublimation in art remains a continuous task, but one that never becomes stale or empty, as does the repetition born of emotional deadlock. Rather, each new endeavor constitutes a fresh beginning leading to another partial solution so that, if all goes well, each new work becomes more powerful and interesting than the preceding one.

Is there any difference between art and other forms of sublimation? The contemplation of all outstanding feats of sublimation can inspire feelings that are similar to those evoked by works of art. When we admire a bridge, a beautiful carpet, a precision instrument, a heroic deed, a mathematical equation, or any other valuable achievement, it is not only its usefulness that evokes admiration. All of us have experienced the difficulties of taming the instincts, of building ego structure, of becoming human. Therefore, we can experience something of the struggle and of the triumph of sublimation even when we do not personally benefit from its results and when we have no technical understanding of the specific difficulties that had to be surmounted. Most products of sublimation, however, are in themselves emotionally neutral, even though they arouse aesthetic pleasure or even inspire awe.

Art, on the other hand, retells the story of transformation; it offers primarily the pleasure of witnessing the process. Art's value to society consists in stimulating sublimation and influencing its direction. Artist and audience travel together in two directions, from the primitive source of the creative impulse toward its final form, and again from the contemplation of form to the depth of complex, contradictory, and primitive emotions. In this adventure conscious, preconscious, and unconscious processes complement each other. It is thus probable that affect, which is contained but not neutralized, is essential to art, whereas other forms of sublimation would be disrupted by similar quantities of raw libidinal or aggressive drive energies.

The art therapist who sees in sublimation a process essential to emotional health will want to shield it from untimely interference, and this will influence the nature and timing of therapeutic intervention. In work with the severely disturbed and the retarded, much depends on the art therapist's perception of the boundaries of sublimation and of the role of precursory activities. The theoretical orientation presented in this paper encourages a search for the vestiges of sublimation even where, in the full sense, it is out of reach.

As we recognize its powers we must guard against any starry-eyed belief in salvation through sublimation, and we must avoid oversimplification. We must remember that art and sublimation are not identical. Art serves a great many purposes, both in the life of individuals and in the cultural and practical lives of peoples, all of them likely to become the art therapist's concern. Kenny's story is a good example of the many functions art therapy may serve within the confines of a single session. Premature insistence on sublimation in the face of other pressing needs can be as destructive as failure to recognize its value.

Note

- ¹ Ordinarily, children would have to wait until their sculptures have been fired before painting them. But since the choice of color often yields important information about the emotional meaning of the sculpture, an exception is made during the first evaluation session, and the child is encouraged to paint the wet clay.

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Addendum—Sublimation

Elizabeth Stone

Edith Kramer's landmark chapter describing the vicissitudes of sublimation and its application to art therapy stands as a veritable cornerstone in our literature, timelessly spanning the roots of art therapy understanding to its contemporary practice. Kramer championed sublimation as the central underlying mechanism in her therapeutic approach (Kramer, 1958, 2000, 2001) at a time in the mid-twentieth century when this concept occupied a particularly elevated position among psychoanalysts. Originally introduced as one of the crown jewels of Freud's metapsychology, sublimation had actually appeared in his work from the time of his earliest writings (Freud, 1892, 1914, 1923).

Psychoanalysts over the years have continued to elaborate this concept in accord with the new pathways steadily generated within psychoanalytic theory. The concept of sublimation was and remains indispensable as part and parcel of the lifeblood of ego psychology. Heinz Hartmann, a leading pioneer of ego psychology, recognized the role of adaptation in the maintenance of psychic health (Hartmann, 1958) in which sublimation featured prominently. Indeed, ever since, there has been energetic debate about sublimation from staunch proponents (Loewald, 1988) to those who have debunked it (Fogel, 1991, p. 251; Schafer, 1975), yet no concept has ever adequately replaced the rigor of understanding about the role of creativity in the development of psychic structure. This brief essay shall highlight several implications of Edith's chapter in regard to the evolution of psychoanalytic thinking over the years.

Given its historical context, there has been no better or more coherent explanation of how exceptional artwork can come into being than through the concept of sublimation as described by Edith Kramer. The introduction of this theoretical link aided enormously in professionalizing art therapy in the eyes of the psychoanalytic community because art therapy could be seen as freed from art teaching, while remaining consistent with therapeutic objectives. The reflections of art therapists could be valued in consort with those of other allied professionals within the psychiatric treatment team.

Edith's application of sublimation to the art therapy process and product fit in aptly with its time in explaining the kind of internal psychic transformative process that can take place using art materials with individuals of extremely impaired functioning and with fragile ego structures in varying states of dissolution. Kramer reminds us of the complex intrapsychic mechanisms involved in the creative process that promote multitudinous degrees of satisfactory healing experiences. Differentiation among these mechanisms (displacement and other defensive maneuvers) has remained essential to deepening the clinician's comprehension of the individual's therapeutic experience. The extent to which sublimation and other processes are operative aids in the assessment of ego strength, yet the ability to use the therapeutic working alliance must also be seen as a decisive assessment factor, as will be further explicated here.

Through the clarity of Kramer's cogent writing, sublimation became firmly embedded within general art therapy theory. Edith expressly conceived of the art therapist's role as involving carefully timed therapeutic interventions in order to shield the sublimation process from inopportune interference, such as externally imposed directives, in spite of clearly understanding that we have no such control over intrapsychic processes of the mind. While a seeming contradiction, being able to hold two (or more) dissimilar and even opposing concepts in mind is essential for a therapist's capacity for reflection. That very shield that Edith described also protects the inchoate creative process's flourishing within the maelstrom of psychic disorganization so that the individual can experience a modicum of pleasure, thus encouraging the continuation of this often-arduous effort.

In short, Kramer aimed to protect ego strength and emotional health (Kramer, 2001) in order to permit the "therapeutic self" to unfold within the art therapy experience. This psychic positioning by the art therapist can be seen as a precursor to today's emphasis upon resilience and the positive psychology movement.

Just as Freud frequently permeated his writings with hints of concepts yet to be developed by succeeding

disciples, Kramer's writing, too, contains nascent concepts. One well-known example from the literature of Freud is that the theory of object relations was developed after Freud's death, but seeds of object relations theory can be found in his early writings, for example, in "Mourning and Melancholia" (Freud, 1917). The nuclei of what we can argue is the role of object relations can be found in Edith's writing, and even embedded within her notion of sublimation.

Kramer downplayed the power of the therapeutic relationship while undoubtedly recognizing the importance of the art therapist's supportive stance, and the benign non-intrusive climate necessarily generated. Today we argue for the centrality of the relationship in bringing about therapeutic change and even sublimation in art therapy. We conceptualize the art therapist's capacity to therapeutically *contain* and *foster a* sense of authenticity, where the patient can feel truly "held" (Winnicott, 1965). This holding provides the basis of the patient's freedom to express the kind of imagery that might never have otherwise come into being. It is within the context of relatedness that the patient's ego functions are quickened to muster whatever ego strength is available to create or pull together imagery steeped in meaning and transform it from its unformed, unimagined raw state.

Kramer affirmed the art therapist's benign supportive stance as essential and pleaded for the necessity of sometimes going further to offer direct help when needed. She described the non-intrusive contemplative atmosphere essential for self-reflection and affect to flourish. She also wrote that "At other times we may be the first to provide the essential catalyst that had been missing in the patients' lives, Kohut's (1966) 'gleam in the mother's eye' encouraging ego functioning." This gleam not only fosters normal ego functioning, but actually becomes central to the entire therapeutic relationship. Without this gleam, sublimation would not stand a chance of gaining traction. We thus now extend Kramer's thinking by arguing that the therapeutic relationship is *central* to the success of art therapy and fundamental to the process of sublimation.

Kramer's story of Jack affords us a brilliant example of how the role of the therapeutic relationship remains pivotal, not only in fostering but actually powering the process of sublimation. She shows us how the loss of the relational connection interrupts creative engagement. When Jack found out that his beloved art therapy intern was to leave, his internal relational world collapsed as he stormed out in a rage. The art therapist stepped in and offered him containment and a temporary "restoration" of an object relationship, even if not with the beloved intern.

The art therapist "transformed" Jack's torn paper from a destructive act into a potential "gift," in the most concrete of terms, thus offering him the possibility of feeling anchored within a new symbolic relationship. At that moment, the art therapist engaged Jack's internal relational world so that he could become calmer, more receptive and thus temporarily reorganized so that he could connect not only with the art therapist but with other patients in the session, giving them his "gifts" of torn paper with their initials. We see how the strength of the relationship at the center of the therapeutic working alliance can function as a containing force against powerful affect that threatens to disorganize and disrupt the internal representational world destroying any possibility for the creative process to take hold.

When Jack was left alone the next day, he broke the clay work that he had made when working with the student before she left. His aloneness revived his loss of her depleting him of internal resources. His affective connection with her and the meaning embodied in their relationship had previously enabled him to function and make clay objects, thus holding him together so that sublimation was possible.

Gordon, too, as Kramer explained, would have been unable to create his magnificent whale without his many preceding art therapy sessions. Previous sessions anchored him firmly within the therapeutic relationship, making the transformational experience possible. His trust in the art therapist, coupled with the confidence he had built up in his own skills, finally permitted him to produce this miracle, in spite of his deep longing for a denigrated and abusive mother, tragically and traumatically unavailable to him.

Edith outlined the ingredients that comprise sublimation as a defense: displacement, identification, symbolization, and so forth. The importance of *identification* cannot be underestimated and is based on the therapeutic engagement with the art therapist. Identification also recalls earlier unconscious positive identifications, even if they are minimal when object ties have been impoverished. Identification stands as an important catalyst in bringing about the transformative process, the sum of which we call sublimation. Idealizing elements, part and parcel of identification, play a crucial role in fostering the sublimation process.

With further advances in contemporary psychoanalytic thinking, our understanding of the internal

ingredients operative in sublimation has now been extended beyond Freud's initial dual drive theory based upon the instincts (Freud, 1920). Recognition that other relational motivational systems are equally valid would not have been possible when Edith outlined her application of sublimation to art therapy. Whereas conflict within the drives had been seen as bedrock, many other aspects of our existence can be seen as being in conflict including affect, trauma, and much more, and benefit from this transformative process.

Today, patterns of relatedness involving expectancies of patterns of self- and interactive regulation (Beebe & Lachmann, 2003), have all but replaced the drives as a way of thinking about object relations and the therapeutic relationship and have been demonstrated in early developmental research (Beebe & Lachmann, 1988, 2002, 2013). We can clearly see that using the notion of expectancies of relatedness in Kramer's beautiful illustration of Jack's traumatic reaction to the loss of his student intern and his subsequent transformation of the torn paper via sublimation is better understood than it would have been using instinct theory.

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6

Variations on a Freudian Theme

Three Art Therapy Theorists

Elinor Ulman

Any particular scientific outlook represents only one possible way of organizing the raw material under consideration [but]...one often gets the impression that one theoretical outlook is the correct one.... one seldom hears acknowledgement that the organizational symbols behind one's outlook are, to some extent, subjectively chosen. We select our conceptual framework not only on the basis of intellectual judgment but also because it is congenial to our way of thinking and because the type of clinical work that follows from it suits our personality. Being aware of this subjectivity...introduces a welcome tentativeness.

Susan Deri

Inspired by the above quotation (Deri, 1984, p. 18), I shall explore the connection between the theoretical ideas and the personal value systems of three writers on art therapy: Margaret Naumburg, Edith Kramer, and myself. By doing so, I hope to promote among art therapists that “tentativeness” that Deri saw as welcome for the analysts she was addressing. All three of us claim intellectual descent from Freud, but differences among us have shaped the development of art therapy in several different directions.

I begin by noting briefly the salient features of Freudian theory that some find congenial and that arouse the misgivings of others. Then I recapitulate some early definitions of art therapy by these three authors. Next, I speculate about personal factors that may have entered into their choice of beliefs. Last, I present case material to illustrate my preferred methods, and to dramatize the complexity of the issues that must be faced when circumstances dictate the choice of any approach to art therapy.

Some Features of Freudian Thinking

What are the key features of the theory that tend to determine people's choice of Freud as a guide to understanding themselves and other people and to shaping therapeutic interventions? Fundamental, I believe, is the concept that *conflict is inherent in the nature of man*. The human need for reconciliation of opposing internal forces has been recognized under many non-Freudian guises. Traditional symbols such as *original sin* give way to Freud's new metaphor—the epic struggle of *ego and id*.

Many people shrink from what they perceive as the harshness of the view that conflict is inborn, preferring to believe against all odds that everyone is born good, but in generation after generation that goodness is somehow distorted by wicked parents or society. (But who made society?) To some of us, however, it seems that recognizing how hard it is to grow up into a good human being makes for a feeling of compassion toward ourselves and others. It is much less discouraging to view one's struggles as one's share of man's fate, than as signs of one's inborn inferiority or victimization on the part of evil parents or society (the collective parents).

Another aspect of Freudian thinking that attracts some as much as it repels others is the concept of *sublimation*. The theory of sublimation postulates that humanity's great achievements—in art, science, and heroic self-sacrifice, as well as more everyday civilized social behavior—are fueled by sexual and aggressive energies. Is the thought that out of the dungheap springs the rose cause for disgust or for amazed admiration? For those who find Freud's thinking congenial, the idea of sublimation does not denigrate the rose on the basis of its humble origin; rather, it recognizes in the rose a testament to a miraculous transformation.

Inner conflict and sublimation are only two facets of Freudian thinking that are understandably rejected by many people. Both can be looked upon as corollaries of Freud's basic discovery: the key role of the *unconscious* in human life. This concept, too, is rejected by many. The thought that one is truly *unaware* of a very important—even powerful—part of oneself is frightening, and therefore not easy to accept. Acceptance entails, among other things, a high tolerance of ambiguity. Insofar as the art therapists we are considering ascribe to Freud's views, we can assume considerable common ground among them, whatever their differences.

Three Theories of Art Therapy

Naumburg

Although both Naumburg and Kramer relied on psychoanalytic insights, the divergence between them (in both practice and theory) tended to widen over time. A knowledgeable friend once remarked that Naumburg took the psychoanalytic patient off the couch and stood him in front of an easel. The consequences of her doing so were far-reaching. In Naumburg's own words, art therapy as she practiced it based

its methods on releasing [the unconscious by means of] spontaneous expression; it has its roots in the transference relation between patient and therapist, and on the encouragement of free association. It is therefore closely allied to psychoanalytic therapy.

(Naumburg, 1958a, p. 516)

Treatment depends...on a continuous effort to obtain [the patient's] own interpretation of [his or] her symbolic designs.... The images produced are a form of communication between patient and therapist; [they] constitute symbolic speech.

(Naumburg, 1958b, p. 561)

Here I want to state parenthetically my opinion that Naumburg's professed application of psychoanalytic techniques in art therapy is not to be taken entirely at face value. In particular, she speaks somewhat loosely of *free association*; what she reports sounds more like *conscious interpretation* by her patients of their art products. They are not asked to make the difficult attempt to abandon censorship of speech that is demanded of the analysand. Likewise, what she terms *transference* often sounds more like a *therapeutic alliance* between herself and a patient.

Naumburg (1958a) cited the advantages of introducing painting and clay modeling into psychoanalytically oriented psychotherapy as follows:

First, it permits the direct expression of dreams, fantasies, and other inner experiences that occur as pictures rather than words. Second, pictured projections of unconscious material escape censorship more easily than do verbal expressions, so that the therapeutic process is speeded up. Third, the productions are durable and unchanging; their content cannot be erased by forgetting, and their authorship is hard to deny.

(p. 512)

Fourth, the resolution of transference is made easier. The autonomy of the patient is encouraged by his growing ability to contribute to the interpretation of his own creations.

(p. 514)

Thus, art is seen as an added ingredient that makes possible an improved and streamlined psychoanalytic procedure; Naumburg viewed art therapy as a *primary* as well as an *adjunctive* form of treatment. The client's experience of the creative process is not even mentioned at this point as a benefit of the kind of art therapy Naumburg had come to advocate. But it was not always so. A decade earlier, she had written:

A vital implication [of] studies...made on children's art expression as an aid to diagnosis and therapy is that imaginative, creative expression is, in itself, a source of growth and sustenance as well as a language of communication in the life of every individual.

(1947/1973, p. 89)

Kramer

Kramer's basic ideas have more in common with those of the earlier than the later Naumburg. Throughout her writings, Kramer finds in art itself the explanation of the art therapist's special contribution to psychotherapy.

She went beyond Freud himself in her use of “the insights of Freudian ego psychology to elucidate the problem of quality in art” (Kramer & Ulman, 1977, p. 22), but her understanding of the healing quality inherent in the creative process is firmly based in Freudian personality theory. In an early formulation (1958) she described art as “a means of widening the range of human experiences by creating equivalents for such experiences” (p. 8). Using these equivalents the artist can choose, vary, and repeat what experiences he will. He can reexperience, resolve, and integrate conflict. Throughout history “the arts have helped man to reconcile the eternal conflict between the individual’s instinctual urges and the demands of society” (p. 6). But the conflicting demands of superego and id cannot be permanently reconciled. The art therapist makes creative experiences available to disturbed persons in the service of total personality. He must use “methods compatible with the inner laws of artistic creation” (p. 6).

Three of Naumburg’s four books on art therapy had already appeared when Kramer published her first book in 1958. Later, practices stemming from Naumburg’s “dynamically oriented art therapy” (the title of her last book, 1966) came to be known as *art psychotherapy*, and Kramer herself coined the phrase *art as therapy* to define her work (1971). When I began to work on my own definition of art therapy in 1961, these terms were not yet current, but I will use them retroactively in discussing later developments.

Ulman

It is almost a half century since my first attempt to define art therapy so as to encompass *both* art psychotherapy and art as therapy. In 1961, I stated my belief that “the realm of art therapy should be so charted as to accommodate endeavors where neither the term art nor the term therapy is stretched so far as to have no real meaning...” (p. 19). I designated

therapeutic procedures as those designed to assist favorable changes in personality or in living that will outlast the session itself...Therefore, specialized learning that leaves the core of the personality untouched is not part of therapy.... The art therapist often must tolerate defensive or escapist uses of art materials but this is never his goal.

(p. 19)

I then offered a very condensed definition of *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....

The proportions of art and of therapy in art therapy may vary within a wide range. The completion of the artistic process may at times be sacrificed to more immediate goals. Stereotyped, compulsive work used to ward off dangerous emotions must sometimes be permitted. Communication and insight may take priority over development of art expression. On the other hand, where no fruitful consolidation of insight can be foreseen, the exposure of conflicts may be deliberately avoided in favor of artistic achievement.

(p. 20)

Discussion

In the 1950s, it was relatively easy for both Naumburg and Kramer to assert that their own views and procedures represented all that art therapy was or ought to be. But as early as 1961, when I first put forward what was intended as a comprehensive definition of art therapy, it seemed clear that no discussion of psychoanalytically based art therapy could afford to ignore the divergent ideas of both these thinkers.

Although both leaned heavily on Freudian personality theory as the basis for understanding people's psychological needs, they saw its implications for the *practice of art therapy* quite differently. Kramer subscribed more fully to Freudian *principles*, but it was Naumburg who emulated the psychoanalyst's *techniques*. Kramer developed her own methods of eliciting the most effective possible art, in the name of therapeutic gains for her young clients.

Subjective Factors in the Development of Theory

What personal attitudes are likely to have played a part, not only in their general choice of Freudian views, but also in their development of art therapy theory on the basis of those views?

Contrasts between Naumburg and Kramer

Naumburg, born in 1890, grew up in New York, where her immigrant father had become a successful businessman. Her parents were of their time, and it was left to Margaret's generation to rebel against the rigid conventionality of their late nineteenth century beginnings. Perhaps this accounts for the embattled quality of her writings. In both her early career as an educator and her later career as a therapist, she tilted against the establishment, whether academic or psychiatric (Frank in Detre et al., 1983, p. 114).

Naumburg's education and experience seem to have inclined her toward eclecticism. She was a critical thinker who made her own synthesis of ideas from various sources, not an idea-hopper flitting from one theoretical notion to another. Perhaps it was just chance that Naumburg's first experience with personal analysis was with a Jungian; Jungian ideas were certainly important in her early thinking about art therapy (Naumburg, 1950, pp. 15–34). She later undertook treatment with a Freudian psychoanalyst, and it was largely from Freudian sources that she subsequently derived her techniques: associative work, attention to transference, and the liberation of repressed material. In fact, she acknowledged primary indebtedness to Freud, Jung, and Harry Stack Sullivan (Frank in Detre et al., 1983, p. 114; Naumburg, 1953, p. 3).

Kramer was born about a quarter of a century after Naumburg. Her early years were spent in pre-Anschluss Vienna. Many members of her family and their friends were in the arts. Her parents were unconventional people who had rebelled against their own families' middle-class values. Some of their associates were the younger members of Freud's early circle, so she was familiar with psychoanalysts and their ideas, and her own analysis was along orthodox lines. While she is open to theoretical developments springing from ego psychology, Kramer has never subscribed to any school of thought that repudiated Freud's teaching.

An important key to the ideas of Kramer and Naumburg lies in the place held by *art* in the life of each. Kramer is first and foremost an artist; painting has been the abiding passion of her entire life. Small wonder, then, that artistic sublimation, which has been such an important reward of her lifework, should be the cornerstone of her beliefs about how art therapy works. Her primary commitment to art also made her happy with being an *adjunctive* therapist, for unlike a primary therapist, this left her free to devote 4 out of every 12 months exclusively to painting. (Some adherents of Kramer's general thinking do not agree with her view that art as therapy cannot stand alone as a primary form of treatment.)

Naumburg knew a great deal about art and art history, and her responses to the art of her own time were knowledgeable and sensitive (Frank in Detre et al., pp. 112–113). Also, she undoubtedly learned much from observing the work of her sister, Florence Cane, at the Walden School (Cane, 1951/1983). Thus, she was able to introduce the teaching of art into her work as a therapist when appropriate (Naumburg, 1966, p. 131). She also recognized that art therapy often enhanced the quality of a patient's art, because it released the same unconscious forces operative in all art (Naumburg, 1953, p. 7). Most of the illustrations she chose for her publications are expressive artworks—far from the impoverished stick figures that sometimes suffice (or are encouraged) in art psychotherapy.

Despite Naumburg's understanding of art, her primary identity was not that of an artist. She has been described as "an educator who became a psychologist and an art therapist" (Kniazze in Detre et al., 1983, p. 115). Naumburg came to view art therapy as an independent mode of treatment that offered numerous advantages over the "talking cure," where treatment depended entirely on verbal exchange. In her later years, she yearned for recognition as a psychotherapist, especially in psychoanalytic circles. The role of *primary* therapist, with its implied responsibility 365 days a year, suited her to a tee, for *art therapy* was central to her life.

Ulman's Background

My own personal history and inclinations were likewise influential in the development of my beliefs about art

therapy. I am about five years older than Edith Kramer, and we entered the art therapy field at about the same time. I grew up in Baltimore. My parents were middle-class liberals, and most of their associates were teachers and professional people. I was the first member of the immediate family to become an artist; painting was my first profession and my main occupation for about eight years. In 1966, explaining my emphasis on particular aspects of art therapy, I wrote, "When I started working in a psychiatric clinic in the early 1950s, I envisioned myself as a potential art *teacher*, not as an art *therapist*" (p. 9, emphasis in original).

I add today that my landing in a psychiatric setting at all was fortuitous. I was an artist but, having become blocked in my painting, was earning my living in other ways. Homesick for the world of art and artists, I looked for a career with a legitimate relation to art, even if unable to resume being a painter myself. I went on (in 1966) to say the following:

Guided by the new approaches to art education enunciated by such writers as Florence Cane (1951) and H. Schaefer-Simmern (1948), I wanted to be the kind of art teacher I wished I had had. Naumburg stood alone at that time as a spokesman of psychoanalytically oriented art therapy. I did not feel qualified to follow in her footsteps, but was pleased and excited when some of the clinic patients led me a little way along that road. A much larger number of my patients, however, did not try to translate the symbolic content of their pictures into words, yet it seemed to me that they too were getting something valuable from their work in art that nothing else could supply.... It was eight years later that Edith Kramer's book *Art Therapy in a Children's Community* [1958] was published.... Kramer analyzed from the vantage point of Freudian theory the place of the arts in the emotional economy both of the individual and of society. The subtle relationships between psychoanalytic and artistic insights began to come clear to me, and I was provided with theoretical backing for my unarticulated feeling that my functioning as an artist-teacher and an art therapist were not so far apart.

(p. 9)

At this point I need to mention other personal factors that have helped determine my thinking. First, I had entered analysis shortly before my first foray into art therapy. The three analysts I eventually saw, though to varying degrees unorthodox, gave their primary allegiance to Freud. Certainly, my hours on the couch were not devoted to the discussion of rival psychological theories or philosophies of life, but it seems likely that my analysts' attitudes exerted influence in my eventual adoption of a generally Freudian outlook.

Second, though I drifted into art therapy specifically because I was a frustrated painter, I am as much a word person as a visual person. My talent and taste for literary expression are at least equal to my talent and taste for the visual arts. I found the world of verbal psychotherapy fascinating and wanted to develop an understanding of art therapy that embraced Naumburg's ideas as well as Kramer's.

Having welcomed Kramer's exposition of the psychological and social functions of art, I made my own formulations concerning the place of the arts in human development (1971, p. 93):

In the terminology of Susanne Langer, the business of the arts is to give form to feeling, and this is the basic method whereby man creates his world. Every child needs to be an artist insofar as he must find a means to conceive himself and the world around him and to establish a relation between the two.... But the task does not end with childhood, and the arts serve throughout life as the meeting ground of the inner and outer worlds.

Later, I elaborated further on the same theme:

Cultural history and the developmental history of each human being alike bear witness to a universal inclination toward the arts as a means of reconciling two conflicting demands: the need for emotional release and the need to discover order and impose organization.... The artistic process calls on the widest range of human capacities. Like maturation in general it demands the integration of many inescapably conflicting elements, among them impulse and control, aggression and love, feeling and thinking, fantasy and reality, the unconscious and the conscious.... The function of the arts has been explored in terms of numerous theories.... The common thread uniting these many views is recognition of the inherently integrative character of the arts, that is their power to unite opposing forces within the personality and to help reconcile the needs of the individual with the demands of the outside world....

True mastery of life's tasks depends upon a disciplined freedom, whose model may be found in the artistic process.

(1977, p. 14)

Since I came to art therapy from my own experience with art, it is no surprise that my enthusiasm for *art as therapy* happens—for this very personal reason—to be greater than my enthusiasm for *art psychotherapy*. However, I recognize the validity of both applications of psychoanalytic theory to art therapy practice. Art psychotherapy and art as therapy can exist side by side in the same room at the same time, or in the work of the same therapist at different times. In my own life as a clinician I moved between the two, using art as therapy where I could and shifting to art psychotherapy where the situation seemed to call for it.

Art as Therapy with Adults

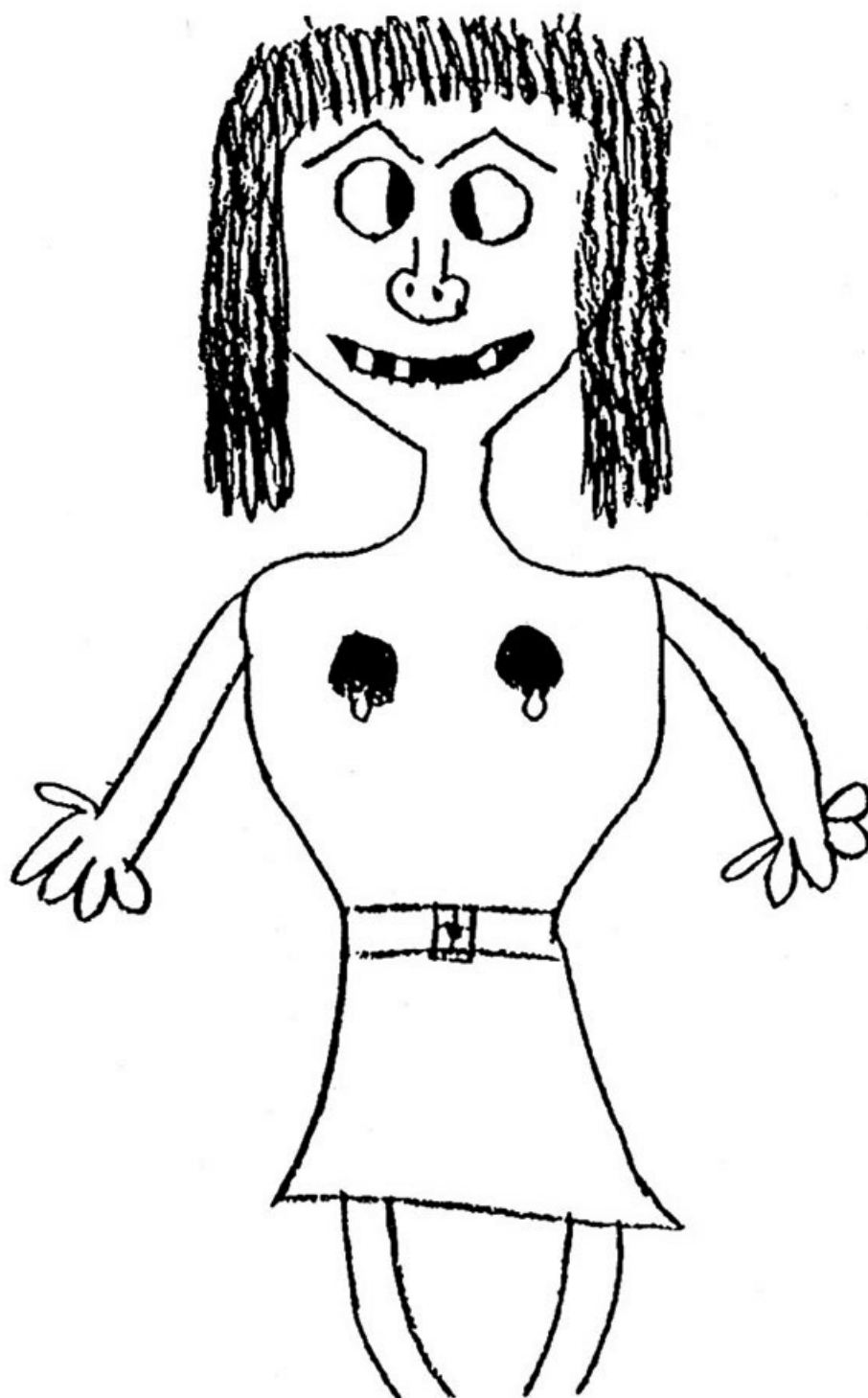
The following two case vignettes are intended to make clear what I mean by art as therapy, and why I have found so much satisfaction in it.

Mary

Mary readily became interested in using art materials. She had no extraordinary aptitude for art, very little formal education, and showed no signs of unusual intelligence or verbal skill. She had lived on a farm her first few years, then had grown up in an orphanage. She was in her late 20s when I met her in the psychiatric ward of a general hospital. She had been diagnosed as a paranoid schizophrenic, but soon after admission, her more florid symptoms abated. [Figure 6.1](#), however, suggests the severity of her illness. In it we sense the horrifying self-denigration and the violent extremes of her sexual ambivalence.

Other early drawings reflect the childhood stereotypes Mary brought to the renewed experience of using art materials. Like [Fig. 6.1](#), they had an extreme rigidity, a quality she came to recognize and deplore in her art. Gradually, her work became less symptomatic, and took on the decorative charm of folk art. At first proud of these productions, she later disparaged them as “too proportionate,” her term for the stiffness and “hardness” she had come to dislike as much in her work as in her personality.

[Figure 6.2](#) was painted when Mary had been in the group for about three weeks. We were equally excited about it. I took pleasure in her new-found grace, as she stepped back to decide where her picture needed another flower. She joyfully declared, “It’s the first thing I’ve ever done in my life that isn’t *neat!*” She went on to talk of her restaurant job: how she and the other waitresses drove each other frantic, because she went into a tailspin if the salts and peppers she’d arranged a certain way were moved around.



[Figure 6.1](#)



[Figure 6.2](#)

Mary developed pride in the originality of the many pictures she made without any models or assistance from me. At first, she begged me to do her work for her, and got very angry at my unwillingness. Then, almost in the same breath, she would accuse me of not letting her do anything her own way. Now she was sorry that her brutal ex-husband wasn't around to see her artwork. "He never thought I could do *anything*...He took my mind away from me. But it started in the orphanage. In the orphanage everything was thought for us, even time. I have no meaning of time."

Through art, Mary caught a glimpse of her own worth and capability. The flower picture taught her, too, that she could relinquish her obsessive-compulsive defenses without precipitating disaster. Instead, the free play of feeling, controlled and channeled into her art, allowed her to function more effectively than she ever had before.

Mary's pictures suggest another sacrifice we sometimes make when we opt for art as therapy. The closer the work comes to art, the less its diagnostic value is likely to be. "Bad art always invites speculation about the artist and good art never does" (Kramer & Ulman, 1977, p. 21). Mary's early work, as shown in [Figure 6.1](#), is a raw, easy-to-decipher presentation of symptoms. [Figure 6.2](#), on the other hand, tells no more about her than that, at a given moment, she was able to function fully in artistic terms.

What is true in the small world of art therapy is also true in the larger world of art:

Daydream art, self-serving autobiographical apologies, and unintended revelations of pathology inevitably invite speculation about their authors' problems and motivations. Great art, on the other hand, invites us to think not about its author and his experiences, but about our own experiences and ourselves.... Every great work of art has a life of its own quite separate from the biography of its maker.

(Kramer & Ulman, 1977, p. 21)

Mary's story gives justification to the frequent claim that art can serve the expressive needs of inarticulate people. Janet, on the other hand, was adept in the use of words but used them mainly in the service of defense. Her experience exemplifies the usefulness of art in cutting through the emotional smokescreen some highly verbal people are able to erect.

Janet

Janet's story, like Mary's, exemplifies the aspect of art therapy that depends less on interpretation than on the experience of a special kind of functioning. The artistic process itself is a momentary sample of effective living,

providing an invaluable glimpse into modes of thought and action that have wide application outside the artistic realm. Furthermore, a client may derive potentially useful insights from art experiences neither designed for, nor subjected to, analysis of their symbolic implications.

Janet's work illustrates this kind of therapeutic art experience. She was a pretty, intelligent, young alcoholic woman. Before joining the art therapy group at the clinic where I worked, she had made many attempts to learn about perspective and to discover rules that would help her achieve "correct" graphic representation. She was justifiably dissatisfied with the tight, flat landscape she made on her first visit. She was trying, she said, not to get lost in details, not to be overprecise; as a result, her picture turned out to be at the same time both vague and overworked.

My first intervention was to introduce Janet to rhythmical exercise and scribbling, as a way of searching for more inwardly derived, less conventional imagery (cf. Cane, 1983, pp. 56–80). [Figure 6.3](#) was developed from a scribble, about a month after Janet started attending the art therapy group. The strength, movement, and depth she was now able to achieve constituted an artistic accomplishment. Janet herself translated this into psychological terms, saying, "For the first time I really know what my therapist means when he says I must learn to trust my intuitions." In these words she acknowledged a new experience of inner freedom, and a new awareness of modes of action more effective than her habitual overintellectual attempts at planning and controlling her life.



[Figure 6.3](#)

Janet mentioned that the scribble had suggested to her a dress form, and that she had placed it in her own preferred position, inside a window looking out. She thus spontaneously called attention to symbolic details that identified the figure as a self-image, but the picture's most significant symbolic association was never talked about.

One of Janet's legs had been amputated when she was still a child; her disability dated back to a congenital malformation, and was at the root of many severe problems. Janet and the clinical staff were well aware of these ramifications. Their symbolic expression in the dress form, full of life yet immobilized, impaled on its single peg leg, offered Janet little new insight on a conscious level. It seems likely, however, that Janet's enthusiasm about this esthetically transformed self-representation helped her at an unconscious level to better accept her mutilated state.

In another connection Janet remarked, "I'm all id and superego," and indeed the observation was apt—the id drunken, violent, promiscuous; the superego wearing an Alcoholics Anonymous halo and a mask of sweet devotion to helping others. In her experience with art, Janet found at last and recognized some moments of successful ego functioning.

[Figure 6.4](#) was painted more than a year after the dress form. Its chill and loneliness say something about Janet, but also evoke a similar mood in many others. At a modest level, Janet here achieved the quality of art.

Like many adults, Janet readily translated into words the insights derived from her art experience. Insight often accompanies the changes brought about in adults by art as therapy, even though the therapist has not set insight as a goal. We note that in Janet's case it was the formal qualities of her pictures that spoke back to her, confirming what she had experienced while making them. Subject matter was fairly unimportant.

This kind of spontaneous verbalization of new insights happens frequently with adults who use art as therapy, but is far less likely to occur with children. The line between art as therapy and art psychotherapy is more likely to become blurred with adults than with children.

The Consequences of Therapeutic Choice

Sometimes circumstances other than the needs of a given client dictate the choice between art psychotherapy and art as therapy, and every choice entails a sacrifice of whatever lies along and at the end of the road not taken. Sometimes an art therapist is free to choose within a wide range—a range whose limits are set only by her own capabilities. At other times, choices are limited by other factors, like availability of personnel, money to pay for their time, institutional policies, etc.



[Figure 6.4](#)

Greta

To dramatize the consequences of choice between art as therapy and art psychotherapy, let us consider two

pictures by Greta, a good-looking, sun-tanned, blonde woman in her early 30s. She came to the day hospital where I was working a few hours a week, and was told, in my absence, about an opening in the art group. Greta enthusiastically agreed to the four-week commitment to attendance, the rule that the staff and I had set.

Unfortunately, the staff member who introduced Greta to the various therapeutic activities available did not know enough about either art or art therapy to explain how different this particular group was from a regular art class. In keeping with the nature of the entire program—it consisted of group activities followed by group discussion—and because I was available for very few hours each week, we had arrived at a structure that would make the most of the limited possibilities. At each session, the group agreed on a theme suggested either by me or by one of them. Art work was limited to 45 minutes, after which the pictures were put up and subjected to group discussion. Thus, in setting the stage for art psychotherapy, we had made it very unlikely that art—and hence art as therapy—could flourish.

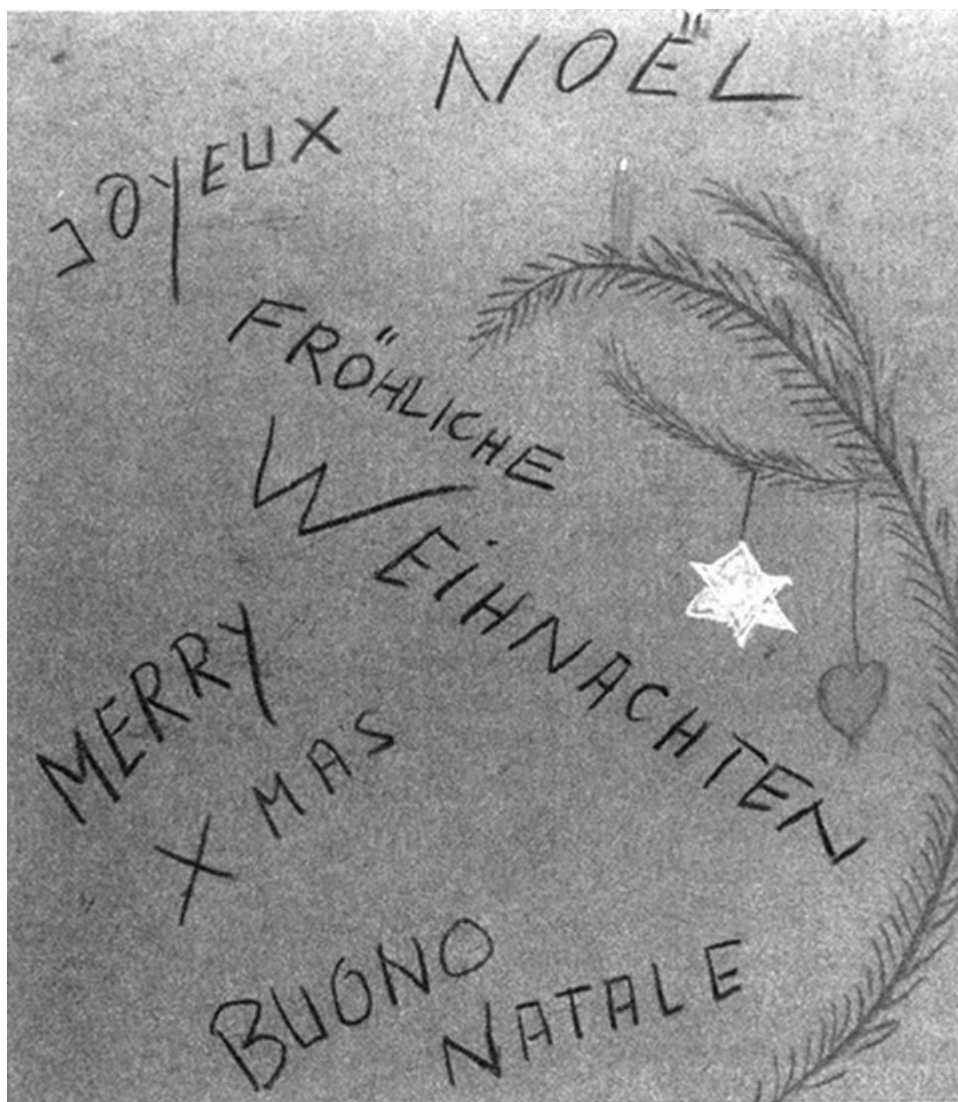
On Greta's first visit, the group agreed on an idea from one of them. Draw the *animal* you would like to be if you were born back on this earth as an animal. Greta was furious at the regimentation, the strict time limit, and the pressure to discuss the pictures and listen to others' comments. [Figure 6.5](#) is the eloquent expression of her rage. She called it a "Bird of Paradise" and claimed to see nothing in it but the beauty to which she aspired! A member called it "the terrible tyrant of the classroom." He and I sensed that Greta's tightly controlled ferocity was largely directed at me.

The art psychotherapy character of the group had accidentally revealed the potential value that art as therapy might have had for Greta. Half regretting that I could not transform the setting into one more congenial to her, I nevertheless looked forward with great interest to further experiences of her power for vivid graphic expression, and wondered whether the group would permit her to maintain the massive denial with which she had greeted her first revelation of feeling.

I was never to find out. Greta managed to evade the next three sessions of the art group. Corralled by a staff member into meeting her obligation, she showed up for the last session before the Christmas break. Knowing how hard the holidays are for people suffering from mental breakdown, I assigned a topic: Try to put into a picture your feelings about the upcoming holiday. Greta was subdued and withdrawn, obviously depressed, quite different from the rather arrogant bird of paradise of our first encounter. She worked slowly; in itself her weak drawing with its many Christmas greetings ([Figure 6.6](#)) expressed little.



[Figure 6.5](#)



[Figure 6.6](#)

By this time a change had taken place in the day hospital schedule, and the drawing time of the art group of eight was immediately followed by a meeting of the entire community—about 30 clients and all staff members who were available to attend. We decided to carry the artworks to the meeting and pin them on the wall, where they might attract the attention of others and become the focus of the larger group's discussion.

The leader was usually a young psychiatrist who was a great confronter. He zeroed in on Greta's six-pointed star, asking why she chose a Jewish symbol to hang from her Christian tree. For a few minutes Greta tried to maintain that the Star of David was simply easier to draw because it could be made from two triangles. Dr. Miller pooh-poohed this excuse; he and Greta both knew she could easily draw a five-pointed star.

Suddenly, the floodgates opened. Greta started by telling the community about her father. He had been a fairly high official in Hitler's Germany; Greta knew him only as the warmer and more loving of her parents. Now, as an adult American with many Jewish friends, she could not come to terms with the knowledge that this beloved man had been responsible for the death and torture of many innocent Jewish victims.

Then she turned to the special meanings that Christmas had for her. It was on Christmas that her sister had been almost killed in a skiing accident, and her mother had coldly withdrawn, leaving all the responsibility on Greta's young shoulders. And what about the loving father? He had been jailed after the war and was awaiting trial for his crimes when, just a year before her sister's accident, he was found hanging in his cell on Christmas Eve.

Dr. Miller was famous for not permitting community members to leave the meeting no matter how urgently they pleaded. Having finished her story, Greta asked if she could leave. Dr. Miller, rendered speechless like the

rest of us, merely nodded. The whole group was stunned. As we stared at Greta's weak, empty little Christmas cryptogram, I'm sure I wasn't the only one to think of the red heart hanging from the tree as linked with Greta's father hanging in his cell.

This cathartic outpouring was entirely new in the day hospital staff's experience with Greta. It seemed to have resulted from the Xmas theme assigned in art therapy in keeping with the methods of art psychotherapy.

Greta's time in the hospital's 30-day treatment program was almost over, and I did not see her again. From the two experiences we had, there is no way to guess which art therapy approach would have yielded more benefit to Greta. Only one thing is sure: under the circumstances at the day hospital, she couldn't have both. We had made our plans with the hope of offering the best we could to the greatest number of clients; inevitably, this was not always the best possible treatment for every client all the time.

Conclusion

I hope this glance at the work of three theorists will encourage a rising generation of art therapists to become acquainted with the broad range of practices, and to maintain the flexibility that will enable them to choose the best available method in their work with each individual client. In 1961, I wrote that: “when we talk about cause and effect, art therapists are in the same boat as the rest of psychiatry—mostly at sea. If favorable changes occur we don’t know exactly how much an esthetically valid painting or how much a dramatic new spoken insight had to do with it.” (p. 19).

Freudian-based art therapy, as it has descended and evolved from the theoretical and practical differences among Naumburg, Kramer, and Ulman, presents great possibilities for favorable change. Yet we must also face up to the limitations of therapeutic work, whatever its theoretical basis. It has been remarked that the net achievement of psychological treatment in general has been to cure the healthy and maintain the sick.

Accepting this as a realistic expectation of our endeavors is perhaps less cynical than it seems at first blush. The sick may be maintained in the desperation of an old-fashioned back ward or in the dignity of a day hospital whose program may offer art therapy, among other beneficial opportunities. It is a mistake to underestimate the vast amelioration that may take place short of cure.

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7

Object Relations and Art Therapy

Arthur Robbins

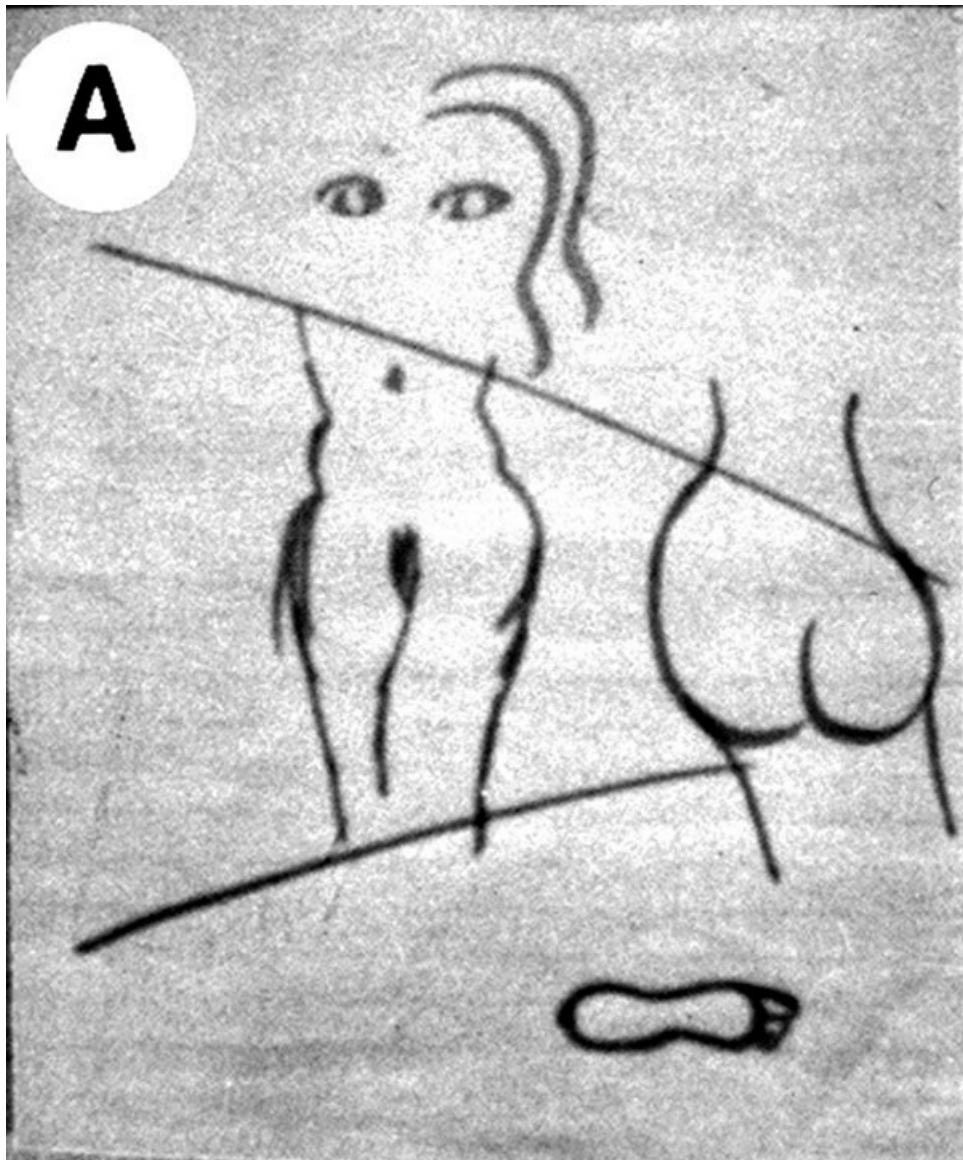
An Encounter with a Patient's Inner World

A patient comes into my office. I am immediately aware of her eyes, with their sad, liquid emptiness. Her face is expressionless, an occasional smile breaking through. At 47, she is unmarried and very tired. As her story unfolds, I learn that she does not need to work, for she has a small income from her parents' estate. This should allow her some ease, but she busily, even frantically, moves from one task to another. She feels her life rush by her, becoming increasingly aware that the span of one lifetime is not endless. Paradoxically, she feels younger than her age.

Life has been a series of short and long love affairs for this woman. Some dissolve before they begin; others are filled with pain and remorse. As she talks in a vague poetic way, I am interested and intrigued, but strangely disconnected. There's an ethereal quality about this patient that defies solidity or definition. The one thing that comes through loud and strong is the depth of her loneliness and sense of being lost. I feel the impulse to be warm and protective, even as she eludes me, like sand slipping through my fingers. I'm reminded of an old movie, *Hiroshima Mon Amour*, the story of a young woman's personal disaster as mirrored in an atomic holocaust. For her, eroticism offered a desperate anchor in the midst of a chaotic world.

I ask this woman to draw a picture about herself, with the hope that I will get a more defined picture of the inner world in which she dwells. She protests: "I don't have enough time to do it in the session." So I ask if she would be willing to draw about herself at home. She readily agrees.

Next session she brings me a set of pictures, all looking quickly drawn in a monochromatic blue. There is movement in her drawings, but a lack of dimension. Although particularly pleased with one picture ([Fig. 7.1C](#)) that she says describes the sensual part of herself, the part that craves contact and needs to be touched, she has nothing else to say about this drawing. She does give some information about the other pictures, however. The hands reaching out ([Fig. 7.1B](#)) represent the part of herself that needs to be a part of something bigger. In the fourth ([Fig. 7.1D](#)), representing the Jewish community she loves, she expands further: "All those people around a big ark in a semicircle meet and are part of something bigger. Again, I am aware of eyes, as those in the picture stare out and search to be taken in. Her drawings are like soft, sensual fragments, reaching out to say, "Hold me."

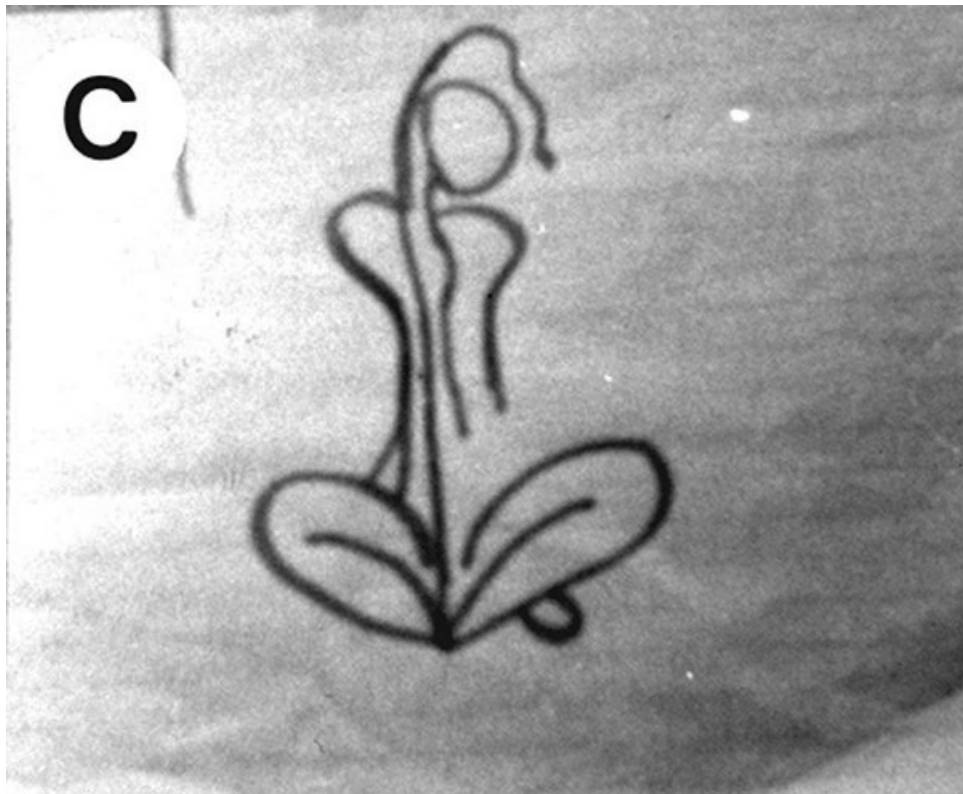


[Figure 7.1A](#)

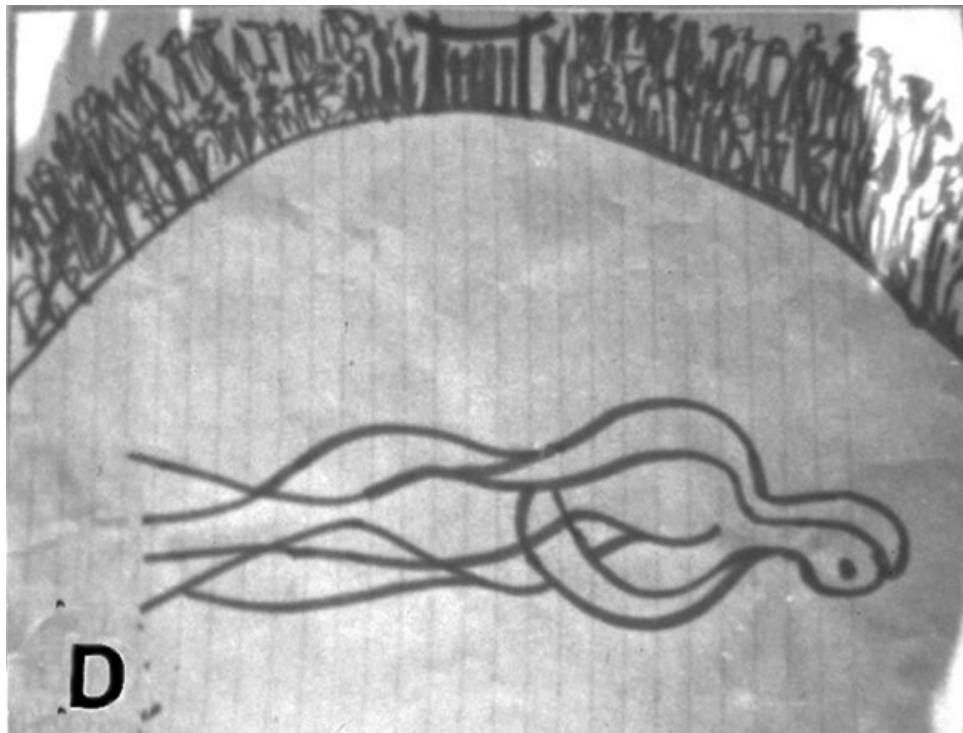


[Figure 7.1B](#)

The patient's representations of her body ([Fig. 7.1](#)) seem segmented rather than forming a flowing whole, leading me to wonder whether the holding she had received had been given by someone who was disengaged and unrelated. Putting these impressions together, I see the religious force giving her a feeling of aliveness and superficial cohesion and, along with her eroticism, acting as a compensatory mechanism for her lack of the most basic of connections, that of the mother and child's early resonance.



[Figure 7.1C](#)



[Figure 7.1D](#)

Although this patient has not spoken of her mother, I sense her presence in the room. She is a brisk, hurried person, easily overwhelming to her child. The child who still dwells within this patient is hungry for contact, while at the same time feeling frightened of being overwhelmed and controlled, as she was by her mother. These dual pulls cause her to fragment and to become diffuse when intimate contact is offered.

At the same time as images of the mother permeate the atmosphere, a sense of her father crowds into the

room with us, in spite of his having gone unmentioned by the patient. I suspect he is the one who supplied physical contact and warmth in a nonverbal way, offering her some semblance of definition.

Discussion

In this brief description, I have attempted to hint at the complex interaction of objective and subjective realities that create a psychological space between two people, from the beginning of therapy. Within this space, past and present merge to create a unique mood and atmosphere. I experience the patient's inner representations of her past expressed in the present. I sense, feel, and see the affects, moods, and attitudes originally connected to her past relationships, as they are represented in images and pictures that literally fill my office.

These representations speak of the *me* and *you* inside each of us that create our individual perceptions of the world, and at the same time induce and shape the social world's response to each of us. The representations within any given patient make contact with the relationships I carry inside me. My internal mother, father, and child touch those of the patient at points of similar experience, perception, and feeling, as we get to know one another. It becomes clear that in any single encounter between two people, there are multiple levels of consciousness entering into the engagement, as the relationships from each person's past make contact, and occasionally lose sight of one another.

Art adds a dimension to this engagement. Sometimes the art mirrors or deepens what is already going on in the relationship. In other instances, the art form may offer something diametrically opposed to the verbal dialogue. This added dimension gives a new perspective on our internal relationships, as it brings us to new levels of consciousness.

It is these early internalized relationships, with their effect on one's current reality, which form the core of object relations theory as I use it in my practice. I am not referring to one unified theory that can be found in a single book, or is espoused by a particular theoretician. My use of this term reflects my own distillation from a body of theory in psychoanalysis.

Going back to its roots in psychoanalytic theory, the "object" in object relations theory refers to the who and what in which a person's libidinal energy is invested. By "libidinal energy" I mean that constitutional reservoir of energy and life that is part sexual, part aggressive, but is more than either. It is the fuel that motivates each of us to reach out, and to find relief and contact with the world. Within this framework, human behavior is conceptualized within a tripartite system of id, ego, and superego, which, when unbalanced, creates the conflicts manifesting themselves in the range of defenses and symptoms characteristic of the neuroses.

The id forces, which reflect primitive fantasies, wishes, etc., constantly try to make themselves felt and to find satisfaction. Derivatives of these forces are felt throughout life in such forms as dreams and fantasies, and are the stuff of primary process thinking. With maturation, the ego and superego counter and modify the raw id forces: the ego, with its rational, logical, secondary process thinking, working to integrate the demands of outer reality with the inner world; the superego, with its belief system consisting of such notions as the ideal, good, bad, and evil, influencing the ego's reactions to the id. An imbalance among these forces is thought to arise when the oedipal crisis is not successfully resolved.

Psychoanalytic treatment of the neuroses is directed at analyzing defenses, resistances, and the transference; as well as dealing with such issues as shame, guilt, and anxiety. In the neurotic individual, there is a clear sense of an established internal me and you. Much emphasis is placed on making the unconscious conscious, and on bringing primary process material within secondary process organization. The ideal outcome of therapy is modifying the defenses of the ego and prohibitions of the superego, to allow the patient's life space to expand and to tolerate a richer symbolic and imaginative existence.

The patient I described in the opening paragraph does not fall within the neurotic category. Like many, she falls into the wide continuum of primitive mental states including—the psychotic, borderline, narcissistic personality, mood disorder, psychopath, and schizoid—all of whom suffer from deficits and problems in the early mother-child relationship. Therapy for these patients cannot be in making the unconscious conscious. That is not possible, as the disparate systems of mental structure lack integration and cohesiveness. The task, therefore, becomes one of building rather than uncovering, and of completing lost dialogues of the early maternal matrix.

Resonance is important in this kind of therapeutic encounter. The therapist "mirrors," or offers emotional responsiveness, which facilitates the process of empathy, crucial in this treatment process. For instance, in the description of the patient I mentioned in the opening pages, a central theme of treatment would be object loss:

the absence of a central figure to give cohesion to the patient's life. The cognitive awareness of this issue by itself would be of little help to her. She would need a relationship in treatment that would both repair the damages of loss, and give her the courage to live through her feelings of pain and abandonment.

As in all treatment where the problems involve inadequate early object relations, there is a paradox. The therapist cannot actually *be* that which the patient lost, yet the therapist's presence and actual living with the patient's problems serve to repair the original damage and problem. In this treatment, we experience patients' early losses and problems, contain and organize their experiences, and hope to give them a climate where trauma, disappointment, and confusion can be reorganized on a higher, more satisfying level. Other issues in dealing with more primitive mental states are loss of boundaries and regression to fusion states, both of which will be tested out and experienced within the treatment relationship.

The Role of Art

Art, in this context, can be a container or organizer that mirrors internal object relations, as well as associated defenses and developmental problems. The relationship offers a safe framework within which to investigate and experience the object world. The expressed art form will exhibit the various levels of definition the relationship creates. Thus, in the opening clinical example, the abstract, but self-contained quality of the art mirrored the quality of the initial therapeutic relationship.

Art therapy offers the possibility for *psychological space*—that which is created through the interactions of two individuals—to be reorganized by mirroring or complementarity (offering opposites). This space has much in common with what Winnicott calls *transitional space* (1971). It is an intermediate area that is neither inside nor outside, but which bridges subjective and objective reality. By extension, dead or *pathological space* can also occur, either in the art form or in the relationship, when expression is weighed down by oppressive defenses. Relationships are experienced and programmed to recreate sterile childhood interactions. Pathological space is one particular dimension of a transitional space, and can be experienced on at least two different levels.

In the creative act, the various representations of the patient's world are shaped and reflected through artistic form. This also happens within the interpersonal therapeutic relationship, and can either complement or mirror what is going on in the art expression. The therapist's skill is brought to bear in maintaining a positive, supportive relationship as a background, or structure, in order for the art therapy process to proceed. When pathological space takes over the interaction, it requires ingenuity and creativity to ferret out the hidden object relations, and to find the appropriate art form to regenerate psychological space.

Implicit in these notions of transitional and pathological space is the idea that relationships are characterized by different energy systems, which shape and form the space around us. Within each system, there are different levels of openness or closure, completeness or incompleteness. In primitive mental states, the art therapist offers a creative experience to help move the energy system from one level of differentiation to another. Another way of putting it is that we offer the missing link to complete the Gestalt or whole, through mirroring or complementarity.

Art therapy, then, strives to promote new levels of perceptual organization, involving shifts in energy patterns. The art form offers an added means for working with internalized splits and polarities, and integrating them into new wholes. The representations from our past are expressed through image and symbol, and expand the boundaries of objective reality. Each of these images is shaped by energy, sensation, and color with its own rhythm, volume, and weight. Being nonverbal in nature, these symbols and images are often difficult to express clearly in verbal form, and therefore lend themselves well to art.

This introduces the complex question of the use of words in art therapy. Secondary process thinking, with its foundation in words, must be evoked if the ego is to gain mastery and understanding of primitive material. Although there is secondary process thinking in the logic and judgment used in giving artistic form to a personal image, words are more directly hooked to reality. Changing poetic metaphor into art expression serves as a transition to the world of words, and helps to make sense of the truism that, although verbal material is strongly connected to reality, not all of reality is encompassed by words. From this perspective, different levels of reality can be experienced and understood within the context of nonverbal expression. The art form, then, organizes object relations and mirrors them back to the patient.

Developmental Object Relations

Inherent in the clinical use of object relations theory is a deep-seated understanding of and sensitivity to developmental lines, and how they manifest themselves in adult normality and pathology. Although Freud and his heirs postulated a developmental schema that begins at birth, they believed that the Oedipal crisis was so overwhelming that it overrode all that went before. Margaret Mahler incorporated Freud's drive theory, but also saw importance in the first three years of life, and the vicissitudes of the mother-child interaction in shaping the personality (Mahler, Pine, & Bergman, 1975). It is here that the foundations of an inside me and you are laid down.

Mahler's developmental levels begin with the stage of normal autism, characterized by a blissful oneness with mother. At about three months, the process of attachment begins, with what she calls *symbiosis*. Slowly, out of a nondifferentiated mass, the me and you inside the child become defined. As we trace the stages of symbiosis, where mother and child struggle with separateness and sameness, individuation and differentiation are born, and the child proceeds through the subphases of *hatching*, *practicing*, and *rapprochement*. The child's growth—from symbiosis to *separation* and *individuation*—culminates in achieving an *identity* and *object constancy*.

At this point, at about two and a half, the child has a firm sense of *self* and differentiated *other*, and can relate to people as wholes, rather than as need-satisfiers. A child can now tolerate ambivalence, having mended the splits of "good" and "bad," and can maintain a narcissistic equilibrium by a form of self-feeding and self-affirmation that is unique to himself or herself.

Pathology of Object Relations

Horner (1979) gives a fine outline of some of the problems associated with each developmental period, connecting pathology with issues stemming from faulty early object relations. Problems in the autistic phase form the basis of primary infantile autism, which is characterized by a lack of attachment and organization. Psychopathic personalities are viewed as having had problems in making primitive attachments, although having had a satisfactory initial period of normal autism. Around the fourth and fifth month, when normal symbiosis starts, failures in differentiation create difficulty in discriminating inner and outer reality seen in psychotic states. Schizoid character formation is seen as stemming from denial of the attachment, which begins in the differentiating phase of symbiosis.

Finally, in the rapprochement stage, occurring somewhere between 12 and 18 months, there are failures in integration and self-cohesion. Problems here result in the borderline and narcissistic personalities. Both types retreat from autonomy, the task of the rapprochement crisis, but they characteristically do so in different ways. The borderline personality tends toward fusion states and a pervasive use of splitting good and bad in the search for the ideal; whereas the narcissistic personality takes refuge in a grandiose self. Although differing in form, there is in both an attempt to return to the perfection of an early state of oneness with mother. The affective disorders are also associated with failures in the rapprochement stage. These patients have not resolved the dilemma of good and bad existing side by side in one space. All that is good and nurturing remains on the outside, while their “bad” hunger and greed stay on the inside.

Art Therapy, Creativity, and Play

As just described, each developmental problem generates a particular clinical picture, with its own pain and anxiety, which is recreated in the therapeutic relationship. The art therapist is faced with the challenge of differentiating sometimes similar pictures and reacting appropriately.

Put another way, each requires a complex art frame, to help transform pathological into therapeutic space. Where pathological space lies stagnant, therapeutic space promotes new solutions and new potentialities, with the accompanying sense of a self being reborn. There is room for new relationships and expanded levels of awareness.

The challenge for the art therapist is to provide an art experience that makes this transition possible, and keeps therapeutic space alive. Canned recipes related to each developmental level cannot hope to address issues of such complexity. What is called upon is the art therapist's artistry—in using his or her conscious symbolic awareness of the patient's artwork and the relationship—to keep the therapeutic process moving.

Winnicott's conceptualization of creativity and play help tie together the threads of developmental theory, the use of art, and therapeutic technique. Winnicott approaches these relationships from the vantage point of how individuals handle inner and outer space. He begins at the start of life, when the mother's anticipation of her baby's needs allows the infant to maintain the illusion that mother's breast is part of the infant.

From birth, therefore, the human being is concerned with the problem of the relationship between what is objectively perceived and what is subjectively conceived of, and in the solution of this problem there is no help for the human being who has not been started off well enough by the mother. *The intermediate area to which I am referring is the area that is allowed to the infant between primary creativity and the objective perception based on reality-testing.* The transitional phenomena represent the early stages of the use of illusion, without which there is no meaning for the human being in the idea of relationship with an object as perceived by others as external to that being.

(1971, p. 11, italics in original)

Creativity, then, is seen within the context of human development. The origins of illusion provide the foundation for the creation of the transitional space of inner and outer reality. In this space, the child at first maintains the illusion that the world is his or hers, and that he or she can maintain the blissful state of oneness. Only gradually is this illusion of oneness reorganized, to take in the demands of outer reality.

The goal of development, however, is not one of giving up illusion, but of developing the skills and techniques to make our illusions reality. Creativity, within the context of human relationships, permits one's inner imaginative world to become congruent with the outside, so that each person can shape their destiny. The ability to actually *be* the artist of one's social world is contingent on having successfully met the developmental challenges of one's past.

At times, because of the deficiencies and problems of one's past, artistic expression may be a means to rediscover creativity and innovation, although this creativity may not carry over into social relationships. We all know of artists for whom this is true. Art alone, without a supportive therapeutic relationship, will not repair developmental deficits.

In order to recover early creativity and recreate the transitional space so necessary to bridge inner and outer realities, both patient and therapist must be prepared to play, says Winnicott. In fact, he describes treatment as play or, in some cases, as helping the patient to become able to play. If art therapists are to serve this role, they, likewise, must be ready to play. Play, as described by Winnicott, is not aimless activity or simply having fun, although fun may be one of the ingredients. Play in therapy involves the capacity to relax intellectual controls, and to become non-goal oriented and open-ended, in experiencing and working with psychological space.

In this space, images and symbols move into consciousness with their own logic and organization regarding time and place. Through symbolic play, patients are helped to organize psychological space, both within the art form and within the art relationship. Form and content become one, through a synthesis of primary and secondary processes. This also allows the merging of bound and unbound energy, and balancing between fusion and separateness, organization and loss of control. Therapeutic play, then, becomes the means by which

to create a “holding environment” of relatedness and resonance, within which deficits in early object relations can be repaired, and the potential for creative living can be regenerated.

Approaches for Patients at Different Developmental Levels

It should be noted that problems from each developmental period require a different form of “holding.” For instance, in patients who have suffered extreme deficiencies in the normal autistic phase resulting in autistic psychosis, the holding environment in the art form and relationship involves structure, sensory contact, and a capturing of the rhythm, in disrhythmic patients.

Patients who have been traumatized in the early stages of symbiosis, when self and other have not been clearly defined, require structure and boundaries, as well as clarity and definition. Because their worlds are so chaotic and disorganized, the holding needs to be gentle, but firm, with words to clarify and to connect the worlds of image and outer reality.

For the psychopathic individual, whose capacity for attachment has been severely impaired, the world of power and games is the language that connects him or her to people. To be effective, the art therapist must enter this world, and play within its rules. Demonstrating a degree of savvy and alertness to the psychopathic game plan seems very important. Conversely, “feeding” this kind of patient with materials or love, with the hope of providing and promoting attachment, is a misuse and abuse of the therapeutic relationship. Here, as in all instances, avoiding experiences that are out of synchrony with a patient’s object life is the prime diagnostic and therapeutic issue, requiring skill and artistry as well as thought.

Much has been written about the borderline patient, and the author refers the reader to Masterson and Kernberg as important resources in this area. Here the patient is stuck in the rapprochement phase of separation-individuation—the “terrible twos,” when a parent often feels he or she can do nothing right. The child, aware of separateness yet frightened of aloneness, wants to go in two different directions at the same time. The dilemma is to separate while maintaining connection. As he screams, yells, and says “No!” the child’s cries for autonomy are enmeshed with the silent need to be held, a need often rejected when the parent tries to come near. In a two-year-old this is understandable. In an adult patient, the picture can be confusing and infuriating. Maintaining a cognitive understanding of these issues is of immeasurable help to the art therapist.

This patient literally consumes both art materials and patience. The task of the art therapist is to keep a very strong and clear perception of what the patient is regressing to, when he or she becomes frightened and “disappears” beneath a cloud of hunger for succor and support. Also, the art therapist must not be taken in by swings between devaluation and overevaluation, and must be sensitive to the ever-present splits of good and bad. This patient is wonderfully adept at splitting a therapeutic team into warring camps. Also part of the picture are such defenses as projective identification (identifying with what we project outward), withdrawal, introjection, and denial. Manifestations of these must be attended to and confronted in the art therapeutic play. Needless to say, a passive approach is not the best holding environment for the borderline patient.

By contrast, the idealization a narcissistic patient offers an art therapist isn’t usually defensive in nature. Unlike a neurotic, who idealizes to defend against hostility, idealization is an important developmental step in his or her treatment process. This patient has not been adequately mirrored or affirmed by a consistent maternal object, so the art therapy interaction can provide a crucial reparative opportunity, offering the long-sought-after mirroring and definition missed in the early family matrix. The interplay of art and the relationship can vary. At times the patient may take in the mirroring of the art in a way that parallels the therapeutic relationship. At others, the patient’s ability to deal with the much wanted/feared mirroring is so tenuous that it can only be tolerated nonverbally.

Depressive mood states offer another example of splitting, but one that differs in quality from that used by the borderline personality. Also arrested at the rapprochement level, patients with affective disorders have not been able to integrate the good and bad inside themselves and have held on to strong, hostile introjects while expelling all that is good. Art exercises are directed at helping patients find strength and self-worth, through the discovery of their own artistic expression. The nourishment found in the experience of mastery, promotes the discovery of a good me that had been lost, fused with an internal bad object.

The art therapist’s assessment of developmental level and his or her ability to experience, organize, and reflect back the inner state of the patient provide the environment for the patient to reclaim a lost experience, and to find new levels of self-definition and integration.

Again, I cannot emphasize too strongly that growth occurs from the process of going through the pain of an

unmet stage of development, rather than from the therapist's gratifying the patient's hunger. I repeat the paradox of treatment: I am with you, but separate; I understand your need, but I cannot take away your pain. To rob a patient of his or her anger, pain, and despair, no matter how well intentioned, is to do a disservice. What art therapists can offer is a holding environment, which can make pain bearable, and can allow progress and growth to proceed.

Implied in this approach is the notion of duality in our internal psychic structure, a duality that necessitates experiencing at one and the same time softness and hardness, structure and lack of it, distance and closeness, warmth and cold. The resonance art therapists offer patients complements these dualities, so that the aesthetic expression flowing between patient and therapist allows ample room for the complexity of authentic communication. There is a constant possibility of the integration of opposites, as well as a synthesis of primary and secondary process. Room also exists for progression and regression, fusion and separateness.

Conclusion

Object relations theory as applied to art therapy is but a method to seek out and organize an array of different impressions coming from many levels of awareness. Together, they offer opportunities for the creative use of one's personal resources in responding to therapeutic communications.

An art experience seems to be an ideal form in which to understand the complicated interconnections of creativity development, object relations pathology, and treatment technique. The nonverbal image captures the inexplicable essences of our past relationships, at the same time that it gives them shape and meaning.

As art therapists, our skills in integrating all this offer a special and powerful dimension to a therapeutic team. Our challenge is one of utilizing these concepts from psychiatry and psychoanalysis, while maintaining the visions and perceptions we have as artists. Within this perspective, verbal and nonverbal behavior coalesce into a mind/body whole as we, as artists and therapists, give recognition to our respect for continuity and individuation.

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Addendum—Object Relations

Eleanor Irwin

Definition

Object relations theory refers to a set of psychoanalytic developmental and structural concepts that place the infant's need to relate to those around him or her at the center of psychological motivation (Akhtar, 2009, p. 194). Psychoanalysis is, by its nature, an object relations theory, focusing as it does on the impact of the child's early relationships; the ways that these experiences influence and shape unconscious conflicts; the development of psychic structure; and the replication of the past in the present (Kernberg, 1980). Object relations theory is based on the premise that the child "takes in" elements from the outer world from birth onward, forming representations of self and significant others. In this way, the young child is *shaped by*, and, through inborn capacities, *actively shapes* the caregiving environment.

Strongly influenced by perceptions, mental representations, kinesthetic, auditory, and visual memories, the child gradually builds a psychic structure that ultimately becomes the self, whose structure and function are directly impacted by interpersonal experience. With growing experiences in the give-and-take environment, the child's rudimentary ego skills gradually help give form to his or her character and personality. Especially in the first 18–24 months, as the child's *brain* slowly becomes his or her *mind*, right hemisphere, bodily based sensorimotor modes become active, followed by left hemisphere development of language-based linear thinking. As the child's immature brain interacts with the mother's mature brain, and as the combination of gene transcription and the caretaking environment exert influence, an inner world comes into being. And in this way, the child, an active player in this drama, gradually becomes able to do for himself or herself what was done *to* and *for* him or her, for better or worse.

Internalization and Formation of the Core Self

The formation of the child's mind and personality takes place over time. The infant "takes in" the world through a process called *internalization*, a generic term that refers to several processes that take place on the journey toward the formation of a cohesive self. The term internalization refers to various way-stations, as it were, as the child moves toward greater psychic structure, including *incorporation* (where self and other are thought to be one); *introjection* (where self and other are "part-object," but not yet fully integrated); and *identification* (where there is greater differentiation between self and other, and selective traits become part of the self). These modes of internalization are most prominent in the first three years of life as the child unconsciously, pre-consciously, and consciously moves along a continuum toward a core self and basic identity.

Object Relations and the Importance of Early Life Experience

Recent remarkable advances in infant research, attachment theory, developmental psychology, psychoanalysis, and neuroscience have underscored the crucial importance of the early caregiver who helps to establish the scaffolding that shapes the brain that becomes the mind. When a “good enough” mother (Winnicott, 1958) is sensitively attuned to the infant, she facilitates the child’s eventual capacity to self-regulate emotional states through a secure attachment. Echoing the importance of attunement in the development of a healthy core self, D. N. Stern spelled out the progression of a sense of self, which develops from 2–3 months to 15 months into *intersubjective relatedness* (i.e., an emergent self, a core self, a subjective self, and a verbal self, 1985). Stern writes that experiences with caretakers lead to the formation of *RIGs* (“Representations that have been Generalized”), which represent a *preverbal* generalized memory of how things are likely to proceed on a moment-to-moment basis. This provides the growing child with a general schema about how “the world” operates, a concept that is akin to Freud’s “unconscious” and the neuroscientist’s “implicit self” (Schorer, 1994, 2003). Taking in both optimal and less-than-optimal caretaking experiences, the child forms fantasies about “good” and “bad” experiences, and those experiences set the stage for the duality of self and other representations as “good-or bad-me” and “good-or-bad-other.”

Splitting and the Duality of Self/Object Representations

The concepts that underlie object relations theory had their beginnings in the work of Melanie Klein (1932; Hinshelwood, 1991), who is generally credited with being the originator of object relations theory. Klein, Freud's faithful disciple, differed from Freud, however, in emphasizing *relationships* rather than the drives. The child, she wrote, experiences himself or herself as "good" (loved and loving) or "bad" (hated and aggressive), defensively splitting between these two polarities to keep "the good" apart from "the bad," lest, in fantasy, he or she might be abandoned. Only with "good enough" development is the child able to move from the envy and aggressiveness of the earliest paranoid-schizoid position to the depressive position, able to tolerate the ambivalence of *loving and hating*. Then the integration of "part objects" can take place, enabling "the other" to be seen as a "whole" object.

Some of these object relation concepts were seen differently by other British theorists, including W. R. Fairbairn (1952) (who coined the term *object relations*, believing the child to be "object seeking" from birth); D. W. Winnicott (1958, 1965, 1971); M. Balint (1968); and H. Guntrip (1969). They had differences with each other as well as with Freud and Klein, but emphasized the *reality* of the mother-child dyad, disagreeing with Klein and her emphasis on the infant's phantasy life. This was especially true of Winnicott, who as a pediatrician-analyst, had intensive experiences with mother-child dyads.

American ego psychologists, including Erik Erikson (1950); Edith Jacobson (1964); Margaret Mahler (1968); and Otto Kernberg (1976, 1980) also viewed development as the growth of relations with others, although they held to Freud's drive theory, and saw the child's development through psychosexual and psychosocial lens. Interpersonal psychoanalysts, influenced by Henry Stack Sullivan (1953), who disagreed with Freud's drive model, favored a *relational* structural model instead. Jay Greenberg and Stephen Mitchell (1983); and Stephen Mitchell and Margaret Black (1995) were strong advocates of interpersonal object relations theory, and were especially helpful in sharpening awareness of the "relational" aspects of transference and counter-transference issues. However, while the above theorists agree on many points, they also differ on many others, especially Freud's drive theory, the role of aggression, and aspects of technique, particularly transference-counter-transference influences.

Points of Agreement among Different Object Relations Theorists

While theorists disagree about the role of aggression (i.e., is it inborn or a reaction to frustration?) and technique (i.e., how much emphasis on transference, how much on counter-transference?), all agree in general that

1. Object relations theory attempts to explain how the outer world is “taken in” and, with the child’s active participation, shapes the inner world.
2. There is development from the early so-called primitive relatedness in the infant, to complex mental functioning in the child, and later, the adult (see Tronick, 1989). Klein describes this process as the infant making his or her way from the paranoid–schizoid position to the depressive position. Using different terminology, ego psychologists discuss this process in terms of the child’s developing ego/superego structure.
3. An object representation refers to accumulated mental images from multiple experiences with another, organized by cognitive processes and, especially, affect. The object representation, however, does not refer to an *image* of another, but to a *relationship* with another.
4. The vicissitudes of the early years are more important in the formation of the psychic structure than the impact of the oedipal period, as stressed by Freud.
5. The internalization of the “good me”/“bad me” and the “good other”/“bad other” representations exerts a strong unconscious influence on the child’s psychic life, usually before the age of three.
6. The duality of “good” versus “bad” self and other representations early in life ultimately become part of the psychic structure. The “good” self and the “ideal” self-representations constitute components of the ego and the benign superego; the “bad” self and the aggressively invested, dissociated representations of the “bad” and/or “false self” (Winnicott, 1965) constitute the immature, punitive superego that can turn against self and/or others.
7. If development proceeds in a healthy manner, internalized object relations can be assimilated into later, more integrated structures (Jacobson, 1964), as individuals become able to tolerate the ambivalence of loving and hating, an inherent part of all relationships.

Summary

As psychodynamic treatment has shifted from a “one person” psychology (with the focus on the patient) to a “two person” psychology (with a focus on the interactive process between patient and therapist), there is greater realization of the ways that the therapist can function as a “new object” in the patient’s life, bringing about repair of developmental deficits. Similarly, new findings in child research, the attachment literature, psychoanalysis and neuroscience, coupled with greater attention to attunement and cycles of “disruption and repair” (Schoore, 2003; Tronick, 1989) in parent–child as well as treatment relationships, can help the therapist sharpen clinical skills to be more effective with those in need. As Winnicott (1971) pointed out long ago, there are marked parallels between the parent–child relationship and that of the therapist–patient. As we continue to become aware of how we impact “the other,” we also become more aware of how we, in turn, are impacted by “the other,” in the delicate dance called psychotherapy.

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8

Mentalization-Based Art Psychotherapy

Dominik Havsteen-Franklin

Introduction

Mentalizing through the arts has a long history, because mentalization theory defines the process of how we are able to utilize imagination in the service of conceiving mental states in self and others. In this chapter, I hope to show how making art in art therapy can underpin the process of mentalizing, where exploring the art object mobilizes a capacity to reflect on interpersonal events. The term *mentalize* was used as far back as 1807 and first appeared in the *Oxford English Dictionary* (OED) in 1906. The two definitions provided by the OED (Stevenson & Waite, 2011) run concurrently in art therapy practice:

1. To construct or picture in mind, to imagine, or give a mental quality to
2. To develop or cultivate mentally, or to stimulate the mind of

Mentalizing is the capacity to imagine what mental states of self and other underlie behaviors. For example, a furrowed brow and being attentive might indicate focused thinking, concern, or perhaps confusion, depending upon a number of relational and contextual factors. Mentalizing is the process by which we give meaning to the interpersonal quality of the behavior between oneself and the other. It happens for most people spontaneously and implicitly, and is fundamental to relating. Therefore, mentalizing in art therapy is usually about the interpersonal context. Bateman and Fonagy (2004) describe mentalizing as

[t]he process by which an individual implicitly and explicitly interprets his own actions and those of others as meaningful on the basis of intentional mental states, e.g., desires, needs, feelings, beliefs and reasons.

(p. 302)

From a mentalizing perspective, it is of therapeutic importance that making art is in the presence of another who can be contingently responsive, attuned, and curious so that the image can be understood in terms of what is happening in the person's immediate relationships, in the therapy and in current interpersonal contexts. By this I am also referring to the interactional nature of being in the space within which the art object is made. The therapist makes a range of implicit and explicit responses based on the patient's relational context, and the therapist is also helping the patient to mentalize their own conscious or pre-conscious thoughts, beliefs, and desires through the exploration of the image.

Needless to say, mentalization-based art therapy has an inherent aim to mentalize. This means that the wonder of the engagement is overlaid with curiosity that seeks to establish a process of being curious for the patient. Mentalization-based art therapy is not about finding the answers, although the work moves toward plausible explanations for behaviors. Mentalization-based work focuses on establishing a capacity to be curious and explorative within grounded perspectives of self and others. Fonagy and Allison (2014) draw upon the essential feature of mentalizing as,

[p]ut simply, the experience of feeling thought about in therapy makes us feel safe enough to think about ourselves in relation to our world, and to learn something new about that world and how we operate in it.

(p. 376)

Changes in social functioning begin with the realization that we can understand misunderstandings about what oneself and the other may be experiencing. The following clinical example illustrates this point where the therapist makes observations that impact on the patient's orientation within their social context.

Clinical Example 1: Harriet

When Harriet, aged 21, white, British, diagnosed with borderline personality disorder came into the therapy room after receiving weekly art therapy sessions for around six months, in a very heated way, she returned to the theme of describing how much she hated her mother because she felt infantilized by her. She described a number of examples, such as her mother cleaning up her room when she was not there, doing her washing when clothes were left on the floor, and buying her food. The patient felt that these were acts of deliberate antagonism, which sometimes drove Harriet to self-harm by cutting her arms. She would retreat into a depressed state about her dependency on her mother and how she felt so trapped and persecuted.

In the session, the therapist reflected on how difficult this experience appeared to be for her, especially the feeling of being trapped. The therapist tried to explore what else might be happening for her mother without precluding the possibility that her mother was being infantilizing toward Harriet. This didn't appear to be particularly helpful. However, during this time, the patient carefully drew a range of different sized circles on a piece of paper (Fig. 8.1). When the therapist inquired about the image, the patient was shocked at what she believed was standing out on the page—a letter A. She assumed that the therapist could see the same letter, but they appeared to the therapist to be randomly positioned circles, as if floating in space like bubbles.

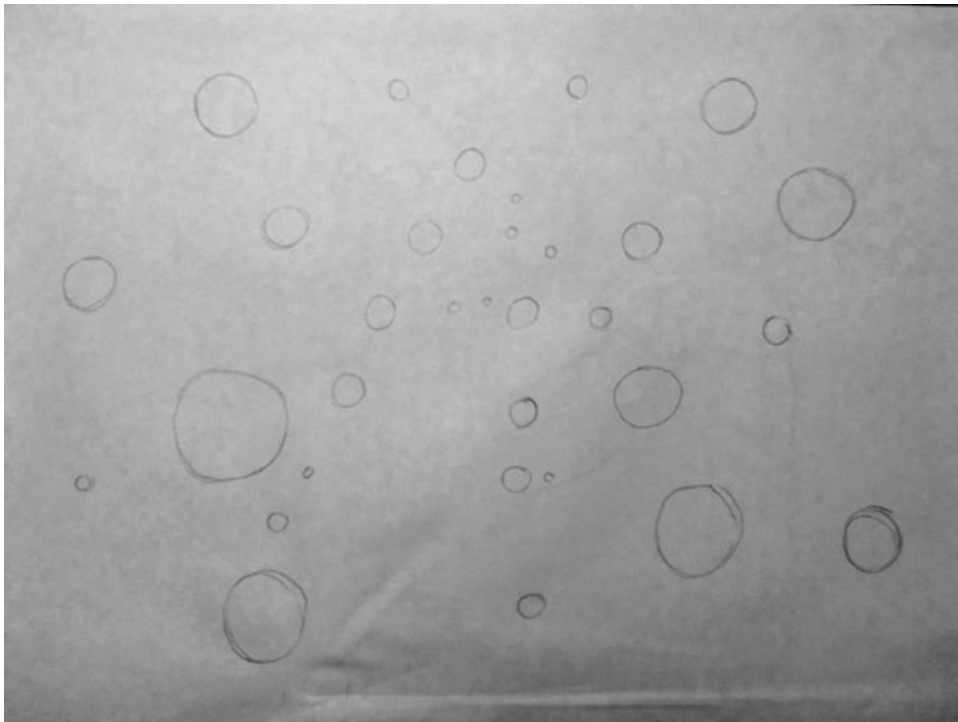


Figure 8.1. Circles

Harriet: *"What, you can't see it? But it's so obvious!"*

Therapist: *"I really can't. What is the letter that you can see?"*

Harriet: *"It's an 'A,' right there. You must have seen that!"*

Therapist: *"Oh yes, I can see it now, but it wasn't very obvious to me. What is an 'A' to do with?"*

Harriet: *"I think it's to do with Alice in Wonderland. I watched the movie last night."*

Therapist: *"Oh I see...I'm really struck by your sense that I could see what you could see. I might be wrong, but I wonder if this is what happens sometimes with your mother? Maybe she doesn't always know how you will feel when she clears your things away?"*

Harriet: *"I don't know really. I tend to get really angry and then I go to my bedroom and lock the door so I don't have to listen to her going on and on. I don't believe her when she tries to give me an explanation in any case."*

There are several important features about this short transcript; the therapist asks a lot of open questions, being genuinely curious about what the image is that Harriet has made. The therapist is transparent about not being able to see the letter A. The focus is less on the metaphorical content; for example, the therapist feels that the image is quite tenuous, like bubbles that could pop—which he associates with a fragile ego state—and that she might flare up, lose her boundaries and her capacity to mentalize very suddenly. The patient also refers to Alice in Wonderland, which the therapist feels might be about her regression into a fantasy world where she retreats into her bedroom and locks the door. However, the main focus of the intervention is on using the image to reflect on assumptions about what is happening in someone else’s mind.

This is because from a mentalization perspective, what precedes the capacity to play with symbols is the capacity to sustain a basic capacity to mentalize. The therapist embodies a sense of curiosity, but with particular parameters. The reason for this is that, although the therapist may use associations and symbols to help inform him about the patient’s interpersonal situation, using symbols more explicitly requires careful navigation to keep the affect and interpersonal events present in the patient’s mind. In other words, it would be easy for the patient to use symbols in a defensive fashion, where a meaningful focus on the interpersonal context and associated affect might become overshadowed by more disorganized or rationalizing dialogue.

However, the artwork will have symbolic content, and in the next clinical example with someone with a complex depression, the use of symbols is explored in more detail within a mentalizing model. In the above clinical example, the aim was to begin mentalizing Harriet’s experience of being persecuted—the feelings, events, thoughts, beliefs, and desires of self and other within those contexts. By the end of the dialogue the sequence of events reveals a general pattern of behavior, *feeling angry—retreating—self-harming*, that the therapist and patient can begin to reflect upon in terms of her assumptions about what the quality of another person’s intentional mental states might be.

The shift from a fixed perspective that is generalized, polarized, and disruptive to relations to being interested in exploring perspectives, including the therapist’s, is facilitated through a genuine and compassionate sense of curiosity. The use of the image as reflecting qualities of mental functioning is particularly useful in terms of demonstrating the opacity of mind to oneself and others. However, the image may also be used in ways that undermine the capacity to mentalize—for example, through perceiving the image as a concrete pre-determined communication.

Four Conceptual Dimensions of Mentalizing and Their Relevance to Art Therapy

The development of a theoretically cogent model of how the individual functions socially within an interpersonal field has been identified under the broad canopy of mentalizing. While it may appear that the concept of mentalization is simple, it draws upon many strands of theoretical orientation and conceptual domain from psychoanalytic theory (Holmes, 2006; Kernberg, Yeomans, Clarkin, & Levy, 2008) and developmental schools of thought. The ontology of the concept of mentalization has been reviewed by Choi-Kain and Gunderson (2008) who have examined the conceptual domains of mentalization that are underpinned by empirical evidence. These four domains are *affect consciousness*, *empathy*, *psychological mindedness*, and *mindfulness*.

Affect Consciousness

The image is a method of communicating and embodying affective states. According to Schaverien (1999), the process of art therapy can facilitate the embodiment of feeling states when there isn't another vehicle of expression available to the patient. Nowell Hall worked in a therapeutic community in the United Kingdom. She describes the image making process for one resident as "a way to communicate something of her feelings" and goes on to state that "making an image can create a bridge and a way of 'speaking' out of states that might be described as the depth of despair" (1987, p. 171). Becoming aware of feeling states and the associated affect(s) is commonly linked with representations at a bodily, visceral, and motoric level; as well as those that are more developed, such as poetic reflections on personal experiences. In this way, the image made within a mentalization based approach is versatile, and can be successfully used to mentalize different experiences of affect.

Empathy

Empathy is commonly considered to be a key change agent in psychotherapy (Bohart & Greenberg, 1997; Elliott et al., 2011). Given that the image is a way of embodying the emotional world of the patient (Schaverien, 1999), it is perhaps not surprising that the therapist is able to empathize with material that is often more readily available through the image than in verbal modes of expression.

This can also be reciprocated where the art response allows mutual empathic attunement. As Allen (1995) states, "Making art together breaks down barriers and boundaries between people, creating compassion and empathy" (p. 163). Taylor Buck and Havsteen-Franklin (2013) also reflect on a therapist's disclosure to enhance the empathizing process,

[A]n art psychotherapist said that she used image making in the session to describe a shared sense of "stuckness" in the therapy that enabled the patient to explore what had led the art psychotherapist and patient to be at that juncture.

Within a mentalizing model, it is the collaboration between the art therapist and the patient that is considered to be fundamental to the change process and that requires the therapist to demonstrate an empathic response as well as help to facilitate empathy in the patient. This can be done both verbally and artistically, as illustrated above.

Psychological Mindedness

Psychological mindedness according to the *Psychodynamic Diagnostic Manual* (Gordon, 2010) is considered to be a way of describing the person's capacity to observe and reflect on an array of feelings, values, goals, or experiences for self and other within a present and longer-term view of the self. Ferrara (1996, p. 47) writes about her studies of the cross-cultural implications of psychological mindedness in art therapy:

The structural transformation that occurs in the levels of emotional awareness also occurs in the art

development. When giving form to mental images and creating art, the process often involves sensorimotor reflexive or bodily sensation as in the kinaesthetic, scribbling stages of artistic development (Lowenfeld and Brittain, 1987). This process is similar to the initial levels of emotional awareness. In the interpretive process in art therapy, the client is encouraged to move towards awareness of blends of feelings, or blends of blends of feelings.

Ferrara suggests that the continuum of psychological insight forms out of the patient's method of producing imagery, and that the therapist can facilitate the art-making process to become aware of the nuances of emotional experience.

Mindfulness

A mentalization-based approach to art therapy highlights the humble endeavor of understanding without having pre-conceived notions about what is being revealed through the image. Art therapist Michael Franklin (2010) understands the approach of a therapist beginning the work with a patient as being someone who is getting to know a stranger.

The goal is to be mindfully present to presenting imagery and behavior, bracketing out points of bias or impulsive interpretations that might contaminate a fresh, beginner's mind.

(p. 163)

The stance of the mentalizing art therapist is best understood as making mindfulness explicit, showing the patient how to be mindful of their own actions and thoughts and what is being revealed through the image—as a way of allowing the image to unfold.

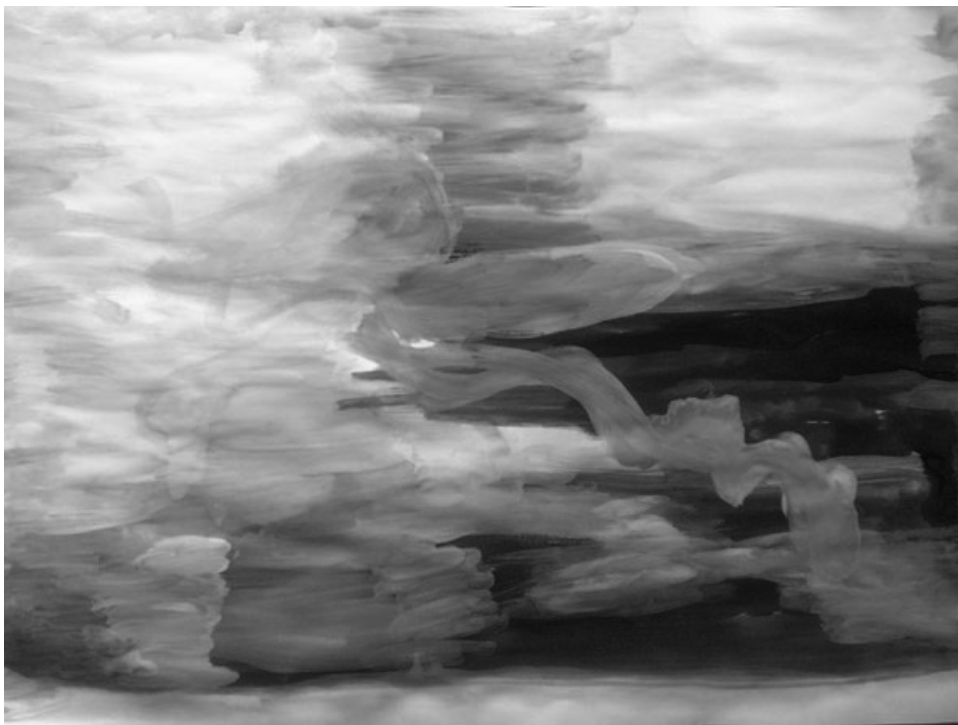
Clinical Example 2: Harmonie

Harmonie was referred for an assessment within a community arts psychotherapies service, and was seen for art therapy because, as her care-coordinator said, “she loves painting.” The patient had been hospitalized a number of times for severe psychotic episodes where she felt the world was very hostile, and thought that she had been born from a Viking family. She was actually an older British black Afro-Caribbean lady. When she entered the therapy studio, she said that she wanted to “be corrected.” Through discussion, it became apparent that she meant that her paintings of the sky needed to be improved. When she painted the sky ([Fig. 8.2](#)), she said, “It’s just the sky...There’s nothing more to it.” Further exploration resulted in the patient becoming impatient and distracted, looking around the room.

In this example, the therapist had also painted a sky with a solitary house while the patient had been painting, and the therapist asked the patient about how she saw his image ([Fig. 8.3](#)).

In the course of further exploration, it became clear that the patient wanted the therapist to paint a garage with a pink car, other houses and a sea. The therapist painted these things under close instruction from Harmonie, and what became apparent was that the house she would like to occupy in the image was isolated from the black community, which she feared despite being black herself. She said that she could only live with the white community, even though she felt that they were distant from her. During this art therapy assessment session, this became an important theme, and there was a sense that her underlying struggles about her identity were being disclosed to someone whom she could tentatively trust. However, the therapist often experienced Harmonie’s lack of eye contact and concrete reactions as being dismissive and distant responses.

It was not possible in this assessment period of three sessions to understand what the underlying assumptions about the therapist were, but her change of behavior and interest suggested that there was a shift from seeing the therapist as a distant white man, to someone who was prepared to attune with her world.



[Figure 8.2](#) Sky



[Figure 8.3. Painting made by the art therapist under instruction from the patient](#)

However, despite the beginnings of a therapeutic alliance, during the course of these assessment sessions, there were constant threats to mentalizing, where she wanted quick results, mainly to be “corrected.” Indeed, Harmonie often seemed detached from her feelings. She spoke in a matter of fact way about white and black people, referring to neuroscience research that appeared to be part of a delusional rationalization, as providing evidence that supported her claim that she was white. She often returned to treating the therapist as someone who was distant and disinterested, in the same way as she initially appeared to be disinterested in the therapist and more interested in correcting her artwork.

Non-Mentalizing

In this clinical example, the patient struggled to make contact with the therapist in a meaningful way. The breakdown in mentalizing and the ensuing prementalistic states can be embodied in her initial response to the drawing of her house “It’s just a house.” It may be the case that the image is just a picture of a house, however further exploration made it clear that there were three interrelated prementalistic states:

1. Harmonie wanted to be corrected. As a method of learning from another, correction would assume the authority of the therapist, where the therapist was right and the patient was wrong. The image, despite being fluid and complex arrangements of clouds in the sky, with considerable expressionistic appeal, was assumed to be incorrect. Therefore Harmonie’s primary understanding of the therapist’s purpose was to direct her and to teach her about a concrete activity with some immediacy. Her attendance to art therapy and the use of it as a teaching class appeared to be used to avoid contact with the therapist, what Allen and Fonagy (2006) have referred to as “teleological thinking.” The act of a goal-orientated concrete result at the cost of mentalizing. This emphasis on teleological reasoning is also likely to underpin her concrete beliefs about neuroscience as providing a biological purpose for her argument about being white.
2. Harmonie appeared to relate to the world, perhaps in a similar way to how she believed the world related to her, with disinterest and detachment. During the assessment, there was a sense that her interpersonal difficulties were based on issues of racial conflict, and that the therapist was part of a white world from which she felt distanced and excluded. Likewise, the therapist felt excluded from her world. Harmonie appeared to want to be in control of her environment throughout the session, both in her explanation of what the art therapist should be doing and her making of the image, as if to make a general statement about herself and how she manages her relation to the world. The belief follows that “if I can be in control of the image, I am in control of my internal world.” This type of prementalizing is referred to as “psychic equivalence” (Fonagy & Luyten, 2010)
3. The arguments that Harmonie put forth to support her explanation of being a white person appeared to be very detached and methodical, giving a quality of unreality that was sometimes clearly delusional. The moments of unreality, driven by her complex theory about neuroscientific claims, appeared to be devoid of emotions and relatedness. In early development, the first experiences of playing are often characterized by the infant’s either/or perceptions of pretend objects. For example, either the ball is the sun or it is a ball, but not both. Leuzingher-Bohleber, Canestri, and Target (2010, p. 57) describe this as the “pretend mode”:

In disassociated thinking nothing can be linked to anything—the principle of the “pretend mode”, in which fantasy is cut off from the real world, is extended so that nothing has implications.

For Harmonie, her intellectual argument overshadowed any feelings that she might have about her racial identity and her sense of belonging or being excluded.

So, Is Mentalizing New to Psychodynamic Art Therapy?

Perhaps the reader, quite rightly, feels that mentalizing is straightforward and adds nothing new to the existing art therapy therapeutic endeavor. In terms of psychodynamic and interpersonal therapeutic models, mentalizing is a way of conceptually framing the vehicle that carries the work, and therefore cannot be claimed to be novel. A mentalizing approach is a pragmatic choice that works with patients where there is a mentalizing deficit.

There is very little art therapy research that incorporates a step-by-step account of the specificity of these types of sensitive interventions and their impact within the session, in the intermediate, and in the long term. Most often, research focuses on one of those areas, and is usually based on the therapist's perspective on what the agent of change is over the course of the treatment. However, there are illuminating art therapy case studies that show the movement of the patient from holding a fixed perspective to one that is more flexible. For example, Landgarten (1981, p. 207) writes about one of her patients reflecting on her own art work,

The product was most impressive, for it clearly displayed the vast change from the tight, rigid pictures which symbolised herself at the beginning of treatment to the mobilized person she had become.

Mentalization-based therapies have a growing evidence base, perhaps because the models draw upon the fundamental agents of change within most psychological therapies, and the process of change reflects some of the basic tenets of art therapy practice. Generally speaking, art therapists work collaboratively with the patient and are interested in the interactional elements of the work, so that explorations commonly take place that help the patient to reflect on states of mind in self and other. By this I am referring to the possibility of exploring the interpersonal context within which the image is made and developing greater scope for reflective functioning. Art therapists often adapt their personal model in response to questions such as: When is it helpful to be directive? How can affect awareness assist with positive outcomes? In the time available, what can I do that will produce a sustainable result for the patient?

Ultimately the emphasis on mentalizing will be determined by the *problem* of mentalizing. Therefore this model moves away from one size fits all, or that a unique approach is required for every patient, and moves toward the idea that in many circumstances the use of image making can assist with helping the patient to establish a capacity to mentalize.

Mentalization and the Transference

As my experience of working with patients with severe traumas, mental illnesses, and relational problems grew, I found ways of adapting my practice. This meant that the core of my work was about enabling the patient to explore relational possibilities, before more focused work in the transference could ensue. I consider the transference–countertransference matrix to be at the heart of a dynamic model of practice. However, this did not mean that transference-focused work was left behind, but rather that those interests were implicit to the process of establishing mentalizing. As Kernberg, who developed the transference focused psychotherapy (TFP) approach stated, “the initial phases of TFP and the description of mentalization based treatment are practically identical” (Kernberg et al., 2008, p. 616). Working with transference in mentalization-based art therapy with severe mental illnesses is different from a classical transference-focused approach, because the work is always brought back into the present and often in relation to the therapist. The transference is picked up through identifying recurrent relational patterns that appear as generalizations such as “people in power always treat me like that!” The therapist might respond with some curiosity about the implications for engaging in art therapy and how the therapist is perceived. Alternatively, the art therapist might reflect on the implications of this pattern in their current life, what Bateman has referred to as “mentalizing the transference” (Bateman & Fonagy, 2010).

Mentalizing in Art Therapy as Analogous to Parenting

The process of discovery through the image emulates something akin to good parenting. The inspired encouragement and emotional support offered by a parent helping an infant taking their first steps, discovering their feet, or holding a spoon are analogous to the ways that the mentalizing therapist responds to the patient.

In studies conducted by Fonagy and his colleagues, the parents' mentalizing, operationalized as reflective functioning, assessed prenatally, was the strongest predictor of *attachment security* in their infants at 12 and 18 months of age. This may well indicate that the mentalizing art therapist is in a good position to be able to make an impact on prementalizing functioning through the image making and explorative process. Jeremy Holmes (2014, p. xi) referred to the parallels of psychotherapy and parenting when he stated, "what good therapists do with their patients is analogous to what successful parents do with their children."

There is significant interest in relation to the process of image making from a developmental perspective. The use of arts media in an art therapy process has often been likened to preverbal exploration (Dalley, 1984; Frisch, Franko, & Herzog, 2006; Kielo, 1991; Rubin, 1999). For example, Talwar (2007, p. 26) examines the neuroscience of memory recall and concludes, "Non-verbal expressive therapies such as art, dance, music, poetry and drama all activate the subcortical regions of the brain and access preverbal memories." Her findings suggest that the developmental roots of a deficit in mentalizing can be arrived at implicitly through the image-making process.

A wide range of empirical studies have been reported that show that there are severe mentalizing problems in mental health disorders that are influenced by traumatic relational experiences in early development (Bora, Yucel, & Pantelis, 2009; Brüne, 2005a, 2005b; Fonagy, Target, & Bateman, 2010; Stanford, Messinger, Malaspina, & Corcoran, 2011; Subic-Wrana, Beutel, Knebel, & Lane, 2010; Tandon, Keshavan, & Nasrallah, 2008). Weinberg and Tronick (1996) draw on observational evidence that the child at six months old already has established and organized emotional responses for communicating with people and relating to the environment. The hypothesis that art therapy facilitates a representational communication of early experiences in a way that can be understood in terms of the impact of traumatic experiences on present relationships is very significant in relation to enabling a reworking of fixed perspectives established in early childhood.

Curiosity

In mentalization-based art therapy practice, the clinician is looking to develop conditions that are optimal for mentalizing, in a way that is similar to the environment of the developing child. Curiosity is an important element of the mentalizing stance, principally because curiosity as a process helps the patient to facilitate curiosity about themselves and the other; which in turn helps to challenge fixed beliefs. The mentalizing art therapist is interested in what possibilities are produced through the image-making process, inasmuch as they are relative to the interpersonal situation; but the main interest is the process by which the patient generates his or her possibilities. A sense of curiosity that is open to introducing alternative perspectives, can help to challenge patients' assumptions based on early environmental failure to meet their needs. The work stays close to the present. It is about now, yesterday, last week. Once the aim of the therapy becomes about mentalizing, the therapist may become more directive at times, ushering in a new idea or dramatically changing the course of the therapy to keep the focus on the process of being curious.

Mentalizing as a Phenomenological Process

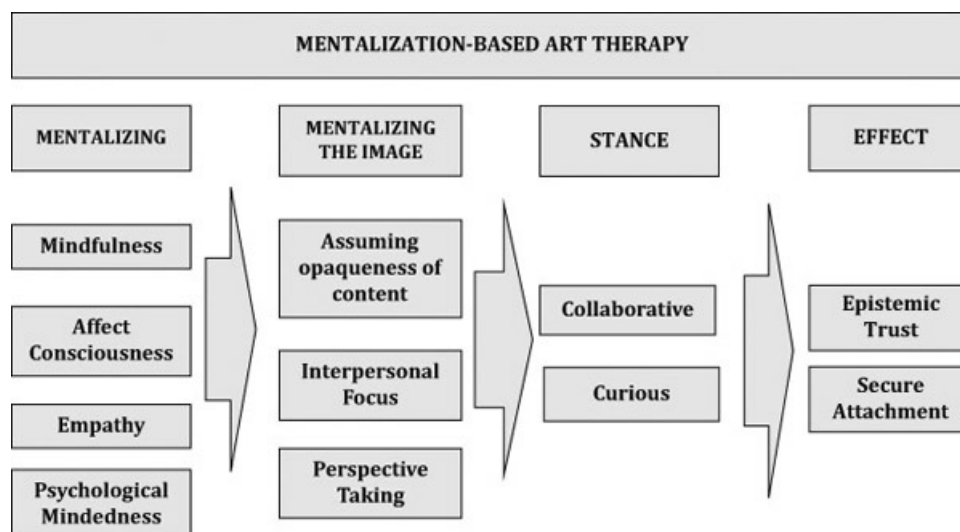
For the therapist, the patient produces an art form that remains ambiguous until there is clarity that emerges through exploration. This process reflects their interpersonal interactions, exploring the content of the image as if seen through an opaque glass, in a similar way to how the mental states of self and other are explored. However, opacity of mind is a condition where the observer assumes that there is an order, a meaning or a definition that can be found, even if it is not. Merleau Ponty describes this with some poignancy when he writes on the subject of inquiry into the reality of observations. On examining a stone, he states,

Even if in the last resort I have absolutely no knowledge of this stone, and even if my knowledge regarding it takes me step by step along an infinite road and cannot ever be complete, the fact remains that the perceived stone is there, that I can recognise it, that I have named it and that we agree on a certain number of statements about it.

(Merleau-Ponty, 1996, p. 320)

This process of finding a common reference point from which to begin enquiry that Merleau-Ponty describes relates to the art therapeutic process—where we are interested in mobilizing the act of being curious, based on the experience of a shared observation where we can agree on certain statements about the image. Those first and tentative statements, regardless of what we feel we know, from a mentalizing perspective are likely to refer to the form, to be metonymic and descriptive. [Table 8.1](#) contextualizes the role of curiosity as a form of phenomenological inquiry within a mentalizing model of art therapy.

[Table 8.1](#) *Mentalization Based Art Therapy Framework*



Clinical Example 3: Dora

Dora was referred for an assessment in an arts psychotherapies clinic in London. She entered the room barely making eye contact. She appeared to know what she wanted to do. She had been imprisoned for threatening behavior and stalking an ex-lover, and now found herself at home with her mother, feeling low and hopeless and unable to make contact with anyone else. Having moved to England from the Middle East in early childhood, Dora described herself as sociable and as having had caring parents, although she felt that her father was very absent. She sat at the table and immediately began carefully painting an image, while we talked about her experience of the assessment and recent events in her life. This was her second session with the therapist, and in the first session, she had painted a fragile plant. After 25 minutes, the patient appeared to have finished her image ([Fig. 8.4](#))

At this point the therapist begins a dialogue about the image, excerpted in the transcription below. During the dialogue, the therapist is predominantly being curious. Moreover, where the exploration of the patient's experience feels to the therapist to be avoided by the patient, the therapist begins to describe the observed form. The therapist then makes a communication about his intersubjective experience, a point at which there is a possible convergence between what might be being communicated by the patient and the association had by the therapist. The therapist continues to treat the content of the image as opaque, "I don't know why, but I had the sense of..." The proposition is owned by the therapist and thus allows for the patient to disregard this as the therapist's experience and not having anything to do with her experience. In a sense, the therapist models *mentalizing*, taking an interest, being curious, taking the content seriously while not disclosing too much about his assumptions.



[Figure 8.4](#) The Sea

In the example the therapist uses a type of questioning that is closely related to a model of scientific enquiry developed by Socrates, often referred to as "Socratic inquiry" (Carey & Mullan, 2004; Hintikka, 2007; Paul & Elder, 2007). However, the therapist *does* hold assumptions and is investigating those assumptions without obviously revealing what those assumptions are. What the philosopher Hintikka (2007, p. 97) referred to as "Socrates's ironic professions of ignorance." In the example the therapist frequently appears to not know what is happening or what the image is about. His undisclosed interpretations were about feeling confused and seduced by the image. He often felt shut out by the patient and sometimes wondered whether there was

something extremely disturbed behind the image, where there was a complete disconnection from reality. However, if this was the case, the patient's reality would become clearer through this method of inquiry: exploring the *what, where, why, how*.

Dialogue

T: I can see that you've also painted something that looks err...alive today.

P: Yeah. I am going to fill in the spaces.

T: What is it a picture of?

P: The sea.

T: And how would you describe the sea?

P: I would leave that to the imagination of the person looking at it.

T: I can see that it started with the spiral and moved to the right. It seems to have the motion of the sea?

P: Yeah, I like the sea. It is alive.

T: I don't know why, but I had the sense of a girl talking about the sea.

P: I used to live by the sea as a child. I would stand by the sea. I was fascinated. Fascinated, looking out to the sea.

T: What fascinated you?

P: I don't know. The sea...it is beautiful.

T: Was anyone else there?

P: My mother.

For this patient, the image came to represent the experiences of being very close to another. It was difficult to know where she was, especially in relation to her mother, and while she found mother very absorbing and "full of life," she described feeling very "lost in her life." I felt that this was first alluded to in her statement that she was "fascinated. Fascinated, looking out to the sea." The mentalizing process entailed trying to explore other possibilities for what was happening with her mother in Dora's daily life, her concern and struggle to look after her daughter, and the feelings that may have emerged from this possible struggle. The therapist attempted to build an imagined dialogue between Dora and her mother, in order for the patient to be able to take different perspectives about mother's quality of experience—rather than assuming that she was like an idealized and colourful sea, within which she could become immersed. The work was focused on recent events, particularly where the patient felt that her mother was preoccupied or withholding. Where for example, she went to her mother for advice about how to recover from her depression, but the mother seemed distracted and unable to talk to her about it. The patient assumed that her mother was withholding knowledge in order to make her more resilient, but said that it just made her feel even more depressed. Mentalizing became central to how Dora engaged with her mother through testing some of her beliefs about herself and others, and was ultimately able to begin a process of separation. We discovered that in the past, this same dynamic was present when she had fallen in love, and had felt that her partner had been withholding love in order to make her stronger. The quality of attention and curiosity offered by the therapist was important in establishing the therapeutic alliance that facilitated this work. The process of learning something new in a mentalization-based model is about facilitating a method to unfold the content of the image within the interpersonal context.

Epistemic Trust

The image in a mentalizing model may be used to express generalized experiences of trauma and their resulting affects; such as despair, hopelessness, fear, or anger. The image has the potential to be used as a way of expressing and containing intolerable feelings. Dalley (2000, p. 84) writes,

The image holds the transference and countertransference responses—the idea that within this the image can act as a container of intolerable and unbearable feelings that can be held, processed and thought about which leads to the experience of being contained and understood.

The mentalizing art therapist can use the image as a space within which another human being who is interested in the individual's experience can be accepted. Such genuine interest in what is happening for the patient in the image making, and as a communication, has the potential to make inchoate experiences meaningful. As seen in the previous clinical examples, the patient's engagement with the image's spatiality and aesthetics can potentiate a symbolic communication to another person. The aesthetic scope of the image can provide organizing psychological principles based on form, structure, and dimensions—thus allowing for perspective taking and exploration, rather than being overwhelmed by undifferentiated mental states. Taylor Buck and Havsteen-Franklin (2013, p. 13) explore epistemic trust in the context of the interpersonal domain of image making,

It is arguable that in individual and group arts therapies, the 'as if' quality can foster contingent interpersonal communication and enhance the possibility of mentalizing by powerfully communicating one person's experience to another; in which case the development of epistemic trust could be seen as dependent upon the communicative potential of the 'as if' quality of the image. The patients' capacity to imagine another perspective behind the opaque behaviours of the other, parallels exploring the interpersonal content of image making and is integral to developing a sense of self-other in the therapeutic relationship.

Essentially the mentalizing art therapy process provides optimal conditions for the development of trust in another human being where there had been convincing evidence that close relationships were harmful, disturbing, or destructive.

Conclusion

Many of the clinical examples in this chapter are actually drawn from an art therapist's work before mentalizing was introduced so widely as an important concept in clinical practice. This is essentially because mentalizing is generally a method intrinsic to art therapy practice with people who are having problems with mentalizing. The drive behind a mentalization-based approach is to model and focus on establishing a process of human development that has been disrupted by processes of interactions with non-mentalizing others.

There is nothing new about this; however, there is something new about what art therapy adds to the mentalizing repertoire. The making and exploration of an art object adds a number of valuable opportunities for establishing an empathic relationship that establishes a wider range of interpersonal possibilities through attunement to the emotional content of the art work. There is also an opportunity to make inchoate, ambiguous or undifferentiated thoughts, feelings, beliefs, and desires more explicit to the patient through exploring the image.

But perhaps more importantly, the process by which the patient becomes aware—what I have called a process of becoming *curious* about the mental states of self and other—is central to the method of bringing about mentalizing for the patient in other interpersonal contexts. The same image has a potentially broad scope: to be used for rudimentary mentalizing about physical, tangible experiences of self and other, to more complex and subtly nuanced experiences of feeling states. Through reflecting on the image with another, the patient experientially develops the emotional acumen to understand their own views about the intentional mental states of self and other.

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Analytical Psychology (Jungian)

9

Jungian Art Therapy

Nora Swan-Foster

*I managed to translate the emotions into images...to find the images which were concealed in the emotion
—I was inwardly calmed and reassured.*

(Jung, 1965, p. 177)

Introduction

Carl Jung deeply appreciated the imaginative psyche and its expression through the image, by which he meant such things as dream images, art productions, expressive arts, myths, visions, or active imaginations. During times of suffering and disorientation, Jung found that image, metaphor, and symbol offered the most profound healing for himself and for his patients.

Jung's thoughts and theoretical concepts provide an essential foundation for the practice and application of Jungian art therapy, yet Analytical Psychology—Jung's name for his own work—extends far beyond this brief chapter. Despite his ideas being personifications of certain structures and functions of the psyche that describe tangible human experiences, Jungian psychology often remains unknown or misunderstood. Jung's ideas and case vignettes embrace the dissociative, transpersonal, and creative nature of the psyche with its transformative capacity expressed through complexes, archetypes, and symbols. Furthermore, Jung's continued influence within our contemporary culture is undeniable, illustrated by the breadth and depth of writing and research that has weathered time.

This chapter highlights Jung's contributions to the field of art therapy and explores several important notions, among them, how the ego processes unconscious material—images and art in particular. Also what do psychic energy and complexes have to do with symbols that ultimately facilitate healing? Understanding the fundamental theory behind Jung's technical concepts and definitions supports clinical integrity and enriches applications and approaches. This chapter begins by briefly considering relevant historical points regarding Jung's departure from Freud and Margaret Naumburg's personal experiences with Analytical Psychology that influenced the conception and formation of art therapy.

Foundations for Analytical Psychology and Art Therapy

Beginning in 1900, Jung was at the center of psychoanalysis at the Burghölze psychiatric hospital in Switzerland where he established himself as a clinician and researcher. These early professional years were greatly influenced by Eugen Bleuler's psychiatric accomplishments, exposing Jung to complicated mental conditions such as schizophrenia and dissociation. He was encouraged to consider patients' verbalizations as purposeful with unique meaning. His pioneering research using the Word Association Experiment included investigating intergenerational family members, which led to the formation of his theory on complexes and psychic energy. Prior to meeting Freud, Jung had established psychological principles that were rooted in theories of energy and based in biology and physics. These key insights laid the foundation for Analytical Psychology and prepared the soil for the field of art therapy.

Papadopoulos (2006) explained how Jung's dedication to personal experience, illustrated by *The Red Book* (2009), emphasized an alternative methodological approach. In his first lectures between 1896 and 1899, Jung highlighted the importance of real experience and balancing the inner world with the outer without prioritizing one over the other. Jung also embraced the doctrine of *teleology*, which postures "that people are driven to enquire after the cause of things, so much so that he even spoke of a 'causal instinct'" (Papadopoulos, 2006, p. 17). Departing from Freud's ideas on repression and drive theory, Analytical Psychology considers the unconscious material as both purposeful and compensatory for the one-sided conscious attitude of the ego, and while this internal confrontation typically causes psychological tension, the opposition galvanizes a dialectical and dynamic energetic relationship between the conscious and unconscious that forces a change in attitude. Jung theorized that this bridging process was made possible through the "transcendent function" (Jung, 1957/1969).

Jung and Freud

In 1906, after he read Freud's *Interpretation of Dreams*, Jung was so impressed that he sent his published Word Association Experiment research to Freud. The ensuing relationship between Freud and Jung lasted until Jung published *Symbols of Transformation* in 1912 (originally published as *Wandlungen und Symbole der Libido*), which departed from Freud on the issue of libido. Edwards (1987) described how the Freud/Jung split was influential for the field of art therapy:

After Jung's departure, Freud rarely referred to Jung, and then only in scathing terms, but it was Edward Glover who...set out to demolish credibility for Jung's theories. Glover...a strong Freudian loyalist, is... cited as a psychoanalytic authority on Jung. Ernst Kris...in *Psychoanalytic Explorations in Art* (1952), an influential book for early art therapists, derive[d] his...understanding of Jung almost entirely from Glover. The Freud/Jung split is therefore historically important for art therapy and continues to affect present practice.

(pp. 96–97)

Art therapy was seeded during difficult times, in complicated soil. Edwards (1987) argued that Jung's painful theoretical split with Freud resulted in not only an unresolved transference/countertransference issue between them, but also that this divide took on archetypal proportions remaining as a wedge between contemporary psychological communities such as art therapy. Further, Edwards believed that the founding fathers continue to exert emotional and intellectual power that is reinforced through oral traditions during art therapy training due to the absence of Jungian theory. Jung's case narratives are interspersed within his *Collected Works*, suggesting his approach is diffuse and enigmatic when in fact his case examples illustrate and reinforce his theories. Nevertheless, Jungian psychology remains in the shadows of clinical conversations and presentations, even though Jung's ideas and concepts are integral to the art therapy profession. In fact, his theories were exceptionally modern, and today many of Jung's terms and practices are now seamlessly integrated into psychological approaches and contemporary thought, usually without reference.

Naumburg and Jungian Art Therapy

Margaret Naumburg was sympathetic to Jung's ideas (Edwards, 1987) at the time she founded Walden in 1915. Both Naumburg and Florence Cane undertook a Jungian analysis with Beatrice Hinkle, the first American psychoanalyst who turned away from Freudian theory because of his views on women and the feminine psyche. Naumburg's analysis occurred between 1914 and 1917, "a time when relationships between Freudians and Jungians were at their most acrimonious" (Edwards, 1987, p. 95). As the first translator of Jung's *Symbols of Transformation* (1912) (published under the title *Psychology of the Unconscious* in 1916), Hinkle's intimate connection with Jung's ideas undoubtedly affected the unconscious psyches of both Naumburg and Cane, and like interconnecting roots of aspen trees, informed and fertilized the forming roots of art therapy.

Many years later, Naumburg (1950) took an in-depth but poised view as she compared the Freudian and Jungian approaches to symbols and pictures. Drawing from art therapy case material, she concluded that psychoanalytic theorists neglected the patient's views. Naumburg's belief that patients must make "interpretations of their own symbolic material" (p. 33) claimed therapeutic territory for art therapists to focus not just on the art, but also on the therapeutic relationship; this approach encouraged the development of the patient's relationship with the art. Not only does this follow Jung's advice with dreams, but Naumburg's emphasis on spontaneous art also echoed Jung's approach toward psychotherapy and art making, thus her advocacy for patients was fully in line with Jung's clinical views (Jung, 1931/1966). In addition, Naumburg and Cane developed innovative patient-oriented art therapy in which a devotion to the expression of the creative instinct was prioritized as curative. They relied on the spontaneous healing elements arising through the art rather than viewing the art as expressions of regressive or infantile tendencies that required interpretations to support ego development. This methodological trust in the innate healing capacities within the individual resonated with Jung's ideas on imagination and play, where true consciousness is not simply about ego development.

Naumburg (1950) referenced H. G. Baynes' art psychotherapy case histories perhaps because he worked closely with Jung through the 1930s, but he was also a significant supporter of art therapy. Baynes is known as having a major influence on Irene Champernowne, who established Withymead—a Jungian art therapy community—in the early 1940s (Stevens, 1986). Champernowne learned "the essentials of art therapy—how to enter into the drama of the painting with the patient, how to drop...into the individual's myth...how people can create their myth by dreaming, painting and modeling...how Jung had done this himself...[Baynes] knew all about *The Red Book*" (Stevens, 1986, p. 24).

However, as Edwards (1987) elaborated, what "remained of Jung in Naumburg's later writing seems to have been absorbed into her own theories of art therapy, which she steadfastly contrasts with more reductive approaches" (p. 95). Clearly, Naumburg never rejected the influences of Jungian psychology although she showed a preference for Freudian terminology, which was perhaps influenced by the powerful movement in the United States that aligned itself with Freudian theories (Edwards, 1987). We might hypothesize that had she aligned herself with Jung and Analytical Psychology, art therapy may have been discredited. As it was, she needed to convince medical institutions of its benefits, which resulted in a wisely carved path to avoid the acrimonious challenges of her times.

Jung the Art Therapist

Jung was a prolific and innovative psychoanalyst and art therapist in his own right. His work evolved from his rigorous and courageous psychological passage made evident with the publication of *The Red Book* (2009), in which his inner private experience of the image, symbol, and the collective unconscious were explored and key concepts formulated between the years of 1914 and 1930. Besides using art, Jung developed a method called *active imagination* where attention is turned inwards in order to cultivate a dialogue with inner images and symbols all the while seeking a reflective and psychological perspective. While the art process stimulates a natural condition for active imagination to take place, formal active imagination combined with art therapy is a powerful method used to access the unconscious (Wallace, 1987). Jung firmly believed this self-experimentation through the expressive arts was an essential process for expanding the ego's relationship with the unconscious. The technique incorporated his notion of drawing on two kinds of thinking: *directed* and *nondirected*. Directed thinking is associated with the intellect, the linear and differentiating aspect of the psyche, while nondirected thinking is associated with the image-producing aspect of the psyche used in art therapy. Weaving together these two types of thinking from the conscious and unconscious psyche is referred to as the *synthetic* or *constructive* method. These are fundamental tools of Analytical Psychology and are often used in art therapy approaches.

Jung was not a trained artist, but throughout his life he was an artistically creative and productive individual, particularly during times of personal crisis when he turned inwards for orientation and nourishment. Unlike his contemporaries, Jung did not marginalize or pathologize the creative process or the imaginative psyche, but openly valued and depended upon it. He pursued an investigation of his own psyche first, to *see* and *hear* the unconscious as image, and to research and outline a practice within psychology. He religiously wrote, drew, painted, and carved stone pieces as representations of his inner world, relying upon these creative processes to deepen his relationship with the unconscious. Jung brought his inner life into written and visual form, which created a foundation for the field of art therapy, and this was embellished by his clinical work where he also emphasized the regular use of art materials and fantasies to gain a truer elucidation of the therapeutic process and psyche's movement toward wholeness.

Jung's creative process was first recounted in *Memories, Dreams Reflections*. As a boy, he carved a manikin, a transitional object that held parts of himself (Jung, 1965, p. 34). Later this memory gave credence to *personality number one* and *personality number two* (introvert and extrovert) (Jung, 1921/1971). Gaining liberation through creative activities and dreams, Jung highlighted the creative instinct in Analytical Psychology, defining the psyche with five basic instincts or drives (hunger, sex, reflection, action, creativity), rather than just the sexual instinct (Jung, 1937/1969, p. 118).

The Red Book

After *The Red Book* (2009) was published and the original book went on tour, there was something of a seismic shift in collective consciousness. With Jung's most private process on exhibit, people engaged in formal and informal discussions about the various facets of Analytical Psychology. Jung's inner process was revealed to the world, not only displaying and confirming the psychological depths to which he traveled but also colorfully illustrating in detail his encounters with the unconscious. Jung's personal process was the structure for his new psychology that embraced an expansive view of libidinal energy and symbol formation. The traveling show included images from early paintings of nature and carvings to his paintings from *The Red Book*, all of which confirmed Jung's reliance on dreams and art materials during his psychological descent and transformation. As we can see today, Jung's paintings are detailed and colorful with a specific personal visual language that symbolically contained not just his theoretical beginnings or the aftermath of his separation from Freud in 1913, but also reflected and responded to the cultural crisis prior to World War I of prevailing fatalism (Jung, 2009). His daring self-experimentation resulted in a literary expression of a new psychological paradigm that would help to bridge the old world and the new.

Mandalas

For a time, Jung painted mandalas on a daily basis while serving in WWI in Switzerland. The mandalas provided him with a contained ritual space for detailed expression and reflection. While a common art therapy exercise today, Jung accidentally discovered this process, realizing that the circles were visual representations of the state of his psyche and his relationship to the *Self*. Jung's concept of psychological wholeness often described as the center and the circumference of the psyche. Consequently, mandalas influenced Jung's thoughts on the relationship between the personal and collective unconscious and the inherent *teleological movement of individuation*, or natural developmental progression of the psyche.

Jungian Art Therapy

Jung was a firm believer in using art materials, but he noted that the diversity within the psyche meant that no one therapeutic approach would suit every individual. He found early therapy focuses on assimilating aspects of the *personal shadow*—hidden or repressed psychological material—while later work may engage the *archetypal* or *primordial* layers of the psyche. Therapeutic stages are often visible in art therapy, not in a linear way, but in spiraling simultaneity that takes place in the making of the art and the non-making of art:

Urging my patients...to paint...I am met with...objection...I usually reply that...it is not a question of beauty but only the trouble one takes with the picture...To paint what we see before us is a different art from painting what we see within.

(Jung, 1929/1966, p. 47)

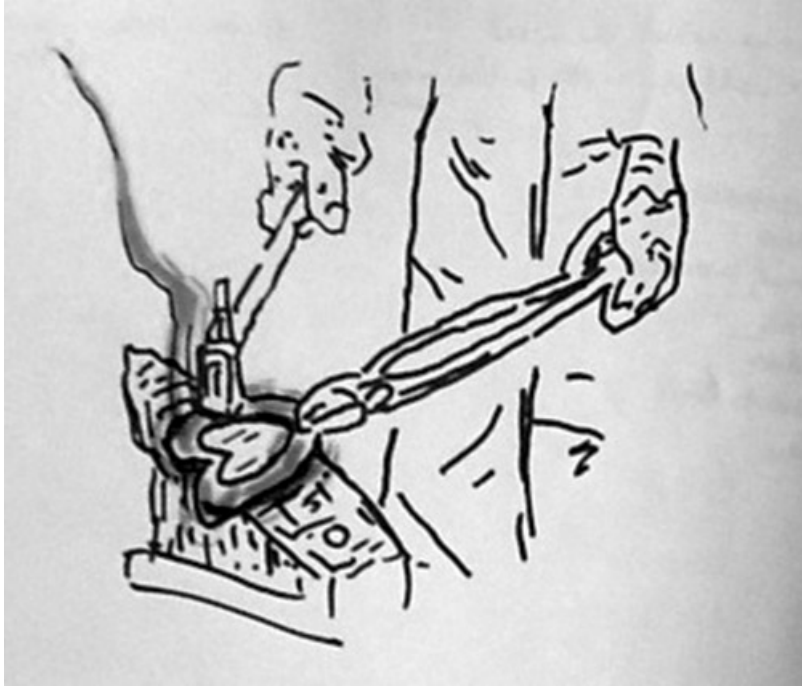
Jung further explained that “it is not a question of art at all—or rather, it should not be a question of art—but of something more and other than mere art, namely the living effect upon the patient himself” (Jung, 1966, p. 48). Jung’s thoughts were affirmed when a patient of mine said, “At first I didn’t want to do art...but I found it freeing. The next step of showing the sketchbook of ugly feelings to you is hardest,” because her inner world would become known, revealing not just her vulnerability, but also the image’s vulnerability to possible interpretations. Jung valued this unfolding art process as a transformative one:

But why do I encourage patients to express themselves at a certain stage of development by means of brush, pencil or pen? I wish to produce an effect...he puts down on paper what he has passively seen, thereby turning it into a deliberate act...he is actually doing something about it...[T]hese rough-and-ready pictures do indeed produce effects which, I must admit, are rather difficult to describe...he is freed from a wretched state of mind by working at a symbolical picture.... He is no longer dependent on his dreams or on his doctor’s knowledge; instead, by painting himself he gives shape to himself. For what he paints are active fantasies...he strives to catch his interior agent, only to discover in the end that it is eternally unknown and alien, the hidden foundation of psychic life.

(Jung, 1966, pp. 48–49)

Jung encouraged his patients to “give shape” to themselves, not just elucidate dream content but to make visual representations so as to move the process of the unconscious forward through “drawing, painting, or modeling. Often the hands know how to solve a riddle with which the intellect has wrestled in vain. By shaping it, one goes on dreaming the dream in greater detail in the waking state” (Jung, 1957/1969, p. 86).

When Lucinda dreamed of herself as a blacksmith hammering on a red and yellow heart-shaped metal piece, I asked her to draw it. The image ([Fig. 9.1](#)) reflected the “hammering out” process regarding her views about her life as an exile and the changes associated with her heart. As a compensatory image, the dream and drawing marked a turning point in her analysis, making her inner world visible. Jung said, “[I]t is the function of consciousness not only to recognize and assimilate the external world through the gateway of the senses, but to translate into visible reality the world within us” (Jung, 1931/1969, p. 158). Not only did the image reflect the endurance for the required alchemical process of heat and pounding that the therapeutic work required of us, but the drawing supplied further symbolic and metaphorical language for the painful inner experiences with which she was grappling.



[Figure 9.1](#)

Jung's Definitions: Map of the Psyche

To better understand how the image mediates and regulates the psyche, it is important to consider Jung's terms and definitions. Imagine a circle divided in half with a horizontal line. The top half represents *consciousness* and the bottom half the *unconscious*, which contains the *personal* and *collective unconscious*. The *collective unconscious* holds cultural content as well as ancestral, archaic material that resides furthest from consciousness. Based on his research and clinical observations (verbalizations, dreams, cross-cultural patterns and symbols), Jung defined the collective unconscious as "the whole spiritual heritage of mankind's evolution, born anew in the brain structure of every individual" (Jung, 1937/1969, p. 158).

These conceptual areas of the psyche are energetically linked by the progression and regression of libidinal energy, referred to by Jung as *psychic energy*. The *ego* resides in the seat of consciousness, serving as an orienting principle that contains identity, experiences, memories, and feelings. It expresses itself through the *persona* (mask) with either an introverted or extroverted typology (Jung, 1921/1971). What is disavowed or unwanted by the ego is considered *shadow* and remains in the unconscious until it is recognized by the ego. The ego engages with shadow content from the personal and collective unconscious through overpowering encounters with personal complexes (autonomous feeling toned images or thoughts) that contain archetypes (patterns) at their core and have the capacity to alter or transform ego consciousness. For instance, we may encounter someone with whom we wish to impress (*persona*) but we actually doubt ourselves (*shadow*); in this conflict, we may reject the feelings, yet we may have particular autonomous thoughts and behaviors (complex indicators). When we "confront our complex"—make it more conscious with art making and metaphors—we discover the archetypal pattern at the core of the complex, which then provides an expanded transpersonal view of our personal situation.

Complexes and Psychic Energy

Understandably, art therapists prefer the archetype and the symbol because they are most directly concerned with the visual imagination, but two primary dynamic forces that deepen an understanding of Jungian art therapy are often neglected. These are *complex theory* and *psychic energy*, both of which enable the psyche to become both approachable and visible.

Complexes

Jung defined a complex as an emotionally charged autonomous collection of images and ideas within the psyche. When activated, they can temporarily displace aspects of the ego and stimulate us to act in affect-laden ways. Complexes remain dormant in the personal unconscious until they are infused with sufficient psychic energy to become known—through physical or emotional outbursts, symptoms or somatic experiences, and/or ideas or passions. In other words, complexes are energy bundles; they are both inevitable and autonomous and they make us human. Complexes are formed in early childhood and contain roots to the parental *imagos* (an unconscious positive or negative image) that shapes the mother/father complexes. Jung viewed the psyche as dissociative, a landscape made up of many *splinter psyches* (Jung, 1931/1969, p. 97)—or autonomous complexes—that influence or gain control over the attitude of the ego: “The *via regia* to the unconscious...is the complex, which is the architect of dreams and of symptoms” (Jung, 1931/1969, p. 101).

In [Figure 9.2](#), Lucinda illustrated two contrasting aspects of her ego (identity) complex: one that hides like a dust bunny versus the dragon, a cultural style of expression that may overwhelm people. Painting both sides brought humor to the tension, but clarified what she wished to reclaim and what she wanted to release. By confronting these two opposing images, Lucinda reconciled what she valued beyond family expectations. Her watercolor shows how psychic energy comes into form and vivifies the individuation process.



[Figure 9.2](#)

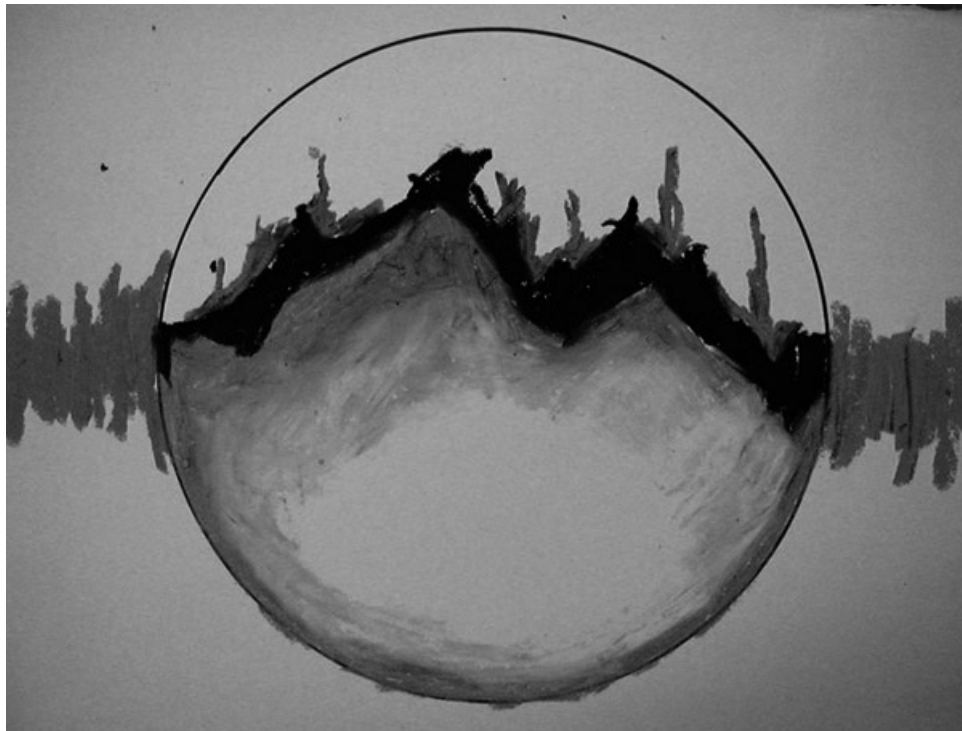
Jungian art therapy naturally facilitates a reconciliation of the internal conflicting opposites because the art expresses, documents, contains, and clarifies the condition of the psyche. Placing what is partially known into a shape or form outside the body not only expands one’s awareness, but also frees one from the grips of the complex so that a constructive process of curiosity, reflection, and an eventual shift in viewpoint can occur. The ability to reflect upon the foreground and background of art images challenges the ego to expand its relationship to the unconscious as well as the world. When a spontaneous art process flushes out unknown complexes from the unconscious, the resilient ego is challenged and thrown off center like clay on a revolving potter’s wheel. The repair is not just therapeutic but also symbolic of adjusting one’s relationship with the unconscious: a slowing down, reaffirming the connection between elbows and knees, realigning and attuning one’s focus on the relationship between the hands and the clay so as to begin anew.

Psychic Energy

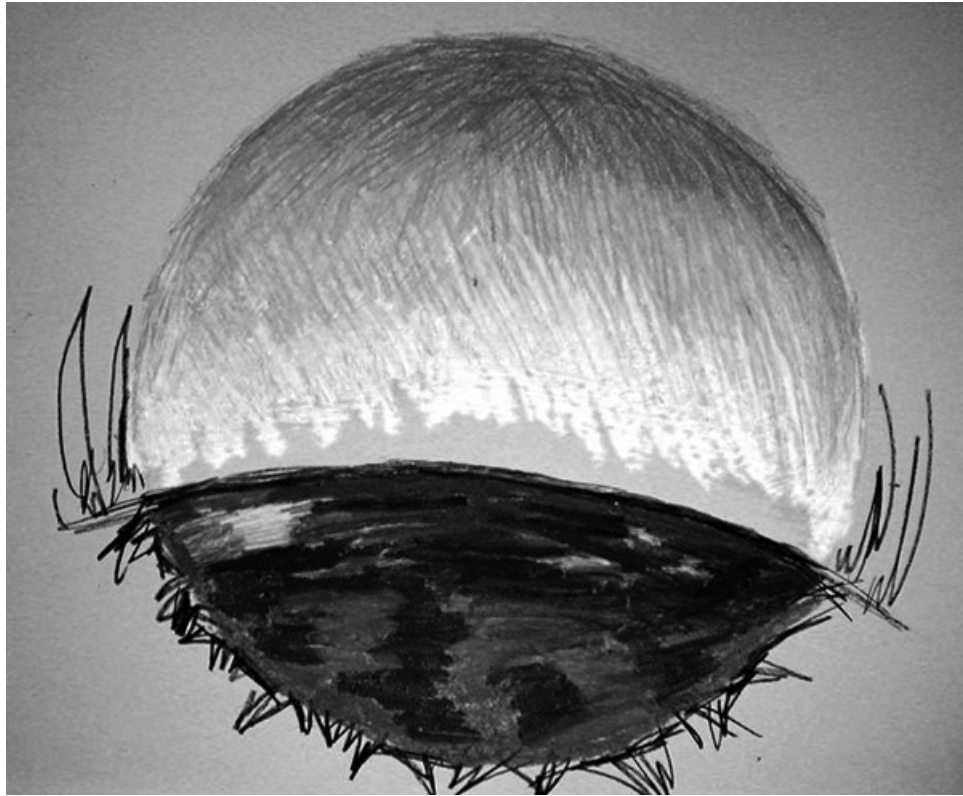
Psychic energy is the lifeblood of Jung's psychology. Its movement determines that we are alive; it carries emotions, is made up of instincts and contains the innate healing and regulatory capacity of the psyche made known to us through images and symbols. Psychic energy, evoked by such things as dreams, words, art images, or relationships, is a dynamic force that provides will, purpose, and the potential for transformation. The energy moves toward consciousness (progressive) as well as away from consciousness (regressive) creating a dynamic interplay between the conscious and the unconscious psyche. The speed and quality of this energy is also expressed through such things as line quality, pressure, intensity of color, shapes and forms, and choice of materials. While progressive psychic energy is more acceptable to the ego, Jung's departure from Freudian theory meant that Jung considered regression of energy (introversion) not repression of content, but as psyche's purposive attempt to deepen and expand consciousness.

When a resilient ego becomes temporarily "swamped" by a personal complex, there may be a rejection of the content (shadow), projection of the content onto others or the world (shadow projections), identification with the complex (inflation), or finally confrontation with the complex (integration), which initiates the process of loosening its autonomous and repetitive grip. As the ego engages with the complex and assimilates its "gifts," it regains its seat of consciousness and the complex falls back into the unconscious.

Jane, who was learning to trust her unspeakable feelings (complexes and shadow content), made a series of mandalas over many months to visually contain and tolerate the challenging psychic energy that was primarily manifesting through uncomfortable somatic reactions. The following four mandalas, taken from a larger series, demonstrate how well art illustrates the flow of psychic energy. For many weeks Jane felt a regression of psychic energy that forced her to draw waves of lingering melancholy and depression ([Figure 9.3](#)) along with simmering anger and "burning" rage ([Figure 9.4](#)). During the process of creating the mandalas with oil crayons, it was essential for Jane to accurately articulate the contrasting states of suffering that arose within her—a gradual process that led to a more concentrated yet balanced psychological position ([Figure 9.5](#)).

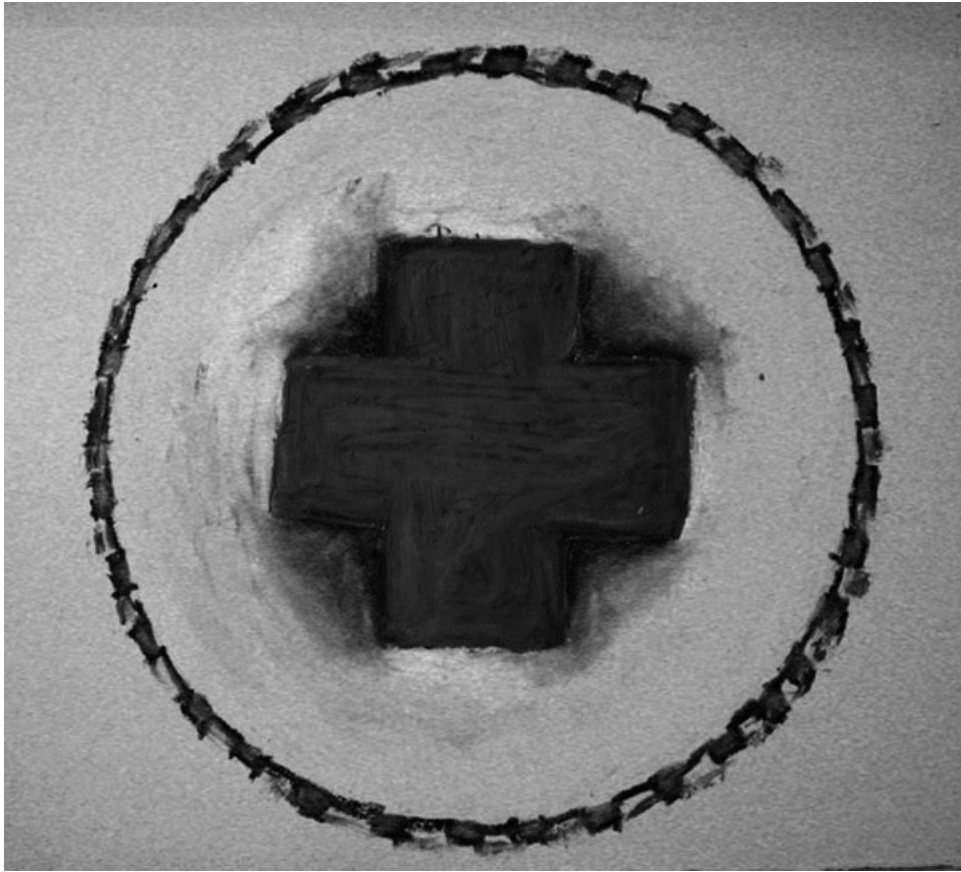


[Figure 9.3](#)



[Figure 9.4](#)

The unconscious offered a compensatory image that contrasted the state of her ego when Jane had a dream of a frog that she then drew ([Figure 9.6](#)). Unknowingly, her drawing even expressed the layers of the psyche, as imagined by Jung, with the frog situated in the collective unconscious. As she explored and assimilated the shadow material, her psychic condition shifted. The frog is a rich and complicated archetypal symbol, but Jane's personal associations were initially most important because they expressed her abhorrence of the frog, suggesting powerful *personal* shadow content associated with self-worth. Jung (1931/1966) said "we must renounce all preconceived opinions...to discover what things mean for the patient" (p. 157). While Jane reclaimed disowned parts of herself, on an archetypal level the frog served as a unifying symbol because it contained both the instinctual and spiritual aspects of the archetype. Essentially, Jane's mandala process documented the natural healing that occurs with the regression and progression of psychic energy and the arrival of a meaningful symbol. Working with her associations to the frog gave Jane an opportunity to discuss an expanded view of herself in the world (sky) with all its possibilities (stars). Eventually, she would express this psychological transformation in her everyday relationships and life activities.



[Figure 9.5](#)

Archetypes

As psychic energy flows from the complex into an archetype, the archetypal image is activated and becomes partially known. Throughout his life's work, Jung revised his definitions of the *archetype*, but it essentially serves as a psychological construct theorized to describe unconscious universal structures, inherited blueprints, or templates that organize psychic energy along certain repeatable and recognizable paths originating in the collective unconscious. *An archetype forms the core of a personal complex.* Unlike the complex, it *cannot* be seen directly, nor represented directly nor confronted directly; but it is recognized by universal images, symbols, or patterns. Examples of archetypes are expressed through common images such as mythological characters, clocks, circles, trees, rivers, spirals, oceans, or mountains among others.



[Figure 9.6](#)

Archetypes have a dual nature imagined as a bi-polar spectrum with the infra-red wavelength on one end (instinctual nature) and the ultra-violet wavelength on the other end (spiritual nature). The instinctual and spiritual poles of an archetype provides a two-sided view of the same organizing principle existing in the unconscious. For instance, Jane's frog expressed her creative instinct as well as the mysterious psycho-spiritual energy.

In Jungian art therapy, archetypal images carry transcendent and transforming potential, and the art products tend to be universal, powerful, and long lasting, particularly if the ego is sturdy and receptive. But focusing only on archetypal content can bypass the personal and interpersonal experiences of the therapeutic moment, because such a focus may feel diminishing and abstract in the face of strong personal emotions. If the ego is unyielding or easily susceptible to being overwhelmed, archetypes flood the psyche and lead to psychological disorientation or even psychosis, in which case it is therapeutically beneficial to hold archetypal associations in abeyance. If archetypes are idealized, clinical treatment can be jeopardized by mania and avoidance, or ego inflation through over identification or glamorization. However, when the ego is sturdy, archetypes provide compensation for what is lacking in the conscious psyche; they contain powerful healing qualities and choices expressed by transforming symbols and when subjected to mysterious or spiritual

archetypal experiences, the psyche is changed forever.

Image and Symbol

Images are reflections of psychic energy, while symbols are formed following a dedicated dialogue with archetypal material through active imagination. Simultaneously, the symbol becomes infused with personal meaning that impacts the conscious attitude. Not all symbols have an equal impact on the psyche, but generally symbols attract, organize, hold, and carry psychic energy and transform our psychological development by moving the energy from the unconscious to consciousness. In Jungian art therapy, a differentiation is made between signs and symbols: Signs are fully known to us (a stop or yield sign), while symbols represent archetypes and express what is only partially known to us.

Rejecting Freud's reductive process of associations, which is like a string of beads, moving from one association to another until arriving at the final association, Jung's *synthetic method* requires a continual and precise return to the *original image* with each association. With directed and nondirected thinking, the synthetic method unifies the dualistic (conscious/unconscious) nature of the psyche eventually producing the symbol. When the ego becomes too one-sided, the symbol or the art image offers compensation for the ego's condition. Such as with Jane's frog, a sense of personal meaning is accelerated through circumambulating the image and collecting associations that amplify the complex and reveal the archetypal layers. In art therapy, this association process may occur when looking at such things as lines, shapes, colors, orientation and perspective, and placement, as well as the content.

While Freud brought value to unconscious material, he treated it through a reductive analysis that primarily explained the symbols as infantile wishes with the unconscious as a receptacle for repressed contents. Jung viewed the unconscious as purposive and compensatory and the regression of psychic energy as self-regulating. Because psychic energy activates the complexes and their archetypal core, symbols serve to unite the rational and irrational aspects of the psyche. The ego's ability to cultivate an understanding of the living symbol is psychologically liberating. Symbols provide some structural understanding of the unconscious because they represent what is partially known to us while some portion remains unconscious. Jung thought they arose from the central organizing principle (Self) within the collective unconscious; they could be healing, destructive, or even prophetic. In a 1929 letter, Jung wrote:

Freud should have said "symptom" or "metaphor" [instead of symbol]. The symbol never arises in the unconscious...but..."in self-formation." It comes from the unconscious raw material and is formed and expressed consciously. The symbol needs man for its development.... It grows beyond him, therefore it is called "God," since it expresses a psychic situation or factor stronger than the ego...(I call it the self)...it supplants the ego in essential respects.

(Jung, 1973, pp. 59–63)

Jung's belief in the innate healing capacity of the psyche expressed through the symbol led others to assign a somewhat spiritual or mystical tone to his interest in the transpersonal nature of the psyche. These numinous experiences simply refer to a shift in consciousness from the ego to the Self. However, the religious psyche was one of Jung's most expansive psychological contributions that validated ineffable archetypal experiences rarely mentioned but often expressed through art therapy processes.

Transcendent Function

How does the psychological shift occur? When we see the art image as separate, our inner world becomes visible; a painful conflict may be evoked for the ego when the tension of the opposites comes into view. A shuttling to-and-fro between our inner experience and what we see before us (from the unconscious) constellates the tension that is ignited with enough psychic energy for “a living, third thing...a new level of being, a new situation...the transcendent function manifests itself as a quality of conjoined opposites” (Jung, 1957/1969, p. 90). In this method, the ego must deliberately engage with the unconscious material that is pushing for a change in consciousness. Jung further clarified when he wrote:

[T]he production of unconscious compensations is a spontaneous *process*; the unconscious realization is a *method*. The function is called “transcendent” because it facilitates the transition from one psychic condition to another by means of the mutual confrontation of opposites.

(Jung, 1939/1969, p. 489)

In other words, the transcendent function is a method, a function and an expression of psychic energy, and the symbols contain the unification of opposing energy (rational/irrational) within the psyche. Symbols are not created artificially, but are cultivated until they spontaneously emerge out of the collective unconscious as something that is partially knowable or understandable by the current condition of our conscious psyche. Active imagination strengthens the symbols. When the transcendent function moves the psyche toward wholeness as an individuation process, a felt sense of unification is awakened between the ego and the unconscious that is described as transcendent, numinous, or transpersonal, and celebrated by the living symbol.

Individuation

Individuation does not result in isolation and individualism, but urges us to become more whole by working to integrate our shadow—our human faults—and at the very least take responsibility for them. Indeed, because the Self offers a larger perspective beyond our own ego, it pushes us toward an intermingling of our private life with that of our community, shifting us out of our isolation. Complexes and archetypes also press upon the ego to surrender and sacrifice so as to integrate what is offered from the archetypal layers. Similarly making art involves a continual process of surrendering and sacrifice—we place marks on a virgin piece of paper or overwork a painting that was once acceptable.

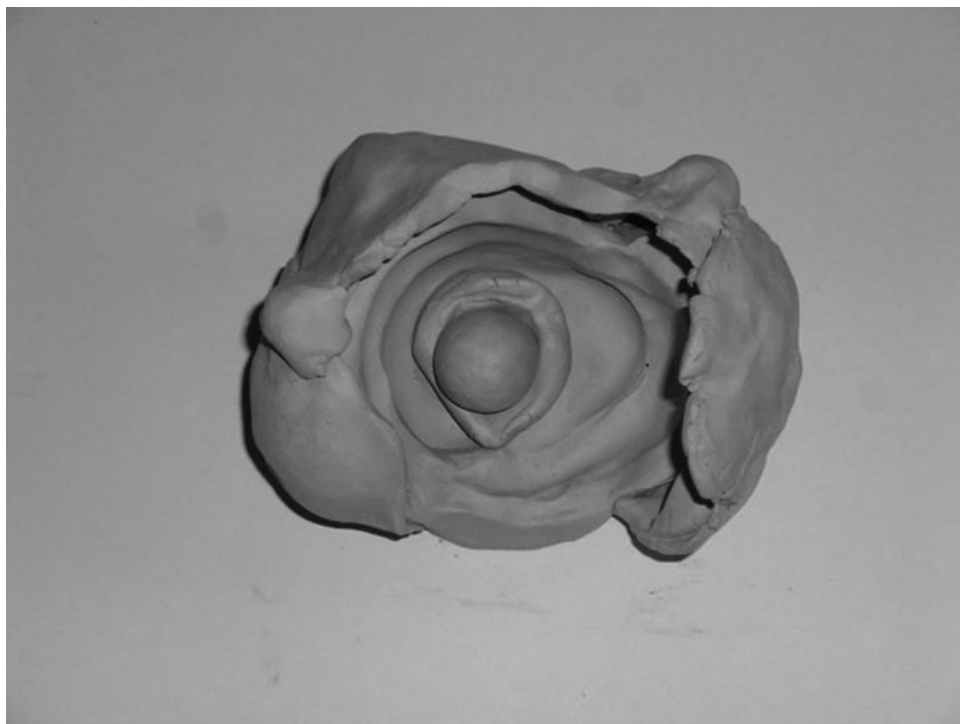
Because archetypes are colored by our complexes Jungian art therapists simultaneously consider the personal and archetypal layers of the psyche found in the art as support for the individuation process. For instance, in a recent art therapy, group members drew mandalas in response to a discussion of a conflict. The presence of the Self was palpable when the members placed the mandalas in a circle and noticed the synchronicities in patterns, stories, and symbols that revealed individual tasks as well as the group's collective efforts.

Psyche as Self-Regulating

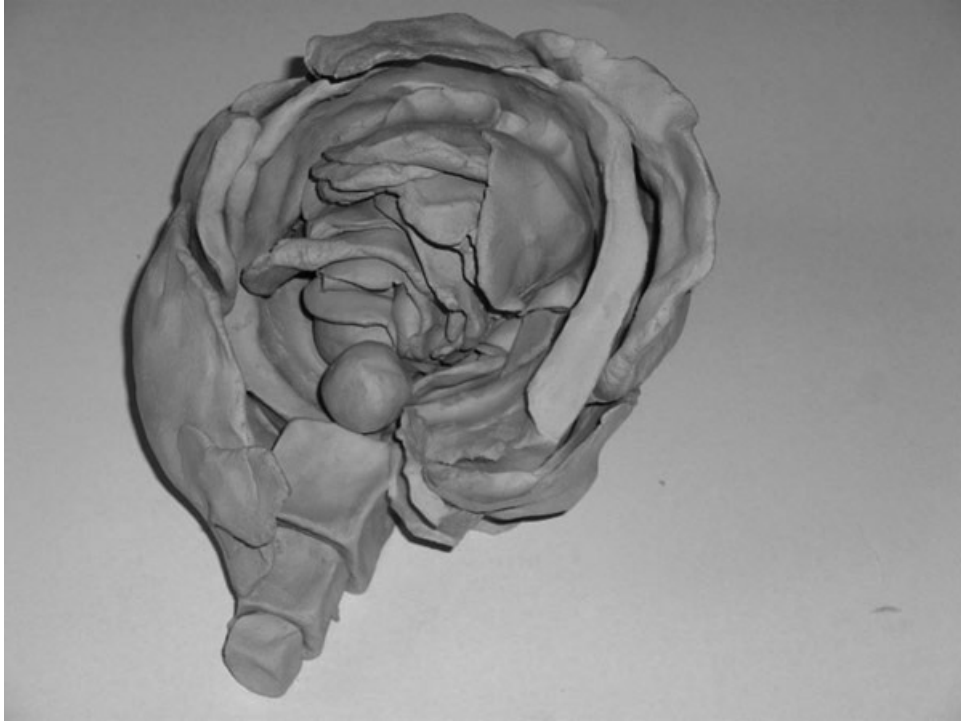
Because psychic energy moves between the conscious and unconscious, Jung saw the psyche as a naturally self-regulating system. Jungian art therapists working with early childhood traumas and somatic material are especially attentive to these fluctuations of energy (affect regulation and attunement). Art supports the therapeutic process of confession and elucidation by making shadow material visible (Jung, 1929/1966, p. 68). While art holds the unspoken story relegated to the shadows, Jungian art therapists are trained to consider the ego state, the potency of complexes and the archetypal forces that may interrupt or bring about healing.

While it is occasionally important to support ego functioning with art directives, the unconscious may counteract the resisting will of the ego with powerful compensatory imagery. If the ego resists, the healing function of the unconscious is overlooked and disregarded; increased symptomatology may ensue. This is clinically relevant for early childhood trauma because “the ease with which the counteraction can be eliminated is proportional to the degree of dissociability of the psyche and leads to loss of instinct” (Jung, 1957/1969, p. 80). Disconnection from instincts leaves the young psyche unconscious, autonomous, and adrift, and can occasionally result in the unleashing of self-harming or self-sabotaging behaviors. Jungian art therapy depends upon the self-regulation of the psyche while navigating the complex and the painful struggles that become visible.

Holle used clay ([Figures 9.7](#) and [9.8](#)) to express painful memories of maternal sexual abuse. For months she reproduced a similar form (archetypal structure) that varied in size and texture. Psychic energy was expressed through how she touched the clay—her emotional and verbal expressions as well as her preverbal somatic memories became visible, held by the clay forms. Holle revealed what had remained hidden and inexpressible (shadow); the repetitive image reflected the purposive nature of the creative psyche with its innate healing function. While the clay process expressed various aspects of Holle’s trauma complex, eventually the layers shifted to balls that were first inside but were then kept separate, illustrating a process of differentiation as well as a process of individuation. The clay provided both process and structure for Holle as she pieced together her story, and found a path out of the grips of not just the personal mother complex but also the archetypal energy associated with early childhood abuse by her mother.



[Figure 9.7](#)



[Figure 9.8](#)

Through the use of art materials, Jungian art therapists work to stitch together the tattered psyche that has been severed from both its instincts and its connection to the Self. Spontaneous painting and collage or loose directives such as “draw a shape and fill it in with how you’re feeling using lines, shapes, and colors” or “mold your conflict into clay” will initiate a process of building inner connections and uncovering what is nonverbal, hidden deep within the psyche. The art forms provide an archetypal structure into which psychic energy flows, like the riverbed that fills with water to reveal the affect-laden aspect of the complex. Stepping away from the clay or picture after the creation evokes a separation process, one of dis-identification, differentiation, clarification, and amplification with the support of verbal exchanges between client and art therapist. As one engages with the art in the liminal transitional space, so as to “get to know it,” the ego’s one-sidedness may soften and expand, as the person finds appreciation for the visual expression of affect that brings a new level of consciousness.

Analytic Attitude and Art Therapy

Cultivating a personal symbol or image for our work aids in the development of an analytic attitude that respects both the personal complexes and the archetypal process. Jungian art therapy is viewed as a hero's journey, a descent into the unconscious, an alchemical process, or one of initiation. Over the years, the pregnant woman has provided me with a metaphorical lens and archetypal images that remind me of my relationship with the client, the art, and the unconscious. *Gateway*, *Attending*, and *Passage* (Swan-Foster, 2012) are three archetypal patterns that may surface within therapy. *Gateway* is a time of anticipation and *Passage* is the effort put into the birth of the new, while the *Attending* phase concentrates on tending to and caring for the art and the whole psyche in the way the pregnant woman cares for herself and her unborn. The pregnant woman cultivates a presence of *being* while also *becoming* through confronting, sorting, amplifying, and reflecting on personal and unconscious material. Relating to the art expressions with this perspective requires a softening of consciousness and a capacity for symbolic thinking. Art therapy sessions may have an abundance of images at risk of being nailed down and defined, but instead the art therapist needs to be *Seeing* (Wallace, 1987) and *Attending* to the mystery of the individual's unique process, trusting in the purposive nature of the psyche that is now knowable through its capacity to provide visual evidence through images, art productions, and meaningful narrative responses. The images speak for themselves.

When we are easily sidetracked by goals and interventions, we overlook the “cure” often found within the image that can be developed and enriched by symbolic material. An analytic attitude implies that the unconscious leads the way in the therapeutic work and that the therapist brings tools and knowledge but enters without knowing the path. Only then, while sharing with and being observed by the analyst, can the natural healing occur. Undoubtedly, this requires a level of devotion and fortitude for uncertainty and paradox, along with a desire to ask *what is the purpose of this image?* Asking this question implies a relational attitude of trust and respect.

Another premise of Jungian art therapy is the willingness to be *touched* by the art—to experience some healing from the work. As a partner in an alchemical process, the therapist is “part of the psychic process of treatment and therefore equally exposed to the transforming influences” (Jung, 1929/1966, pp. 72–73). Jung is referring to an attitude of curiosity and openness to the material's influences, teleological movement, and the uncovering of shared meaning. Holding this attitude, Jung recommended the therapist undergo his or her own therapy, which remains an essential ingredient for successful art therapists today. Most valuable is how art reflects and is reflected upon in sessions, establishing an intermediary space for personal complexes and transference/countertransference experiences to become visible through the art within the container of the client/therapist dyad (Schavarien, 1995, 2001).

A Jungian practice also presents a challenge: On the one hand, overly defining concepts and terms trap the psychology as lifeless and concrete, while on the other hand, the seduction to idealize and inflate archetypal images may inhibit recognition of the personal suffering. One side is overly mechanistic and tends to devalue the unconscious, while the other side uses imaginal material to bypass the personal in favor of the collective unconscious. Resisting one-sidedness, Jungian art therapy requires a deliberate wrestling with the opposites—the conscious and the unconscious—until something new becomes known. Then the archetypal lens amplifies and affirms the painful but meaningful purpose that individuation imposes upon us. The question becomes then, *How will we bring this new attitude into the world?*

Conclusion

For Jung, it was not enough to marvel at the contents from the unconscious. Instead, he believed one must live in relationship with the unconscious material, following the threads so as to stitch, tie, and knot them into one's daily life. The symbol comes to us not to entertain, but to provide an expansion of the ego's view, compensating for what is predictable. Art therapists seek associations and amplifications, so that metaphors and symbols become accessible and the Self—the creative matrix of the whole personality—is increasingly more knowable to the individual. This forward movement of psychic energy of the individuation process requires a sacrifice to the creative process and an honoring of the visual gifts gleaned from the unconscious contents it reveals. The visual offerings are not neglected, but are rather incorporated into daily life. Jungian art therapy makes visible the transformations within us, enabling us to feel alive with greater trust in the unconscious and our relationship with it. When this process is awakened and occurs on a regular basis, healing through art, images, and symbols is not only possible, but becomes an essential way of living a meaningful psychological life.

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Addendum

Jung as an Artist

Michael Edwards

Because Michael Edwards, an art therapist who trained as a Jungian analyst, described Carl Jung's own artistry so well, I have excerpted some of what he wrote in his chapter for the first edition of Approaches to Art Therapy here.

In his own life and in his approach to analytic treatment, Jung anticipated ideas about using imagery in therapy to which most art therapists would subscribe. Although not a trained artist, Jung was quite a talented amateur landscape painter. However, it was not with landscapes but with inner sources of imagery that Jung was preoccupied (Jaffé, 1979).

In *Memories, Dreams, Reflections* (1963) Jung describes a boyhood of vivid dreams and eidetic fantasy images. At 10, at a time of stress and personal alienation, he discovered relief in making a secret totemic figure:

I had in those days a yellow, varnished pencil-case of the kind commonly used by primary-school pupils, with a little lock and the customary ruler. At the end of this ruler I now carved a little manikin, about two inches long, with frock coat, top hat, and shiny black boots. I coloured him black with ink, sawed him off the ruler, and put him in the pencil case, where I made him a little bed. I even made a coat for him out of a bit of wool. In the case I also placed a smooth, oblong blackish stone from the Rhine, which I had painted with water colours to look as though it was divided into an upper and lower half, and had long been carried around in my trouser pocket. This was his stone. All this was a great secret. Secretly I took the case to the forbidden attic at the top of the house...and hid it with great satisfaction on one of the beams under the roof...I felt safe, and the tormenting sense of being at odds with myself was gone.

(p. 34)

Jung later describes how, in 1913, while still feeling disoriented by the trauma of his break with Freud, he found stability by building symbolic structures with stones from the Zürich lakeshore:

I went on with the building game after the noon meal every day, whenever the weather permitted. As soon as I was through eating, I began playing, and continued to do so until the patients arrived; and if I was finished with my work early enough in the evening, I went back to building. In the course of this activity my thoughts clarified, and I was able to grasp the fantasies whose presence in myself I dimly felt.

(*Ibid.*, pp. 168–169)

Throughout his life, particularly at times of personal crisis, Jung drew, painted and sculpted representations of his inner experiences. This was not a peripheral activity, but a vivid source of personal insight into his situation; informing the development of many of his theories. No other major psychologist attended to his own inner life through imagery in this way. In fact, Jung's ideas can best be understood in the context of the value he attached to the subjective reality of spontaneously generated images.

Freud had led the way in giving recognition and importance to such imagery, especially in dreams, but there is a distinction. Freud treated the dream, the fantasy, or the unconscious factor in a picture as a puzzle to be solved and explained, whereas Jung attempted to relate to the unconscious image as an entity in its own right. In doing so he examined images from a number of perspectives, cultural as well as psychological. His is an open, hermeneutic mode of interpretation, lacking the economy and elegance of Freud's method, but offering

instead a reevaluation of traditional ways of understanding inner experience.

Realizing the psychological value that he personally discovered in exploring images from the unconscious, Jung began to encourage his patients to make visual representations of their dream and fantasy material. This began at least as early as 1917, and continued throughout his analytic work. His closest followers worked in a similar way. The paintings and drawings were not generally made during the sessions, but were nevertheless considered integral to the ongoing therapeutic process:

But why do I encourage patients to express themselves at a certain stage of development by means of brush, pencil or pen?...At first [the patient] puts on paper what has come to him in fantasy, and thereby gives it the status of a deliberate act. He not only talks about it, but he is actually *doing* something about it. Psychologically speaking, it is one thing for a person to have an interesting conversation with his doctor once a week—the results of which hang somewhere or other in mid-air—and quite another thing to struggle for hours at a time with refractory brush and colours, and to produce in the end something which, at its face value, is perfectly senseless. Were his fantasy *really* senseless to him, the effort to paint it would be so irksome that he could scarcely be brought to perform this exercise a second time. But since his fantasy does not seem to him entirely senseless, his busying himself with it increases its effect upon him. Moreover, the effort to give visible form to the image enforces a study of it in all its parts, so that in this way its effects can be completely experienced.

(CW16, 1966)

Jung does not seem to be describing either catharsis or sublimation, but the idea that the patient enters into a relationship with an unconscious image. Jung continues: “It is true, I must add, that the mere execution of the pictures is not all that is required. It is necessary besides to have an intellectual and emotional understanding of them: they must be consciously integrated, made intelligible, and morally assimilated. We must subject them to a process of interpretation.”

...Jung never published an extended account of his experience with imagery, although he refers often to the technique of “active imagination,” in which the drawing and painting of images from the unconscious can play a crucial part.

Active Imagination

Edith Wallace

Because Edith Wallace, a Jungian analyst who was also an artist, described such a beautiful example of “active imagination” in her chapter for the first edition of Approaches to Art Therapy, it is excerpted here.

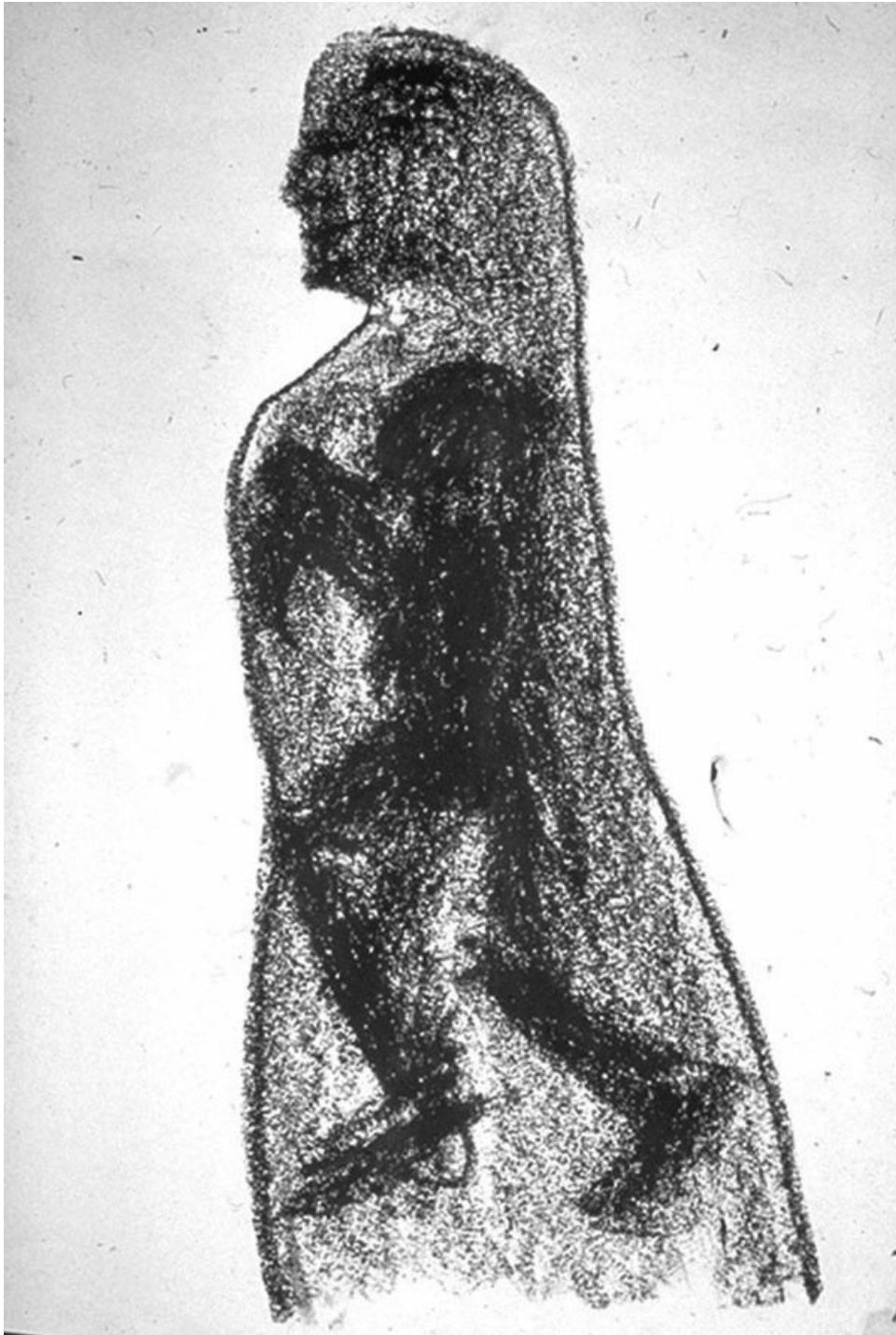
An Example of Active Imagination

Setting the stage for transformation can be a very active pursuit and quite hard work. Following is an interesting illustration of the balance and timing between activity—what we can and must do—and standing still or taking a “leap in the dark,” not knowing where it will land us.

It is the story of a young woman—in her late twenties—who, as the first two pictures show ([Figs. 9A.1](#) and [9A.2](#)), was struggling to get out of the protective womb of the mother. She then had some visual images that—characteristically—moved; so there was a process going, a story which she wrote down and later illustrated. This young woman had been working with me for some time, and so was now ready for such a process. Although active imagination can and often needs to be done by the analysand on his/her own, there must be some supervision, and there must be readiness.



[Figure 9A.1](#)



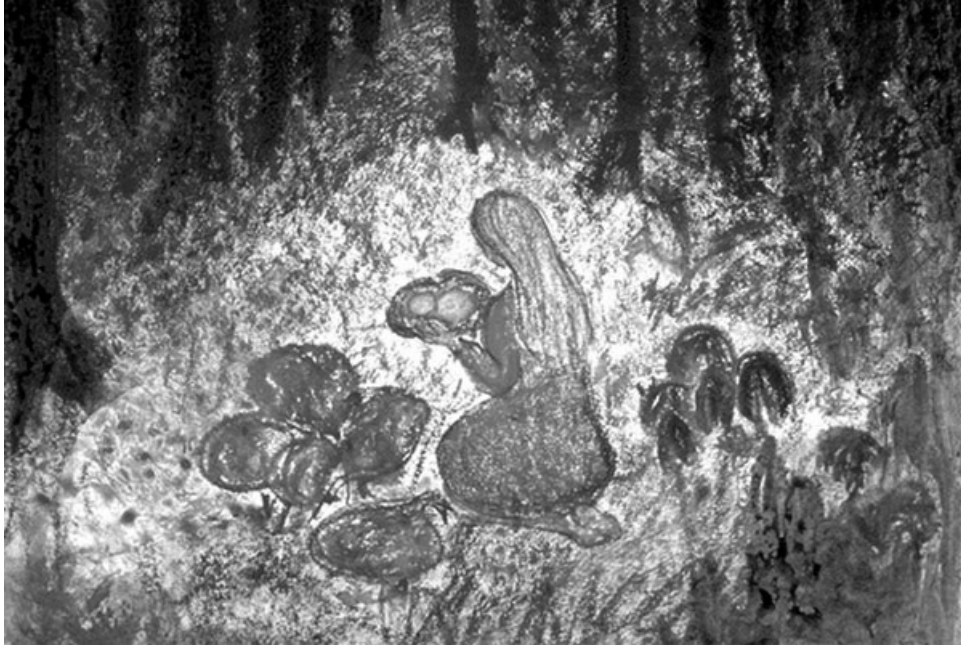
[Figure 9A.2](#)



[Figure 9A.3](#)

Christina's Story

December 29th. I can see only darkness; then I see that there is a lake with faint reflections of light on it. The water leads into a tunnel. I am in a green boat on the lake; I have a pole to push the boat forward. I go into the tunnel ([Fig. 9A.3](#)). The only source of light is a small white light in the distance. It illuminates the walls of the tunnel. They are wet and shiny. It is very quiet, the water is motionless. Only the boat makes ripples on the surface as it moves forward. I push the boat until the passage becomes too narrow and I leave the boat and dig. I had expected rock, but there is crumbly earth. I break through and find that I am looking out on a huge vault, like the inside of a huge bowl. I am on the side, about two-thirds up. There are lights in the crevices above, like a firmament, but I know it is all deep under the earth. I must get down to the bottom. I find that I have a sturdy white nylon rope, and I fasten it to something securely and let myself down. The bottom of the vault is pitch dark, and swampy. I manage to move on by stepping on tufts of grass. Then I feel rather than see a huge snake. She is not threatening, but very powerful. I get up on her back and she carries me. We come to a place where I see a blue glow, like an iridescent blue glass bowl. Around it dance flames; they are blue like the inside of candle flames. Around the blue flame sits a circle of dwarflike little men, guarding it. In the middle of the blue is something gleaming white-yellowish; I can't see what it is.



[Figure 9A.4](#)

December 30th. Then suddenly I am inside the blue bubble, which now seems as high as a room. It has a round hole in the middle of the bottom; out of the hole shoots up a jet of water, and it balances a luminous white large pearl—the white thing I saw from afar. As I look at the shimmering pearl dancing on the water, I know that I shall fall into the hole if I take it. I hesitate, stretch out my hand, withdraw it. Then I take heart and take it. I fall, and am on a meadow with spring flowers ([Fig. 9A.4](#)). I look at the pearl in my hand. It feels soft, gelatinous. It is now a small object of the form of a child, but all covered with the gelatinous substance, so that I can't see its limbs or its features. I know I must protect it from drying out. I find some huge green leaves, and I pluck some and carefully wrap the child into them.

January 1st. I take my leaf-wrapped bundle and go into the forest. It is a spruce forest, no undergrowth, all dark and quiet. An animal comes toward me on the path, a wolf with yellow eyes. He quietly tugs on the bundle; I understand he wants me to come along. We go to the left into the forest, off the path, and go until we reach a freer space and a brook. We follow it back up to its source. It comes out of a little pool, very clear, but so deep that one can't see to the bottom. On the water is a big strong leaf, shaped like a receptacle for my bundle. I put my bundle into this leaflike bowl and am just about to take my hands off when I see the edges curl together and the water begins to move, in a churning and downward-sucking motion. I snatch the bundle back. I have it safely, but now the water recedes when I try to catch some in my hands to moisten the bundle. The wolf has watched all this; now he looks at me inscrutably, turns and vanishes into the forest. I begin to worry; where shall I get water so that the bundle doesn't dry out? Then it starts to rain gently; I go back down alongside the brook until I come to the edge of the forest. Night has fallen. There is a moon, and some misty clouds.



[Figure 9A.5](#)

I have come to a pasture. I see a cow and walk toward her ([Fig. 9A.5](#)). I see that the leaves of my bundle have wilted and take the top leaf off to look at the child. The cow starts licking it, and slowly there emerges a boy-child with black hair and blue eyes.

January 5th. I need milk for it. I am thinking about milking the cow, and then I see she has vanished. In front of me stands a young woman. She has bared breasts, she is beautiful. I know she is a whore; I also know that she is the one who has abundant milk for the baby.

Discussion

This is a transformation story, a new birth, a change from daughter to mother, from being carried and protected to being responsible for carrying and protecting a precious child, that was behind the luminous pearl which she acquired through her own effort and trust. At first she has to be active: (1) she pushes the boat with a pole; when she gets stuck (2) she digs; (3) after finding a rope, she fastens and lets herself down on it; (4) she moves on by carefully stepping on tufts of grass to avoid the swamp; (5) she climbs on the back of a huge snake who carries her; all along knowing she wants to get to the bottom of it, though she is already deep down under the earth.



[Figure 9A.6](#)

The encounter with the snake is an important moment in the story ([Fig. 9A.6](#)). The huge snake is an elemental creature who now carries her, and is female according to her own statement. Her wish to be carried is also a need, not to be expected from her own mother or any substitute, but from an elemental archetypal force in nature, also in her nature.

Then comes the “leap” for the pearl, and after that decisive step there is a change. The light quality, the very atmosphere—as the illustration shows—has changed. This is reminiscent of the Grimm story of “Mother Holle.” A girl who lost her spindle while spinning by a well is sent by her wicked stepmother to bring back the spindle. In despair she jumps into the well where the spindle was lost, and finds herself on the same kind of sunlit, flower-strewn meadow as in [Fig. 9A.4](#). She shows the same courage and fortitude, and tasks also await her, as well as a reward. Christina is now concerned for the child in need of her care—she becomes the caring, carrying, protecting mother also looking for nourishment.

In the gnostic “Hymn of the Pearl,” in which a young man is sent by his father to retrieve a lost pearl, the pearl represents the soul. The young hero at first forgets all about his mission and gets into bad company, but finally, in real distress, he remembers and returns home with the pearl, the soul regained. The dwarflike figures in Christina’s vision are guardians of the pearl, those underground helpers we all have, the “cabiroi” of whom Goethe in *Faust* (Part 2) says: “Small in length, mighty in strength.”

There is one more crucial moment in Christina’s story. Guided and challenged by a wolf, she comes to a source of water where she can wet her bundle which needs to be kept moist (= given life). She is ready to take her hands off the bundle when she notices that the water recedes “in a churning, downward-sucking motion.” Now, and this is crucial, she is alert enough to snatch the bundle, to prevent this newborn child from disappearing into the unconscious, when all the work would have been lost. At this moment the wolf leaves, as if he had been sent to test her.

Now help comes in the form of rain—from above, in contrast to the pool of water—from the earth. The cow, who has appeared in the moonlit landscape, is not the one to provide milk to nourish this new-found spirit, represented by a boy-child. Nourishment must now come from a human being, a young woman who knows how to relate to men, even though, as a whore, she is not the best representative of a fulfilling, intimate relationship. The transformation is from a child, protected and carried by the mother, to an adult who knows how to care for her own soul, and how to protect and find nourishment for her new-found spirit.

The consequence she had to accept was to move away from the mother world; for one thing, it was now

time for her to work with a male analyst. This also helped her to withdraw projections, like expectations with negative feelings for her mother. The Great Mother—earth, snake—had come to her aid, and had made her courageous actions possible. Such archetypal forces reside in all of us, often strong and driving.

Although Jung did not do “art therapy,” the use and understanding of images are of utmost importance in Jungian work. The aim is not to produce art, but to use that which comes from hidden sources—which can be brought to light through art media—to promote consciousness, understanding, growth, and transformation. It is always a process, whether for the artist—the “patient,” or the healer. Through highlighting and illustrating what Jung meant by “active imagination,” I hope I have clarified what may be of use in art therapy, a process that accelerates both healing and creative potential—which are synonymous in my mind. If we do not live our potential—or at least part thereof—we become sick. Living our potential means health and wholeness.

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Part III

Humanistic Approaches

10

Art Therapy

Humanism in Action

Bruce Moon

Author's Note

The clinical vignette in this chapter is, in spirit, true. However, details have been changed to ensure the confidentiality of persons with whom I have worked. The case illustration and artwork presented is an amalgamation of many specific situations. The intention is to provide realistic accounts of an art therapist's work, while also protecting the privacy of individuals.

In the second edition of this text, Rubin (2001) titled Section II "Humanistic Approaches." It was comprised of five chapters describing art therapy practice from phenomenological, gestalt, humanistic, person-centered, and spiritual perspectives.

In preparing to write this contribution to the third edition, it struck me that that title may have been a misnomer in that humanism, in relation to psychotherapy, has more to do with the therapist's way of being in the world, than his or her methods, techniques, or procedures. Thus, humanism cannot really be an art therapy approach.

In the earlier edition Rubin also commented, "Although psychodynamic approaches still dominate art therapy, it would seem that humanistic ones continue to increase in popularity" (p. 120). Thus, Rubin proved prescient in that the ensuing years have seen a dramatic shift toward humanistic orientations and away from psychoanalytic ideology in art therapy. It is my sense, in fact, that humanistic orientations underlay how most contemporary art therapists think about themselves and their practices.

A Brief Overview of the Roots of Humanist Psychology

Humanistic psychology emerged in the 1960s and 1970s as a *third force* alternative to Freud's psychoanalytic theory and Skinner's behavioral approach. Humanistic psychology over time has come to be most closely associated with Carl Roger's (1951) *Client-Centered Therapy*. Rogers asserted that therapists' personal characteristics and attitudes, in conjunction with the quality of the client-therapist relationship, were of greater significance than therapists' techniques or theoretical orientation. Rogers revolutionized psychotherapy theory by emphasizing the client's role as the primary change agent (Corey, 2005).

Under the umbrella of humanistic psychotherapies are the aforementioned person-centered, gestalt, transpersonal, and existential orientations. Each of these perspectives shares many of the same values. Some of these core principles are that people are essentially trustworthy, ultimately responsible for the quality of their lives, and capable of self-directed and meaningful change.

All of these perspectives are phenomenological, in that they value personal experience and subjectivity. While they don't discount the importance of objectivity, they regard objective knowledge as only one part of the bigger picture. Similarly, each also emphasizes the importance of the *here-and-now* therapeutic moment (Yalom, 1980). Integral to the here-and-now emphasis is a commitment to understanding and valuing the therapeutic relationship.

In contrast to psychoanalytic approaches that view the therapy relationship as partly or primarily a product of transference, humanistic and existential understandings focus on the real and genuine qualities in the relationship.

Generally speaking, all psychotherapies value self-awareness. Self-awareness in the broadest sense refers to an understanding of the self that is primarily seen as the sum of life experience and unconscious knowledge. In humanistic thought, self-awareness is also deeply concerned with the human condition, that is, the basic goodness in people and the human potential for growth and change. Part of the therapy process is understood as helping the individual to embrace their basic goodness and to assume responsibility for the quality of his or her life.

How Humanistic Orientations Impact Therapists

As noted above, Rogers (1951) contended that the therapist's ways of being and attitudes are more influential, in terms of helping clients change, than are techniques or interventions designed to get clients to change. Corey (2005) noted, "Research on person-centered therapy seems to indicate that the attitude of therapists, rather than their knowledge, theories or techniques, facilitate personality change in the client" (p. 169). Therefore, therapists operating from a humanistic orientation endeavor to authentically meet their clients where they are, on a person-to-person level, rather than with the intention to diagnose, manipulate, or design strategic interventions in a prescribed manner (Broadley, 1997).

For art therapists operating from a humanistic orientation, the therapy process involves three primary tasks: (1) being present, accessible, and open to clients; (2) honoring clients' thoughts and feelings in the immediate experience; and for some (3) engaging in artistic self-expressive activity along with clients.

Through these avenues, art therapists strive to form an atmosphere of psychological safety, promote a quality of relationship marked by predictability and congruence that conveys a sense of empathy and acceptance, and if they work alongside their clients, in an unspoken way introduce the metaphor of a shared journey of artistic self-exploration. When these are attended to with an attitude of genuine caring, acceptance, and respect, clients are able to gradually let down their defenses, loosen their resistances, and move toward healthy artistic self-expression, which in turn leads to more fulfilling levels of functioning.

Existential Art Therapy

As noted above, there are a number of therapeutic orientations that fall under the umbrella of humanistic psychotherapies. The brand I have been most associated with in my career is existential art therapy (Moon, 1990, 1995, 2009). One of the foundational ideas in existential art therapy is that there are a number of ultimate concerns of human existence, including aloneness, suffering, longing for meaning, and awareness of death. These ultimate concerns have been addressed over and over again throughout history in famous artworks, for example, the works of Alberto Giacometti, Jean Dubuffet, Jean Fautrier, have been specifically linked to Existentialism, and they are nearly always present, in one way or another, in clients' art.

Thus, according to this orientation, the primary thrust of therapy is engaging the client in a creative struggle with the ultimate concerns of human existence. Most important to an existential foundation is the idea that art making leads individuals toward a state of mindfulness. Mindfulness leads to creative anxiety, creative anxiety leads to action, action facilitates change and fosters expression, and expression deepens mindfulness. There is a circular, reciprocal relationship amid the phenomena of anxiety, expression, and awareness (Moon, 2009).

As an existential art therapist, I believe that one of the underlying realities of human existence is that we are ultimately alone. This aloneness compels us to be responsible for our lives; nobody can live them for us. Regardless of how close we become with one another, the ultimate separation is almost impossible to span, and this quality of existence stimulates the longing for meaningful relationships, and for community.

When a client and I make art in the presence of one another, a sense of connection is created and isolation is reduced. I have seen this happen in many diverse settings: psychiatric hospitals, cancer treatment centers, community counseling agencies, prisons, university classrooms, hotel meeting rooms and conference sites, and nursing homes.

An Example: The Story of Lorraine

When I first met Lorraine, she was 19 years old and in deep emotional distress. She'd been admitted to the emergency services unit of the psychiatric hospital after several months of increasing social withdrawal and isolation. Although still living with her parents, she had essentially retreated to the confines of her small bedroom. Lorraine had a well-documented history of personal success and social achievement. She'd always done well in school and was well liked by her peers at the community college she'd been attending, and by coworkers at the retail store where she worked part-time. She'd been in a steady relationship with a young man for more than a year, but had recently broken up with him. It was a surprise to all who knew her that after a semester break, she had not registered for any classes. Her mother, who brought her to the hospital, was deeply concerned and confused by Lorraine's uncharacteristic behaviors.

In the first few days of her hospitalization, she seemed to be fairly comfortable with the hospital staff, and she attended activities and groups on the unit, although she participated only superficially. By the end of the first week, however, she was spending a great deal of time alone in her room, and the staff members' efforts to engage her were often rebuffed. She was clearly quite depressed, but unable or unwilling to talk about why.

During a treatment team discussion about these concerns, I suggested that we consider asking Lorraine if she would be willing to participate in one of the art therapy studio groups that took place in the creative arts building. This suggestion was contrary to the treatment team's position that campus activities were usually not permitted until clients had fully engaged in therapeutic groups on the unit.

My colleagues were also worried that artistic expression might intensify the feelings that Lorraine had not yet been able to talk about. Although I appreciated their concerns, I countered that art making could also be a safe way to express feelings without having to necessarily put them into words, and that the process of making art with others in the studio could be very helpful in reducing Lorraine's isolation.

This assertion caused a fair amount of intra-team debate. Some team members opposed making an exception to the norm of active engagement on the unit. Other members were concerned that nonverbal expression might amplify Lorraine's feelings and perhaps lead to even more withdrawal. Eventually the team leader interceded, saying that he would keep my suggestion in mind, but for the present, the treatment plan would proceed based on the general philosophy of the team that valued involvement in on-unit activities prior to engagement in the larger hospital programs.

Over the next two weeks, Lorraine's withdrawal worsened and she became even more isolated. At a subsequent meeting, team members expressed concern about how little contact she was having with her peers and the staff. As the discussion proceeded, one of the attendants mentioned that he had noticed Lorraine drawing in her room from time to time, and several sketches had been found in her wastebasket. This rekindled the idea of using art as a way to relate to her. Although the team leader still had concerns that artistic expression might "intensify her unexplained feelings and potentially loosen her already unstable ego-boundaries," he suggested that we try engaging her in the art therapy studio.

Later that day I approached Lorraine as she sat alone in a corner of the recreation room. I introduced myself and said, "I am an artist and I've heard that you like to draw." She didn't look up from the table, but muttered a quiet response. I told her I'd like to see her work if she wanted to share it. I went on, "We have an art studio over in the creative arts building. I wonder if you'd like to join us?"

Lorraine asked, "What do you do there?"

"What each artist does is really up to them. We meet from 1:00–3:00 Monday through Friday, and usually spend most of our time just making art, but we often talk about our work too...you know, what we are trying to express, give each other feedback, that sort of thing."

She looked up and her face seemed to brighten a bit. "I don't know, I guess I could try that," she said.

"That's good," I replied. "I'll see you tomorrow."

Lorraine attended her first session the following day. She entered the studio hesitantly, as if she was afraid. I welcomed her, introduced her to a few of the other client/artists and offered to show her around the studio and help her get oriented as to where the various materials were kept. I pointed out features of the space, sometimes greeted another artist, sometimes she almost smiled. Although Lorraine by no means initiated much in the way of social interaction, she did, in fact, seem interested in others' artwork, and this was a marked

contrast to her isolative behavior on the unit.

When we'd completed the studio tour, I asked Lorraine what she would like to do.

"I guess I can draw anywhere, so maybe I'd like to paint," she said.

"That's fine," I said, "there are a number of options to choose from. You can paint on a canvas board, or Masonite panel, or we can build a frame and stretch a canvas. What would you prefer?"

"I've painted on canvas boards before, so that would be good."

Lorraine gathered several jars of paint, assorted brushes, and a container of water, and began to work. Although she did not engage in the social repartee that occurred among other artists in the studio, she was not alone, and she was engaged with materials.

Now and then colleagues from verbally oriented helping professions have suggested to me that if clients' experiences are not put into words, then no real therapeutic change has occurred. But in the initial stages of existential art therapy, there are few things more important than getting started, touching brushes to paint, and applying pigment to the surface. In addition, a number of other artists—her peers and I—surrounded her, and an almost tangible, yet unseen, energy permeated the studio.

In conversation over the years, Shaun McNiff and I have often discussed the idea that artistic activity has a lot in common with alchemy, in that both involve the interactions of different elements. In alchemy, lead is mysteriously turned into gold, and in the art studio painful feelings are transformed into artworks. In the studio, creative energy flows among artists' movements, media, images, interpersonal connections, and interactions. The existential art therapist encourages clients to create from the difficult places of their lives with a deep faith that artistic processes will succeed in transforming painful thoughts, feelings, and images into something new.

When there was about half an hour left in the session I invited the artists to form a circle of chairs in order to share what they had been working on with their peers. When everyone had gathered, Jennifer, a young woman who was struggling with depression, volunteered to begin. She'd been working on a painting of an empty and rather bleak room using subtle blue-grays, muddy umber, and black. She placed her canvas on the floor in front of her and said, "I am not really sure why I decided to paint this; it just came to mind. But as I look at it now, it seems right...reminds me of how things are."

I responded, "Jennifer, I think that images come to us for a reason. Like they want to tell us something."

She looked at her painting hesitantly. "Well, maybe it's telling me there's really nothing inside. Not much to offer," she said.

I said, "Looks lonely." Addressing the other artists, I asked, "If one of you opened a door and found yourself in this place, what would you do?"

Tony, an older man, answered, "Not much going on there. I think I'd go back the way I came."

Jamie, another college-age client, spoke up, "If I was there I think I'd feel lonely."

Yet another artist, Marianne, added, "To me it looks a little like a jail cell. I'd probably think about all the things I've done wrong."

As these words left Marianne's lips, a hint of a smile came over Lorraine's face. She said, "Looks like a safe place to me. No one there to tell you what to do, bother you, or hurt you."

Jennifer sighed. I asked if she wanted to say anything more about her image. She quietly said, "No."

After a brief pause, Lorraine placed her painting on her lap. She did not say anything. The image appeared to be of an old-fashioned Mason jar filled with bands of vibrant color. At the bottom of the jar there was a small dark shape reminiscent of a kidney bean. The top of the jar was securely in place.

Jennifer reacted, "Lorraine, I really like all the colors and layers in your painting."



Figure 10.1

Tony said, “It looks colorful, but closed up tight.”

Lorraine did not respond.

Marianne offered, “Reminds me of the canned goods my mother always had in our basement when I was a kid. I’m not sure what you were trying to say but it sure looks provocative. I mean, all those bright colors and that dark shape at the bottom. What is that?”

Tears began to roll down Lorraine’s cheeks and she opened her mouth as if to speak, but no words came.

There was a heavy silence in the room. After a moment I said, “Lorraine, you don’t have to say anything about your painting. We don’t need to know what it means to you...we can see that it has meaning. But it is important for you to know that your tears and this painting are welcome here.”

When everyone had had a chance to say what they wanted to say about their artworks, and we had cleaned up the studio, I watched through the studio window as an attendant escorted Lorraine, Marianne, Tony, and Jennifer across the campus toward the living unit. The four of them seemed to be in conversation, and while I have no idea what they were talking about, they were talking, and Lorraine was not alone.

Lorraine was in the hospital for a few more weeks, and she attended a good number of art therapy studio sessions and created several interesting, enigmatic paintings.

When she was discharged, she was referred to my private practice, and we worked together once a week for over a year. She eventually created artworks that more explicitly expressed feelings related to a pregnancy and abortion she’d kept secret from her family and former boyfriend. Sometimes she talked directly about shame, regret, loneliness, and anger. But more times than not, Lorraine preferred to work as long as possible during our sessions and talk as little as possible.

For most clients, being in art-based therapy can be quite difficult. Very few people want to be in therapy. They do not come in response to their good feelings. Most often art therapy is initiated because the client is in some form of crisis. The painful events and specific circumstances that lead people to seek art therapy are as varied as the individuals themselves. Artists have always known that a primary source of their creative work is the emotional unrest brought on by their struggle with the ultimate concerns of existence. A central tenet of existential art therapy based is that people relate to such concerns either by attempting to ignore them or by living in what Yalom (2005) described as a state of mindfulness.

For clients like Lorraine, making art with others offers a safe way to express the troubling, frightening, and difficult feelings that come from unutterable emotional wounds.

It is important to note that in the vignette above I made no attempt to interpret Lorraine's Mason jar painting. Nor did I affix particular meanings to her subsequent works. Rather, I provided an environment of acceptance and caring that enabled her to explore and express feelings creatively and come to her own conclusions. Likewise I made no effort to fix things for her, or to ease her pain. Still, as Lorraine made art about the circumstances of her life, and as she creatively dealt with very difficult feelings, she paradoxically felt better. As with so many clients, it felt good to express feeling bad.

In existential art therapy emotional healing and artistic self-expression are synonymous. From a humanistic perspective, the work of art therapists is to be present with clients, to honor whatever they bring to the studio, and to make art alongside them that is tied to the creative struggle with the core issues of meaning, aloneness, freedom, and death. The heart of humanistic art therapy is found in relationships among therapists, clients, and artworks that emerge as expressions of these concerns.

The work of humanistic art therapists can be captured in the metaphor of a shared artistic journey with clients. The purpose of the journey is to explore the meanings and themes of clients' lives as they emerge in artistic processes and products, and through authentic interactions between therapists and clients. Art therapists working from this orientation refrain from acting as authoritative interpreters of clients' art, or as diagnosticians; rather, they aspire to enact humanism by encouraging clients to make their own interpretations and become immersed in the healing creative flow of artistic self-expression and genuine interpersonal sharing.

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11

Gestalt Art Therapy

Janie Rhyne

Introduction

Like most approaches in our field, Gestalt art therapy has developed in alignment with theories and practices underlying broader-based disciplines. Gestalt art therapy grew out of two very different movements. The first, Gestalt psychology, developed from laboratory research in perception and learning; the second, Gestalt therapy, evolved from applications in psychotherapeutic practice. Gestalt psychologists have earned respected places in academia, but do not extend their concepts to clinical applications. Gestalt therapists base much of their practice on some theories of Gestalt psychology, but have adapted them to support therapeutic interventions. Gestalt art experience incorporates ideas from both, aiming for their integration in a Gestalt approach to art therapy.

From Gestalt Psychology to Gestalt Therapy

Gestalt perception and its implications were investigated in laboratory experiments by German psychologists in the early 1900s. They were interested in how organisms make sense of what they perceive in the world around them. Wertheimer, Kohler, and Koffka, fleeing from Nazi Germany, brought Gestalt psychology to the United States. Lewin and Goldstein, also emigrating in the 1930s, were influenced by Gestalt principles. Lewin, a social psychologist, was known for his “field theories,” especially as applied in group dynamics. Goldstein, a neuropsychiatrist, was the leading exponent of “organismic theory,” stressing the unity, integration, consistency, and coherence of a normal person; and that pathological disorganization was the result of an oppressive environment.

Fritz Perls came to New York in 1947, also in flight from Nazi Germany, but with an in-between decade of living in South Africa, where he and his wife Laura practiced psychoanalysis. Laura had studied Gestalt psychology in her training, and Fritz dedicated a 1949 book to Gestalt psychologist Max Wertheimer. In New York they met writer Paul Goodman, who, from their incomplete manuscript, elaborated and made comprehensible the theoretical base of Gestalt therapy in *Gestalt Therapy: Growth and Excitement in the Human Personality* (Perls, Hefferline, & Goodman, 1951).

Laura stayed in New York and Fritz wandered, eventually finding his place in 1963 at Esalen Institute in California. From that time, he was hailed as the founder of Gestalt therapy; he was then 70 years old. From a lifetime of wandering, both geographically and ideologically, Fritz brought to his way of working a rich mixture of personal and theoretical ideas. As a practitioner he demonstrated his rebelliousness, his early fascination with theater, his education as a psychoanalyst, his training analysis with Wilhelm Reich, his pragmatic use of some findings by Gestalt psychologists, and his courage in challenging “phoniness”—in himself as well as in others. He also acted as a director of improvisational theater with patients, with the group members and himself enacting personal dramas in the interest of an awareness of human complexity.

Fritz invented therapeutic techniques, too; he experimented with them, continuously exploring how he could use them to be more effective. Unfortunately, many of his “techniques” have been popularized as “rules and games,” that some may use as a substitute for personal effectiveness as a therapist. Fritz decried this reduction of his creative methods to mere “gimmickry.” Though he basked in the image of himself as a great performer and often played the clown, he took his therapeutic task quite seriously and was dedicated to authenticity as a psychotherapist.

Though Gestalt therapy focusses on “organismic” functioning, other humanistic therapies also assume “wholeness”; some stressing an explicitly “holistic” approach. Which approaches are defined as “humanistic” depends on the context. Since the 1960s, “new” psychotherapies have sprung up like plants in the rainfall after a dry season. In the midst of this proliferation, roots and branches get intertwined; it is not easy to see what they sprouted from, or what directions they are growing in, or which will thrive.

The approach that I developed and called “Gestalt Art Experience” (Rhyne, 1973/1996) is humanistically oriented. From the rich soil of California in the 1960s, it sprouted and grew like a weed, natural and indigenous. Workshops with Fritz Perls and training at the Gestalt Institute of San Francisco fostered its growth, as did dialogue with other humanistic therapists. Innovative therapeutic approaches were growing rampant there and then; Gestalt art experience was one of them. I brought to my training in Gestalt therapy education and experience as a professional artist. Also, for some years I had worked with people using art as an expressive language. And I was intrigued by how implications of Gestalt psychology supported my own understanding of art as communication. So I brought with me some seedlings that I had gathered in other times and places.

Gestalt Assumptions and Applications

The basic assumption of Gestalt therapy is that individuals can deal effectively with their life problems. The central task of the therapist is to help clients fully experience their being in the here-and-now, by becoming aware of how they prevent themselves from feeling and experiencing in the present. The approach is basically non-interpretive, and clients carry out their own therapy as much as possible. They make their own interpretations, create their own direct statements, and find their own meanings. Finally, clients are encouraged to experience directly in the present their struggles with “unfinished business” from the past. By experiencing their conflicts, instead of merely talking about them, they gradually expand their own level of awareness, and integrate the fragmented and unknown part of their personality (Corey, 1982, p. 98).

Rooted in existential philosophy and phenomenology, Gestalt stresses assumptions of personal responsibility for the course of one’s life. Gestalt therapists challenge clients toward growth and the development of their innate potential. In keeping with other existential psychotherapies, the therapist maintains genuine contact with the client. Believing that no one can be other than subjective in any relationship, existential-minded Gestaltists aim for authenticity rather than objectivity. The therapist enters into the relationship mutually with the client, accepting that the therapeutic process will change both. Transference is not encouraged; it is seen as avoidance of the present-centered, person-to-person relationship.

Gestalt work with dreams is similar to how a Gestalt art therapist evokes clients’ awareness of meanings expressed in their visual imagery. Dreams are assumed to represent existential messages that reflect current ways of being in the world. Clients recognize that the dream configuration is their own creation. They are asked to “work through” their self-created images by “taking the part” of each person and thing in the dream. For Gestalt art therapists, this is an effective way to elicit more awareness of personal meanings made graphic through art media.

Art and Gestalt Approaches

Several years ago, I wrote about how the linkage between Gestalt psychology and Gestalt therapy was easily observable in the activity of art therapy (Rhyne, 1980). Theories that are difficult to explain in the abstract can be immediately comprehended when they are applied to understanding concrete referents in the forms of art. In an expressive art therapy process, the concepts are transposed into vivid percepts.

In my work as an art therapist, patients, clients, students, and I communicate verbally, of course, but we do so mostly in reference to some representations they have created in non-verbal media. So we have the concrete artifact present among us; its presence allows us to experience and express immediate perceptions and awareness. We do not have to talk *about* configurations, figure/ground relationships, dynamic movement, contact/boundaries, coherence and fragmentation in the abstract; rather we speak *of* these phenomena in the very act of perceiving and becoming aware of what is obviously there. Though we can't be sure of how directly the *content* of expressive forms portrays the ideas and actions of the image-maker, we presume that humanly created forms show similarity in *structure* with human behavior. So instead of talking about *isomorphism*, we are observing the sense of the theory as we apply it (Rhyne, 1980, p. 77).

We contact each other through the presence of the drawing, seeing the interplay of lines, shapes, and forms within the wholeness of it as a Gestalt. Moreover, enactment of the forms, through sounds, gestures, and movements, brings into play kinesthetic and other sensory, immediate perceptions. Without pushing for interpretations, we explore the dimensions of the drawing and elaborate its impact, through active, present experiencing. Personal meanings may or may not emerge in the course of discovering; the client's expressive process is directed toward an expanded awareness of what makes sense in his or her own life. No matter what direction we take, we will still be relating what we do to premises gathered from Gestalt psychologists: though we need not ever mention their theories nor use their vocabularies, my client and I have applied their tenets in the kind of Gestalt therapy I like to do (Rhyne, 1980, p. 78).

Other Gestalt therapists incorporate art, in keeping with their own ways of working with clients; among these, Joseph Zinker stands out as an articulate proponent of *Creative Process in Gestalt Therapy* (1977). In the chapter, "Art in Gestalt Therapy," he writes:

The reason drawing or painting may be "therapeutic" is that, when experienced as a process, it allows the artist to know himself as a whole person within a relatively short period of time. He not only becomes aware of internal movement toward experiential wholeness, but he also receives visual confirmation...from the drawings he produces.

(p. 236)

Zinker is a painter as well as a practicing therapist, and he believes that "all creative activity begins with movement." He designs "Gestalt art workshops" so that the participants begin literally moving their physical bodies in space, responding to the rhythms of accompanying music. They start drawing only after they have been enabled to

ground their bodies and locate their energy...Participants are asked to get into their mobility by concentrating their energy on moving from inner activity outward. Music facilitates this process. They are encouraged to move at their own pace and in their own idiosyncratic way. All movement is good. All spontaneous activity is nurtured and supported.

(p. 242)

Celia Thompson-Taupin, a registered art therapist active with the Gestalt Institute of San Francisco, also leads Gestalt art groups. In "Where Do Your Lines Lead?" she tells how she involves groups in making and enacting their own experiences.

The line game is played by tacking a large sheet of paper on the wall, and having on hand a basket of crayons or pieces of chalk of various colors. One person at a time is "it." That person comes up to the paper and is told, "Select a color and draw a line or a shape." That being done, he is told, "Now another,

with a different color.” I usually ask the person to make the sound and movement of each line or shape. Other group members are encouraged to mimic and get into the spirit of how each line feels to the person who is “it.” At this point, many choices are open. One possibility is the “gestalting” of the two lines or shapes by “it.” Another...is to say to “it,” “Now use people in the group to be your lines and dramatize what is going on. You are the director of the play for the next few minutes—and you can also be one of the characters. It’s your show.” What happens from this moment on is rarely dull and often involving for the whole group.

(1976, p. 113)

Violet Oaklander, in *Windows to Our Children* (1978), tells of her Gestalt work with children and adolescents. She encourages them to express their feelings with art media, dream work, role playing, storytelling, creative dramatics, and other kinds of enactment. She writes that her “goal” is to help the child “become aware of herself and her existence in the world.” Dr. Oaklander is a certified member of the Los Angeles Gestalt Therapy Institute and uses Gestalt in her practice of marriage, family, and child counseling. Increasingly, other therapists and counselors are including Gestalt art experience in their repertoire of therapeutic modalities, synthesizing ideas from many sources, applying them in ways appropriate to their own specializations.

For many years I have led Gestalt art experience groups, sometimes in weekend or five-day workshops, and sometimes ongoing, continuing for weeks or months. I find group art experiences invigorating for me and for those who join in. They are lively and exciting; participants stimulate, support, and challenge each other—and me. There are slow times, too, and desperate struggles to break through deadening layers of “unfinished business” that get in the way of savoring present awareness and contacts. In many ways, the groups are therapeutic, directed toward encouraging people to shed neurotic patterns and get on with living fuller, more constructive lives. I still lead such groups and still find them exhilarating.

During the years, I have also worked with clients in one-to-one sessions, in longer-term, quieter, and more individualized ways. With some clients, I find that a Gestalt approach that is supportive as well as challenging can strengthen them, as they seek to take charge of and change the course of their troubled lives. I will describe and illustrate one way in which a client and I are currently working through her present problems.

Structured Gestalt Approach with a Client: Wendy

This way of working through visual/verbal perceptions illustrates visual thinking in action; it demonstrates how “thinking with the senses” can be part of a therapeutic process. Rudolf Arnheim (1969) has insisted that physical and psychological phenomena are isomorphic—their forms are similarly structured. In this kind of Gestalt art therapy I assume that the clients’ created images are isomorphic with their behavioral patterns. Thus, the dynamics of perceived structures in drawings can be transposed into a recognition of behavioral patterns, and then into an expansion of clients’ awareness of how they can bring about changes in their existence.

Clients are asked to make sequential abstract drawings representing their responses to a series of words naming emotionally laden experiences. The whole series is a Gestalt—a configuration created by the clients. Each drawing is a part of the sequence; each drawing is also a Gestalt itself. So when we discuss the drawings, we arrange them so we can see them all at once and, at the same time, so we can pick up any one for selective study.

In observing the drawings, we focus on structure and form as content; we pay attention to implied directional movements in the lines and shapes; we are interested in interrelationships among forms, and in perceiving how these imply dynamic tensions. We are especially observant of figure/ground relationships; we identify forms that seem to demand attention. We ask how these visual images may be related to present concerns in the client’s actual living. We scan all the drawings together, looking for visual patternings that make sense in terms of the client’s actual behaviors. We pool our resources and our perceptions, in order to foster the client’s healthy growth and integration.

A client, whom I call Wendy, is making her way through troubled times; she has been in therapy with me for almost a year. She is a very attractive, 25-year-old woman. Only recently has she discovered that she is also very perceptive and intelligent. Now she wants to actively develop her capabilities in real life. This is not easy for her. As her history shows, Wendy has rebelled against what she doesn’t want, but has not yet found out what sort of life she does want and can create responsibly.

Wendy was born and bred in a town big enough to have a country club, a gathering showplace for upper-middle-class success, solidarity, and privilege. Wendy’s family “belongs;” in their immaculate home, the prime values are godliness, cleanliness, propriety, orderliness, rationality, and conformity. Within this value system, the family has prospered. Wendy has defied their values and has no sense of belonging anywhere.

Wendy has three brothers and no sisters. She remembers that even as a small child, “running away” from her family was her way of finding her “spot.” Sometimes she literally ran into the woods, refusing to be found; at others she climbed a favorite tree and hid in its branches, or nested herself in the vines covering an old stile crossing a fence that bounded the family land. Wendy also has vivid memories of intense excitement in discovering how brightly she could cover things with color; she loved leaves and grasses and bits of bark collected on “little walks in the woods.” She felt an affinity for small things and enjoyed “getting lost” in fantasies where she felt free to “be air” or “a leaf floating in a breeze.” Wendy still has fearful dreams of being very little, trying to get away from being “choked” or “belted” by large parental figures who attempt to curb her wanderings.

During high school, Wendy went even more into her inner world of fantasizing. After two years away at art school, she found friends who also questioned, but didn’t accept their answers. Back in her hometown, she fell in love with an artistic young man who seemed to know what he wanted; Wendy came with him to the university to go on with her art. The young man soon left her; Wendy became pregnant in a rebound affair with another man she barely knew. She gave birth to a daughter, but refused to marry the baby’s father. Wendy’s frustrated family angrily disowned her. On Aid for Dependent Children for the last three years, Wendy has lived alone in a trailer park, with her little girl as her companion in fairy-tale fantasies that the “world out there” was not worth confronting.

But, as time passed, Wendy began going to bars at night, meeting and getting involved with men, wanting relationships. Her dependency needs led her into too-close, too-fast sexual affairs; her needs for independence kept her out of any relationship that might lead to marriage. Wendy’s family wanted to “re-own” her while dictating the terms—get married or get a job. They knew nothing of her “sleazy” life at a local bar for

“derelicts.” She visited her parents’ home, agreed to accompany them to the country club, but her mother had hysterics when Wendy donned a “sweatshirt” dress for the occasion. Furious at her family’s demands, she still longed for their acceptance. Alternately defiant and ashamed, Wendy doubted the existence of God, but felt she was surely going to hell.

Wendy came into therapy with me, paying my reduced fee with money she earned as a “cleaning lady.” She described her life as being like that of a rabbit, scuttling around in underground burrows, connected by long, dark tunnels. She poked her head out in the light of reality with real fear that she would be destroyed. Now she is venturing out more. Her old conflicts with her mother are now out in the open, and there are fierce confrontations. Her mother still slams doors in her anger, and Wendy is left alone, but now she no longer runs away and hides.

At night, in the security of her trailer, she sometimes paints large, sloppy pictures of her frustration. At other times, she writes in a journal, questioning and wondering about religious beliefs broader than those of her parents. She battles with men, too, not wanting to settle for “sex for sex’s sake.” Wendy’s drawings and paintings are full of activity. They reflect her determination to take an active role in directing her movements in her own life space—sometimes underground in her introspective times, and sometimes out in the open, fighting to make a place for herself and her daughter. Her life-style is rather “schizzy,” with rapidly shifting figure/ground relationships, polarities, conflicts, and frequent ambiguities.

Wendy is aware of what she is experiencing; she is frightened and concerned. She is also showing her courage in dealing with the choices and decisions she must make. She says, with sadness and fortitude, “Nobody else can do it for me; it’s all up to me.” Wendy’s present concerns are with the transition from childhood dependency to adult independence. Her difficulties in maturation, however, involve problems that were not dealt with in her past. As a child, Wendy’s natural development was thwarted by her family’s imposition of a rearing that ignored her individuality.

In working with Wendy, as with other clients, I am guided by my own beliefs about human nature, and my personal constructs of how individuals can maximize their fullest maturation. I believe that, from their psycho-evolutionary history, human organisms are naturally endowed with innate urges for survival, and for the actualization of inherent potentials. These are the prime motivations for all behavior. Human beings strive toward growth, selecting from their environments whatever resources are available for assimilation. Human beings try to change incompatible circumstances; what they cannot change they adapt to, and they come to terms with environmental realities. Thus, innate “urges” toward self-realization and existential “musts” toward autonomy direct all of us toward a sense of unity within ourselves, and toward an appreciation of differences in contact with others.

Wendy expressed her natural creativity early in her life, but it was neither appreciated nor even recognized by her family or the nuns charged with her education. They tried to force her into a mold where she didn’t fit. Wendy responded by creating a private world where she felt at home. Her innate urge for actualization of her own potentials was, still is, healthy and intact. She has not yet realized that she must also come to terms with what she cannot change in her environment. Her existential struggle is with her conflicting directions: of moving out into more contact with outer actualities and, at the same time, staying with the further exploration of inner resources available to her as she makes her own choices.

The drawings shown here are taken from a series of those done by Wendy during the last few months. As with other clients, I initially asked her to make simple abstract drawings of her experience of eight primary emotions: (1) fear, (2) anger, (3) joy, (4) sadness, (5) disgust, (6) acceptance, (7) anticipation, and (8) surprise. Sometimes I also ask for drawings of “being sane” and “going crazy.” We spend at least one session looking at the drawings together and tape-recording their descriptions, associations, and sometimes personal interpretations of their visual messages. I ask the clients to compare the drawings in terms of similarities and differences, and to verbalize any recognitions of figures that emerge, and of patterns of which they are aware. The clients do most of the talking; they express in words whatever the experience evokes in response to their creations.

Afterward, I suggest that they do drawings of other experiences that seem important—to develop and elaborate the themes that pattern their lives. We continue this process of letting one drawing lead to the making of another; sometimes I suggest the topics, sometimes the clients do. Between us, we keep ourselves up to date, using drawings made between sessions to enhance our awareness of current happenings in their lives.

I will use some of Wendy's drawings and some of her words to demonstrate some of how clients and I work together, how we use these graphic representations as guidelines to direct the therapeutic process in times of transition. I have chosen six drawings from a fuller series made initially by Wendy and kept up to date with others created by her from time to time. I have chosen to illustrate how Wendy expresses (1) anger and fear; (2) anticipation and surprise; (3) acceptance; and (4) present state.

I based my choice on my observation that how people express these emotions reflects their openness to initiate changes. I perceive *anger* and *fear* as being emotionally loaded with past-oriented, deeply enmeshed habitual "fight-or-flight" reactive behavior. *Anticipation* and *surprise* are more future oriented. Self-fulfilling prophecies show up in the guise of *anticipation*. Willingness to open up to novel experience is suggested in *surprise*. *Acceptance* is present oriented, indicating readiness to "come to terms" with others and the environment. *Present states* are expressions of what is figural in the person's here-and-now experience.

To our first five sessions, Wendy brought paintings she had made during the past few years, as well as those she was presently working on in her trailer. We used these as references, while she described the events and processes in her life. For her sixth session, I assigned the "homework" of doing drawings of commonly experienced states of mind. Wendy made the drawings of *anger*, *fear*, *anticipation*, and *surprise*, and we explored what they meant to her during the following three sessions. Wendy's words, as I quote them here, were taken from tape recordings made while she was describing the drawings of emotions I had assigned to her as "homework" during the months of June, November, and the following January.



[Figure 11.1](#) "Anger"

Anger ([Fig. 11.1](#)) "is coming down from the top...those white pointed shapes are coming down into the gray...the anger eats the gray...I mean it overpowers that and it cuts through...[the black squares and rectangles] come out from the side...they are rational...they are over the white shapes [anger]. The squares [rationality] move around the triangles [anger]...the crosshatching is whatever I am angry at...another person,

outside world...noises that happen.”

Fear (Fig. 11.2) “is a vertical rectangle on the left side...two thick vertical lines...a nose is coming out and this is what it’s looking at...all this white space...and there’s absolutely nothing in that white space ’cause there’s nothing to fear. Inside the rectangle there are all the things...I’m thinking to fear about...a strong black line is a kind of block that keeps fear in check...just like the square black line keeps surprise in check.”

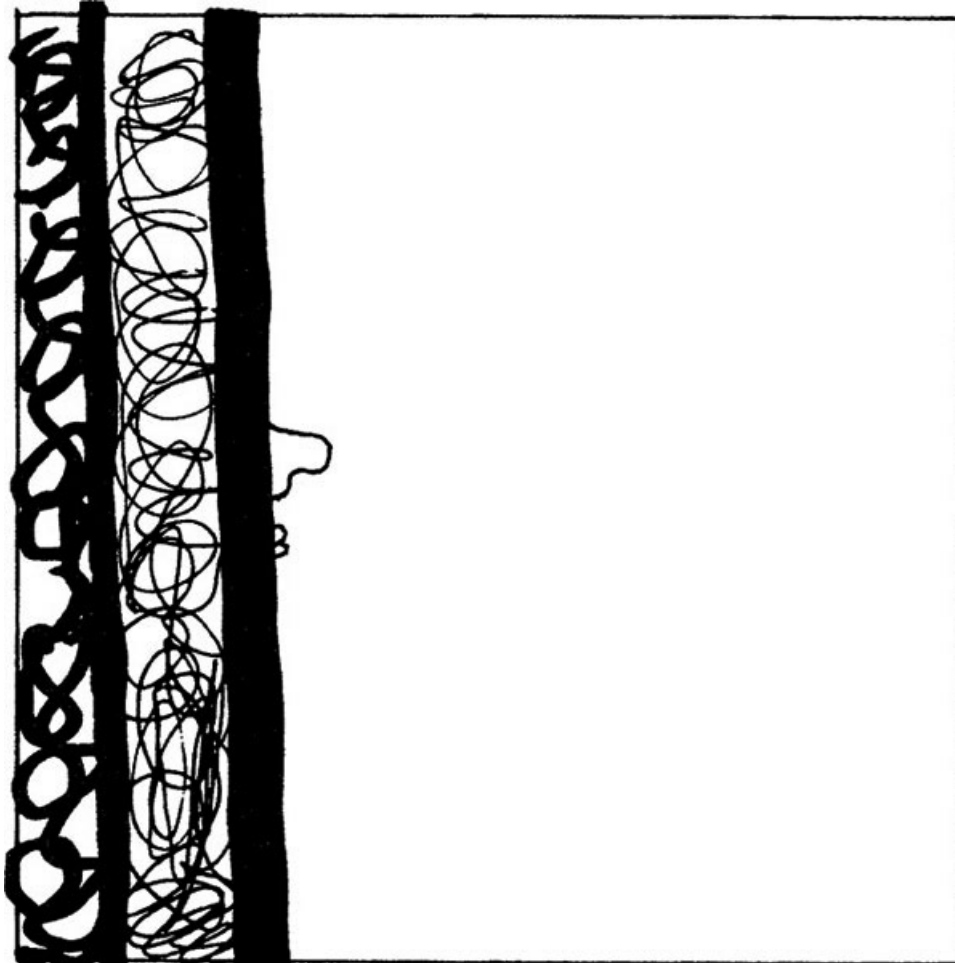


Figure 11.2 “Fear”

Anticipation (Fig. 11.3) “is a nice thing to feel...an exciting thing. When I anticipate something, that takes up my total thought so that’s why the background is black. This white shape coming down from the top is almost like a fish jumping into a pond and he hasn’t touched the pond yet. He’s just about there. A fish knows that he wants water but he doesn’t know what the next hole is going to be like.”

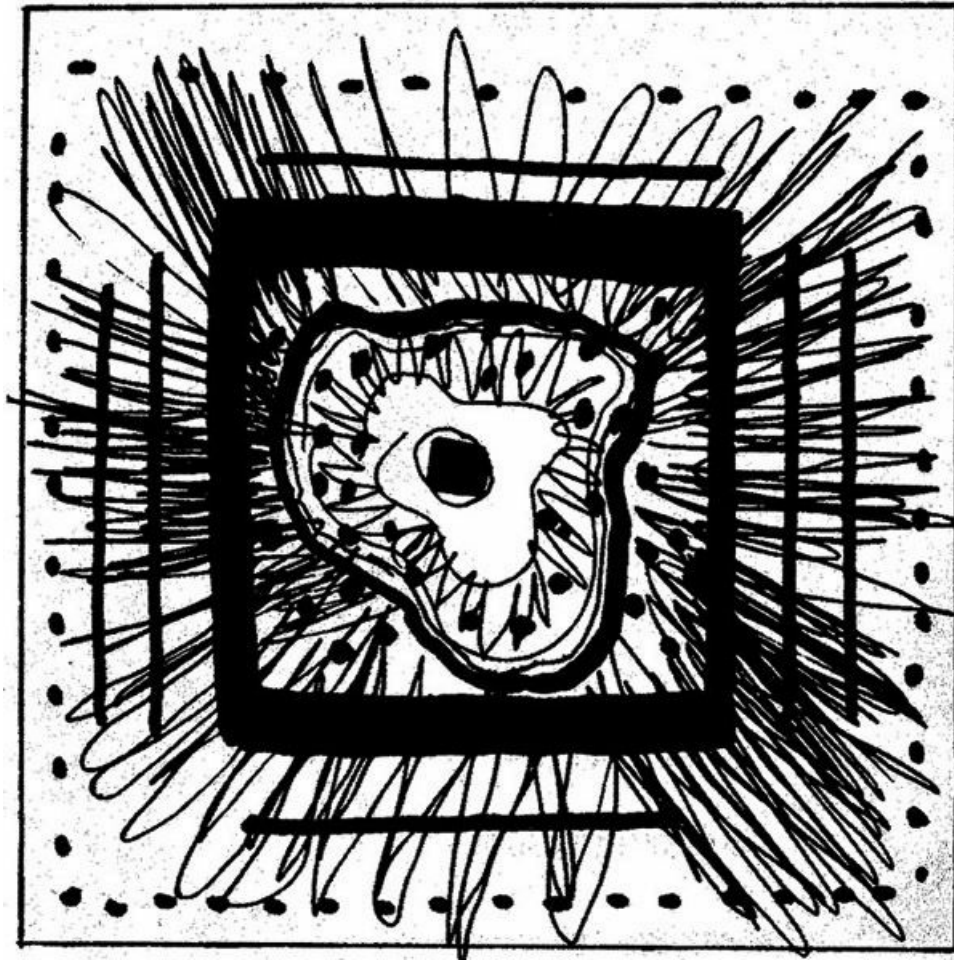
Surprise (Fig. 11.4): “inside the square is an organismic shape...and inside the organism is a little-bitty black square...that’s the point of surprise...and the squiggling lines that are spreading out...that’s my reaction to surprise...it’s a shock, sometimes...but the outer square, done with the heavy black lines, sort of keeps the surprise in check.”

Our weekly sessions continued for three months. Then she began cancelling and postponing sessions, phoning and saying, “Something came up and I can’t come.” Her voice would trail off when I asked for reasons. After six weeks of no sessions, Wendy called for an appointment. Although she kept it, she spent the time avoiding contact with me or with her own problems.



[Figure 11.3](#) “Anticipation”

I then asked her to make drawings of some emotions named by me; *Acceptance* ([Fig. 11.5](#)) was made at that time. Wendy spoke of it in rather impersonal terms: Acceptance “was the hardest to draw...another person is on the top...shapes like black teeth...and I’m the white teeth on the bottom...the part in between is the outside world...all those black dots...thoughts and different people, everything else...the up-and-down lines are the interactions between two people...they’re roots...mine are going up to the other person...the horizontal lines are the uniqueness of each person...I’m the black line at the bottom...with wavy distrust lines between me and my teeth. I’m rejecting two thin black lines from the other person that come down in the center...but I am accepting one that has come down through my teeth and my distrust line and other obstacles to get into the heart of mores and values.”



[Figure 11.4](#) "Surprise"

For the next week's session, I suggested that Wendy do drawings of emotions that she was experiencing, and name the ones she considered important. She did a series of figurative drawings, depicting herself as a child. Then, after another week's absence, she brought in a drawing that she named *Contempt* ([Fig. 11.6](#)). "My face toward me...eyes and a striped beak, a large and a powerful being looking down on a small embryonic being that can't help itself...at first I identified with that little being and then I saw myself turning into the monster."...While describing it, she confessed that in the last few months she had "fallen in love," gotten pregnant, had an abortion, and was desperately confused about her own "evil and sin." We stopped taping; Wendy was sad and crying for the "little embryonic being," but she was also ready to begin working through her conflicting perceptions and directions in moving into the world.

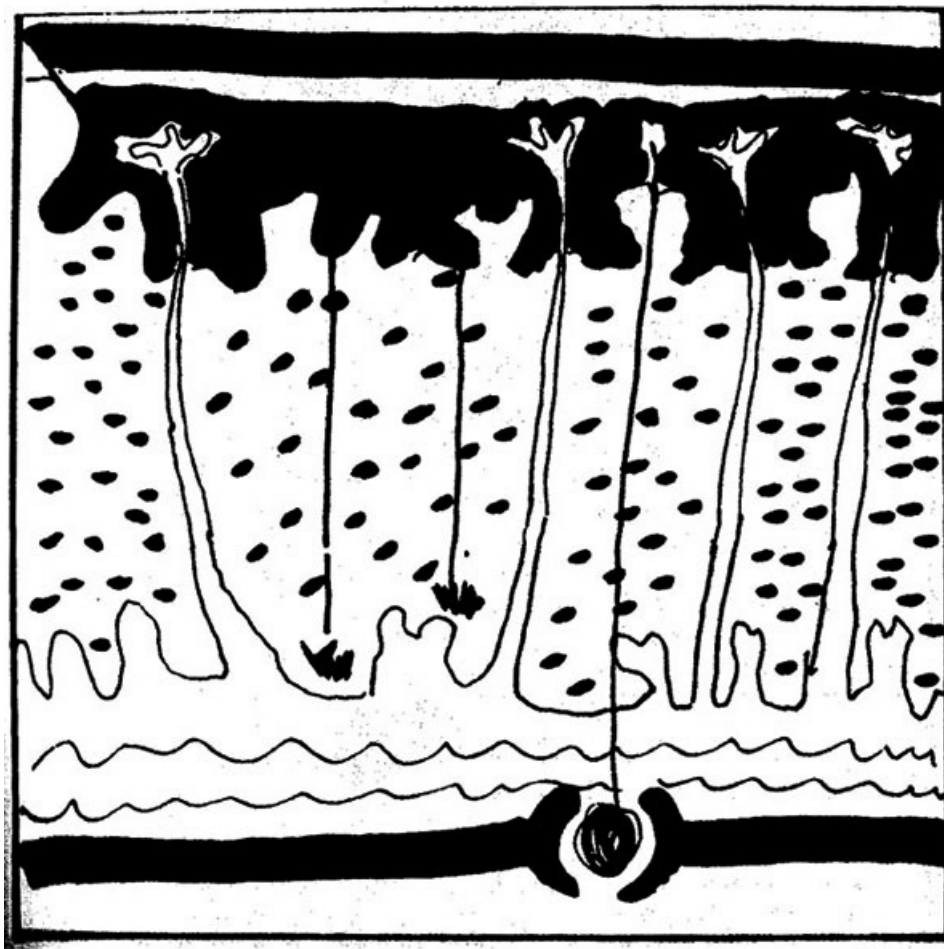
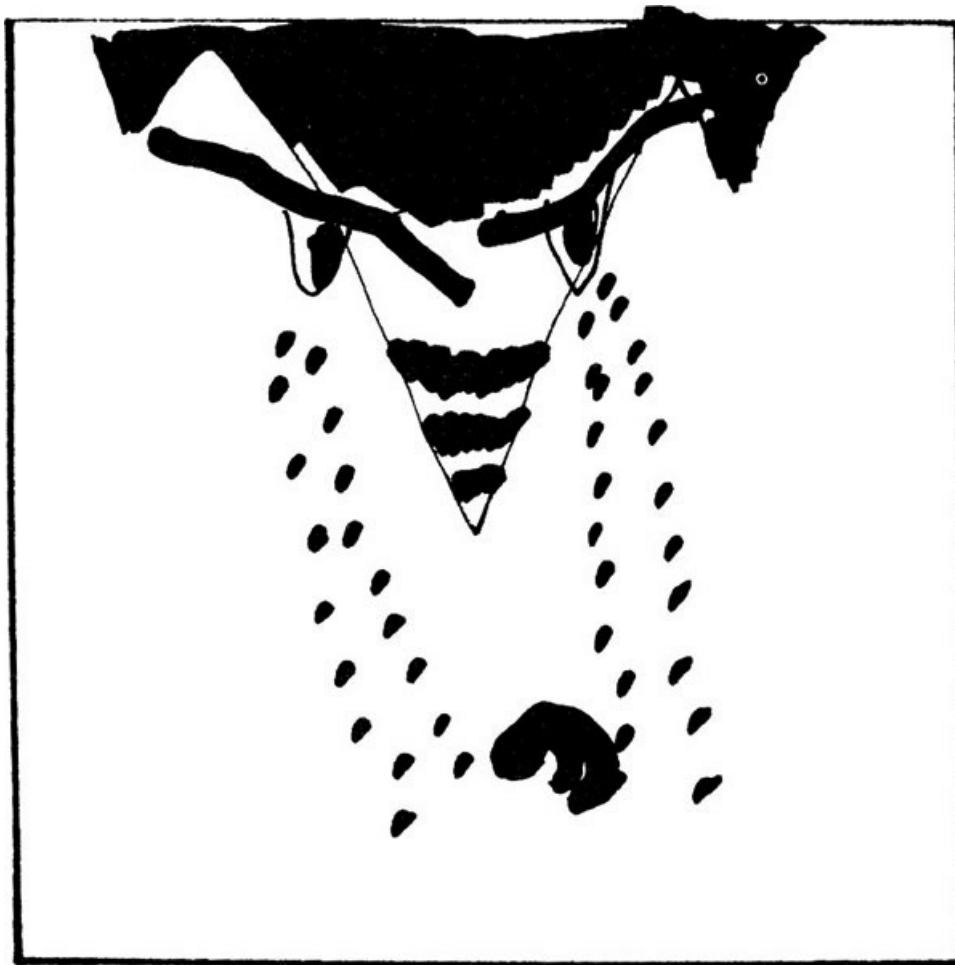


Figure 11.5 “Acceptance”

In *Anger* (Fig. 11.1) she had dramatized coming down into the “outside noisiness” of “whatever”; the force of her “white anger” is interrupted by “rational squares” that move across, getting in the way of her movement. She uses heavy black lines as boundaries around her sharp angry thrusts. She keeps *Fear* (Fig. 11.2) and *Surprise* (Fig. 11.4) “in check” with heavy black lines, but there is a lot of activity going on inside and between the boundaries. Wendy *Anticipates* (Fig. 11.3) with pleasure and excitement and considers *Acceptance* (Fig. 11.5) with distrust, but also with willingness to let someone reach into the heart of her private space. Wendy’s labeling of the present as *Contempt* (Fig. 11.6) allowed her to face both her helplessness and her power. In the months following, Wendy always kept her weekly appointments, bringing with her drawings and paintings that emerged from her deepening sense of her own values and goals.



[Figure 11.6](#) “Contempt”

Working through these polarities has not been easy for her. She has become more aware of how her message relates to feeling helpless in her family of origin; having an abortion, thus using her power to take away life; and being a mother, who is now responsible for making a way for herself and her child in the “outside” world.

Wendy’s visual language, in many drawings not shown here, includes a heavy black line as a boundary between inner and outer realities. She also frequently uses irregularly shaped dots to describe the outside world. In *Anticipation* ([Fig. 11.3](#)) no boundaries or outsiders are involved. In *Contempt* ([Fig. 11.6](#)) Wendy does not include either the “outer world” or any boundaries between the two related figures. She now knows that both of these are aspects of her personality, and that she must own and integrate them into her awareness, if she is to function effectively.

Though the kind of structured activity I have described with Wendy is quite different from the spontaneous enactments often used in Gestalt art therapy, with groups and individuals, the same principles apply here as in the freer approach. The simple abstract drawings are considered as a part of a larger whole; qualities and properties are interactive within the field; the client describes and interprets her own drawings in visual/verbal language; I keep in contact with the client through the presence of her drawings; and, most important to me, we are working together with the existential aim of facilitating the client’s awareness that she is responsible for choice-making and for self-direction in living her own life.

Summary

Gestalt art therapy deals with the whole configuration of personal expressiveness in visual messages, in voice tone, in body language, and in verbal content as well. Gestalt art therapy is aimed toward encouraging—even insisting on—responsible, honest, direct communication between client and therapist. Contact between them can be the mutual exploration of visual statements; and can also involve enactment in movement, vocalization, and other active manipulation of persons and materials in space and time. This is done in such a way that the therapist can observe—and sometimes enter into—the art drama being created by the client.

Theoretical backing for this sometimes rowdy behavior comes from the Gestalt concept that human activity, like any other organic activity, is that of an organism contacting and interacting within the configuration that is our environment. Through our senses we become aware, we perceive, we gain insight about the nature of the world and of our place in it, by contacting what's "out there" directly with our innate organismic perceptual system. Thus, Gestaltists encourage experimentation and exploration through sensorimotor activation, believing that this often facilitates the recognition and clarification of problems.

In a therapy session, the therapist is also a part of the configuration—another organism who naturally perceives and actively responds. A Gestalt art therapist is also likely to focus on the active movement in the art done by clients. He or she interests clients in the forms and patterns of their visual message. He or she encourages clients to actively perceive what is going on in lines, shapes, textures, colors, and movements. He or she wants clients to experience their created forms, and to make this experience a part of their organismic awareness. He or she aims to evoke in clients a sensing of how their forms can express personally involving meanings.

Gestalt art therapists are more likely to give workshops than to present papers. Like other practitioners, we have our bags of tricks and even games and gimmicks that we can write about, demonstrate, and sometimes teach to others. But the theories of both academic Gestalt psychology and applied Gestalt therapy, still require eliciting from intelligent, human organisms their own awareness and insight.

Gestalt art therapy is not for everybody, neither for all art therapists nor for all clients. It is surely not the only kind of good therapy. It doesn't always work; some patients are not able to mobilize themselves, much less manipulate their environments. Insight seems to be unavailable to some patients; holding them responsible for their perceptions is too much to ask.

Though many of us have advocated "lose your mind and come to your senses," we know that "use your senses and come to your mind" is what we aim for. Gestalt art therapy demands that clients must "do the work," not only of creating the representations, but also of recognizing their own self-configurations. Despite all the emphasis on the experiential in Gestalt art therapy, the theoretical background and actual practice involve therapist and client in a highly cognitive activity. Rudolf Arnheim says that those who practice the arts are "thinking with their senses" (1969, p. v.).

That's a premise underlying the work of all Gestalt art therapists; the theories of Gestalt psychology are based on this respect for human nature's ability to recognize the forms that balance and satisfy. Gestalt art therapists work toward activating in all clients their potential for perceiving—in their own visual messages—their needs and their resources. Like other Gestalt therapists, we work very hard not to get in the clients' way when they gain the true insight that they, on some level of awareness, can sense and use their own resources for activating growth and excitement in their unique human personalities.

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Recommended Readings

The best of Fritz Perls' writings are:

Perls, F. S. (1947/1969). *Ego, hunger and aggression* New York, NY: Vintage Books.

Perls, F. S. (1969). *Gestalt therapy verbatim*. Lafayette, CA: Real People Press.

For an enjoyable experience, which is also truly informative: *Gestalt Therapy Integrated* by Erving and Miriam Polster. New York, NY: Vintage Books, 1973.

For a number of varied approaches used in Gestalt therapy: *Gestalt Therapy Now* by Joen Fagan and Irma Lee Shepherd (Eds.). New York, NY: Harper/Colophon Books, 1970.

Another collection of articles is: *The Handbook of Gestalt Therapy* by Chris Hatcher and Philip Himelstein (Eds.). New York, NY: Jacob Aronson, 1976.

The *Gestalt Journal*, published semiannually (Box 990, Highland Park, NY 12528) includes new ideas and arguments from Gestalt therapists and has given Laura Perls the attention she deserves.

12

Person-Centered Expressive Arts Therapy

A Path to Wholeness

Natalie Rogers

From the very nature of the inner conditions of creativity, it is clear that they cannot be forced, but must be permitted to emerge.

Carl Rogers

Part of the psychotherapeutic process is to awaken the creative life-force energy. Thus, creativity and therapy overlap. What is creative is frequently therapeutic. What is therapeutic is frequently a creative process. My own integration of the arts into therapeutic practice is called “person-centered expressive arts therapy.” The terms *expressive therapy* or *expressive arts therapy* generally include dance, art, and music therapies; as well as journal writing, poetry, imagery, meditation, and improvisational drama. Using the expressive arts to foster emotional healing, resolve inner conflict, and awaken individual creativity is a relatively new, expanding field.

What Is Expressive Arts Therapy?

Expressive arts therapy is an integrative multi-modal therapy with the emphasis on the healing aspects of the creative process. Movement, drawing, painting, sculpting, music, writing, sound, and improvisation are used in a supportive, client-centered setting to experience and express feelings. All art that comes from an emotional depth provides a process of self-discovery and insight. We express inner feelings by creating outer forms. When we express these feelings in visible forms, we are using art as a language to communicate our inner truths.

In the therapeutic world based on *humanistic* principles, the term *expressive therapy* has been reserved for nonverbal and/or metaphoric expression. Humanistic expressive arts therapy differs from an analytic or medical model of art therapy, in which art is used to diagnose, analyze, and “treat” people. Rather, we believe in the ability of individuals to find appropriate self-direction, if the psychological climate is empathic, honest, and caring. Our tradition draws from many humanistic psychologists—notably Carl Rogers, Abraham Maslow, Rollo May, Clark Moustakas. These pioneers defied the authoritarian medical model and created a relationship model of personal growth in which the therapist respects the client’s dignity, worth, and capacity for self-direction.

Using the arts expressively means going into our inner realms to discover feelings and to express them through visual art, movement, sound, writing, or drama, without concern about the beauty of the art, the grammar and style of the writing, or the harmonic flow of the sounds. Although interesting and sometimes dramatic products often emerge, we leave the aesthetics and the craftsmanship to those who wish to pursue the arts professionally.

We use the arts to let go, to express, and to release. Expressive art therapists are aware that involving the mind, the body, and the emotions brings forth intuitive, imaginative abilities as well as logical, linear thought. Since emotional states are seldom logical, the use of imagery and nonverbal modes allows the client an alternate path for self-exploration and communication.

The creative process itself is a powerful integrative force. Verbal therapy usually focuses on emotional disturbances and inappropriate behavior. Like verbal therapy, the expressive arts move the client into the world of emotions, yet add a further dimension—a way to use the free-spirited parts of the personality. Therapy can include joyful, lively learning on many levels: the sensory, kinesthetic, conceptual, emotional, and mythic. Clients report that the expressive arts help them to go beyond their problems, to find a new sense of soul or spirit, and to envision themselves taking constructive action in the world.

What Is Person-Centered?

The client-centered or person-centered philosophy of my father, Carl Rogers, is the foundation on which my mode of expressive arts therapy rests. This approach requires the therapist to be empathic, open, honest, congruent, and caring, as he or she listens in depth and facilitates the growth of an individual or a group. Central is the belief that every person has worth, dignity, the capacity for self-direction, and an inherent impulse toward growth.

I base my approach to expressive arts therapy on this very deep faith in the innate ability of each person to reach toward full potential. Just as Carl veered away from psychoanalysis and interpretation, so, too, have I rejected analytic and interpretive forms of art and movement therapy. In terms of methodology, this means I follow the client's lead as he or she discusses their art, movement, or writing. The words of my father are always with me:

“Empathic understanding means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this acceptant understanding to the client. When functioning best, the therapist is so much inside the private world of the other that he/she can clarify not only the meanings of which the client is aware but even those just below the level of awareness. Listening, of this very special, active kind, is one of the most potent forces for change that I know.”

(Kirschenbaum & Henderson, 1989, p. 136)

I want to emphasize the words “communicates this acceptant understanding to the client.” It is a rare experience to feel accepted and understood when you are feeling fear, rage, grief, or jealousy. Yet, this empathic response heals.

As friends and therapists, we frequently think we must have an answer or give advice. However, this overlooks a very basic truth. By genuinely hearing the depth of the emotional pain and respecting the individual's ability to find his or her own answer, we are giving clients an opportunity to empower themselves and discover their unique potential. Empathic listening also encourages peeling the layers of denial and defense, which allows clients to feel safe to try the expressive arts as a path to becoming whole.

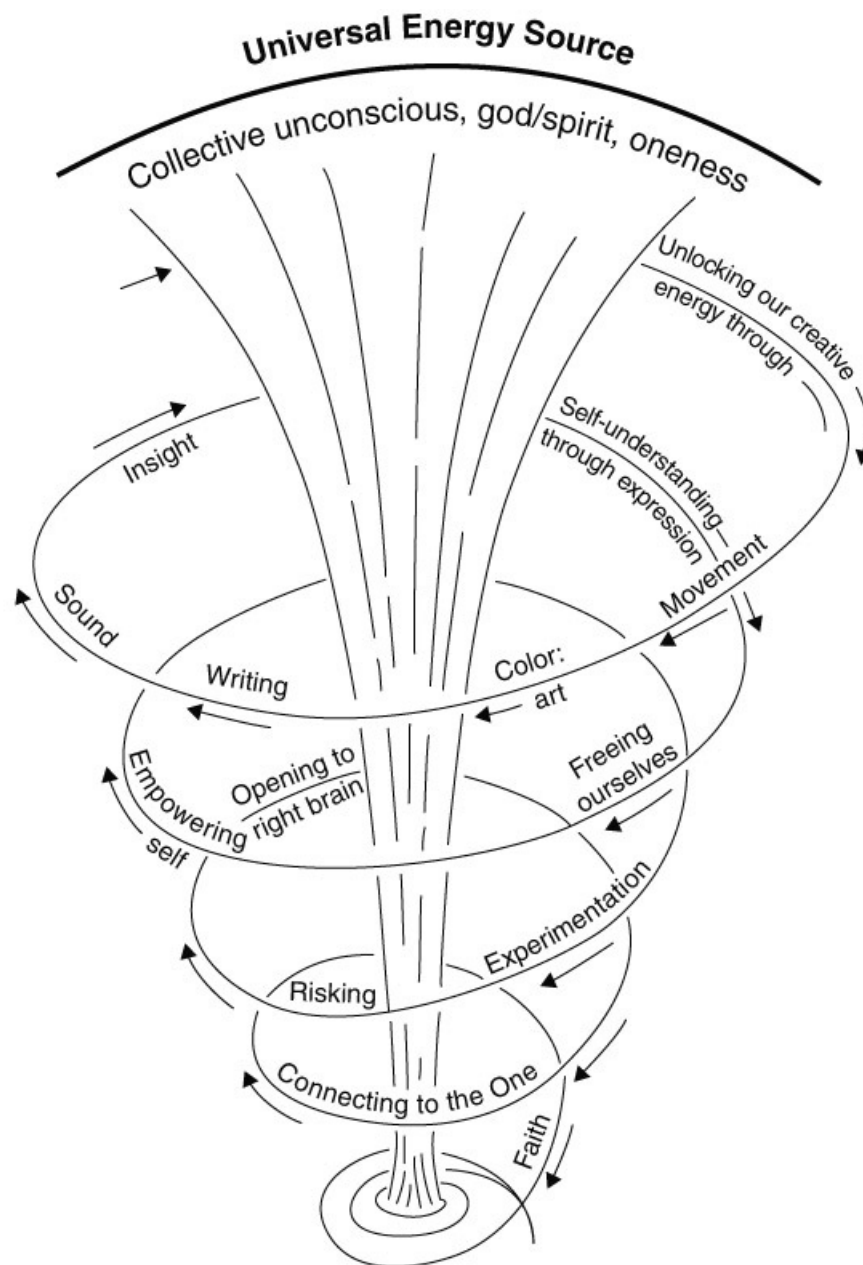
The Creative Connection®

I have coined the term *the creative connection* to describe a process in which one art form stimulates and fosters creativity in another art form, linking all of the arts to our essential nature.

Using the client-centered roots of my psychological training as well as training in movement and art therapy, I made some personal discoveries. I found that when I danced a sad or angry feeling in the presence of an empathic, non-judgmental witness, my feelings and perceptions shifted dramatically. When I drew the images after moving, the art became more spontaneous, expressive, and revealing. If I followed the art with free writing, I plunged further into guarded feelings and thoughts. Thus, I realized that the empathic witness to art, movement, and journal writing is similar to a client-centered therapist.

I also conceptualized the notion that using the arts in sequence evokes inner truths that are often revealed with new depth and meaning. Movement unlocks our creative energy, which gets expressed in visual art. Expressing the self through visual art fosters poetry or spontaneous writing. As we take risks and experiment, we are capitalizing on the brain's right hemisphere and its capacity for nonverbal, nonlinear experience. Inner healing takes place because of this "creative connection." (See [Fig. 12.1](#): "The Individual Creative Force.")

The creative connection process that I have developed stimulates a form of self-exploration similar to the unfolding petals of a lotus blossom on a summer day. In the warm, accepting environment, the petals open to reveal the flower's inner essence. As our feelings are tapped, they become a resource for further self-understanding and creativity. We gently allow ourselves to bring forth what has been denied to awareness—that which rests in our unconscious. Simply put, we cannot integrate all aspects of self without involving all aspects of self. We reawaken our creativity by engaging in the process of creativity.



The Individual Creative Force

The Creative Connection Process: By moving from art form to art form, we release layers of inhibitions, bringing us to our center—our individual creative force. This center opens us to the universal energy source, bringing us vitality and a sense of oneness.

Figure 12.1 "We Are All One"

Using Expressive Arts with Clients

Traditional psychotherapy is verbal, and the verbal process will always be important. Although offering the arts as another means of expression is a departure from the way my father worked, I am respectful of the integrity and self-direction of the client, and try to empathetically enter his or her frame of reference. Yet I have discovered that using the arts as another language brings me even closer to the client's world. The I-thou relationship is enhanced as I listen to clients' exploration of their movements, images, or sounds. Even more amazing is the fact that in creating the art, clients' feelings shift.

Incorporating movement, sound, art, journal writing, and guided imagery enhances the therapeutic relationship in many ways. Using the expressive arts helps clients to identify and be in touch with feelings, explore unconscious material, release energy, gain insight, solve problems, and discover the intuitive and spiritual dimensions of the self.

People ask me how I introduce the expressive arts in a counseling session. Some time during the first three sessions, I describe the client-centered philosophy and the expressive arts process...

As an expressive arts therapist I have training in the use of movement, art, and guided imagery to help you to explore—to go on your inner journey—through symbolic, nonverbal modes. At times, I will offer these methods to you. Often a healing process occurs by using this type of spontaneous, free expression. We need not be concerned about the artistic quality of the product. However, the product can give you new information about yourself. I do not use art to diagnose you or to interpret you. The art and movement processes are available to you as another avenue of self-exploration and healing. The arts can also be another language to use to communicate with me.

At this point, I ask for some reaction from the client. Some people are eager to use the materials. Others say, "I can't draw," or "I'm not a creative person," or "I've got two left feet and can't dance." I reassure them that it is not a test of their creativity, or drawing or dancing ability, but a method of self-discovery. Those who are fearful usually lose that sense, if they decide to take the risk and try some form of art expression.

I also assure clients that when I offer them the opportunity to express themselves nonverbally, they always have the option to say "No." I might say, "I will make suggestions and encourage you, but the decision is up to you. I will respect it." I may hear a sigh of relief from the client, yet I often find that many are eager to use the expressive arts modalities.

Trusting the Client's Path

People who observe me in a demonstration counseling session often ask, "How did you know whether to suggest art or movement or sound with that client?" I don't know, in the sense that there is a right or wrong art form to offer. I use clues from the client, and most importantly, I trust the client to tell me the appropriate path. I always give a choice.

People also ask, "At what point do you offer the opportunity to use an art process?" There are many possible entrees to choosing art as a language. When a client is expressing strong emotion, for example, I often ask, "Would you like to explore that in color or movement as well?" The client may say, "No, I need to talk some more." That is perfectly acceptable to me. If he or she says, "Yes, that seems like something that would help me discover more about this feeling," I will then ask, "Would you like to draw, or move, or make sounds?" I follow the client's lead. If a client chooses visual art, I sit silently as an empathic witness.

Then I ask the client to tell me what the experience was like as he or she created the piece. We look at it together and I encourage the client to describe it and give it any meaning. He or she is allowing me to enter his/her world of imagery and imagination. If the client wants to move or dance the picture, that furthers the journey. I constantly check: "Does this feel right to you? Do you wish to explore more? Am I understanding you correctly? Do I get your real meaning here?"

Here the reader might ask, "Why is the person-centered approach to expressive art therapy so important to you, Natalie? Why do you create this non-judgmental, permissive, accepting environment? Why do you insist that the therapist not interpret the art or movement? Don't you believe these art forms tell volumes about the client?"

These are valid questions. I do believe the arts express many lost or undiscovered aspects of Self. I also realize I cannot possibly understand the real meaning of the art as the client experiences it, unless I listen deeply, asking the client the type of questions that can help him or her explore these meanings. It would be arrogant on my part to think I know better than the client (no matter how much training I have had) what he or she is trying to portray, or what an image or movement means.

I always treat a client with the same kind of respect that I would want from a therapist. I have had experiences where people have looked at my art, and have immediately told me what I am feeling or what the art means. To be misunderstood after revealing a very personal and private part of myself leads me to mistrust the person who interpreted the art. My reaction is, "I don't think I will ever show him another piece of my art!"

Our art is extremely personal. To gain someone's trust I believe we must honor their experience. To do otherwise may close down the client's creativity, or break the rapport between client and therapist. If the client happens to like the therapist's interpretation of the art, then he or she will return again and again to find the meaning from the authority figure—the therapist—rather than develop the ability to find meaning for himself or herself.

Also, we know that the creative bud is very delicate. Dozens—no hundreds—of people have told me they stopped painting, dancing, writing, or singing, because they were judged, graded, or put down as a child. Teachers flunk children in art class, tell students to mouth the words of a song, or ridicule their dancing. One degrading evaluation can stop a person from ever again picking up a paintbrush, singing with friends, or expressing themselves through dance. When we work with clients, we need to remember that creativity has to be nourished and supported by honoring and respecting their courage in sharing it with us.

How do I help clients process their art? First, I ask them to explain what the process was like. "What were you feeling as you were painting (or moving)?" Another inquiry would be, "What do you feel when you look at your picture (or sculpture or collage)?" Here are some other suggestions that help the client find meaning in their art:

- Let the image speak to you. What message does it have for you?
- Have a dialogue with the image. Write the dialogue in your journal.
- Tell a story in the third person about this image, starting with "Once upon a time."
- Try putting a title on your artwork as a way to enhance its meaning.
- If there is a section of the drawing or painting that is vague or seems incomplete, try another picture

expanding on that part.

- Find the section that is most troublesome. Do another painting that will explore that section.

In all of this, I am a companion on the client's path of self-exploration. I am not leading the way. I do not know the final destination. I can hold the lantern while the client blazes the trail.

I might suggest using movement and/or sound to express the line, rhythm, or color in a painting, which helps a person to embody their art. Movement is also a way to expand feelings by putting them into kinesthetic form. It is a potent avenue for self-awareness, insight, and healing. When a client expresses fear, for example, the therapist might say:

Would you be interested in exploring that feeling through movement? Find your space, close your eyes, and let the feeling express itself through your body. You could take a pose, showing your fear. Put sound to the pose, if you wish. Then let that posture shift. Take a pose of how you would like to feel in that situation. Notice the kinesthetic shift it takes to get from the first pose to the second. Try it again. What are you learning about yourself?

The reader can best understand this dynamic process between therapist and client by viewing the two-hour live demonstration DVD, *Expressive Arts Therapy in Action with Natalie Rogers (2012)*. You can witness the transformative power of moving beyond words and the effectiveness of the person-centered approach as the young woman, Suzen, struggles with a career decision. In the first hour, she expresses her deep desire to leave her tedious accounting job to devote her energy to the healing work she does with horses, but is trapped by negative thought patterns and afraid of going broke. She explores her fears and self-doubt and dilemma through the use of movement, pastels, and clay. In the second hour, just a week later, there is a dramatic shift from confusion to clarity and reawakening of her self-esteem. I discuss the facilitation process in an interview with the producer, Victor Yalom, after the two sessions and give voice-over comments during the sessions to help the viewer understand why I am doing what I am doing.

The Healing Power of Person-Centered Expressive Arts

It is difficult to convey in words the depth and power of the expressive arts process. I hope that in sharing the following personal episode, you will vicariously experience my process of growth through movement, art, and journal writing in an accepting environment.

The months after my father's death were an emotional roller coaster for me. The loss felt huge, yet there was also a sense that I had been released. I felt that his passing had opened a psychic door for me, as well as having brought great sorrow. Expressive arts served me well during that time of mourning.

A friend invited me to spend a week at a cottage on a bay. I painted one black picture after another. Every time I became bored with such dark images, I would start another painting. It, too, became moody and bleak. Although my friend is primarily an artist, her therapeutic training and ability to accept my emotional state gave me permission to be authentic.

I also went to a weekend workshop taught by another friend, an artist/therapist. I spent my time sculpting and painting. This time the theme was tidal waves—and again, I drew black pictures. In my grief, I felt overwhelmed. Painting the black tidal waves over and over expressed my sense of helplessness (see [Fig. 12.2](#), “Black Wave”). One clay piece portrayed a head peeking out of the underside of a huge wave.



[Figure 12.2](#) “Black Wave”

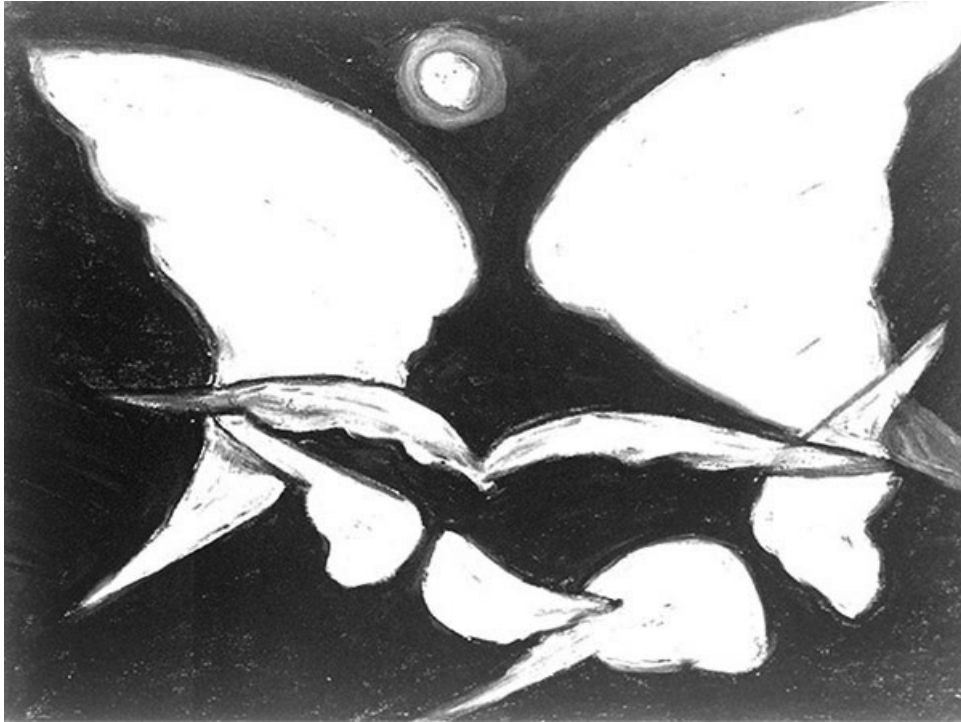
The details of emptying my parents’ home, making decisions about my father’s belongings, and responding to the hundreds of people who loved him was taking its toll. Once again, my artwork gave free reign to my feelings, and yielded a sense of relief. Being encouraged by my friend to use the art experience to express and understand my inner process was another big step. I thought I should be over my grief in a month, but these two women gave me permission to continue expressing my river of sadness. That year my expressive art reflected my continuing sense of loss, as well as showing an opening to new horizons.

As is often true when someone feels deep suffering, there is also an opening to spiritual realms. Three months after my father’s death, I flew to Switzerland to co-facilitate a training group. It was a time when I had a heightened sense of being connected to people, nature, and my dreams. I experienced synchronicities, special messages, and remarkable images. One night I found myself awakened by what seemed to be the beating of many large wings in my room. The next morning I drew the experience as best I could ([Fig. 12.3](#), “White Wings”).

One afternoon, I led our group in a movement activity called “Melting and Growing.” The group divided into pairs, and each partner took turns observing the other dancing “melting,” and then “growing.” My co-

facilitator and I participated in this activity together. He was witnessing me as I slowly melted from being very tall to collapsing completely on the floor. Later I wrote in my journal:

I loved the opportunity to melt, to let go completely. When I melted into the floor I felt myself totally relax. I surrendered! Instantaneously I experienced being struck by incredible light. Although my eyes were closed, all was radiant. Astonished, I lay quietly for a moment, then slowly started to “grow,” bringing myself to full height.



[Figure 12.3](#) “White Wings”

My heart had cracked open, leaving me both vulnerable and with great inner strength and light. A few days later, another wave picture emerged. This time bright blue-green water was illumined by pink-gold sky ([Fig. 12.4](#), “Blue-Green Wave”).

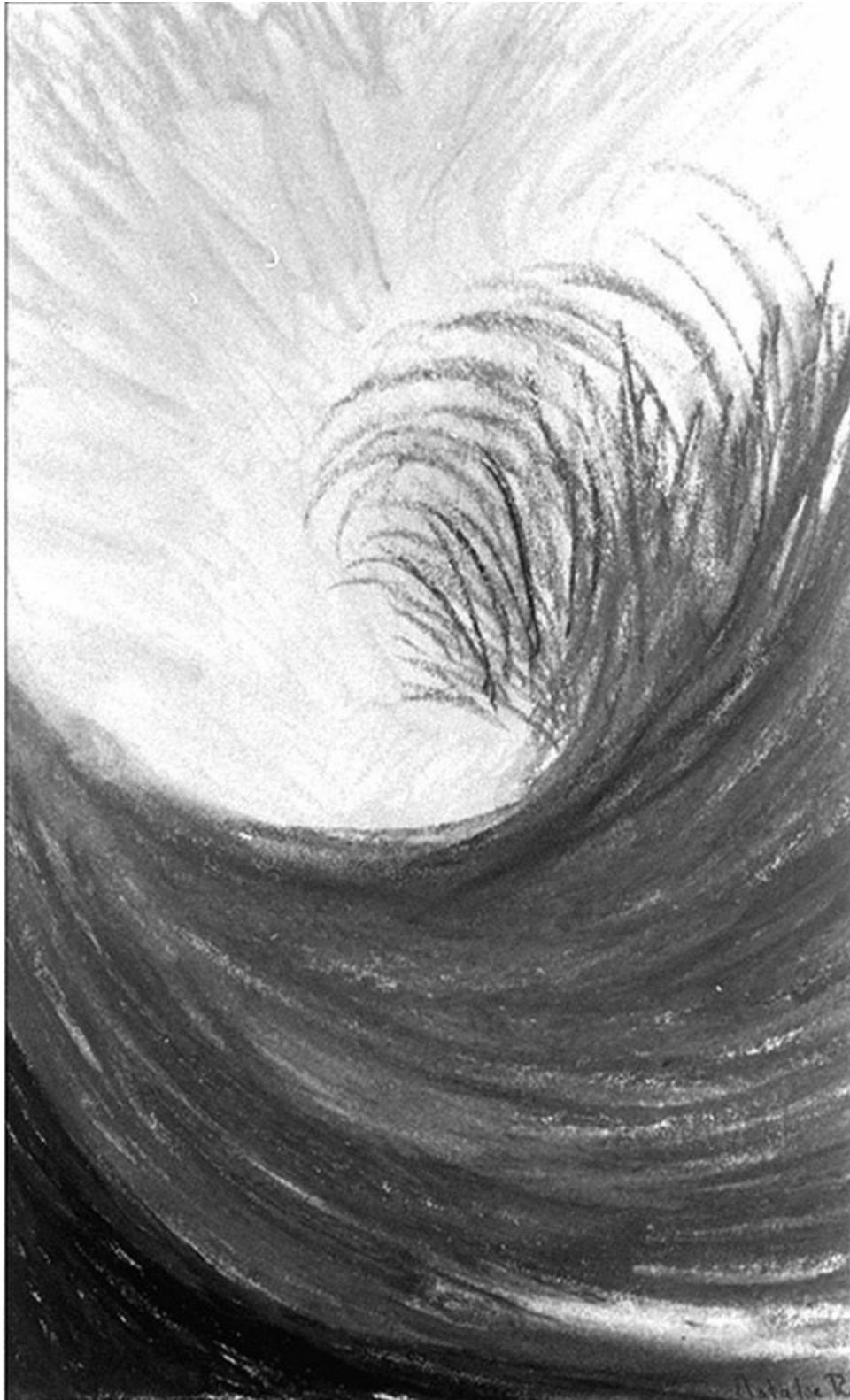
I share these vignettes for two reasons. First, I wish to illustrate the transformative power of the expressive arts. Second, I want to point out that person-centered expressive arts therapy is based on humanistic principles. For instance, it was extremely important that I was with people who allowed me to be in my grief and tears, rather than patting me on the shoulder and telling me everything would be all right. I knew that if I had something to say, I would be heard and understood. None of my colleagues interpreted my art or gave me advice on how to grieve.

My Humanistic, Person-Centered Credo

People often ask me how my theory and counseling differ from my father's. People who view the two videotapes where I demonstrate counseling (Rogers, 1988, 1997) or who witness me in person, tell me they perceive my deep connection to my father's way of being. Like Carl, I usually go into an altered state of consciousness as I enter the frame of reference of the client. I try to be intuitively in tune with the feelings, as well as some of the unspoken messages. I call this "listening to the music as well as the words." I continually respond so that the client knows he or she is understood. Together, we adjust any misunderstandings. Clients can be our best teachers

Each of us has our own set of values. The credo I have developed over 25 years as a psychotherapist summarizes, in a very personal way, my person-centered expressive arts philosophy:

I am aware that going on one's inner journey can be a frightening, exhilarating, exhausting adventure.
I will be present for you, but not intrusive.
I have faith that you know how to take care of yourself. I won't be responsible for you or take away your power.
Nor will I abandon you.
I will respect you and your decisions for yourself. I have faith in your ability.
I will support you and encourage you on your inner journey.
I may challenge you and your belief system, at times, but I will always respect you and your truth.
I will encourage you to try new things, to take risks into the unknown of your inner world, but I will never push you.
I will offer you expressive arts media to help you open to your innate creativity and discover your inner essence. You are free not to use these media.
At times I will give you my opinions and feedback but will always check it out to see if it is meaningful to you.
I will honor my own boundaries and yours to the best of my ability.
I will share my value system and beliefs with you so that you know why I am saying and doing what I say and do.
I am open to learning from you at all times.
I make mistakes, do things I'm not pleased with, and am misguided at times. In such instances, I will say so. I am able to say, "I'm sorry."



[Figure 12.4](#) "Blue-Green Wave"

Expressive Arts for Healing and Social Change

So far I have been discussing the use of person-centered expressive arts with individual clients. In my second book, *Expressive Arts for Healing and Social Change*, I focus on the potent use of the Creative Connection process to enhance all types of groups as they help people go on their inner journey for transformation, healing, and social action. My passion has been cross-cultural work, and I have had the good fortune to work in almost all countries in Europe, and many in Latin America and Asia. My mission in this group work is to help people understand each other's differences and similarities and learn how to communicate constructively across cultures. The arts—movement, visual art, music, and psychodrama—are vehicles that help us along the journey to mutual understanding.

As with personal counseling, facilitators need to create a safe space where participants can feel accepted, valued, and heard at a deep level. Building a trust level within the group is paramount to developing open, honest communication. The following diagram ([Fig. 12.5](#)) shows how the group member starts by gaining self-insight through the arts process, eventually relating to the local community, then the world.

The Creative Connection Process

This diagram shows how, as we first journey inward through the expressive arts, we tap into the unconscious and become aware of new aspects of self, thus gaining insight and empowerment. Then, by connecting to at least one other person in an empathic and supportive environment, we learn ways to relate to the community. As we learn how to be authentic and empowered in a small community, we are then inspired to move to the larger circle. We become co-creative and collaborative, being able to access our higher purpose and powers. This connects us to the world—other cultures and nature—with compassion. This connects us to the world—other cultures and nature—with compassion.

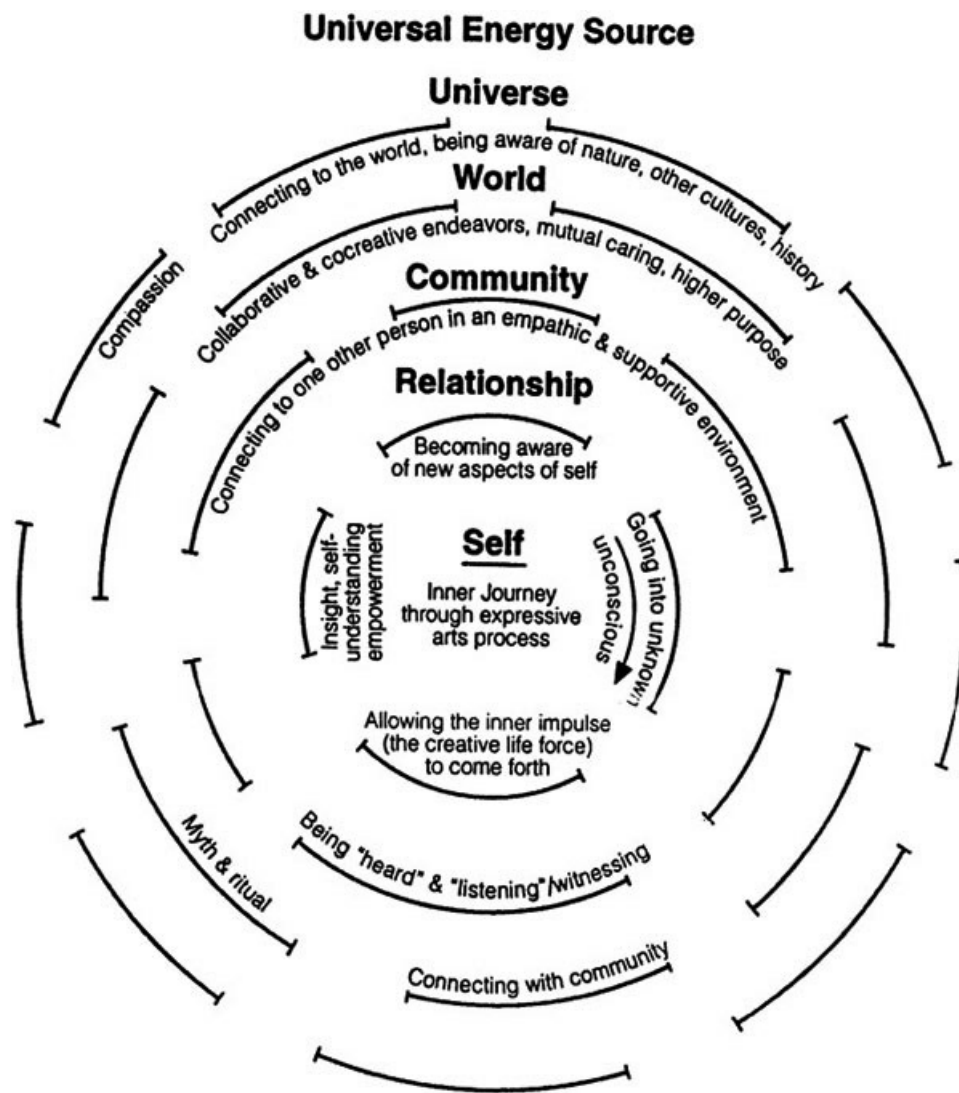


Figure 12.5 We Are All One

Cross-Cultural Understanding

In 2006, three of us created a workshop, “Bringing Israeli and Palestinian Women Together for a Peaceful Future: Using Listening Skills and the Expressive Arts to Bridge the Divide.” Details of the planning and process are in my book, *The Creative Connection for Groups* (2011). Twenty women came to Neve Shalom (Peace Village), Israel, for a two-day workshop. Israeli–Palestinian hostilities were acute. We created a person-centered environment where we heard the pain, suffering, and anger coming from each ethnic group, and by using the nonverbal language of the expressive arts, amazing results happened. At the end of the two days, we asked them to give us feedback by finishing this sentence, writing in their own language: “For me this group was like...” Here are some of the answers: “A gift, an opportunity,” “A strong emotional experience, perhaps a turning point in my life,” “An important experience, temporary.” No one wrote a negative response.

We also asked, “What did you learn?” A few of the replies: “That the other side suffers, too.” “You can meet and talk about everything.” “That religious women can be faithful to their commandments, but free in their behavior.” “We all want a place, respect, and freedom.”

How did such profound shifts happen in two days? We used several expressive arts explorations or exercises to help each woman discover her own feelings and thoughts before encountering someone from the “other” group. On arrival, after introducing ourselves and describing the intent of the workshop, we invited the women to get acquainted using movement, scarves, and music. This was a way of “breaking the ice,” or relieving some of the anxiety and fear that prevailed. In the afternoon, we offered an exercise called “Experiencing Inner and Outer Peace Through Art.” Each woman created a picture depicting her sense of inner peace. A second drawing was of “your sense of outer peace.” A third drawing asked them to use color to show what they saw/felt as blocks to peace. We asked them to write some sentences about each picture. By the end of the morning, each woman had delved into her own personal feelings of hope and frustration. I believe it is important to have this first step of self-knowledge before entering into any kind of encounter with the so-called other, or the person that you believe is causing the suffering.

In the afternoon, each woman was asked to pair with someone from the other ethnic group to share the art and written words and have a discussion. Asking the women to first *listen* to each other’s art and feelings before entering into confrontational dialogue also facilitated mutual understanding. Of course the confrontations and hostilities were expressed as well, which is an important part of the process. As facilitators our role was to slow down the conversation long enough so that each person actually heard what the other had to say.

On the second morning, the intention was to have a nonverbal conversation using clay. We asked the women to find a partner from the “other” group. They placed one large piece of paper (18" × 24") between them as they sat at opposite ends of a small table. Each woman had a large chunk of clay.

The instruction was for one person to place a piece of clay (in any shape) on the paper. No dialogue was allowed. The first woman might create a tower and place it on the paper. The second woman might add the shape of a head on the tower, changing the meaning of the piece. Whether this is accepted, nonverbally, or is shifted in some way by the original creator is part of the dynamic. One person may want to protect her clay pieces by keeping them at her end of the paper. The other person may make a decision to enter the other’s space by placing a shape there. This was the “conversation” between the two people. It continued for about 20 minutes.

Then we asked them to write about their experience. Finally, they talked with their partners. We hoped they would also share what they wrote.

Again we were amazed by the women’s focus and concentration during the art process. As facilitators, we quietly wandered around, observing various interactions. Some women laughed as they “played” together. Others were in a serious mood. On one paper, little piles of clay were placed close together forming the beginnings of a circle. On another, the pieces of clay seemed distant from each other. One tower kept growing. In another place, the pieces looked like a bridge.

An animated discussion followed. Some conflict or disagreement arose between some partners. When we gathered as a whole group to share the outcome of the project, we heard different kinds of stories. Here is one that provided the women insight into their different perceptions about how to be together.

A Jewish woman said: “I was reaching out, but there was always the wall that she was building. I was feeling trapped.”

Her Arab partner: “The truth was that I went into this with a lot of stormy emotions. I wanted to create a strong base for myself. I know she is a good person, but I felt she was interrupting my base—invading. I felt it everywhere. I made a wall; she put a hole in it. There was a moment when I felt I needed a strong center. Even when I created that important center, she put a ring around it. I took it off. It was like a war. I felt I needed to protect myself.”

The Jewish partner: “I took my tea bag and planted it in the middle. She brought some of the black coffee from the coffee pot. That was the place I felt connected, as if we were putting bandages on wounds.”

The Palestinian woman: “I felt I needed to protect myself. I made an entrance; she created another entrance. I closed the door from that side and I enlarged my door. I feel sorry for her because I can feel the gap between us. I became connected when she took spaces out of the house we built.”

In response, I paraphrased: “It seems that one of you had a sense of reaching out to the other. Yet your partner felt it as constant invasion. It is important to ask yourselves what you can learn from this. It can help you understand how another perceives your behavior. How can this help each of us communicate more perceptively?”

It was important that I emphasize what they could learn—how they can view the situation from the other person’s point of view—rather than focusing on who is right or wrong.

As the two days came to a close there were songs and laughter. One woman said, “If we are willing to confront, we are willing to love. We had the courage to do that.” Another woman said, “When we build a wall to keep someone out, we also build our own wall.”

Transcending Inner Polarities

When I work with groups we often spend time brainstorming our “inner polarities” and come up with long lists: love/hate, strength/weakness, close/distant, introvert/extrovert, happy/sad, peaceful/violent, and so on. Although the opposites may appear to be “good” or “bad” characteristics, it is not that simple. While people in denial may need to acknowledge and accept their grief, other individuals may need to allow themselves feelings of delight or optimism. In Jungian terms, the “shadow” is that aspect of the self that is unknown or that lives in the realm of the unconscious. The parts of the self we have rejected, denied, or repressed are frequently thought of as destructive or evil impulses. The shadow parts take emotional and physical energy to keep in check. To know, accept, express, and release the dark side in not-hurtful ways is essential in preventing these powerful forces from being acted out in violent forms.

However, we can also relegate to the realm of the unconscious our creativity, strength, rebelliousness, sensuality, sexuality, and willingness to love. So, when we risk exploring the depths of the unconscious, we may find many lost treasures. Discovering our unknown parts allows them to become allies: long-lost sub-personalities that we need in order to be complete. We become more whole, energized, compassionate people.

The expressive arts are powerful tools to help us uncover anger, fear, shame, loneliness, apathy, and the deep well of depression. I have been present while many clients or group participants have used movement and art to express their fear of death, of going insane, or of staying forever in the deep dark pit of depression. When given a voice, an image, a sound, a dance, the fears can become forces for change. When accepted for exactly what they are, they can help us on our road to recovery.

Accepting our shadow may be less difficult than embracing the light. When we talk about embracing the light, we are talking about opening to our spirituality, our ability to experience love, compassion, and all-encompassing states of consciousness. Many of my personal expressive art pieces convey my sense of the spiritual (see [Fig. 12.6](#), “Feminine”).

In my years as a therapist and group facilitator, I have found that people are often uncomfortable acknowledging and feeling love. They readily accept negative thoughts about themselves and others, but find themselves fending off compliments, caring, and affection. We tend to armor ourselves against receiving love. Being able to give and receive, whether from another person, animals, or a universal energy source, may be the prerequisite for being able to offer unconditional love.

The Path to Wholeness

Since not all psychotherapists agree with the principles embodied in this chapter, it is important to state them clearly...

All people have an innate ability to be creative. The creative process is healing. The expressive product supplies important messages to the individual. However, it is the process of creation that is profoundly transformative.

Personal growth and higher states of consciousness are achieved through self-awareness, self-understanding, and insight.

Self-awareness, self-understanding, and insight are achieved by delving into our emotions. The feelings of grief, anger, pain, fear, joy, and ecstasy are the tunnel through which we must pass to get to the other side: to self-awareness, understanding, and wholeness.

Our feelings and emotions are an energy source. That energy can be channeled into the expressive arts to be released and transformed.

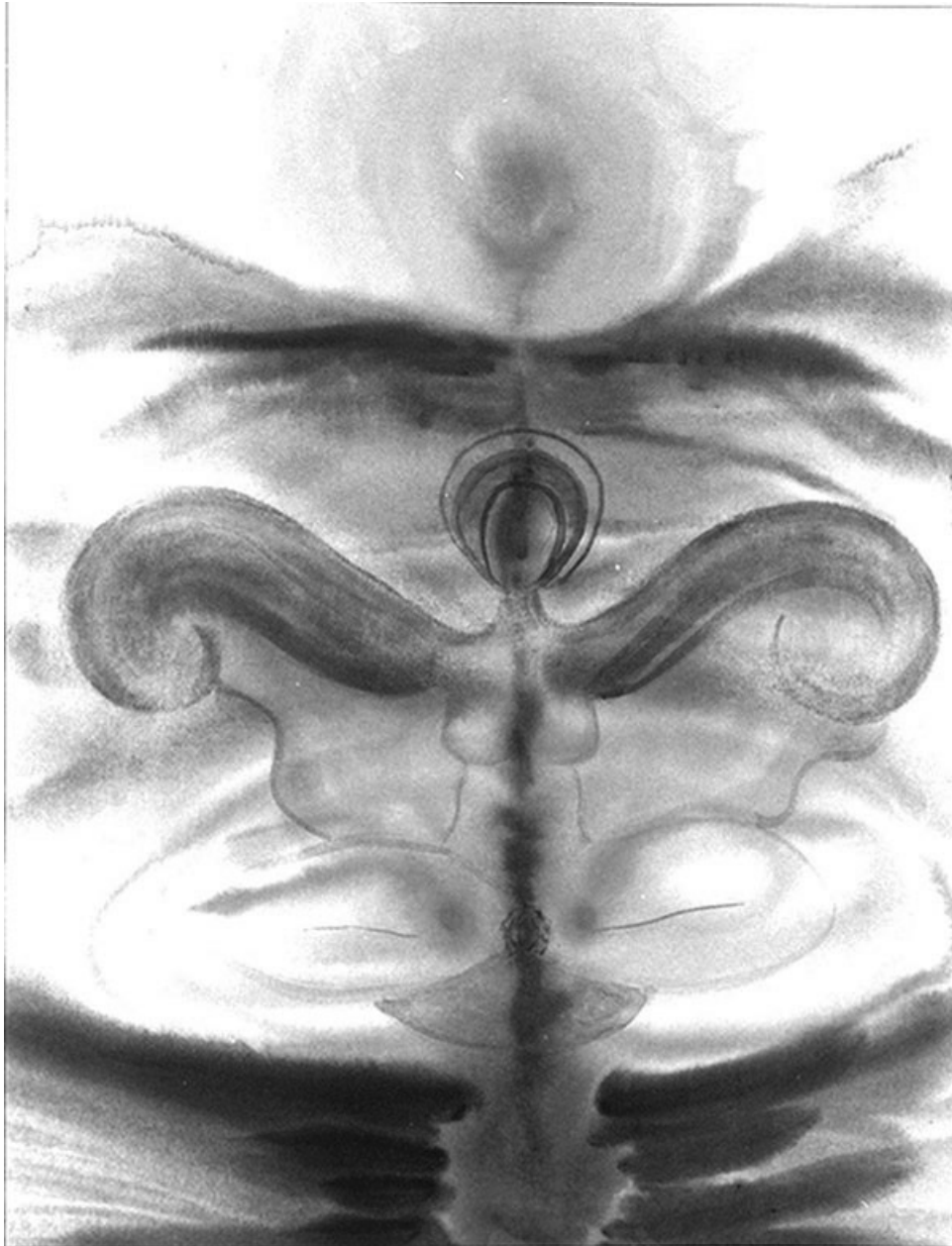
The expressive arts—including movement, art, writing, sound, music, meditation, and imagery—lead us into the unconscious. This often allows us to express previously unknown facets of ourselves, thus bringing to light new information and awareness.

Art modes interrelate in what I call “the creative connection.” When we move, it affects how we write or paint. When we write or paint, it affects how we feel and think. During the creative connection process, one art form stimulates and nurtures the other, bringing us to an inner core or essence, which is our life energy.

A connection exists between our life force—our inner core, or soul—and the essence of all beings.

Therefore, as we journey inward to discover our essence or wholeness, we discover our relatedness to the outer world. Inner and outer become one.

There are many discoveries to be made with this work: Finding spirit, soul, the ability to laugh at oneself, new wisdom, or the knowledge that with each struggle in life there are major lessons to be learned.



[Figure 12.6](#) "Feminine"

In our goal to become whole people, more fully actualized and empowered, awareness is always the first step. Without awareness, we have no choices. Personal integration is part of the natural flow of events when we use symbolic and expressive media. Once we uncover unknown aspects of self, the process includes letting these parts find their rightful places in our psyches. Then we are more able to experience the ecstatic universal oneness, a sense of being connected to all life forms.

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13

Positive Art Therapy

Gioia Chilton and Rebecca Wilkinson

Introduction

Positive art therapy combines art therapy with positive psychology's mission: to promote well-being by building upon what is good in our lives. In this model, concepts such as well-being, positive emotions, character strengths, flow, meaning, and achievement are defined and linked to art therapy practice and professional development. Art therapy is theorized to improve well-being through its ability to increase positive emotions, enhance relationships, provide opportunities for engagement, and illuminate purpose and meaning (Wilkinson & Chilton, 2013). This chapter includes clinical vignettes and interventions to illustrate the application of this approach.

Positive psychology builds upon the foundations and practices of mental health practitioners and art therapists with a new perspective that enables us to be more effective in our attempts to help others not only to survive, but to *thrive* in the face of adversity. Positive art therapy (Chilton & Wilkinson, 2009; Wilkinson & Chilton, 2013) combines art therapy and the benefits of the creative process with positive psychology's mission to promote well-being in our clients and our communities by building upon what is functional and good in our lives. Positive art therapy can be implemented with different populations, at varying stages of treatment and in a wide range of settings. This is an approach we use not only with our clients, but also for ourselves and for the profession of art therapy. The immense challenges we face in the world today call for people to be functioning at their highest possible level, and this approach provides empowering tools to enable us all to do so.

When we teach graduate students about positive psychology, we often start by having them make artwork about "what a happy and fulfilled life includes for you." We might suggest to you that, even before you proceed with this chapter, *you* put down this book and do the same! What does *your* happy life include? What would you be doing, and where would you be? Who would be there with you? How would you be feeling? We also suggest that you refer back to this image, as we examine the world of happiness and well-being.

Positive Psychology: History, Definitions, and Assumptions

Positive psychology is the scientific study of positive experiences, positive character, positive meaning, and the positive institutions and communities that promote their development. Positive psychology emerges from humanistic principles holding that human beings are inherently good and motivated to reach their full potential. It builds upon Maslow's (1971) concept of self-actualization, Frankl's (1985) exploration of finding meaning in the face of adversity, Rogers' (1951) client-centered therapy, Horney's (1951) pro-social model of human behavior, and the seminal work of Jahoda (1958), who outlined a framework for understanding the components of mental health as opposed to the elements of mental illness. Positive psychology has sought to provide empirical validity for these theories. It has been termed the *science of well-being*—that is, optimal physical, psychological, and social functioning.

Positive psychologists have noted that historically, psychology theory and practice have focused more on alleviating mental illness and reducing suffering (Gable & Haidt, 2005), and less on exploring mental health, well-being, and positive functioning. This can not only be attributed to the virtue of compassion, but also to the *negativity bias*—an evolutionary mechanism that naturally commands our attention and propels us to channel resources toward correcting what is not functioning in our environment. The negativity bias can be understood through a figure/ground metaphor, in which negative experiences seem to *pop out* at us, in contrast to the positive background of everyday human experience (Vaish, Grossmann, & Woodward, 2008). In other words, as the nightly news demonstrates, “bad is stronger than good,” but this may not mean there is more bad than good in our lives (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001, p. 232).

The negativity bias also helps to explain why the medical model, with its emphasis on identifying and addressing illness and disease, has dominated the delivery of psychotherapy services (Maddux, 2002). The medical model has served us well—through it, we have been effective in addressing disorders such as depression and anxiety in much of the developed world. This is definitely something to celebrate, but in the field of mental health in general, and in clinical and institutional settings in particular, psychotherapy has not historically focused on happiness and well-being as treatment outcomes (Seligman, 2002).

A positive psychology approach assumes that the components of mental health—that is, happiness, feeling better, being more productive in life—should all be goals in psychotherapy. Positive psychologists suggest that pathology arises when our attempts to realize our inherent capacities for well-being and fulfillment are thwarted. In contrast, optimal functioning occurs when people experience high levels of well-being; they see their lives as having purpose and meaning, and they have a sense of autonomy and control over them (Seligman, 2011).

Indeed, positive psychologists suggest that people with physical and/or mental challenges can, despite these limitations, be coping well and experiencing a high level of fulfillment in their lives, and on the other hand, that people may be free of illness and still be unhappy and highly dysfunctional (Keyes, 2007).

Viewing even the most distressed persons as more than the sum of damaged habits, drives, childhood conflicts, and malfunctioning brains, positive psychology asks for more serious consideration of those persons' intact faculties, ambitions, positive life experiences, and strengths of character, and how those buffer against disorder.

(Duckworth, Steen, & Seligman, 2005, p. 631)

Recent research demonstrates that experiencing high levels of well-being leads to greater physical health and longer life, improved work performance, good citizenship, and stronger social networks and societies (Diener, 2012). It has also been found that well-being is highly correlated with *resiliency*: the capacity to bounce back from adversity, and to preventively buffer against future stress (Fredrickson, Tugade, Waugh, & Larkin, 2003). For this reason, positive psychologists urge that we devote as much energy and as many resources to identifying and examining the factors that promote well-being—such as personal strengths and social connections—as we have previously devoted to examining the symptoms and elements of disease.

Positive Emotions, Engagement, Relationships, Meaning, and Achievement: PERMA

Research into well-being indicates it is strongly correlated with several significant domains of human experience. Seligman (2011) conceptualized PERMA as an overarching framework that outlines what he and other positive psychologists have determined are the most important pathways to well-being. PERMA stands for *Positive Emotions, Engagement, Relationships, Meaning, and Achievement*. In the following sections, we explore each of these components, while also linking them to the theory and practice of art therapy. Although we examine them as if they were discrete domains, in fact they have an impact on and are often integral to one another. We examine how art therapy uniquely contributes to PERMA and well-being, with its ability to increase positive emotions, to enhance relationships, to provide opportunities for engagement, mastery, and flow, and to illuminate purpose and meaning (Wilkinson & Chilton, 2013).

Positive Emotions

Well-being has strong emotional components: experiencing more pleasant emotions—hope, love, contentment—and fewer unpleasant emotions—guilt, anger, worry. Theoretically, emotions are shaped through natural selection to improve adaptation to the environment (Darwin, 1872/2002). We know that strong *negative* emotions have survival value; they activate the fight, flight, or freeze response. However, the value of *positive emotions* was less well understood until Fredrickson (1998) helped to identify that, by broadening perception and building psychological and social resources, they significantly increase resiliency. Fredrickson (2009) suggests that positive emotions can also *undo* the effects of negative emotions; and can counter the downward spiral evident in depression, in which depressed mood is compounded by narrowed pessimistic thinking. By creating an interplay of broadened thinking, greater accesses to internal and external resources, and improved coping, positive emotions lead instead to *upward* spirals of physical and psychological well-being.

Discussing emotions can be challenging, however. In Western science, emotions were devalued as the enemy of rational thought (Jaggar, 1989). Plato (1992) wrote that we had to control them, lest they carry us away like runaway horses. Recently, scientists have recognized that some dichotomies—like emotion vs. intellect—may be false and misleading. We now know that how we think about things shapes how we feel, but we also know that how we feel shapes how we think (Izard, 2011).

Research has shown that expressing emotions, particularly ones that may be challenging, is therapeutic (Kennedy-Moore & Watson, 2001). However, experiencing positive emotions can also be critical at key points in therapy. With clients who are suffering, positive emotions can help relieve acute distress that can be overwhelming (Rashid, 2014). Positive emotions such as *hope* may also be critical at the inception of therapy, when belief in the possibility of change is so important, yet so fragile (Snyder, 2000; Yalom, 1995). Positive emotions also open us up to exploration and play, which promote creativity and new ways of thinking (Fredrickson, 2009).

In art therapy, one of our fundamental assumptions is that making art can help with the expression of a greater range of emotions than words alone—art making allows complex feelings to be released, expressed, communicated, and understood (Kramer, 1971; Naumburg, 1966). Art brings feelings into consciousness and encapsulates them through expressive form (Langer, 1957). Research has demonstrated that making art can also repair and elevate mood (Bell & Robbins, 2007; De Petrillo & Winner, 2005; Drake, Coleman, & Winner, 2011).

Proponents of studio-based art-as-therapy are therefore correct—since just the process of doing art evokes positive emotions. A more directive approach may be beneficial as well; since focusing on positive elements through art can also increase positive emotions (Dalebroux, Goldstein, & Winner, 2008; Henderson, 2012). Art making both creates and becomes a way to express positive emotions (Chilton, 2014), affirming what the art therapy world has long known—that art making may be one of the most effective modalities for both conveying and improving mood.

In art therapy, positive emotions might emerge through multiple avenues: the art making process, directives designed to evoke desirable feelings, and, as we will discuss later, from social support. Some examples of positive directives include: visual gratitude journaling; mandalas of peace, love, and/or joy ([Figure 13.1](#)); symbols for what motivates you and gives you hope; a time when someone did something for you or you did something for someone else and felt good about it; a pleasant experience you want to savor; or art gifts for yourself or for someone in need.



Figure 13.1 “Mandala of Peace and Love”

Made by medically ill client after visualizing what it would be like if she felt better.

Let’s explore how we might induce positive emotions in art therapy on a short-term psychiatric care unit. Patients in this setting are often in crisis, but are still expected to participate in therapy groups with people they have only just met. We start sessions with a standard check-in, asking people to share whatever they are willing to reveal about what brought them to the unit. This allows them both to express their distress and to commiserate with others who are there, a process that we know reduces feelings of isolation and promotes a sense of universality (Yalom, 1995).

We also suggest that they identify something that went well thus far in their day. This request subtly shifts their focus to positive elements in their immediate environment. Along with reports, such as the fact that they had been feeling overwhelmed and/or suicidal, or that they were hearing voices telling them to hurt someone; they might add that another patient was kind to them, or that they slept for the first time in days. The simple suggestion to attend to something specific that went well—differentiated from “gratitude” that is more generalized and may not be as helpful in times of crisis—reduces negativity bias and frequently creates a small but noticeable brightening of affect.

We follow the sharing of their situation and the positive warm-up with a hopeful visualization and a positive art therapy directive. We ask if they can remember a time when they felt better or, if not, if they can *imagine* feeling better. Invariably, most patients can reflect back or project forward to feeling peaceful or more motivated and hopeful; and, when doing so, they experience those positive sensations in the moment. Then we ask the group to make artwork about “what it would be like if you felt better, if whatever brought you to the hospital had improved.” The art process itself, and the feelings of support generated when group members explore the imagery and meaning in each other’s artwork, creates “upward spirals of positive emotions that counter downward spirals of negativity” (Garland et al., 2010, p. 849).

Variations of this approach can be utilized with clients that range in functional ability. And, because

authentic emotional expression of anger, frustration, or suffering is often necessary before clients can move to more positive states, timing is critical. However, accessing positive emotions, like hope and a sense of connection, may be essential at many key stages of therapy. We believe that therapists with a conscious understanding of the benefits of positive emotions will be more attuned to their use and development.

Engagement Using Strengths

The second domain of PERMA, *Engagement*, means that we are most fulfilled when we are enacting our character strengths. Peterson and Seligman (2004) identified a need to complement elaborate descriptions of mental illness, such as those in the Diagnostic and Statistical Manual (American Psychiatric Association, 2000), with an equally comprehensive articulation of strengths. They developed a taxonomy of character strengths and virtues which exist in cultures throughout the world (Peterson & Seligman, 2004), and proposed that we typically exhibit several *signature strengths*, core attributes that represent what we do best. Using our highest strengths appears to positively impact all domains of well-being, leading to increases in positive emotions, better relationships, a deeper sense of meaning, and greater feelings of engagement and accomplishment (Peterson & Seligman, 2004).

Positive psychologists theorize that psychopathology may result as much from a deficit in strengths as from pathology and weakness (Peterson & Seligman, 2004); and that we need to not only identify and develop our strengths, but also to differentiate between the ones that energize us and those that deplete us (Biswas-Diener, Kashdan, & Minhas, 2011). They suggest that some of our strengths may emerge to a greater or lesser degree in different situations, and that weaknesses can be reframed as an overuse of strengths that have not been tempered to meet the demands of a given situation. Several effective tools for assessing strengths have been developed, including the *VIA Inventory of Character Strengths* (Peterson & Park, 2009; Peterson & Seligman, 2004) among others.

In art therapy, we have long proclaimed the virtues of art in accessing and showcasing clients' strengths (McGraw, 1995; Riley, 1994). Yet we have noticed that many art therapists speak only in general terms about strengths. We often have our clients choose from the *VIA*'s list of 24 strengths—which include characteristics such as courage, wisdom, love of learning, integrity, justice, humanity, generosity, humor, curiosity, loyalty, perseverance, modesty, spirituality, forgiveness, zest, social intelligence—and make visual symbols for those attributes.

If clients struggle with identifying their strengths, we ask them to pick qualities that family members or friends might assign to them, or to focus on the qualities of someone they admire. Exploring these attributes, which they might either not have noticed or may have minimized, can be very empowering. In our work with clients dealing with substance abuse, for example, we have them symbolize the strengths they bring to their recovery ([Figure 13.2](#)). Donald (2008) suggests a similar directive with breast cancer survivors, in order to highlight coping skills.

Betts (2011) noted that, although many art therapy assessments have effectively correlated visual elements with symptomatology and diagnoses, few have articulated parallels between graphic content and strengths. Exciting possibilities exist in matching the *Diagnostic Drawing Series* (Cohen, Mills, & Kijak, 1994) or the *Person Picking an Apple From a Tree* (Gantt, 1990) with strengths inventories. We can also further capitalize on strengths that are uniquely illuminated during the art process or reflected in the art work—such as investment, creativity, imagination, attention to detail, ability to focus, as well as developmental level, perspective, intensity, proportion, figure-ground relationships, depth, and balance.



Figure 13.2 [“Recovery Warrior Mixed Media Assemblage”](#)

A client in an inpatient addiction treatment center channeling her “warrior spirit” in an homage to her recovery.

Engagement and Flow

Flow, a state of effortless concentration, focus, and attention (Csikszentmihalyi, 1991), is another critical element of engagement. When we are in flow, there is a loss of self-consciousness. We become so engrossed that our experience of time is altered—we have a sense that it is either speeding up, or that what felt like hours was only minutes. Flow occurs when there is a balance between skill and effort, when the activity is challenging enough that it is not boring, but not so challenging that it feels insurmountable (Csikszentmihalyi, 1991). Because flow is intrinsically rewarding, it naturally leads to an increase in positive emotions and improved well-being (Rogatko, 2009). Csikszentmihalyi (1991) wrote that flow is essential for a full and happy life, because it is a crucial part of what makes life worth living.

We know from personal experience and empirical research that art making induces flow (Burkewitz, 2014; Lee, 2009). The science of flow provides additional empirical support for an *art as therapy* approach. Art making channels anxiety, transforms chaotic energy, and promotes concentration. Art activities that produce absorption and deep focus—such as creating mandalas, working with clay, painting, beading, and knitting—can be very effective in inducing the experience of flow. Art therapists can promote flow in various ways, including the timing of interventions, the use of environmental elements such as music and lighting, and tasks that optimize a balance between skill and challenge (Chilton, 2013).

Meaning

Meaning and purpose also contribute significantly to overall life satisfaction (Park, 2011). Meaning is how we make sense of things, how we create coherence in our lives through finding and creating patterns and connections (Baumeister & Vohs, 2010). People who have experienced difficulties but are able to engage in *benefit finding*—who, despite hardship, extract positive meaning from their experiences—appear to recover more quickly and fully from adversity (Park, 2011). Contextualizing challenges within a broader understanding seems to create a buffer against hopelessness, to foster resilience, and to lead to *posttraumatic growth* (Tedeschi & Calhoun, 1996). Posttraumatic growth occurs when people who have suffered trauma also experience an increased appreciation of life, and positive changes in their beliefs about their ability to cope.

Posttraumatic growth arises from shifts in perception and perspective. As noted earlier, the negativity bias makes us more prone to notice what is problematic in our environment. In addition, when we are experiencing pain, anger, anxiety, and depression, we are even more likely to perceive our experiences and others more rigidly and negatively. Posttraumatic growth is more likely to occur when we are able to reframe our perceptions and interpretations. Strategies that promote this process include affirming strengths in ourselves and others, and appreciating what is functioning and good in a given situation. Positive emotions also help to create such shifts by broadening perception, while encouraging creative thinking and novel solutions. Fostering connection and sense of belonging similarly help change perception in a positive way.

Art therapy, with its capacity to promote positive emotions and its ability to communicate our internal experience, may be one of the most useful ways to expand our perceptions. Through artistic symbols, metaphors, and stories, we can illustrate the narrative of our lives. The richness of visual imagery provides opportunities to examine and to reframe that narrative, to help us see things differently (Gantt & Tinnin, 2009). Through small shifts in awareness or sudden *Aha!* moments, our sense of ourselves, our stories, and our place in the universe can be transformed.

Narrative analysis of interviews with US and Canadian women suffering from breast cancer has revealed a link between art therapy and meaning-making, which helped study participants enhance their sense of purpose and meaning despite their illness (Collie, Bottorff, & Long, 2006). Similarly, in our work with people affected by cancer, we lead workshops honoring their resilience. We give the directive to “recall a time in your life when you experienced difficult circumstances. In the midst of your troubles, what gave you hope? What got you through?” Their imagery eloquently reflects what helped them survive and even thrive in the face of adversity. One participant, after attending one of these workshops, described her newfound creativity as one of the “gifts of cancer.” Some of the nuances of benefit-finding are evident in her realization that, although she would never have willingly invited cancer into her life, and she would never wish it on anyone else, it had freed her to experiment with her lifelong desire to do art.

Whether for patients with cancer, those hospitalized for depression and anxiety, others struggling with addiction, or highly-functioning but “stressed-out” professionals who simply want to improve the quality of their lives; this directive interweaves positive psychology elements with the artistic process in multiple ways. It directs attention to the internal strengths and external resources that have helped individuals survive. It also elicits positive emotions, such as gratitude and love, which in turn promote more expansive thinking. As a result, when clients reflect upon their imagery; they are more likely to notice in it empowering metaphors for their resilience, and for what is most deeply important to them. This expands the narrative to include their triumphs as well as their traumas. And finally, when that is witnessed by others (either the therapist and/or group members) who also observe positive elements in the artwork, feelings of affirmation and connection are enhanced. Clients usually report that they perceive their artwork very differently, that although it still illustrates the hardship they experienced, it also reveals aspects of themselves and their strengths that they had not been aware of before.

This sculpture (Fig. 13.3) was made by a woman whose sister had had cancer and whose son had been wrongfully incarcerated. She identified herself as an inherently pessimistic person, and often felt that she was “just barely making it.” However, she also realized that her intensity and connection to the darker side of life, which emerged in her artwork in dramatic tones and images of powerful animals, helped fuel her capacity to stay strong for her son and her grandson.



[Figure 13.3](#) "What Gives Me Hope"

That art making helps us to derive expansive meanings from our experiences is not a novel concept in art therapy (Rubin, 1999). What may be new is the empirical framework surrounding meaning in positive psychology, the conscious orientation toward benefit-finding, toward mining our most difficult circumstances for bedrocks of strength and resilience. The emphasis is explicitly on developing strategies to help broaden our perceptions, in order to consider new possibilities and options for improving our lives. We are also pleased to share with the world of positive psychology the goldmine that art therapy, with its capacity to highlight strengths, foster resilience, and expand meaning, brings to those endeavors.

Achievement

Positive psychology refutes the notion that we are driven by unresolved conflicts from the past that compel us to repeat old dysfunctional patterns. Instead, it insists that we can be pulled by the future, toward our highest goals and aspirations (Seligman, 2011). Accomplishing goals and developing mastery are inherent to well-being and satisfaction with life. We feel good when we are able to be active agents in creating our lives.

Helping our clients to develop goals inspired by a vision of their best possible life may not only foster hope for them, but may also help therapists be more effective and to experience a greater sense of accomplishment themselves. We often ask people to write about and picture their *Best Possible Life* (King, 2001), to visualize themselves in the future, imagining that everything in their lives has gone as well as it possibly could, and that all their hopes and dreams have been realized. This becomes the basis for developing treatment objectives that are in line with what is inherently motivating and inspiring to them.

Positive psychologists suggest that treatment will also be more successful if we help our clients explore their hopes and beliefs about their capacity to achieve their goals, about the pathways and resources they have to do so, and about their internal and external motivations (Snyder, 2000). Art therapy assessments, such as the Bridge Drawing (Hays & Lyons, 1981), may be particularly useful in identifying goals, motivations, and pathways (Betts, 2011; Darewych, 2014). When this is coupled with a strengths-based approach, treatment objectives will be more compatible with what is most congruent and inherently motivating to our clients, and sustainable change will more likely occur.

In addition, we know that art therapy, because of its capacity to induce feelings of mastery, accomplishment, and pride, naturally provides clients with a sense of achievement (Kramer, 1971). The artwork itself becomes a testimony to that endeavor—a tangible object that documents milestones reached and accomplishments made in treatment, development, and ultimately, life (Rubin, 1999; Wadeson, 1980).

Relationships

One of the core tenets in positive psychology is that *other people matter*, a phrase coined by Chris Peterson (2006). We address this area last, because relationships are fundamental to our health and inextricably linked to all elements of well-being (Taylor, 2011). In psychotherapy, decades of research have demonstrated that the therapeutic relationship, regardless of theoretical approach, is a critical curative component (Lambert & Barley, 2001). We want to employ strategies that enhance the therapeutic relationship: for example, introducing positive emotions more deliberately; collaboratively telling and changing the narratives of our lives; and capitalizing on strengths built into the therapeutic endeavor, such as courage, honesty, perseverance, and hope (Seligman, 2002).

Art therapists have a phenomenal avenue for creating and developing relationships—we can jumpstart a feeling of rapport by making art together. The art process generates empathy (Franklin, 2010). It vividly introduces others to aspects of ourselves that words alone could not. Relationships are further strengthened as participants make meaning through discussing their art. Art's capacity to evoke positive emotions and broaden perceptions can also positively alter how people perceive themselves and others, which further transforms relationships.

Art therapists, like other clinicians, often create safety in the therapeutic relationship by supportively exploring the distress that compelled clients to seek treatment. And while we know that validating clients' suffering is critical, it may be just as important to implement what, at first blush, might appear to be counter-intuitive interventions that invite hope and feelings of empowerment. For example, having clients visualize how improved functioning would both look and feel, or exploring internal strengths and resources that have helped them thus far, immediately stimulates feelings of hope, support, and love—thus accelerating the building and fortifying of the therapeutic alliance (Rashid, 2014).

Practicing Positive Art Therapy

In applying positive psychology principles to the practice of art therapy, we can safely say that simply the process of making art, because of its capacity to induce flow and a sense of mastery, to highlight strengths, to illuminate and expand meaning, and to increase positive emotions, can be thought of as a positive intervention that promotes PERMA. Other art directives we use to facilitate PERMA include: Depict three positive events that happened during the day and what about you or the situation made them happen, (adapted from Seligman's Three Blessings exercise, 2011); represent a positive memory; identify the things that you value and give your life meaning; depict a door that closed and a door that opened (Rashid, 2014); visualize and make symbols for people and creatures who matter to you or someone who you admire. We hope in the future that the effectiveness of such positive art therapy directives can be formally evaluated through research.

We also apply a strengths-based, appreciative approach to the supervision and training of art therapists and graduate students (Chilton & Wilkinson, 2009; Schreibman & Chilton, 2012). We find that art therapists generally combine the heart strengths of gratitude, love, kindness, and teamwork with the more intellectual strengths of creativity, curiosity, and an appreciation of beauty and excellence ([Figure 13.4](#)). We also explore the individual qualities and values that differentiate us from our peers. With this knowledge, we can seek out populations, treatment models, and work environments that are most congruent with our unique assets so that we, just like our clients, are experiencing more flow, more satisfaction, and more well-being in our lives.



Figure 13.4 [The Strengths that I Bring to Art Therapy: Spirituality, Gratitude, Humanity, and Appreciation of Beauty and Excellence](#)

I created this shrine as a celebration of my love for beauty and excellence. It is an offering to the universe and all that I believe in based on my spirituality. I have asked the universe to please fill this vessel with positive energy and love. I plan to always keep something living inside of it, whether it be a flower or a plant, as another offering and celebration of my strengths and to all that I am grateful for.

H. Wilson, art therapy graduate student
(personal communication, December 2, 2009)

We also encourage art therapists to experience more positive emotions, such as hope, love and curiosity, in their work. This not only helps to prevent burnout and compassion fatigue, but also increases compassion satisfaction—the pleasure and fulfillment we get from our work. Furthermore, we encourage practitioners to explore *positive ethics*; which motivate us to move beyond fear-based compliance with ethical codes, and to connect with the values and aspirations that inspire those standards and bring us to this work (Hinz, 2011).

We have found that engaging in these practices not only improves the quality of our own lives, but also makes our work as art therapists more sustainable. In addition, it invigorates our commitment to help others to feel better and to experience more well-being. We see real possibility for fruitful exchange between art therapy and positive psychology, and strongly urge future research and development in this area. Here's to continuing

this generative interchange between two fascinating domains.

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Part IV

Contemplative Approaches

14

Art Making as Spiritual Path

The Open Studio Process as a Way to Practice Art Therapy

Pat Allen

The primary contribution of a spiritual approach to art making is the opportunity to experientially dissolve dualism. Spiritual practice is undertaken out of the belief in the existence of a force, power, energy, or reality greater than the individual self, and the related belief that it is possible and desirable to experience our relationship with this reality. This force or energy can be called God, the Universe, Nature or Creativity, among other names. In the words of William James (1902/1961) in *The Varieties of Religious Experience*, there is a “belief that there is an unseen order, and that our supreme good lies in harmoniously adjusting ourselves thereto” (p. 59). Making art can become a means to perform this adjustment, as it creates a path to that unseen force that is easily traveled by way of image making.

The idea of a cosmic unity is found at the heart of all traditions. As Seymour Boorstein (1966) states in *Transpersonal Psychotherapy*, “the ultimate goal of the spiritual quest is the experience of oneness with the universe” (p. 5). Typically, laws and rules are relied upon to achieve civilized humane behavior. The practical value of experiencing oneness with the universe is that it leads in a very natural way to compassion for others and the will to do no harm.

All of the world’s wisdom traditions, in addition to providing a creation story and offering some notion of what awaits us after death, also challenge the duality generally experienced in life by holding out mystery teachings. The more esoteric aspects of these traditions were not, however, usually available to the general populace. The Kabbalah in Judaism, for example, could traditionally be studied only by married men over the age of 40 who were already deeply learned in the laws, precepts, and observances of the religion. Historically, only a few individuals in any society were involved in such a spiritual quest. The hermits, mystics, and sadhas lived apart from everyday life.

For ordinary people there was religion, a practical, daily, or once-a-week dose of uplifting or moralizing teaching from a professional. The meaning of life was defined by one’s tradition, and important life passages such as births, marriages, and deaths were served by participating in a community ritual handed down for generations. Just as therapy was originally only available to an educated elite and now occurs in many variations across all social strata, from psychoanalysis to self-revelation on television talk shows, spirituality has also become more egalitarian.

One of the most significant factors in bringing spiritual ideas into mainstream culture has been the arrival of teachers from the East. Over the objections of his monks, Soyen Shaku became the first Zen priest to visit the United States in 1893 to attend the World Parliament of Religions. In the early 1960s, Japanese teachers began developing Zen centers in the United States, and by the mid-1970s had trained a uniquely American generation of Zen teachers. Tibetan Buddhist Chogyam Trungpa (1984, 1996) came to North America in 1970 and eventually founded the Naropa Institute in Boulder, Colorado, which currently houses a Transpersonal Art Therapy training program (Farrelly, 1999; Franklin, 1999; Franklin et al., 2000).

Early students of Eastern philosophy were artists, poets, and great thinkers of the era, like Allen Ginsburg, Jack Kerouac, Thomas Merton, Arnold Toynbee, and psychoanalysts Erich Fromm and Karen Horney (Tworkov, 1994). Suzuki made Zen teachings widely available through his accessible English writings. The ideas and practices associated with many forms of Eastern thought became common currency, especially on the West coast, and by the mid-1970s, psychotherapy was being influenced as well.

Therapists, seekers of another kind, began to see a relationship between spiritual and psychological well-

being. A spiritual quest, however, is only truly meaningful within the context of an engaged life. It is necessary to be able to travel back and forth between the poles of existence: activity and rest, individual and universal, personal and communal, a sense of interior self and a feeling of connection to the web of life. As individual therapists became influenced by their own journey down Eastern spiritual paths, their ideas about the goals of treatment or the expanse of human existence changed to include experiences that extend beyond the self, called the *transpersonal* dimension (Walsh & Vaughan, 1997). Aided by thinkers like Ken Wilber (1997), whose work has mapped a unified theory of the evolution of consciousness, therapists began to define *transpersonal psychology*, and its approach to psychotherapy.

The major differences in practice that grow out of the transpersonal approach are described by Walsh and Vaughan (1997) as an *evolution* in psychology. In psychoanalytic models, therapists put aside their own feelings, offering themselves as blank screens for a client's projections. Humanistic-existential therapists redefined the therapeutic relationship by saying that the therapist ideally opens himself fully to the client's and his own reactions.

To this human participation, transpersonal orientation adds another perspective: the therapist may serve the client best by viewing the relationship as a karma yoga to foster his own personal growth through consciously serving the client.... The therapist's openness and willingness to view therapy as a process of learning and service can provide useful modeling for the client.

(p. 23)

Rather than being an expert, the therapist is a fellow traveler, learning from the client as they learn from experiences leading to a greater awareness of the larger movements of consciousness that affect both. The therapist seeks points of connection and works on the issues mirrored to him by the client; aiming to expand his own consciousness and, as a result, be of greater service to the client. In this way, the therapist and client subtly explore both the reality of the individual self as well as the larger reality of interconnectedness, and perhaps attain a glimpse of the oneness underlying everything.

As practitioners continue their own journeys they attempt to integrate their transformative experiences into their work with others. There is a recognition that this approach is not for everyone, that pitfalls, such as ego-inflation, can occur when there is confusion over what is personal and what is transpersonal. Like every aspect of knowledge, spiritual ideas can be used for good but also for harm. Calling something spiritual can make it seem a noble refuge when it is merely a garden variety avoidance of everyday responsibilities.

The Place of Art

This is why art therapy offers something uniquely valuable for those of us who are concerned with transpersonal or spiritual dimensions. For it gives us a way to bring these dimensions directly into the work we do with others. Rather than focusing primarily on expanding consciousness, like meditation, art making offers a practical path—for the making of images is in itself a *practice*, a *discipline* that offers a grounding in everyday reality.

Practice, here defined as mindful engagement in a discipline on a regular basis, is needed in order to learn how to travel any spiritual path. Art making offers unique possibilities as a method of spiritual practice, because of its ability to travel back and forth between any of the pairs of opposites that comprise our experience of duality in a general sense, while simultaneously allowing personal lessons to emerge for any individual. Guidance about everyday life is as available as cosmic insights about the workings of the universe. The connection between these two can become manifest through making art, allowing what Carl Jung called the “union of opposites” to occur within the individual. Jung, in fact, was one of the first to employ art making in this manner and for this purpose.

Throughout a significant period of his life, Jung engaged in making images and dialoguing with those images. They were created privately as a “self-experiment...trying to understand the fantasies and other contents that surfaced from his unconscious and to come to terms with them” (Jaffe, 1979, p. 66). Of enormous significance was an image of an old man called Philemon with whom Jung shared long dialogues. “Psychologically, Philemon represented superior insight...To me he was what the Indians call a guru... Philemon represented a force which was not myself” (p. 68). After six years of engaging in the practice of art and writing, Jung transcribed his insights in his *Red Notebook*, published finally in 2009 as *The Red Book Liber Novus*, which, in fact, became the sourcebook for all his subsequent theoretical writings.

This work drew him to studies of Eastern philosophy, to the study and painting of mandalas, and to the suggestion to his patients that they take up painting as part of their analysis. Jung came to understand that “Everything living dreams of individuation, for everything strives towards its own wholeness” (Jaffe, 1979, p. 78). He noticed that the form of the mandala, which became prevalent in his art work, was also found in nature from the most minute scale, as in the formation of crystals, to the unfathomably large image of the sun or moon, or the vibrational image of sound when spoken in such a way as to record a visual image (pp. 78–79). Jung found, through his personal explorations, that the unfolding of individual psychology is intricately connected with an innate capacity to know the divine. Art and writing constituted his ladder between the individual and the universal, revealing the divine in everyday life.

Florence Cane, author of *The Artist in Each of Us* (1951), clearly understood that art making can be a spiritual practice. She felt that through creating art, the individual progressed naturally in his or her personality integration. Her teaching methods echo many spiritual practices, in her focus on breath, rhythmic movement, and chanting mantric sounds. “It is as if movement, feeling and thought represented three dimensions, and in learning to use all three, the child were permitted to glimpse the fourth dimension, spiritual awakening” (1951, p. 35). Cane was aware that while engaging in a disciplined practice of art making, one’s problem areas arose naturally; and that the demands of creating art provided reparative opportunities. Like Jung, she saw the unfolding of the individual into unique wholeness as a natural process that needs support far more than intervention. She found the art studio an ideal home in which this process could unfold. Later, Shaun McNiff (1989) carried forward this trend in his painting studios, and in the inclusion of all of the expressive arts in his work and in the training of students.

More recently, Michael Franklin, director of art therapy training in the program founded by Mimi Farrelly in 1992 at Naropa Institute, helps students to integrate personal spiritual practice with their training in clinical and studio art therapy (Cf. Franklin, 1999; Franklin et al., 1999). Embedded in Naropa’s tradition of transpersonal psychology, the program maintains the art-based tradition in art therapy that traces its roots to Edith Kramer (1958, 1971). As committed practitioners of diverse spiritual traditions, Franklin and his colleagues are carefully articulating how art therapists on personal spiritual paths can practice art therapy in the world. Students are clinically trained and able to sit for the counselor’s licensing exam, and at the same time are required to engage in regular spiritual disciplines that will support and inform their work.

Art Therapy and Spirituality: The Open Studio Approach

I had been deeply inspired by both Jung and Cane in my choice of a career as an art therapist. However, my real-life mentor was Margaret Naumburg, and it was from her that I and many other art therapists took our cue. Naumburg had taken a different path, where the same techniques that her sister Florence Cane had employed toward spiritual awakening, were instead harnessed for psychological insight. Rather than a natural unfolding of the human personality, a dynamic process was imagined, in which the individual struggled against conflicts within himself for mental health. The element of involved art making as practice was lost when, perhaps as a sign of the times, one of the strongest claims made for art in therapy was that it “speeded up” the process of gaining insight. And, it was insight, rather than a harmonious alignment of mind, body, and spirit that was considered the therapeutic goal.

Acquiring insight in a speedy manner is not as compatible with making art as it is with making signs and symbols. The premature search for meaning and naming seems to circumvent the creative process, by short-circuiting the energy needed to stay engaged with an image. As in nature, processes of growth and change unfold quite simply on their own timetable and with the right conditions. It is the understanding and providing of the right conditions that makes the art therapist most helpful in work with others. Creativity is always present and will emerge like a blade of grass does through any crack in concrete; but a studio space, held with care and intention, provides the ideal culture for soul to unfold.

After many years of clinical work in the mid-1970s and 1980s, I found that, for me, working psychotherapeutically with others impaired and inhibited my own art making and sense of connection to the creative force. It also seemed that, except for a few champions of the soul like Shaun McNiff (1989, 1992), art therapy as a profession had somehow left the bright thread of spirit out of the weave, as it struggled to achieve self-definition as well as recognition and parity with mental health disciplines.

Going back to my own art in search of the answer to my dispirited condition, I tried to systematically strip away whatever seemed superfluous from art therapy as I had learned and practiced it so far. I was trying to locate once again the healing spirit of art. The three key principles that I rediscovered about art as a spiritual practice are *intention*, *attention*, and *witness* (Allen, 1995a). It is, however, one thing to develop a personal approach to art making that answers one’s own spiritual needs, and quite another to determine whether it has relevance to anyone else.

In 1995, after several years of discussion and experimentation with ourselves and others, Dayna Block, Deborah Gadiel, and I set out to discover whether it is possible to make one’s own art alongside others and be of service at the same time. This intention guided our development of the *Open Studio Project* (OSP), an art studio located in a Chicago storefront, which became a laboratory for these ideas (Allen, 1995b). Over the last 20 years, the Open Studio Process has proved to be a flexible and reliable method of working in art with others. A key breakthrough in understanding the possibilities of the OSP has emerged through the development of a training program for individuals wishing to learn how to facilitate the OSP. Crafted by Karla Rindal, a fellow artist who has been with the Open Studio Project nearly since its inception, the training program has allowed for continued experimentation and refinement of the OSP. While this author has experimented with variations and applications of the OSP, teaching in many settings around the world, intentionally engaging with social issues, with nature, with performative modes of creativity, Karla has continued the basic practice in what might be seen as its “classical form.”

Over the past six years we have collaborated on understanding in even greater depth a process that owes a great deal to traditional art therapy but offers a different way to do it. The Open Studio Process is founded on these elements: *intention*, *attention to art making*, and *witness through writing and reading*. This method is available to art therapists as one way of working, but it demands that any facilitator be honestly engaged in the process every time he or she provides it to others. As more art therapists have taken our facilitation training, a clear distinction between OSP and art therapy has emerged.

Examining the nature of the word *service* in our original intention has given us a key to how the OSP offers something unique to our understanding of both therapy and spiritual practice. The intention to “be of service” is likely present for every therapist. However, it is likely to mean being of service to the client. The intention to be of service to that larger force or source that underlies all reality is an intention of a different magnitude.

Service to the source implies an understanding and acceptance of the interconnectedness of all life. It implies an acceptance of the fact that while we can help to create the conditions for someone to access creativity and feel safe enough to explore, we cannot in any way determine the outcome for another. Service to the source implies that we embrace the mystery that we are part of the larger unfolding of consciousness, while we also exercise our free will in how we participate every day in this overarching enterprise.

While transpersonal psychology offers us many useful concepts with which to craft ideas about the larger dimensions of human consciousness, it remains, as all talk therapies do, a largely intellectual enterprise. The Open Studio Process serves the manifestation of spiritual ideas in tangible ways, while at the same time minimizing some of the traps of both transpersonal and art therapy that remain as vestiges of their origins. Where transpersonal psychology adds modeling karma as a new concept to the practice of art therapy, art therapy can, through the Open Studio Process, manifest these ideas in very concrete ways. By engaging in one's own art making alongside another person, the therapist models in actuality what faith in a force larger than oneself looks like—the process of risk and openness to the unseen.

This approach places certain demands on the art therapist and reorders typical priorities. The basic premise is that Creativity is another name for the life force energy and that art making is one means to receive and cultivate this energy. Just as one would hardly seek a Tai Chi instructor who has only watched videos or observed others practice the movements, or who has refused to show by his own example his commitment to the discipline; only an art therapist with a personal understanding of making art can truly work in this way. Living in the moment with fear and wonder is the very essence of creating and is a necessary condition for this kind of work.

Similarly, concepts such as diagnosis and treatment are given up, as in other humanistic approaches, in favor of the practice of intention and witness. *Intention* in this model is a statement, composed by each person for him or herself, directed toward the universe, acknowledging what it is that the participant wishes to receive from engaging in the process of art making. Intention differs from the idea of a “goal” set by a therapist for a client by acknowledging the autonomy of each artist.

The art therapist, too, makes an intention for herself. She might address her role as facilitator, but it must be one of non-interference and doing no harm. In other words, an appropriate intention for an art therapist would be: “I am open to my own learning, and I do no harm to others as I facilitate this experience.” It would be incorrect to say “I help others gain insight” or “I facilitate the learning of others.” There is a recognition that the primary relationship is between each individual and the creative force, that those present form a community of service to this force and to each other through their personal honesty in their own process, rather than in direct or covert attempts to “help” one another.

For this reason, no comments about the art or the witness writing are allowed. This is perhaps the greatest difference between traditional art therapy of any orientation and the Open Studio Process. While there may be conversation during art making, the rule against comments about art work is observed. Following the art making time, usually two hours long, each person sits before his or her art and looks at it, noticing body sensations, judgments, and reactions.

Then writing begins. Participants are encouraged to write as freely as possible, without regard for grammar, syntax, or sense, adding anything that comes to mind, including judgments or self-observations, without censorship. Everyone is encouraged to describe their work in order to really see it. Dialogue with the image is another way to engage deeply. By addressing a question to the image and inviting it to speak, the artist affirms its autonomous existence as the guise of soul, as well as a willingness to engage with its wisdom. This takes 5 to 20 minutes.

Then, whoever wishes is invited to point out her art work and to read aloud her intention, witness, or any portion of these. The others wait in silence until the next person chooses to read. While there are sometimes sighs, laughter and even tears, which may be said to constitute commentary, the rule against verbal comments is strictly held and adhered to by all, participants and facilitator alike. Even caretaking behaviors and supportive comments are discouraged during the witness reading. Participants who feel such urges are encouraged to invite them into their own process and to understand them as information for themselves. During the reading time, the group members serve as the embodiment of “witness consciousness” (Franklin, 1999), that spacious expanse of no judgments where anything can be held and let go of.

Depending on the facilitator and the nature of the experience, the group may close at that point, or if time

remains, a chime is rung and a brief centering meditation or a physical exercise is offered as a transition to ordinary reality. After formal closure, members sometimes chat socially for a while; and if an individual feels a need for a slower transition to life outside the studio, she is invited to help wash brushes or participate in other aspects of cleanup as a grounding experience.

What takes place in this experience? Can it be considered a form of art therapy? Let's consider each element of the process and the theory behind it.

Intention

Intention acknowledges that each individual is responsible for deciding what he or she wants to understand, change, or accept about him or herself. There is neither the responsibility nor the right to evaluate or set goals for another person. The setting of an intention may be highly personal and specific one day and more global the next. At any given time in a group, the intentions of participants will span the gamut. Some examples of intentions are: "I connect to my creativity and allow it to lead me," "I am open to my learning," "I understand how to intervene in my family issues without doing harm to myself or others," "I release my judgments about ____." "I understand what is behind this feeling of anxiety, depression, helplessness, etc.," "I gain insight into how to facilitate positive change in my life, in my workplace, in my community." We learn from each other and from simply considering what it really is that we intend toward ourselves, others, and the world. However, we also come to see, as Rabbi David Cooper (1997) points out:

It is important to understand that an intention behind an act does not ensure its results. Intention must be balanced by awareness. The greater the awareness, the greater the probability that something good will come out. The denser the awareness, even through one's intentions may be good, the greater the risk that things will not turn out so well. We could do something kind hearted for someone without realizing that this could bring enormous grief into his or her life.

(p. 141)

Learning about intention and the discernment required occurs through modeling and sharing among group members. For example, one participant went through a phase where she was setting intentions for her husband and child rather than for herself. Soon, through her own images and witness dialogues, she recognized the futility of this approach, allowing us all to become conscious of how we often seek to change others rather than ourselves.

Attention through Art Making

Making art is one of the primary ways to refine one's awareness. It is a way to pay attention. The making of images, as any art therapist knows, often unearths the hidden complexities of our lives and feelings. The Open Studio Process encourages engagement with simple materials, but in an involved and sustained way. Participants are encouraged to begin spontaneously and then allow the energy of the image to lead. We follow the image by paying close attention to our physical state. A sense of pleasure or flow is a sign that we are serving the image well. Time may fly or seem endless; other concerns may drop away. If there is music playing in the studio, we may not hear it, or it may carry us to a deep place. Boredom, physical discomfort, or a feeling of being stuck and not knowing what to do next, signal that we are off track. When we notice these sensations, it is time to ask the image for help and guidance.

Stepping back and addressing the image directly, "What do you want?" can sometimes be enough. Otherwise, a brief interval of witness writing can serve to let us know how or why we are resisting the flow of energy of the creative force through the image and back again to ourselves. Often, we discover fear. We may have created an aesthetically pleasing image, but the image wants more and we resist "messing it up." Sometimes an image becomes dark, and we fear that something threatening will emerge. We try to stay with the image. If it is too difficult to keep working, we might just sit and look. Writing and dialoguing is an excellent way to move through any impasse.

The experience of pleasure in art making is one of its crucial values. On the simple physical level, pleasure occurs when we are relaxed. In a relaxed state, ideas or feelings we have not been aware of can arise to be seen and felt. Often the simple cultivation of a sense of relaxed pleasure allows for the unfolding of what we need to pay attention to. Experiencing genuine pleasure also creates a sense of trust. Like having a guide on a mountain climbing or scuba diving adventure, our trust in the image as guide allows us to travel deeper and higher into the complex dimensions of life.

Witness Writing

This is a key component of the Open Studio Process, in which we simply record all that we experience. Often beginning with a description of the piece is helpful, just to train ourselves in the crucial act of paying attention to what is before us. We can describe the image as a way of appreciating it: “You are so bright and full of color...” “I like the way that black line snakes around the top of the page.” We are also free to say what we don’t like and to note ways in which the image is different from what we expected. It is important to examine our judgments as a valuable form of information. If there is something in the image that makes us uncomfortable, it is worth reflecting on. We recognize that the image has a life of its own. Its opinions and wishes may be quite different from ours. Our overriding intention is to serve the image as a manifestation of the creative force.

Therefore, we address the image to learn what it requires. When we ask the image “What do you want?” the answer is usually very clear: “Brighten my background, define my features more clearly, add an owl to the picture.” We may also ask the image what it has to say to us. Direct guidance is almost always forthcoming. It may have to do with the art process or not. The image may tell us to rest, to hold our tongue in a particular situation, to create an image in a particular medium, or to do nothing. The witness writing is a way to practice listening to the inner voice of wisdom, and has proved remarkably useful in illuminating and developing the relationship of the image to the person who made it. In every case, we hear from the image a unique wisdom that enriches not only the writer, but all who are present.

After writing, each person has the opportunity to read his or her writing aloud. Hearing the words and dialogues is powerful, and often reveals yet another level of meaning or impact, both to the one who reads as well as to those who listen. As we sit and listen to one another, the sounds of struggle, joy, resistance, acceptance, anguish, and humor ring with truth. Because we make no comments, we must each sit with the feelings aroused in us by our own truth and that of others.

This self-restraint is a crucial part of the process and trains us to become mindful of what we say, why we say it, and how little of what we say is either necessary or helpful. We see our judgments of others shift and change, as we hear their images speak. The being-with others in this respectful way, owning our own reactions, creates a space for profound empathy among individuals and for the overall human condition. We learn to tolerate strong emotions, rather than to suppress them or act them out through blurted platitudes.

In a sense, the overall process is an action metaphor for the values described by the Dalai Lama (1999): “Spirituality I take to be concerned with those qualities of the human spirit—such as love and compassion, patience, tolerance, forgiveness, contentment, a sense of responsibility, a sense of harmony—which bring happiness to self and others” (p. 22). Images, emotions, words, rise and are seen, and fade as the group itself serves as the witness consciousness sought in meditation. The truth that we are unique yet profoundly connected individuals is felt and experienced over and over. A sacred space is created where truth in all its forms is welcome.

While the Open Studio Process can be practiced by individuals alone, the energy of the group has a compelling part to play. As we hear our own thoughts and feelings echoed by others, or at times hear a counterpart to some emotion that balances our own, we are reminded again and again of the depth and variety of the human condition, and feel ourselves an integral part of the human family. At the close of a group, participants often express feeling nourished and deeply satisfied. The hunger for meaning and connection seems indeed to be met by this humble process.

The Story of Janet

Try to imagine that alongside Janet are perhaps half a dozen others deeply engaged on any given day in painting a tiny watercolor with intense concentration, arranging the beaded covering on a sculpture of a female figure, standing and drawing abstract strokes on a huge sheet of kraft paper taped to the wall, etc. In the background a Celtic harp tape plays, and outside the plate glass window of the storefront studio, commuters walk purposively toward the train, latte in hand, occasionally glancing in, and perhaps wondering why grownups are engaged in what appears to be play during business hours.

Janet's Dog

Janet, an organizational consultant, has a fascinating professional life. As an independent consultant to non-profits, she helps design and organize large-scale fund raising events. She is adept at helping organizations see their strengths and capitalize on them to fuel their mission and keep their work going. The nature of her work is feast or famine, periods of huge effort and then down time, big payoffs at the end of a project and lean months between. Janet has to provide her own structure, and the skill of discernment is crucial to keeping balance in life as well as in her checkbook.

While recovering from bronchitis, Janet formed the intention to nurture herself and to give caring to herself, tapping into and leveraging her own strengths. Her intention read in part:

It means not living for the moment, not buying expensive things, not thinking I'm rich because I get a big contract. It means focus and control. It's a different lifestyle—not running all over the country to visit friends, but following my dream of buying a house...I need enough nurturing—I need more nurturing—images of nurturing.



Figure 14.1 Anger

The image that came to Janet was a dog. He took shape over a number of months. For Janet, who likes to work fast and get things done, creating a sculpture of the dog was a new experience. If she worked too fast, he wouldn't be strong enough; he had to be built up of many layers and finally covered with plaster gauze. Then, when he was all built, his ears didn't look quite right to her and his neck wasn't strong enough. In her witness writing the dog asked to have these parts fixed. Janet did the extra work and the dog approved.

Janet: How did I do?

Dog: Good. You bit the bullet, ripped me apart, or performed surgery, and put me back together—better. Just like the house and mortgage process. Take a look, do something, see results, take the next step, regroup, try again to shape it.

Janet worked on other pieces as well during this time, but the dog presented many challenges, technical as well as personal. He wanted a stand, to look both earthbound and flying, to have both a strong foundation and a

launching pad. His heart was a matter of great concern and care. Sometimes his advice was simple, yet profound.

Janet: Dog, anything else?

Dog: Walk the dog.

Janet: What does that mean?

Dog: First literally—all the dogs in your life—walk them whenever you can. Second, get out yourself and get air and exercise. Third, keep practicing!

The dog finally came close to being finished, but continued to advise Janet and remind her of her goals. From her witness writing:

The dog is lustery and smooth—wild circles are under the surface yet can be seen—especially underneath. I like him—he’s solid, substantial, sturdy, yet sleek and shiny. You can see his bumps, bruises and irregularities (like mine), but they are part of the whole. You can see the glitter stripes, but they are like lines of a past life, scars, sentiments of the future. Looks doughy and determined, but strong enough to get where he’s going—running.

Janet: Want to speak?

Dog: You did good. Your dogged determination is paying off. You are walking the dog. But remember, we dogs need walking EVERY day. Once a week doesn’t do it!

Janet: What else?

Dog: Finish me up, glue me down, put a removable bottom on. Wrap up the hearts and dog—the little one—and find a place for me.

The dog is like the tree, is rooted in the earth—in life, in trust...I really did create something here—extremely satisfying. Paint ‘Walk the Dog’ somewhere on it. Make plans to come back.”

Reflections

Janet's dog was created during weekly groups where five to seven participants gather to engage in the process together. Each person's work speaks not only to its maker but to the group as well. Many of us resonated with the advice Janet received from her dog. Janet continues to use the Open Studio Process as a means to gain pleasure in using materials, to slow down and figure out what she needs in the moment, as well as to explore issues in her life. She is getting married soon and organized an event about weddings, where she gathered all sorts of images, hung them up in the studio, and invited guests to witness the images.

This sort of deepening of any aspect of life is a natural outgrowth of the process, where eventually life itself becomes an amazing, ongoing work of art that we can continually witness and learn from, delight in, and become curious about. Our particular feelings, like anxiety or anger, become like the colors we paint with, and we can decide to tone them down, or eliminate them from our palette for a while, and see how the overall work is shaping up with fresh colors.

The overall outcome of engagement in this process as a spiritual practice is a subtle transformation of personality, as the individual accesses the meaning and purpose of his or her life. Along the way insights are gained, struggles are resolved, and perceptions are sharpened. A larger lens grows through which to view life, putting one's particular faults and failings and those of others into a perspective of lessons to be learned, for the benefit of the world at large as well as for the self.

In the usual practice of therapy the therapist puts his faith in and seeks his guidance from a theoretical point of view. The client puts her faith in the therapist. In the Open Studio Process, it is assumed that there is an intelligence, a force, of which we are a part, that seeks to manifest itself through us; and that if we make the effort, through disciplined practice, to align ourselves with this force, we will be guided to truth and right action. Each of us has something unique to bring to life and to share with each other. "It is in the telling and retelling, as truthfully as we can, and in the genuine witnessing of all the stories of all people that we heal ourselves and the world" (Allen, 1995a, p. 199).

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Focusing-Oriented Art Therapy

Laury Rappaport

Focusing-Oriented Art Therapy (FOAT®) is a mindfulness-based approach that synthesizes Eugene Gendlin's evidence-based Focusing method (Gendlin, 1981a) with Focusing-oriented psychotherapy (Gendlin, 1996) and the principles and practices of art therapy (Rappaport, 2008, 2009). Focusing is a process of listening within to the body's *felt sense* with an attitude of friendly curiosity, and accessing its wisdom toward positive change and enhanced well-being.

As Gendlin (1981b) states, "Creative people have probably always used this method. What is really new in it is the specificity with which we can describe the steps and teach them" (p. 15). From the moment I learned Focusing in 1977, I knew there was something about it that felt similar to the creative process. I immediately began integrating Focusing with art therapy and discovered that it provided numerous benefits. As a beginning therapist, Focusing provided me with clinical skills for compassionate listening and being with a client's (and my own) uncomfortable feelings, along with tools to process the art. Over time, I learned how to help clients to befriend the emerging moment-to-moment unfolding of their experiential process, cultivate self-compassion, access their inner *felt sense* for art expression, and discover their own concrete steps toward healing.

It took 30 years of applying Focusing and the expressive arts with a wide range of clinical populations—including, trauma, severe mental illness, depression, anxiety, chronic and terminal illness, and personal growth—with children, adolescents, adults, couples, families, and groups—to develop it into a comprehensive theory and practice approach within the art therapy field (Rappaport, 1998, 2008, 2009, 2010, 2013a, 2013b, 2014a, 2014b, 2014c, 2014d, 2015; Malchiodi & Rozum, 2011; Rubin, 2010). Although FOAT is viewed as a humanistic and somatic approach, it is applicable to all orientations, including psychodynamic cognitive, behavioral, and so forth.

This chapter provides an overview of the history and development of FOAT, foundational principles, a description of the basic FOAT steps; and five main FOAT approaches: Focusing Attitude; FOAT Check-In; Clearing a Space with Art; Theme-Directed FOAT; and FOAT Psychotherapy Process. Clinical examples are included to illustrate the concepts.

History and Development of FOAT®

Focusing Roots

To best understand FOAT, it is necessary to become familiar with the development of Focusing and its main concepts. Gendlin (1981a) developed Focusing out of research that he conducted with Carl Rogers during the 1960s on what led to success in psychotherapy. The research asked the following questions:

- Why doesn't psychotherapy succeed more often?
- Why does it so often fail to make a difference in peoples' lives?
- In the rarer cases when it does succeed, what is it that those patients and therapists do?
- What is it that the majority of patients fail to do? (p. 3)

After analyzing hundreds of therapy transcripts, they discovered that the success of the therapy did not correlate with the therapist's theoretical orientation, the content of what the client spoke about, or the therapist's technique. Instead, they found that the crucial factor was *how* the person spoke. Those clients who were able to hear how they were "inside," who could go to a place beyond the cognitive mind, were the ones who demonstrated progress in therapy. Gendlin (1981a) coined the phrase *felt sense* to describe this deeper bodily sense:

A felt sense is not a mental experience but a physical one...Physical. A bodily experience of a situation or person or event. An internal aura that encompasses everything you feel and know about a given subject at a given time—encompasses it and communicates it to you all at once rather than detail by detail.

(pp. 32–33)

As you can see, the definition of a felt sense is what art making does. It accesses an inner experience and then communicates it all at once. Art making naturally accesses the felt sense. In other words, the felt sense is implicit in the art, and art externalizes the felt sense.

In order to teach people how to access the *felt sense*, Gendlin developed Focusing as a six-step method:

1. *Clearing a Space*: Identify and imagine setting concerns or stressors aside.
2. *Choose an issue to work on*: Get a *felt sense* of it.
3. *Symbol/handle*: A word, phrase, image, gesture, or sound that matches the felt sense.
4. *Resonate*: Check the symbol/handle for a sense of rightness.
5. *Ask*: Ask the felt sense questions.
 - Useful questions:
 - What makes it so _____ (felt sense symbol)?
 - Imagine what it would look and feel like all healed?
 - What's in the way?
 - What's needed?
 - What's a good step in the right direction?
6. *Receive*: Receive what comes.

It is important to note that the six-step method is useful at the beginning stage of learning Focusing. Over time, the form is not needed, and what is most important is following the moment-to-moment unfolding of the client's process.

Gendlin (1996) developed the application of Focusing to psychotherapy (Madison, 2014 a, 2014b; Purton, 2004). In Focusing-Oriented Therapy (FOT), the client's sense of safety is paramount, taking priority over any intervention—therefore, attending to the quality of the therapeutic relationship comes first. Experiential listening is interwoven throughout the psychotherapy process in order to deepen the client's experience of empathy. The Focusing steps, previously described, are most often interspersed in a psychotherapy session in "bits and pieces," as the therapist carefully attunes and follows the client's experiential process. (This is illustrated in the FOAT as Psychotherapy Process example below.)

Focusing-Oriented Art Therapy Theory

FOAT Foundational Principles

In keeping with Gendlin's approach, the underlying principles of FOAT emphasize the client's sense of safety first. Safety is established through presence, the Focusing Attitude, grounding, clinical sensitivity, and reflection:

Presence

Compassionate, respectful, and trustworthy qualities of a therapist are instrumental in helping to create a sense of safety for clients. To be a Focusing-Oriented Art Therapist, it is essential to learn Focusing for oneself. The therapist is then able to transmit a quality of compassionate presence that is learned through the Focusing Attitude (described below). To be present, it is important to also ask yourself as a therapist: Are you willing to be here? Can you be mindful of your own issues and states of mind and not project them onto your client? Can you be friendly to your own self and the client's felt sense?

The Focusing Attitude

The Focusing Attitude is one of "being friendly" and curious toward the felt sense, as well as to the creative process and art product. The therapist transmits this quality toward the client's felt sense and assists the client in being "friendly" toward their inner experience. The therapist may say to the client, "Can you be friendly to that?" in response to challenging and difficult feelings.

Grounding

Focusing can be done with eyes open or closed. Many find it easier to notice the inner sensations and images of their felt sense when the eyes are closed; however it is important to be mindful that when one closes the eyes, feelings and issues may spontaneously arise of which the client was unaware. Therefore, it is essential that the client's ability to center and ground themselves is established prior to Focusing with eyes closed. Grounding can be established through body awareness exercises, such as noticing what is in the room or outside, being aware of the feet touching the floor, noticing where one's hands are resting, etc.

Clinical Sensitivity

It is important to be mindful of the needs of the clinical population you are working with and to adapt Focusing-Oriented Art Therapy accordingly. For example, when working with clients who have experienced trauma or have severe mental illness, it is advisable to begin with eyes open and not encourage closing the eyes until safety and grounding is firmly established within the client.

Reflection

The therapist demonstrates empathic understanding in response to the client's verbal, nonverbal, and artistic communication. Reflection can occur through:

- *Experiential listening*: The therapist says back to the client the heart and essence of their communication. It is essential that the therapist reflect the felt meaning from the nonverbal communication in addition to words.
- *Artistic mirroring*: The therapist may reflect understanding through an artistic reflection, such as drawing a shape, using a color, or creating an image.
- *Movement mirroring*: The therapist conveys understanding through nonverbal body movement or gesture.

FOAT Basic Step

In FOAT, one can either begin with Focusing or artmaking, depending on the client's needs and interests.

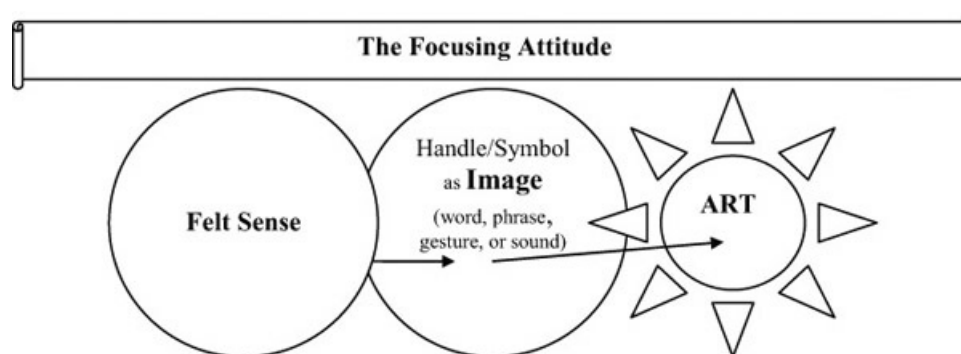
Beginning with Focusing: Expressing a Felt Sense in Art

Depending on the client's needs, the therapist might invite the client to access a felt sense about "How am I right now?" (FOAT Check-In) or in relation to a particular experience—such as peace, joy, fear, anger, relationship, and so forth (Theme-Directed FOAT). The therapist invites the client to bring the Focusing Attitude of being friendly and welcoming toward a felt sense, to see if there are any colors, shapes or images that match the felt sense, and then to express that in art ([Figure 15.1](#)). This process of listening to the felt sense and seeing whether there is an image that matches it is a source and inspiration for art making.

The felt sense may also come as a word, phrase, gesture, or sound—which the client can be encouraged to express it in visual art (draw or paint a word or phrase). If you are comfortable working in other expressive arts modalities, the word or phrase can become a poem or reflective writing; the gesture can be creative movement or dance; and the sound can become music or sound exploration.

Beginning with Art

FOAT can also begin with the artmaking process, as it may be more appropriate or preferable for some clients, especially those in the early phases of dealing with trauma. After creating the art, the therapist invites the client to get a felt sense of the art, and to see if there's a word, phrase, image, or sound that matches it (symbol/handle). This is a useful way to come up with a title for the art, and to sense if the art is needing further work or expression. Focusing helps to ground the artistic experience and to access its meaning.



[Figure 15.1](#) Expressing the Symbol/Handle in Art

FOAT Clinical Approaches with Case Examples

I adapted Gendlin's Focusing steps and Focusing-oriented therapy processes to create five basic approaches to FOAT: Focusing Attitude, FOAT Check-In, Clearing a Space with Art, Theme-Directed FOAT, and Focusing-Oriented Art Psychotherapy Process.

I. Focusing Attitude

As previously described, the Focusing Attitude is fundamental to the FOAT process. I have found that in addition to the therapist's verbal responses to help clients to become "friendly" to and curious about their inner experience (e.g., "Can you be friendly to that...?"), integrating art is especially helpful. Children, adolescents, and adults seem to like pre-cut gingerbread figures to do the following exercise, although many other materials can be used (e.g., drawing, painting, collage, etc.). As an alternative to guided inner Focusing exercise, clients can be invited to imagine and create a person or animal that will be a champion, giving them a positive message that however they are is all right, and that all feelings are welcome.

Exercise: Focusing Attitude

Take a few deep breaths inside your body...being friendly and accepting to whatever is happening within right now [Focusing Attitude]. Ask inside, how would I like to treat myself that would be kinder, gentler, more compassionate or accepting...? [pause]. Allow the body to let you know.... Sense how it would feel for you to treat yourself this way...See if there is an image—or word, phrase, gesture, or sound [handle/symbol] that matches the inner felt sense of how it would feel.... When you're ready, choose art materials that express the felt sense of what it would feel like to treat yourself with the attitude that came to you.

Client Example

Shannon is a 15-year-old adolescent who began exhibiting self-harming behaviors. During a session, I explained to Shannon that we all have the same type of feelings within us—like anger, sadness, and fear, as well as love, joy, and happiness. Most of us haven't learned how to be with the different types of feelings, and so it is healing to create an atmosphere of being “friendly” or kind to them.



[Figure 15.2](#) Focusing Attitude

Shannon chose the gingerbread figure and glued it onto a blue circle ([Fig. 15.2](#)). She then drew a face, added a heart, feathers, and soft pom-poms, and wrote the words, “loving, kind, and OK” (above the heart).

Shannon shared that she is used to hating her feelings and so this is a new way to begin looking at them.

Shannon wanted to take the art home with her as a reminder that it is okay to feel.

II. FOAT Check-In: Focusing Attitude and Felt Sense

A FOAT Check-In is helpful for becoming aware of how one is in the present moment with an attitude of friendly curiosity. It is a useful centering and grounding exercise. It can be done with eyes open or closed, depending on what is right for each client. A FOAT Check-In begins with guiding a client to bring mindful awareness into the body with an attitude of friendly curiosity, to notice how they feel on the inside—and then to see if there's a color, shape or image that matches the felt sense and to then express that in art.

Case Example

Brianna is a 55-year-old woman who was going through a divorce. We had worked together for a year, and there was an established sense of safety with Focusing. As Briana shared her sadness, hurt, and pain, I invited her to do a FOAT Check-In:

Guided Exercise: FOAT Check-In

Take a few deep breaths down inside your body. Notice the breath as it comes into your body and moves out of your body, feeling the support of whatever you're sitting on. When you're ready, gently bring your awareness to the inside of your body, just noticing how you are right now—sensations, energies, feelings, etc. Just notice...*being friendly* to whatever you find right now [pause]. See if there's a color, shape, or image that matches the inner felt sense. It might come as a word, phrase, gesture, or sound. If it does, welcome what comes. Check it for a sense of rightness. When you have it, choose art materials to express your felt sense.

Brianna reached for a purple pastel and began making the shape of a heart—that looked as if it were being torn open (Fig. 15.3). She added pink to the heart and grey in the crevice where the heart was torn. She wrote the words, “Bruised heart” on one side of the paper, and “Will it fall apart on the other?” Brianna said that she had a burning sensation in her heart and chest [felt sense]. The purple, pink, torn-open bruised heart symbolized her felt sense. I listened empathically to Brianna and reflected, “Your heart feels hurt—bruised—and you are wondering if it will fall apart.” Brianna agreed.

Asking the Felt Sense

It can be helpful to invite the client to reflect on their art and felt sense and to ask, “Does it need anything?” I guided Brianna:

“Take a few breaths into your body. Imagine sitting down next to the bruised heart. When you're ready, ask it, ‘What do you need?’”

Brianna closed her eyes, listening within again. After a few moments Brianna picked up a purple pastel and drew the outline of two large hands, and colored them in orange pastel, holding the bruised heart that she had previously drawn. She added yellow light around the heart, and then wrote, “Strong hands holding it together.” Brianna shared that when she asked what it needed, she felt warmth in her chest area [felt sense] soothing the bruised feeling in her heart.



[Figure 15.3 Brianna's FOAT Check-In](#)

This example shows the healing power of both the Focusing Attitude and how Focusing can help clients to hear their own body's wisdom. As Gendlin (1981a) affirms, "Your body knows the direction of healing and life...If you take time to listen to it...it will give you steps in the right direction" (p. 78).

III. Clearing a Space with Art

Clearing a Space with Art is based on Gendlin's "clearing a space" exercise, which has been found to be effective for stress reduction as well as other health and wellness benefits (Grindler Katonah & Flaxman, 1999; Klagsbrun, Lennox, & Summers, 2010; Klagsbrun et al., 2005;). In Clearing a Space with the Art, the client is guided to take a mindful inventory of what's in the way of feeling "All Fine" right now. As each stressor arises, it is kinesthetically sensed—and the client either imagines, or uses the arts, to symbolically place it outside of their body and at a distance that feels right. The expressive arts concretize placing the stressor outside of the body.

Setting the stressor outside of the body, either through the imagination or use of the arts, helps the client to dis-identify with it, promoting emotional regulation and a sense that there is a "me" separate from the stressors. Once the issues are set aside, the client is guided to sense the place inside that is "All Fine"—and to find a symbol/handle that matches the "All Fine Place." This helps the client to access and ground an aspect of self that is intrinsically whole.

Clearing a Space with Art can be used as a daily or weekly wellness tool or as a method integrated into therapy. Research has shown the stress-reducing benefits of Clearing a Space with Art (Castalia, 2010; Lee, 2011; Weiland, 2012; Weiner & Rappaport, 2014).

Client Example

Jenn was a 43-year-old woman who was laid off from a job that she had for 10 years. She was also a single mother of two children, 8 and 10 years old. Jenn was overwhelmed with the loss of income and job security, and the anxiety about her ability to take care of her children. I told Jenn that "Clearing a Space" is an exercise that is helpful for stress reduction and asked her if she would like to learn it. Jenn agreed. I explained that I would guide her in Focusing and that afterward, she could express the experience in art. I led Jenn in the following exercise:

Exercise: Clearing a Space with Art

Take a few deep breaths inside your body...being friendly and accepting to whatever is happening within right now. Imagine yourself in a peaceful place. When you're ready, ask, "What's between me and feeling 'All Fine' right now?" As each concern comes up, just notice it, without going into it. Imagine a way to set the issues at a distance from you outside of your body—such as, wrapping each concern up and setting it at a distance from you; placing it on park bench nearby, or any imagery that comes to you. As you put each issue aside, sense how it feels inside. Check again...Except for all of that, am I "All Fine"?...and see if anything else comes up.

Once you set aside the concerns or stressors, notice how you are inside.

See if there is an image that matches your inner felt sense of the "All Fine Place." Check it for a sense of rightness. When you're ready, be aware of being in the room, stretch, and if your eyes are closed, feel free to open them.

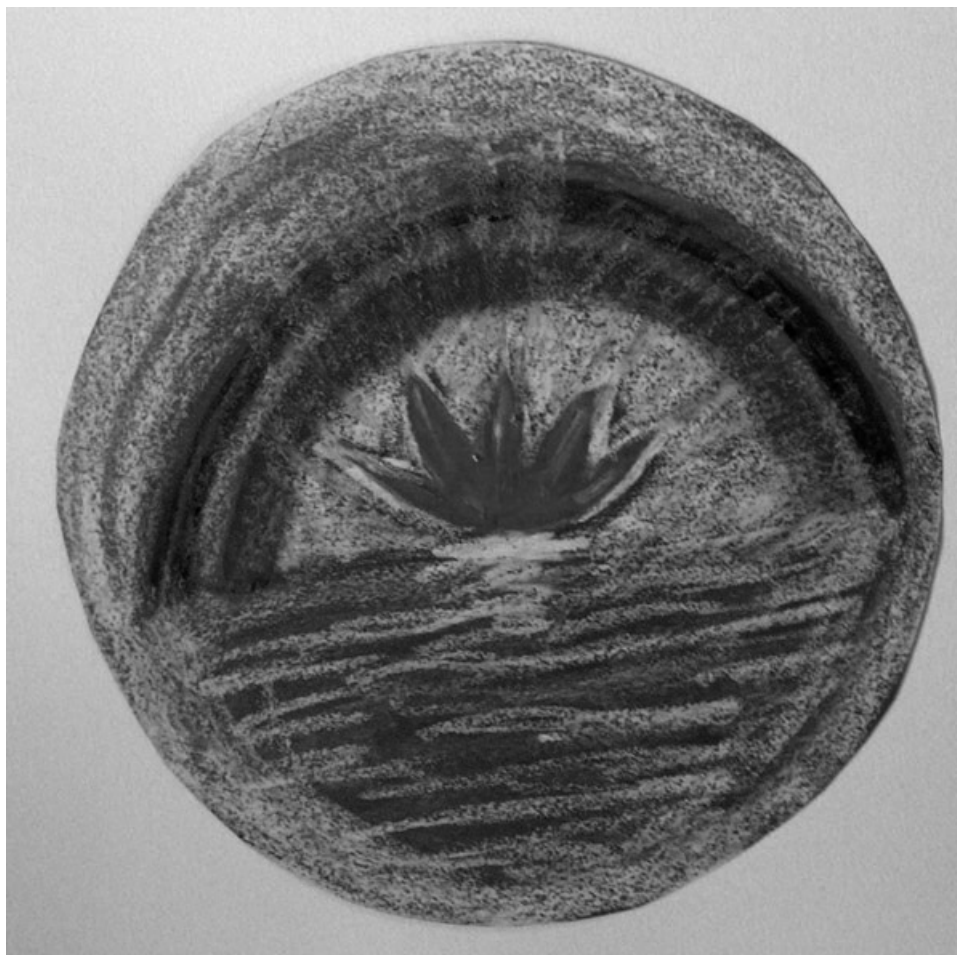
Art expression: Express your experience using the art materials. Some people prefer to only create the "All Fine Place," while others like to include the stressors they are setting aside as well as the "All Fine Place." Trust what is right for you.



[Figure 15.4](#) *Clearing a Space with Art—Setting Stressors Aside*

I offered Jenn some cards to write or draw the stressors on, as well as a box to put them in. Jenn drew and wrote on four cards: pain in her head and body; sadness; worry about money; and a drawing of herself alone in darkness ([Fig. 15.4](#)).

After Jenn placed the cards in the box, she closed it up. She then chose a pre-cut circle shape and began drawing a lotus flower in the center, on top of green, blue and white water. Jenn added a vibrant rainbow that filled the top of the drawing ([Fig. 15.5](#)).



[Figure 15.5](#) *“All Fine Place”*

She shared, “It felt good to separate those feelings out and put them in the box. In the Focusing, I felt a warm feeling come over me and had the image of the flower and rainbow, all sitting on the pond. The ‘All Fine Place’ helped me to re-find my strength. It’s the first time since losing my job that I feel some hope—that I can do it!”

Options for Clearing a Space with Art

There are four different versions of Clearing a Space with Art (Rappaport, 2009, 2014d):

- *CAS Art-Concrete Imagery* uses the art process alone, without guided inner Focusing, for clients in the early stages of trauma, anxiety, or severe mental illness. Clients are given instructions to create a container to hold their stressors. They draw, write, or use other art materials to symbolize their stressors, which they put into the container. Afterward, they sense how it feels to set the stressors aside—and create a new art piece to express how it feels to take a break from the stressors (“All Fine Place”).
- *CAS Art-Directive Imagery* is used with clients who need some structure, but would like an inner

guided experience (e.g., imagine wrapping the issues up in a package; placing them on a park bench; or setting the issues on a boat that you let out on a lake).

- *CAS Art-Nondirective Imagery* is used with higher functioning people who prefer spontaneous images to arise from within themselves.
- *CAS Art-Hybrid Version* is an alternation between inner Focusing and creating art after the client gets in touch with each issue. This process works well with journaling.

IV. Theme-Directed FOAT

In a Theme-Directed FOAT approach, a topic or theme relevant to a client's treatment is presented—such as: protector, source of strength, wishes and dreams, facing fear, etc. Clients are guided to become aware of the theme, to sense the whole feel of it, to see if there's an image that matches the felt sense, and to express it in art. A Theme-Directed FOAT approach is especially useful with groups, couples, and families, but can also be used with individuals. It is useful in the early phases of trauma treatment when the emphasis needs to be on building inner resources for safety (see Rappaport, 2015 for FOAT Phase-Oriented Trauma Treatment Model; and Rappaport, 2009).

Individual Example: Protector

(Excerpt from Rappaport [2009] *Focusing-oriented art therapy: accessing the body's wisdom and intelligence*, pp. 192–193).

Alissa was a 39-year-old client who had been sexually abused as a child. After several sessions of building safety in the therapeutic relationship, Alissa spoke about a chronic sense of fear that she had—at work, in relationships, and at home. I told her that it can be helpful to imagine a sense of protection, as often with people who have experienced trauma, they did not have the protection that they needed. I explained to Alissa how imagining and feeling a sense of protection can be helpful now—and that I could guide her in a Focusing and art exercise.

The Protector exercise can be offered to clients with or without an inner guided Focusing experience (similar to guided imagery). For clients who are not ready to close their eyes, it is best to introduce it as follows: “Imagine what a protector would look like. It may be a person, animal, something spiritual, from nature, a superhero, etc. When you're ready, create it using art materials.” The following exercise is useful for clients interested in an inner guided experience:

Guided Exercise: Protector

Take a few deep breaths into your body. Feel the support of the chair that you're sitting on and the earth beneath your feet [Grounding]. Let yourself hear the word "protector," and imagine someone or something that you know, or that you make up in your imagination, that can be a protector of you [pause]...Describe the *image* of that protector to yourself. Sense what that feels like inside your body.... What's the whole feel of it? See if there is an image that matches the felt sense of the protector...Check inside your body whether the image feels right.... When you're ready, use the art materials to create the image of the protector.

Alissa drew an outline of an angel with a smiling face, a heart outlined in red, and colored it in with a yellow oil pastel ([Fig. 15.6](#)).



[Figure 15.6](#) Theme-Directed FOAT: Protector

Alissa stated, "I saw the image of an angel. She looks like a guardian angel for children.... I like seeing the image. It's comforting...and feels warm inside."

I kept the drawing in my office and set it out each week before Alissa came in for therapy, to greet her as a consistent reminder of this inner symbol of safety.

Group Example: Source of Strength

I led a four-week cancer support group using FOAT. To reduce stress and enhance resilience, I taught them Clearing a Space with Art in the first week, followed by a Theme-Directed FOAT exercise, Source of Strength in the second week.

Source of Strength Exercise

Take a few deep breaths down into your body...breathing in...breathing out. Become aware of your body where it meets the chair, of your feet touching the floor. Feel how your body is supported.... I'd like to invite you to become aware of something in your life that has been a source of strength. It may be a specific memory, a natural landscape, a beloved pet, a spiritual teacher or teaching, a person known or unknown to you...anything that you experience as a source of strength [pause]. Describe this source of strength to yourself...seeing its image and feeling its strength.

Turn your attention to your body and notice how it feels inside as you focus on this source of strength [pause]. See if there's an image that matches the inner felt sense [pause]. Check it against your body for a sense of rightness. If it's not right, let it go and invite a new image (or word, phrase, gesture, or sound) to come [pause]. When you're ready, bring your attention to being in this room, stretch, and gently open your eyes. Use the art materials to express your felt sense of your source of strength.

Cindy

Cindy was a 64-year-old woman diagnosed with colorectal cancer; she was in chronic pain. After the guided Focusing, Cindy drew a small circular shape with rays reflecting a larger green shape, colored with a thin marker. She wrote the words “creativity” and “energy,” radiating from the smaller circle to the larger shape (Fig. 15.7). At the bottom of the drawing she wrote, “A wonderful French film about the magical effects of a green moon.”

Cindy shared, “I remembered a French film about the magical effects of a green moon. I don't remember the details of the film, but there was a magical quality of the green moon and it had an incredible beauty. I felt the strength and magic of the green moon, taking in its energy of creativity, happiness, and energy. The experience was extraordinary as I could feel the magical energy from the green moon pouring into my body.”

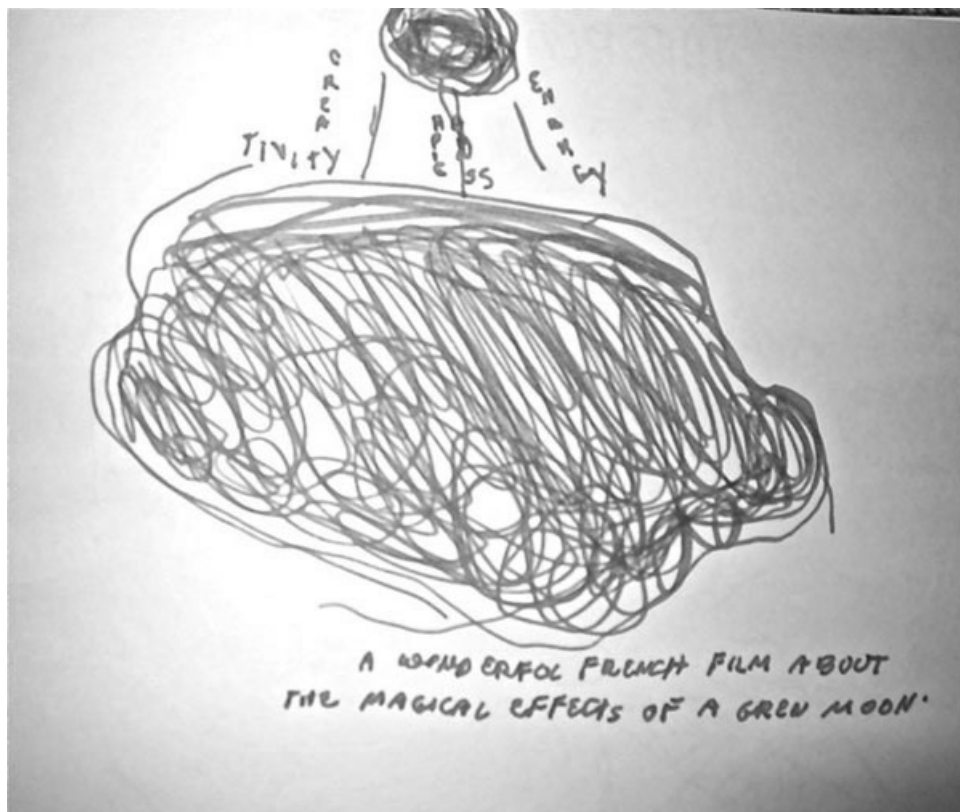


Figure 15.7 Source of Strength

As illustrated, the art externalized the energies from Cindy's source of strength—the green moon radiating into the larger shape, where Cindy felt the “extraordinary” magical effects throughout her body.

V. FOAT Psychotherapy Process

FOAT Psychotherapy Process is applied to more in-depth individual work, where the therapist begins by establishing a safe connection with the client, and then introduces Focusing and art therapy into the process. Usually, there is a point in the therapeutic encounter when the client is beginning to describe a feeling that is not fully clear, or there seems to be more meaning than their words are conveying. This is often a good place to introduce clients to a FOAT Check-in. As the process unfolds, it can be useful to introduce Focusing-oriented questions into the process, such as:

- Can you be friendly to that?
- Imagine what it would look and feel like all resolved.
- Imagine sitting down next to it and ask it, what does it need?
- What's a good small step toward the resolution?

FOAT Psychotherapy Process requires that the therapist stay carefully attuned to the moment-to-moment unfolding of a delicate experiential process. There is often an alternation among Focusing, listening reflection, and expressive arts. The following example illustrates this process.

Client Example

Focusing-Oriented Arts Psychotherapy Process

Kristie was a client in her 30s who had been in a car accident with her boyfriend. She suffered minor injuries, but her boyfriend died as a result of the crash. She felt both guilt that she survived and overwhelming grief from the loss.

After establishing safety through presence, empathic listening, and grounding, I guided Kristie in a FOAT Check-in: “take a few breaths into your body...feel the support of the chair...and follow your breath inside and notice how you are, being friendly to what is there.... See if there's an image that matches the inner felt sense.”

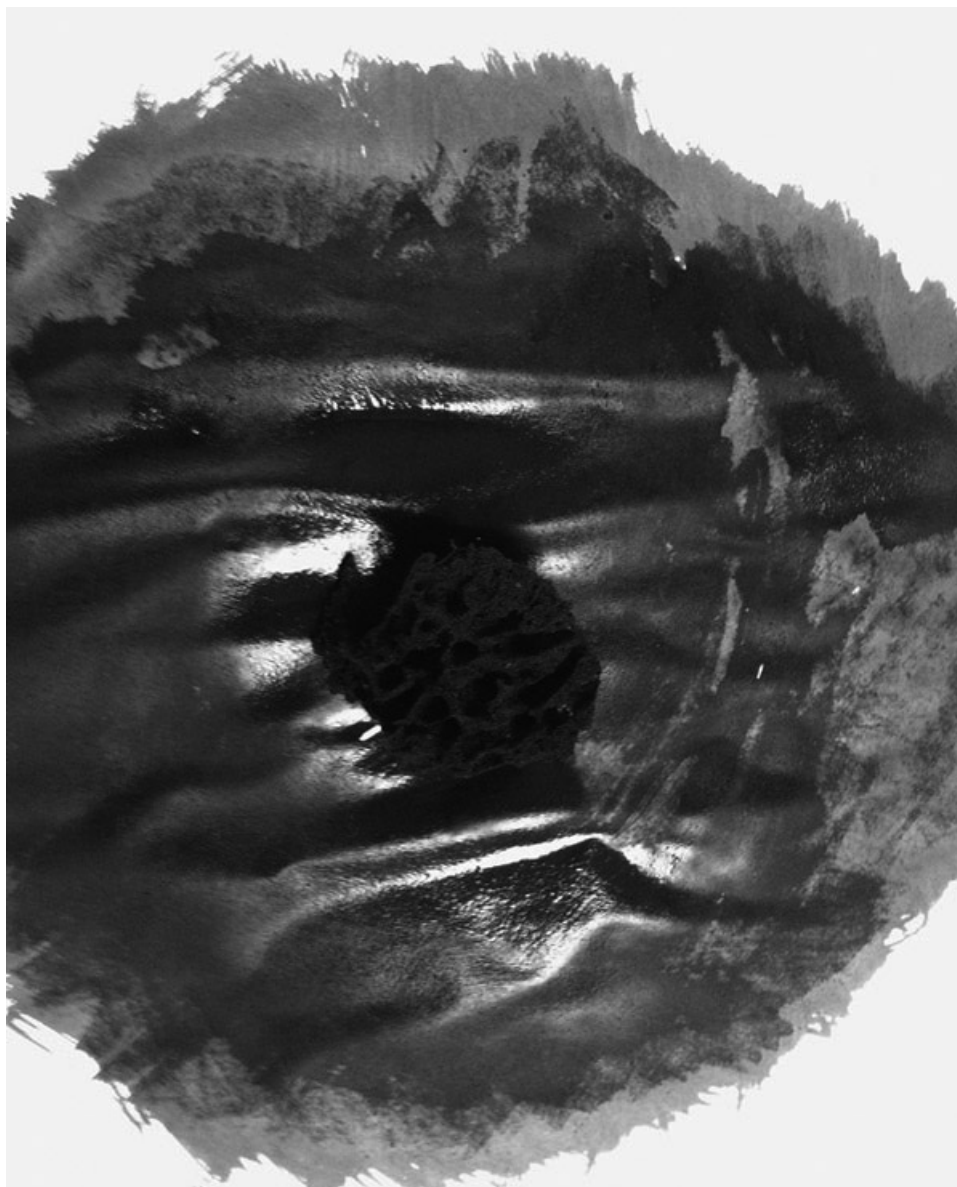
- Kristie(K): There's a big gooey tar-like substance...sitting right here...in my chest...penetrating into my heart. [felt sense and symbol/handle]
- Therapist (T): A big gooey tar-like substance in your chest and penetrating your heart. [listening reflection]
- K: It's too scary though...It's so dense and dark and heavy.
- T: Can you see if you just be curious about it...oh that's interesting...and perhaps take a tiny step of being friendly toward it. [Focusing Attitude]
- K: (sensing)...It feels a little easier...like there's a part of me with it and a little part next to it.
- T: Oh...Can you and I just sit here and keep it company?

Here I am reinforcing the Focusing Attitude to help Kristie maintain the delicate balance of staying present with the feeling without being overwhelmed by it. With very vulnerable places it can be helpful to join the client in keeping company with the strong feeling.

K: [Kristie is quiet for a while. Her face seems more relaxed, and I sense that she is feeling calmer with the tar-like substance.]

T: Sometimes it's helpful to express the felt sense image through the arts. Would you like to?

Kristie takes a sponge, and dips it into black Sumi ink. She places it on a large sheet of paper and begins to add more black ink and paint. She pushes the paint all around the paper, getting it thicker and gooier ([Figure 15.8](#)). When she reaches a stopping place, we both look at the art. I ask, “Is there anything you would like to share?”



[Figure 15.8](#) [Kristie's Felt Sense](#)

Kristie says, “This is how it feels inside of me. It’s heavy and stuck, sticky, and dense. It’s all I see and feel.”

T: Inside it feels heavy, stuck, sticky, and dense everywhere. [listening reflection]

K: Yeah.

T: Would it be okay to go back inside for a moment, to ask it something? [K nods yes]. Imagine sitting down next to it and ask it, “What makes it so heavy, stuck, sticky, and dense?” Just listen...and hear what it has to say. [Asking]

K: [cries deeply]. It says, “That was so scary. I thought I was going to die. Then I was okay, but Ian died. Everything went dark. The death is inside me.” [Receiving]

T: Yes...that was terrifying. And you were afraid that you were going to die. Then you saw that you didn’t, but Ian died. In that moment it’s like the world went dark and now it feels the death is trapped inside of you. [Listening reflection]

K: Yeah. Exactly. I don’t know how to live with this.

T: You don’t know how to go forward in life with this profound traumatic loss. [Listening reflection]

K: Yes.

T: Can we take a moment and go back inside and ask it one more thing? [Asking]. [Kristie nods yes]. Take a few deep breaths down into your body. As you breathe, sitting down next to this place inside that doesn’t

know how you would be able to live with this; when you're ready, ask it, "What do you need?" Just wait, allowing an answer to come from the body sense. It might come in words, images a gesture, or sound. See if you can be friendly and receive what comes [Receiving].

K: I got an image.

Kristie reaches for the pastels. First, she draws a yellow circle around the black painting and sponge. She then adds another sheet of paper and adds a figure embracing the black shape. Next Kristie adds a heart that touches the black shape ([Figure 15.9](#))

Kristie shares: "When I asked what it needed, I felt a warmth in my center surround the darkness. As I sat with it, I then sensed myself holding the blackness. I heard the words, 'It's horrible, but I am here. Ian doesn't want you to die too. He is here with you. He's in your heart with you. It's important for you to live.'"

As can be seen in the FOAT Psychotherapy Process, the Focusing Attitude helped Kristie to develop an inner witness that was able to stand outside the felt sense, while simultaneously experiencing it in a way that was manageable. The FOAT approach provided a healthy cathartic release through the art expression (sumi-ink and sponge), while the "asking" step of Focusing helped Kristy to hear her body's knowing of what was needed for her healing.



[Figure 15.9 What does it need?](#)

Conclusion

As can be seen throughout this chapter, Focusing and art therapy complement each other. Focusing provides clinical tools for the therapist to be able to listen empathically, and assist clients to cultivate self-compassion, regulate their emotion, and access their body's inner wisdom. All of the methods are more than techniques or directives. They are approaches that become a way of being and living, for client and therapist.

Over time, the Focusing Attitude deepens into self-compassion and compassion toward others. Clearing a Space is an effective tool for stress reduction and helps to develop an inherent sense of well-being. The FOAT Check-In is a mindfulness and centering tool that can be practiced daily, while the Theme-Directed Approach can be used to strengthen qualities that one would like to develop. FOAT Psychotherapy Process helps to cultivate the client's inner knowing and trust within themselves, while developing the therapist's unconditional presence and creative wisdom.

All of the FOAT approaches reflect Gendlin's concept, *felt shift*—actual change. In FOAT the felt shift is seen both in the art and the bodily felt sense. As Gendlin (1981a) states, "a felt sense will shift if you approach it the right way...When your felt sense of a situation changes, you can change—and therefore so does your life" (p. 26).

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16

Contemplative Wisdom Traditions in Art Therapy

Incorporating Hindu-Yoga-Tantra and Buddhist Perspectives in Clinical and Studio Practice*

Michael Franklin

Introduction

As art therapy imagines itself evolving as a vibrant profession, fields within the field continue to emerge. Overall, this chapter describes *intrapersonal* and *interpersonal* approaches to art therapy originating from Hindu-Yoga-Tantra and Buddhist traditions. Specifically, contemplative perspectives will be addressed within a karma yoga, socially engaged model of community-based studio work. The result for those who attend such welcoming art studios is a sense of *sangha*, which in Sanskrit means “keeping company in community.” Often associated with refuge taken within Buddhist or Hindu communities, *sangha* also extends far beyond religious affiliations. The multiplication of respectful I/Thou relationships (Buber, 1970) within a group of people creating art together over time flattens hierarchy while amplifying the family-like wisdom of the collective.

If suffering is inevitable and much of that anguish is related to learned class and culture-bound thought-schemas, then methods for clearing this inner debris is needed. By implementing the practices from these time-honored, perennial, traditions, inner awareness multiplies as body-mind connections synchronize. The result is an increased capacity for empathic attunement and compassionate engagement, thereby seeing the other as a reflection of our same, deepest Self. Long before its use in cognitive therapy (Persons, 1989), meditation evolved over the millennia to mend body-mind disconnection. Western authors like William James and Carl G. Jung acknowledged the importance of theology and spirituality as necessary and integral parts of a complete psychology (Coward, 1985; James, 1929; Ryan, 2008; Tart, 1975). For the purposes of this chapter, whether sitting or moving, meditation is observantly being on the spot just as you are and gently realizing from this open state of awareness, that any situation is workable.

Part I: Summary of Contemplative Foundations in Psychotherapy, Counseling, and Art Therapy

Spiritual and Cultural Bypassing

Spiritual bypassing is the premature claim of adept transcendent accomplishment (Welwood, 1984). Gentle inner confrontation of spiritual materialism (Trungpa, 1973) and spiritual promiscuity is necessary in order to mindfully challenge rather than sidestep personal spiritual work, especially in psychotherapy. The same phenomena can be observed in cultural bypassing. Dodging internalized oppression or forms of sanctioned institutional oppression and pretending they do not exist results in detrimental unconscious, shadowed material.

Cultural appropriation is another form of bypassing. Unexamined, frivolously appropriated traditions from other cultures are an all too often endorsed practice in the arts, especially visual art. At what point are we justified in incorporating original ideas from other ethnic-cultural backgrounds into our work? What are the differences between cultural appropriation and cultural appreciation, and when is it acceptable to apply these interests to our work? Further study of the subjects discussed in this chapter from a trained meditation or yoga teacher who thoroughly understands the lineage and practices of that tradition is important.

Buddhism and Art Therapy

Early teachings of the Buddha stressed the Four Noble Truths, significantly abbreviated here: First, since life is unpredictable, experienced as unfair, and based on impermanence, suffering is inevitable. Second, the origins of suffering are rooted in the seductions of desire, including wayward passion, aggression, and ignorance. Third, suffering can be mollified, interrupted, even brought to cessation through mindful detachment. While repetition compulsions manifest for understandable reasons, habitual patterns can be undone. Fourth, is that with right understanding and action, there is a way through (the eightfold path); we need not struggle as we do. This simple yet elegant view of the human condition outlines the parameters of Buddhist psychology. Serving others in art therapy from this perspective requires orienting guidelines like those found in the Four Immeasurables.

The Four Immeasurables and Art Therapy

The Four Immeasurables or limitless ones, in Buddhism are loving kindness, compassion, joy, and equipoise. Contemplatively oriented art therapists develop these qualities of open heart within themselves and also look to support them in their clients. We want the people we work with to discover their own version of personal happiness, to be free of their suffering, to rejoice in the happiness of others, and to see themselves and others with equanimity (Wegela, 2009).

Dharma Art (Therapy)

Chöyam Trungpa Rinpoche, the founder of Naropa University, believed that art emerged from the ordinary sacredness of daily life, a view that has guided our community art studio. For him, materials, physical spaces, and found objects all had generative, inherent potential. Deliberate attention to this everyday sacredness fostered sensitivity to the intrinsic fertility alive in any activity. Observant attunement, when moved into contemplative action, represents qualities of Dharma Art (Trungpa, 1996).

Art as contemplative practice begins with the inner necessity to be ourselves and to let our work emerge from the ordinary sanity that we are. This is the meaning of “warriorship” or being brave enough to be gentle with ourselves (Trungpa, 1984). Trungpa (2005) taught that we are all brilliantly sane with an ordinary core nature of basic goodness. Art is one way to access an authentic expression of this intrinsic truth. As a full spectrum awareness practice, art slows us down and wakes us up from degrees of amoral apathy, by connecting us to the vast continuum of life.

Brilliant sanity, also known as Buddha nature, consists of unconditional, innate features of mind. They are spaciousness, clarity, and compassion; and together constitute additional layers of our core true self (Midal,

2004; Trungpa, 1996, 2005; Wegela, 2009). Beyond neurotic patterns, psychotic states of mind, or immoral actions, is our basic goodness, which relates to our inherent, pure, unstained virtuous core. Contemplative practices, especially when incorporated into therapeutic work, aim to remove the layers of self-deprecating varnish by uncovering these innate qualities of brilliant sanity and basic goodness. The open potential of any moment in a session can reveal these inherent qualities (Kaklauskas, Nimanheminda, Hoffman, & Jack, 2008).

Hindu-Yoga-Tantra and Art Therapy

Essentially, Yoga traditions join together cognitive, somatic, and socially engaged practices to align our finite physical self with our infinite interiorized transcendent Self (Atman). Contemplative approaches to art awaken deeper insight into this numinous equation, by visually manifesting and transforming the fluctuations of our thinking—feeling—relational self. Incremental awareness of our true nature, *Sat-Chit-Ananda*, is the goal of practice. *Sat* translates as “being,” or absolute Being-ness. *Chit* as “consciousness,” or fully awakened awareness. And *Ananda* as “bliss,” or fundamental instinctual joy. Together, this triadic core of our archetypal Self becomes the innermost subject of spiritual pilgrimage. No matter how heinous the acts of a perpetrator, the art therapist working from this perspective strives to recognize these latent characteristics of our true nature in each client. When sitting with a client, we are seeing ourselves as the same embodied consciousness.

Today, particularly in Western yoga studios, many of the traditions discussed in this chapter have been assimilated, sometimes to a muddling degree, into digestible forms of these complex traditions.

Advaita Vedanta, Tantra, and Art Therapy

According to Advaita Vedanta, intrinsic suffering stems from dualistic perception. Unlike an inner self-structure built of ego-based identifications, Vedanta teaches that *Sat-Chit-Ananda* is our innermost conscious state (Feuerstein, 2001, 2003). Unification of these splits is also valued as a core intention of tantric practice (Wallis, 2012). Beginning with Shamanic cultures over 5,000 years ago, tantric traditions unconventionally evolved to untangle polarizing dualities through visual imagery, their science, and intricate rituals to foster inclusion and transcendence (Mookerjee & Khanna, 1977). Mandalas and yantras, which art therapists have sometimes appropriated with little understanding of their origins, are examples of complex imagery used in tantric ritual (Mookerjee & Khanna, 1977).

Additionally, a tantric perspective of art acknowledges instinctual urges as a facet of human drives needing attention (Feuerstein, 2001, 2003). However, tantra sees this expression of drive energy as originating at deeper, subtler levels of human consciousness. Early psychoanalysts were on the right track, however they did not investigate beyond a personal ego and limited unconscious.

Kramer’s psychoanalytic views on sublimation have similarity to a tantric perspective. That is, artistic sublimation is a way to ritualize life forces by redirecting vital, often unchecked classical drive and nontraditional drive energies into ritualized, symbolic equivalents. Like visual alchemy, base urges become transformed into metaphoric truth. Rather than unconsciously act out unexamined impulses and create karmic cause-effect relationships, artistic sublimation contains these instinctual compulsions, resulting in socially productive outcomes (Kramer, 1971, 1977, 1979). Viewers of this artwork are vicariously transformed, as they observe and assimilate paintings of formed chaos or regression in the service of their attentive ego.

Samkhya, the Three Gunas, and Art Therapy

Samkhya is a dualistic system for understanding the ontological categories of existence and how the *one* becomes many (Feuerstein, 2003). Within *Samkhya*, reality or *Prakrti* is exponentially plural, changeable, and represents the endless forms of the natural world while the inner Witness, *Purusha*, is simultaneously eternal, unchanging, and present as the universal Self.

Prakrti is comprised of three main dynamic forces called the *gunas*, which literally means “strand” (Feuerstein, 2001; Vivekananda, 2012). Summary characteristics of the *gunas* are outlined below to help identify inner states and orientations held by the client and therapist within the therapeutic relationship, and therefore also suggest therapeutic interventions.

***Tamas*:** static, inactive, impenetrable, and dormant sedentary embodiment. *Tamas* manifests out of

ignorance. Artistic work may represent stuck ideas, rigid use of materials, or bloated unaware content.

Rajas: energy, action, movement, change, and transformation. Artistic styles could favor quickly produced spontaneous methods or overdoing artwork.

Sattva: harmony/balance, lucidity, joy, wisdom, equipoise. *Sattva* cultivates a flexible perception of events and relationships. Sattva is a proportioned balance of *tamas* and *rajas*. Compositionally, the artist works to achieve Kramer's (1979) evocative power, economy of means, and inner consistency.

Table 16.1 Example of the three *Gunas* inherent in the *Prakrti* of clay

Materials	Tamas (<i>mass</i>)	Rajas (<i>vital energy</i>)	Sattva (<i>essence</i>)
Firing clay	Mass, bulk, density; physically heavy; invites exploration of thickness, weight, gravity, flatness, and solidity; fires hard; perceived as dirty by some.	Thins and mixes with water or solvents; can quickly change form; undoing is practiced.	Pliable, flexible; supports layering; communicates integration of opposites using additive and subtractive qualities; awakens insight into the resistive, integrative qualities of clay.

The Yoga Sutras of Patanjali and Art Therapy

Patanjali's Yoga Sutras were written in four books or *padas*: Samadhi Pada (the absorbed state of attention), Sadhana Pada (spiritual practice and discipline), Vibhuti Pada (the powers of manifestation), and Kaivalya Pada (isolation, solitude, and emancipation). Within this text, Patanjali (100–200 CE) maps the liberating practices of yoga, including ethical lifestyle and the transformational process of awakening awareness (Feuerstein, 1989; Hari Dass, 1999; Hartranft, 2003). Cogent instruction is offered that exposes flawed views of reality and consequently, why we suffer. Patanjali reveals pathways beyond the confusion of suffering through the use self-reflective methods to quiet mind activity. As therapists, if we could settle our thoughts toward stillness, then we would respond to our clients from this place of mounting clarity. The following chart outlines the eight limbs of yoga. Moral and ethical character is addressed by the five *Yamas*, which offer relevant material for ethics courses.

Table 16.2 Patanjali's Eight Limbs of Yoga

<i>Patanjali's Eight Limbs of Yoga</i>		
Samadhi (unity awareness)	5-Yamas (moral discipline)	5-Niyamas (observances for inner pilgrimage)
Dhyana (forms of meditation)	[SELF-ATMAN]	Asana (physical postures)
Dharana (mindful concentration)	Pratyahara (sensory discipline—inner attention/awareness)	Pranayama (breath-work)
5 Yamas (moral/ethical self-discipline)		
Ahimsa	To not harm; non-violent with thoughts, behaviors, and actions. Seeing clients as divine beings, rather than as a cluster of diagnostic categories—to examine one's propensity for micro-aggressions.	
Satya	Truthfulness with thoughts, behaviors, and actions. Striving to approach clients with unconditional positive regard. Judicious application of therapist transparency.	
Asteya	Dispassionate orientation—management of strong emotional desires. Skillful management of countertransference and vicarious trauma observed in artwork and distressing case material.	
Brahmacarya	Conserving energy, self-restraint with frivolous urges and desires. Consistent self-care so we can show up to serve our clients.	
Aparigraha	Releasing the urge to grasp materialistic greed. Clear boundaries with money surrounding the therapeutic relationship—discharging clients when appropriate rather than unnecessarily continuing therapy. Mindful awareness of grasping for self-serving	

outcomes.

Part II: The Material and Imaginal Cultures of the Studio Sanctuary: Sangha and the Practice of Simple Connections

Examples of contemplative interpersonal approaches to art therapy are examined below in terms of studio work within communities that exist in institutions like hospitals, prisons, and in our case, a university system. Remarkably, since the human nervous system is profoundly social (Cozolino, 2006; Franklin, 2010; Schore & Schore, 2008), a community of meaningful relationships—including skillful art therapy mentors along with abundant art materials—begins to disentangle and rebuild social self-structure.

Early in our history, art therapy primarily consisted of daring, altruistic artists going into schools and hospitals to set up impromptu studios. Initially untrained as therapists, they instinctively knew that the healing acorn of art could surely grow and minister to people in situations where suffering proliferated. To them, art was a human right that catalyzed personal meaning and eloquently communicated this emotional information to others.

Loka-samgraha, which means “world gathering” or “pulling people together” in *sangha* communities, serves as a guiding principle within this model (Feuerstein, 2003, p. 48). Direct expressions of unselfish actions, as well as renouncing ownership attachments to outcomes, begin to define a karma yoga view (Feuerstein, 2001, 2003; Kripananda, 1989; Mitchell, 2000). Overall, karma yoga includes a careful inventory of general behavior (*karma*), respectful action (*dharma*), ritualistic acts (*samskara*), and engaged service (*yajna*) (Michael, 2014).

Junge (2010) distinguishes between community arts, the arts in social action, and the studio arts movement in art therapy. While this makes sense from an historical perspective, in my view, these categories blend together in a continuum of applied studio-community-socially engaged approaches. Like two dousing rods seeking moisture, it is with and through the irrigating flexibility of material and imaginal cultures flowing throughout the studio environment that we discover the possibilities of art created in community. Studying these points in the laboratory of our program’s community art studio, which is also discussed in this section, reveals a vast territory where art is therapeutic without necessarily crossing over into clinical practice.

Art educators Wilson, Congdon, and Blandy (2003), write that “Community arts” is an inclusive term encompassing “performing arts (music, theatre, dance, and so forth), multimedia arts; visual arts, literary arts, culinary arts, clothing and textiles, and the multitudes of other forms that people, individually and collectively, create to make the ordinary extraordinary” (Vol. 1, p. 242). The authors suggest that art unfolding in communities springs forth from the daily life of social spaces. Local culture in neighborhoods or institutions, including the shared histories and politics of place, often seed the emergence of community-based arts (Blandy & Congdon, 1987).

Outside the Classroom, into Communities, and Back into the Body of the Studio

I suppose my interest in this branch of art therapy began in elementary school during show and tell. I loved that showing made telling a lot easier. To talk about an object without displaying it made the whole event a clumsy proposition. To only talk about my new puppy in second grade without the class seeing him, petting him, and listening to his squeaks of pleasure would have been ridiculous.

In high school, the art room was a place of refuge and communal salvation. Within this setting, the turbulence of my adolescent years could be managed through what I later came to know as artistic sublimation (Kramer, 1971, 1977, 1979). In college in the mid-1970s, the words *art therapy* were nowhere near my radar. A formalist aesthetic guided the teaching philosophy of my studio professors. Sadly, discussing content with them was a rare event. Finding other mentors who could converse beyond stock phrases like whether the art was “working” became a priority. This phrase of “It works” or “It does not work” both annoyed and propelled me to search further.

The limitations of my studio instructors eventually led me to a professor in art education. Richard Loveless, who was also a student of Viktor Lowenfeld, was eager to talk about stories implicit in our artwork. Since my ceramic sculptures, photographs, and lithographs were content laden, I made a concerted effort to study with him. Richard also directed me to take a class with visiting instructor, MC Richards. Learning from her about Black Mountain College and reading her books (1964, 1973), began to further focus the lens of my instinctive,

yet unformed convictions. MC showed me how clay was alive, and that the classroom could become a studio sanctuary that could support the hard work of creating honest art.

In 1968, Richard started the “New Place,” in Tampa’s Ybor City. It was a studio environment in an old church within an economically depressed neighborhood. Seeing a community need, Richard created the New Place to serve eager youth teeming with expressive energy. Always an enthusiast for technology, Richard had tape recorders, Polaroid cameras, and other assorted materials available for making music, theater, dance, and visual art. It was at this time that I first studied and became interested in the potential of community-based art studios.

Material Culture and Imaginal Culture in the Studio

We study cultures through their objects. Ancient civilizations, while long gone, leave behind artifacts to analyze in order to reconstruct their societies. Each object offers an opportunity to piece together what was functionally and socially true for these ancient people. It is through the imbued life implicit in the craftsmanship and symbolic presence within the object that implanted vitality emerges. When these artifacts or *art-facts*, are excavated, crews of scientific researchers attempt to decipher their meaning.

The magnificence of the art-fact requires interdisciplinary, multidisciplinary, and transdisciplinary methods for studying the import of this material culture. As defined by Bolin and Blandy (2003), *material culture* is:

All human-mediated sights, sounds, smells, tastes, objects, forms, and expressions are material culture. When there is purposeful human intervention, based on cultural activity, there is material culture. This being the case, *nothing* affected by human agency is overlooked as too insignificant for intensive examination, nor viewed as too small for eliciting substantive meaning.

(p. 250)

Communities working in studios create all sorts of *material culture*. Beyond the “human-mediated sights, sounds, smells, tastes, objects, forms, and expressions” of material culture, there is the corresponding interiorized diversity of an artist’s imaginal culture. I formulated the terms *imaginal culture* and *imaginal mindfulness*, to describe the numinous multiplicities of images and contemplative strategies for collaborating with such experiences. Within this view, the internal, autonomous images of imaginal culture (Chodorow, 1997; Hillman, 1978, 1989) dialogue in tandem with intrapersonal sensory input emerging from created material culture (Blandy & Franklin, 2012).

Imaginal mindfulness is a practice of non-judgmentally welcoming the many embodied and independent nuances of imaginal culture. Similar to meditation, focused awareness on imaginal material is essential to maintaining engagement in the art process. Wandering attention is certainly part of any art experience. However, so is concentration. Intentionally observing thoughts emerging from pressing clay into forms merges purpose with free association. Csikszentmihalyi (1997) noted about the “flow state” that happiness was to be found in absorption (Cooper, 1998). And when communities are absorbed together in artistic practice, the entire space is charged with the sanity of engaged, captivating relationships emerging from both material and imaginal cultures.

Table 16.3 A Formula for Creating Community in the Art Studio

A formula for creating community through art: flattening hierarchy and surfacing the ordinary sanity of the community art studio space

1. Loosening defenses, private explorations of honesty	Art, with its capacity to loosen psychological defenses, invites private inner explorations of honesty to fuse with artistic expression.
2. Personal and public vulnerability	Engaging in personal honesty within a group setting fosters personal and public vulnerability. Inner discernment unfolds for when and how to make the private public.
3. Discerning intimacy: making the private public	Private vulnerability, when shared with others, results in public intimacy.
4. Witnessing	Shared intimacy when collectively witnessed by all group members flattens hierarchy and results in community.

(This view, at first assumes a critique-like atmosphere of silence. And if/when conversation emerges, skillful speech becomes an essential shared value.)

When inner truth is shown and told to others, isolation is lessened (Franklin, Rothaus, & Schpok, 2005). The formula below outlines consistent observations of how community is formed in the studio. As the private is safely made public, members become curious about each other's ideas, histories, and artistic ambitions. Through this process the studio group learns to become its own resource.

Relational Aesthetics and Karma Yoga

Relational aesthetics, a term coined by Nicolas Bourriaud (Ross, 2006), considers artwork through the lens of interconnected relationships, rather than from the viewpoint of the fine art object and gallery curatorial practices. In fact, the term emerged after observing tendencies of artists to make their social interactions the art.

This collaborative stance questions hierarchical authority of the expert by instilling creators and viewers with similar importance. Bishop (2004) emphasizes the need for scrutiny to examine curatorial processes for art shows insisting that relational intentions infiltrate the process. Since the therapeutic process, artistic processes, and the group field in the studio all emerge out of relationship, art therapists have embraced principles of aesthetic relational-contact awareness from the inception of the field. Examples would be Kramer's early work in a children's community (1958), the hospital work of Don Jones (1983), Cathy Moon's (2002) studio art therapy, or our community studio (Franklin, 2012; Franklin et al., 2005).

Artist-to-artist engagement forms the overall structure for the art therapist working in this non-clinical version of art therapy. Diagnostic instincts are relaxed and invited to recede. There is no psychological injury to address or treatment plan to organize. Additionally, the medical model that privileges the provider as the expert is replaced with a non-hierarchical structure. Advantaged expertise is reevaluated as roles become intentionally blurred. Essentially, the studio community serves as its own resource for problem solving, celebrating, and managing itself.

Karma Yoga and Art as Service

For many, allocentric service to others makes more sense than a solitary lifestyle defined by austerity and renunciation. Often beginning with volunteerism, people wish to help others, but not necessarily examine personal motivations. Yet feelings of self-worth are often defined by such actions. The *Bhagavad Gita*, which widely addresses karma yoga, suggests a broader perspective. On this side of the developmental altruistic continuum, ownership of results are carefully examined. Personal motivations and associated gains become avenues for self-reflection, a practice that begins to dismantle ego-based self-interest and importance. Shifting desire from craving acknowledgment for the fruits of actions, to devotedly working with detachment, frees the socially engaged artist from possessive desires for public acknowledgement and ownership of cause-effect outcomes.

Table 16.4 Key Related Passages from the *Bhagavad Gita*

Passages From the *Bhagavad Gita* to guide service minded roles in the studio (Mitchell, 2000).

Note: The *Bhagavad Gita*, which means "The Song of the Blessed One," features a dialogue between prince Arjuna and Lord Krishna. Faced with his dharmic [right action] responsibility to battle his relatives, Lord Krishna teaches Arjuna about the many yogas. Initially Arjuna refuses to fight and use his weapons. Lord Krishna then teaches "about life and deathlessness, duty, nonattachment, the Self, love, spiritual practice, and the inconceivable" dimensions of reality (Mitchell, 2000, p. 15).

The Gita inspired many authors including Emerson and Thoreau.

2.48: Self-possessed, resolute, act without any thought of results, open to success or failure. This equanimity is yoga.

2.50: The wise man lets go of all results, whether good or bad, and is focused on the action alone. Yoga is skill in action.

3.19: Without concern for results, perform the necessary action; surrendering all attachments, accomplish life's highest good.

6.2: Know that right action itself is renunciation, Arjuna; in the yoga of action, you first renounce your own selfish will.

18.2: To give up desire-bound actions is what is meant by *renouncing*; to give up the results of all actions is what the wise call *to relinquish*.

These passages from the *Bhagavad Gita* highlight a difficult, yet accessible and practical orientation. Emerging from ancient cultural traditions, yet transcending these origins, how do these quotes relate to any employment as service-work? As an exercise in nonsectarian humility, how can work relationships become I/thou connections? When is the art we do created for the benefit of others? Relinquishing ownership of results and casting intentions to selflessly and respectfully serve others is the key.

The Studio as Healing Environment

Visiting the famed Asclepion in Pergamum Turkey highlighted for me the timeless importance of well-designed healing settings. Named for the God Asclepius, this healing temple site dates back to the 4th century BC, but became famous around the 2nd century AD. As an intentional environment, it offered a version of integrative medicine for treating physical and psychological maladies. One feature was sleeping rooms for purposeful dreaming. For this treatment, priest doctors carried out dream interpretation methods for working with psychological problems. Baths, herbal treatments, dietary interventions, massages, sun bathing, purging, and even surgeries were performed. Looking back into ancient history, we learn about resurgent environmental precursors designed for intentional healing.

A unique example of a setting designed to help others in psychological need was the Retreat in York, England. Founded by Quaker Samuel Tuke in 1792, “The Retreat” was a rare institution for its times (Storr, 1988). Tuke’s intention was to design an environment and services different from the cruel treatments commonly used with psychiatric patients. Quakers, then and now, believe in the inner light of God’s presence. All people embody this light, including those with mental illness, and therefore they too were to be treated with kindness. The Retreat granted safe asylum for reflective solitude. People suffering from mental illness could feel sheltered and begin to heal in this unique setting (Storr, 1988).

Edward Podvoll (1990), psychiatrist and student of Chögyam Trungpa Rinpoche, synthesized innovative methods for working with people in psychotic states. Trungpa’s views of “basic goodness” as the ordinary open potential of any moment that can be known in ourselves, including relational space with another, influenced Podvoll’s work. Knowing our capacity for this form of openness along with Trungpa’s view of brilliant sanity, which is composed of unconditional, innate features of mind (spaciousness, clarity, and compassion), constitutes our core of being (Midal, 2004; Trungpa, 1996, 2005).

Podvoll had a novel understanding of psychosis and how to treat severe disturbance through relationship and community. His work helped launch the Windhorse Project, a communal approach to working with serious mental illness. Podvoll viewed intentionally composed communities as the healing agent. Yielding personal egoic territory between self and the ill other to we-centric connection is essential for a thriving mental health community. Thus, a studio space can offer uplifting support for the emergent potential of basic goodness and the mind-states of brilliant sanity.

Those who enter the studio often claim sensations of retreat and refuge, a point addressed by Joan Erikson (1979) in a keynote presentation at the 10th American Art Therapy conference in Washington DC in 1979. Her talk rankled some and energized others. As a young graduate student in the audience, over time I came to understand how the urge toward professional legitimacy resulted in subtle forms of internalized oppression, where studio-art roots were denied in order for the field to have credibility within the medical model establishment. Later, Pat Allen (1992) would vividly make this point in her landmark article on the Clinification Syndrome.

The Naropa Community Art Studio (NCAS)—Visual Free Speech, Basic Sanity, Sangha, and Simple Connections

The art studio, as a community space, is an environmental intervention. Kendra Schpok sensitively made this point with Merryl Rothaus; both helped to write about our early NCAS beginnings (Franklin et al., 2005) ([Fig. 16.1](#)).



[Figure 16.1](#) [NCAS Space](#)

An abbreviated excerpt from our Mission statement begins to describe this long-term project's overall intention:

The guiding vision behind the NCAS project is to provide a space for diverse groups to gather and create art together. Equal access for our studio members is stressed, particularly people who are marginalized and unlikely to have access to the humanizing practice of engaging in artistic behavior in community. Respect for cultural, ethnic, gender, and spiritual diversity is a founding principal of the NCAS. Unity in diversity, the birthright to pursue creative expression, and the capacity of visual art to contain and communicate the full range of human experiences comprise the essence of our mission and focus. ([Fig. 16.2](#))

Imperative within this conversation is how marginalized groups gain access to settings like studios and how privileges of "race, gender and class shape art practices" in communities (hooks, 1995, p. XII). Vigilant scrutiny of privileged hierarchies in the studio and its surrounds, which is its purpose, supports artistic reclamation of oppressed cultural meaning so familiar to marginalized groups. The studio therefore becomes a political, transcendent act of access to a setting where the human right of visual free speech can be practiced and witnessed.



[Figure 16.2 People Working in the NCAS](#)

Table 16.5 Populations Served in the NCAS

1. Teens	5. LGBTQ youth	9. Youth body image groups
2. Adults with mental illness challenges living independently	6. Stroke survivors with aphasia	10. Young adults with developmental disabilities
3. Parents	7. Elders	11. Outreach to the local homeless shelter
4. Art camps for teens	8. Workshops for the community	12. Professional meetings

The studio is our laboratory for exploring innovative applications of community-based art practices. Exhausting the possibilities seems unlikely as we imagine new uses.

Years ago, when serving as lead mentor in our group for stroke survivors, the following adage occurred to me: *If you provide people with a meaningful experience, they will find a way to communicate.* This statement—along with moving art into art, artist to artist, to foster simple connections—have become the guiding aphorisms for our work in the NCAS.

Over the years, an array of community members have joined us in the NCAS. Materials and processes have guided the way, as members of each group explore styles of personal expression. We have had births and deaths, survivors of fires and floods, attended funerals together, cried and laughed together. For example, during Fall 2010, a serious forest fire broke out near Boulder, Colorado. In eleven days, 6,000+ acres and over 140 homes were destroyed. For three months, Jennifer Harkness and student volunteers offered open-art studios to the families affected by this tragic event.

Like a large dinner table set with abundant free art materials, we gather each week to taste and dine on each other's art and company. We have had various groups form and disband since 2001. Below is a chart of some of the community groups that have participated in the NCAS.

Residencies

Elder in Residence. Early on the NCAS attracted local grant money for after school teen programs. Our studio at the time was located in a large art center, conveniently located near the high school. Our goal was to provide a place for youth between 3:00 and 6:00 PM when most parents were working and supervision was minimal. Simultaneously, we were doing groups for adults who had sustained a head injury or a stroke—in collaboration with the University of Colorado, Speech Hearing and Language Department. Grace, who was in her late 70s, spoke several languages and had had an impressive career working overseas for the State Department. The NCAS helped her to discover her latent talents and enthusiasm for art. As her infectious passion for art grew, I invited her to become the “Elder in Residence” for our teen groups. I have always felt excitement about including the full developmental spectrum in our adolescent studios. With our Elder in

Residence program, a positive grandmother transference was alive and well for our teens. The kids loved receiving her attention, and she in turn felt useful in ways that brought new meaning to her life. ([Fig. 16.3](#))



[Figure 16.3](#) Grace: Elder in Residence

Babies in Residence. We have always invited parents and babies to the studio. Kate Schettler-Goodman, who works in our program, mentors our group for young adults with developmental disabilities. Her baby Bodhi is a frequent visitor, bringing his curiosity to the group, inviting others to join with his creative innocence.

Artist in Residence—Resident Artist. John, a member of our group for adults with mental illness, is a classically trained artist. Since caseworkers clear members of this group to attend, we do not ask about John's diagnosis. For over 10 years, he has been a serious, dedicated member of the NCAS. Therefore, inviting him to be our first artist in residence was a sensible idea. He loves the studio, the participants, and deeply cares about the overall program. Of the studio and his public art process, John has said:

There are only five more days until Naropa Community Art Studio (NCAS) begins for the Spring 2015 semester. I look forward to this time when I again become my part in the most fun thing I do.... My participation allows me to share my knowledge, experience and skills making art with young future art therapists whose roles are acted out in the NCAS with about a dozen participants who have answered a call offering free studio experiences, as I did over ten years ago...The drone of the inner discussion makes for the best background music to grow as an artist. Touch and let it go, idea, touch and let it go, feeling, touch and let it go, blue, and so forth, and back to the breath, touch is not so much the quality of the paper, but what goes on between, with maybe a brush or pen, let it go, breath, interaction, green...

In the NCAS, John works on his personal art as well as teaching others about materials and processes. [Figures 16.4](#), [16.5](#), and [16.6](#) are examples from a series of sketches of NCAS members and one picture from his boat series.

Writer in Residence. Naropa University is well known for its MFA writing program. Founded by Allen Ginsberg and Anne Waldman, The Jack Kerouac School of Disembodied Poetics attracts many talented writers. A few years back, I invited a gifted student, Jason Burks, to join us in the NCAS as our first Writer-in-Residence. Jason attended the group for adults with developmental disabilities. Of his time in the NCAS, he said the following:

As a writer, I was interested in non-verbal forms of communication and, by working with art materials, I became immersed in other types of knowing. The NCAS is based on collective meaning-making that

arises from experimentation, building an identity that is self-created; a type of origin-story of the body in that moment. Certain materials bring out different qualities in each participant, showing parts of themselves or multiple parts of the same self. This vulnerable space allows for connection that language cannot do or does differently.



[Figure 16.4 From Group Member Series—John's Artwork](#)



[Figure 16.5 From Group Member Series—John's Artwork](#)



[Figure 16.6 From Boat Series—John's Artwork](#)

The most moving event during my time in the NCAS was during a sharing session at the end of the day. After a prolific drawing session, a usually silent participant decided to show us his work. Holding his right hand up at face-level, he spoke to his moving fingers in a kind of linguistic dance. He did not use any words we understood: His language was guttural, yet we felt what he was saying because of his intonation, his passion, and the rising and falling intensity of his voice. He was proud, and although we couldn't cognitively follow his narrative, we sensed it reverberating in that room.

On Mentoring

Merryl Rothaus writes:

I have been serving as lead mentor for over a decade in the group for adults with mental illness living independently in our local community. The majority of the participants have been coming since its inception, resulting in a family of artisans and co-explorers of the creative process. “We” is key for me since mentoring is not something I do from the position of expert. Rather, mentoring is a weaving of each individual's freedom of visual, verbal and somatic expression into a collective tapestry. Whether it is a participant teaching me printmaking, being inspired by the usage of egg shells as painting tools, or bringing me back to the present moment through an insightful comment about someone's art, I am consistently humbled by the erosion of boundaries between expert and novice. Through mentoring I become aware of my privileges, the similarities and differences between people, and how to connect through the shared love of making art.

Futuring the NCAS

We wrote in 2005 that “the NCAS has offered our students and faculty a chance to interface with larger social concerns beyond the traditional classroom experience” and that the potential physical and non-physical space of the NCAS could not be exhausted if innovatively considered (Franklin et al., 2005, p. 214). A few years back, a group of enthusiastic students interested in addressing the global scourge of sex trafficking approached professor Sue Wallingford to begin what became a pilot study for NCAS-I (International). Together they and other students went to Cambodia to begin social justice work with various organizations throughout the country. Futuring the NCAS is exciting since it is a free, boundary-less democratic space (Boyte, 2004).

Students know this is their social laboratory to experiment with novel models and applications of community-based arts.

Conclusion

The time is always ripe for investigating old and new paradigms for practicing art therapy. I have often wondered why malls do not have studios, since teens gather there and elders often take their exercise walks there to escape extreme weather. Or airports, where disoriented families move between time zones with tired children. An art therapist with a cart stocked with art supplies could travel the terminals and intervene with engaging art experiences. The possibilities are endless. The social adhesive of the arts, when offered in communities, galvanizes people together in unique ways. Artists working in the 21st century have a civic responsibility to engage both intrapersonally and interpersonally. Indeed, the socially engaged artist and therapist with an understanding of contemplative and therapeutic principles is capable of fostering unanticipated connections, supporting the innate democratic free speech of imagination, and interrupting caustic social patterns. Surfacing the ordinary, open potential of basic goodness in the studio laboratory will guide future art therapists to imagine and manifest new fields within our field.

Note

- * Concerning transliteration, I have chosen to write Sanskrit words in their most Anglophone, phonetic spelling without diacritical marks. While some might disagree with this decision, this project is intended for a wider audience than a select, specialized group of scholars. However, Sanskrit is a language that requires careful pronunciation. If interested to learn more, there are many resources available to consult.

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Part V

Cognitive and Neuroscience Approaches

Cognitive-Behavioral Art Therapy*

Marcia Rosal

Cognitive therapy “is one of the most important advances—if not the most important advance—in the treatment of mental diseases in the last 50 years.”

—L. K. Altman (2006)

Professionals interested in the inner workings of the mind are infinitely fascinated by just how much of our behavior reflects the way we think and feel. Based on current research about the antecedents of human behavior, cognitive-behavioral therapists use knowledge about the thoughts and feelings of their clients to discuss, understand, and ultimately to change behavior. In this model, thoughts and feelings are referred to as *higher cognitive processes*, and clients are asked to learn about, identify, and access patterns and modes of thinking and perceiving. After understanding their cognitive patterns, clients are exposed to a series of techniques designed to change cognitive processes that are detrimental to mental, emotional, and physical health.

This chapter presents an overview of how cognitive-behavior therapy (CBT) principles and art therapy intersect. It includes a short history of the cognitive revolution, an outline of the cognitive-behavioral therapy model, and two current variants of CBT: dialectical behavioral therapy and mindfulness-based cognitive therapy. Case examples will illustrate how art therapy can have a cognitive-behavioral base.

Development of Cognitive-Behavior Therapy

The “cognitive revolution in psychology” (Baars, 1986) took place in the 1970s, but its roots are older. During the early part of the 20th century, behaviorism was dominant. In this model, behaviors could be either learned or eliminated through the use of reinforcements. If a new behavior was the goal, reinforcement was usually an external reward. If decreasing a specific behavior was the target, reinforcement was withheld when the behavior was exhibited.

However, trying to grasp how human behavior differs from that of the rest of the animal world, psychologists realized that the capacity to think, ponder, and use language and mental images greatly affected the learning process. Indeed, reinforcement itself could be an internal process. Many of us have observed ourselves using “inner speech”—whether self-deprecating: “I’m stupid,” “I’m unfit to hold this job,” “I’m incapable of caring”; or grandiose: “I’m ready for anything!” The theory that evolved to explain the profound impact of internal messages on human behavior is called *cognitive psychology*.

Cognitive psychology is a descendent of *social learning theory*. One of the first explanations of the human capacity to use higher mental processes as mediators of behavior was a book, *Social Learning and Imitation* (Miller & Dollard, 1941). They identified two levels of learned behavior. The first, *simple stimulus-response behaviors*, like automatic habits. Second-level behaviors included language, imagery, thinking, and affect. These cognitive operations mediate and facilitate the generation of solutions to a wide variety of problems that people face every day. Acknowledging that many actions are a complex blend of both types of behaviors, they concluded that human beings have a huge capacity for the second type, “higher mental processes” (p. 48).

Whereas Miller and Dollard agreed with psychodynamic theorists that neurotic conflict had unconscious determinants, another social learning theorist, Bandura (1969), conceptualized neurotic symptoms as products of past learning, continually maintained by ongoing environmental rewards.

In essence, social learning theory is about the effects of the environment on behavior, and the effects of behavior on the environment. It also attempts to bridge the gap between the inner mental processes of psychodynamic theories and the overt behavior of learning theories.

Meichenbaum (1977) hailed Miller and Dollard as initiating the “conceptualization of cognition” (p. 109), and for bringing cognitive process back into serious consideration as a tool for behavior change. Bandura (1986) labelled this model *social cognitive theory*. These authors influenced CBT methodology as well: modeling, for example, is a cognitive therapy tool borrowed directly from social learning theory.

CBT Models Today

Early in the history of CBT, Mahoney and Arnkoff (1978) identified three major forms: (1) Cognitive Restructuring therapies, (2) Coping Skills therapies, and (3) Problem-Solving therapies. Today, there are many other variants, including Dialectical Behavioral Therapy (DBT), motivational interviewing (MI), acceptance and commitment therapies (ACT), and mindfulness-based cognitive therapies (MBCT).

Mennin, Ellard, Fresco, and Gross (2013) observed that the unifying goal of CBTs is *behavioral adaptation*. CBT therapists employ “direct interventions towards cultivating more behaviorally adaptive responses in order to survive and thrive in...important [life] domains” (p. 236). They note three guiding principles: (1) context engagement—re-examining problematic situations in order to imagine novel responses, (2) attention change—helping clients sustain or shift attention in order to better adapt to various situations, and (3) cognitive change—gaining perspective or altering meanings of emotionally significant situations. Other important CBT practices include helping clients recognize and disengage from ruminations, negative patterns of thinking and behaving, and damaging self-talk.

The efficacy of CBT for numerous problems is well-documented by thousands of supporting studies, including findings that CBT is associated with changes in brain areas affected by such disorders as anxiety and depression (Hofmann, Asmundson, & Beck, 2013).

Hofmann and Asmundson (2008) identified six basic steps in CBT: “(1) establishing a good therapeutic rapport, (2) having a problem focus, (3) identifying irrational thoughts, (4) challenging irrational thoughts, (5) testing the validity of thoughts, and (6) substituting irrational thoughts with rational ones” (p. 4). Specific CBT protocols have been developed for various diagnostic groups, like a protocol for post-traumatic stress disorder (PTSD) (Ehlers & Clark, 2000) that includes identification and remediation of triggers, as well as cognitive and behavioral patterns that maintain the symptoms. This chapter concentrates on two variants of most interest to art therapists: DBT and MBCT.

Dialectical Behavioral Therapy

DBT was developed by Marsha Linehan (1993a) to treat individuals with a complex set of clinical issues, including resisting treatment and committing acts of self-harm; thus the treatment of choice for those with borderline personality disorder (BPD). The components of DBT are rooted in behavior therapy (using learning principles) and CBT (understanding maladaptive cognitions) (Brodsky & Standley, 2013).

DBT is a skills practice program in which acquisition of skills takes precedence over uncovering maladaptive thinking. Linehan (1993a) underscored mindfulness skills as a core component: “They are the first skills taught and are listed on the diary cards that patients fill out every week” (p. 144). Others include acceptance, distress tolerance, emotional regulation, and interpersonal skills.

According to Brodsky and Standley (2013), “dialectic” (a philosophical construct) was added to accentuate three concepts: connectedness, the inevitability of change, and the notion that truth can be derived through understanding opposing ideas. For Linehan (1993a), “dialectics stresses interrelatedness and wholeness” (p. 31). She conceptualized DBT as a long-term treatment and a set of learning modules (Butler, 2001).

Individual therapy, group skills training, individual phone coaching, and consultation groups or attendance at team meetings are all included in the first module. The goals are to (1) identify and solve problem(s); (2) address behaviors that undermine the therapeutic process; (3) work on problems that interfere with quality of life; (4) gain skills related to self-care, self-soothing, and mindfulness; (5) learn to ask for help when needed; and (6) keep the patient invested in the treatment process through weekly team meetings (Linehan, 1993a).

This first module is complex and often involves multiple therapists so that the patient does not become dependent on one individual, thus decreasing the transference issues that often interfere with the therapy. The other modules emphasize experiencing difficult emotions without suppression or acting out, improving the quality of life, and finally living joyfully (Butler, 2001). DBT requires specialized training and is usually conducted using a team approach. (Linehan, 1993b)

Mindfulness-Based Cognitive-Behavior Therapy

Segal, Williams, and Teasdale (2002) found that adding mindfulness skills as part of CBT for individuals with depression decreased relapse rates. In MBCT patients are taught attentional and meditation skills to increase identification of painful affective states and maladaptive cognitions. Mindfulness helps to “assist in distancing from automatic and self-perpetuating negative thoughts which characterize depressogenic thinking” (p. 139).

As a class-based treatment modality, MBCT combines mindfulness training as developed by Kabat-Zinn and cognitive-behavior therapy for depression as conceptualized by Beck, Rush, Shaw, and Emery (Kenny & Williams, 2007). Patients are taught to observe their thoughts and feelings and then shift attention to something neutral, such as their breathing or other bodily sensations in the here and now. The other aspect of MBCT is acquiring a “nonjudgmental acceptance” attitude toward feelings, even distressing ones.

Early Cognitive-Behavioral Art Therapy Thinking

Although cognitive approaches to therapy are now several decades old, they have not been widely accepted in art therapy, yet the use of CBAT is cutting edge. For over 30 years, art therapists have realized the potential for integrating art into cognition-based treatments. In 1979, Janice Carnes and Janie Rhyne began to write about the relationship of art therapy to cognitive therapy, using the work of George Kelly (1955). He focused on the importance of perception in how people choose to behave, defining it as an active cognitive process. Each individual develops a set of unique perceptions of his or her world through active interaction with the environment, which Kelly labeled a *personal construct system*.

A personal construct is an individual's hypothesis about how one small aspect of the world works. The personal construct system reflects how people organize the entirety of their perceptions and hypotheses. Personal constructs are inherently bipolar. If one construct is, "I find most people to be basically good;" the opposite is implied: "I find some people to be basically bad." Helping the client to identify and understand their personal construct system was the first goal of Kelly's therapy.

In 1979, Carnes noted that, since imagery, visual thinking, and creativity were aspects of cognition, *personal constructs* could be nonverbal. Making art provides an opportunity to express nonverbal ideas which may be the core of an individual's construct system. Carnes suggested that creating art might expand and enrich one's personal construct system; if stronger, the range of solutions to personal problems would be increased.

Rhyne also used Kelly's work as one of several theoretical bases for her 1979 doctoral research, seeing drawings as personal constructs. By having her participants draw a set of "mind states," she could help them come to a broader understanding of themselves and their individual belief systems. Rhyne found that when participants understood the bipolar nature of their drawn constructs, their meaning was elaborated; stressing the link between thoughts and feelings. In this model, cognitive and emotional components of experiences are inextricably connected

Roth (1987, 2001), working with children who had both a psychiatric disorder and an intellectual disability, developed a behavioral art therapy technique she called *reality shaping*. Using a combination of learning strategies, behavioral modification, and art therapy, she was able to help children progress from poorly formed conceptualizations to fully formed representations of a particular image. This is done through repetitive art work, beginning with simple materials and gradually moving the child into more complex media. The result is the creation of a fully formed construct based in reality and, she hypothesized, as a distinct cognitive schema that enhances thinking about that construct. An example of Roth's reality shaping approach was art therapy for a young boy who had set fire to his home. By first helping him create both two- and three-dimensional houses, a schema he produced with variations for the next year, eventually representing and talking about a house and fire.

Art therapists use behavioral methods regularly. For example reinforcement is helpful for children with behavior problems. It also encourages those who have trouble engaging in the art process and helps others to continue working even when difficult. Prompting is a second behavioral technique widely used by art therapists (Mellberg, 1998; Roth, 2001). Examples of simple prompts are (1) "Now it is time to work on your art project" or (2) "Although you say your drawing is complete, there is a great deal of empty space over here, perhaps you would like to add something there."

Based on the work of Carnes, Rhyne, and Roth, I incorporated cognitive-behavior art therapy (CBAT) in work with children with various behavioral disorders (1993) and adults with problems ranging from adjustment disorders to mood disorders (2001). Since art therapists generally focus on feelings, there has been a misconception that cognitive-behavioral art therapy focuses only on thought processes.

According to Mennin et al. (2013), CBT therapists "target a change in existing emotional responses to achieve symptom reduction and distress relief" (p. 237). This is because "cognitions causally influence emotions" (Hofmann, Asmundson, & Beck, 2013, p. 200) and "the relationship between emotions and cognitions is bidirectional because changes in emotions can lead to changes in cognitions" (p. 200).

CBAT Today

Reynolds (1999) stated that “Cognitive behavioral approaches appear almost entirely missing from the creative therapies literature” (p. 165), though recently there have been more such references.

CBAT with Adults

To provide a picture of how an art therapist uses CBAT with adults, I will explore the work of Morris (2014) in relation to the six basic steps of CBT outlined earlier. Morris, who treats individuals with anxiety disorders, presented two case vignettes in her 2014 article.

The first step is to develop a strong therapeutic relationship. There are numerous art therapy techniques that open the door to rapport. Morris utilized a brainstorming art exercise to help clients explore the reasons for seeking treatment, to provide the therapist a picture of the needs of the client, to impart specific information on the client’s problematic experiences, and to build relationship. Utilizing simple art materials like magazine images and markers, the client depicted her panic cycle. Using the drawing, Morris informed her client about “the different components of panic—physiological, cognitive, and behavioral—based on [the client’s] insights from the brainstorm” (p. 347).

Having a *problem focus* is the second step in CBT work. Morris recognized that reducing the number of panic attacks needed to be the goal of the art therapy. She invited the client “to create a visual representation of her panic cycle” (p. 347), thus moving her into the third step, *identifying irrational thinking*. Worries about “floating in outer space” and “dying” were the two irrational thoughts during her panic states. Another client with generalized anxiety disorder, also asked to draw her irrational thoughts, felt that “all eyes were on her.”

Confronting irrational thoughts, the fourth step in the process, is challenging, so. Morris had the clients create two drawings: what they thought would happen consumed by anxiety and what was more likely to occur. Drawing the two poles of an experience echoes Rhyne’s (1979) work based on Kelly’s (1955) understanding that personal constructs are bipolar. For Morris, discussing the two drawings led to an examination of the validity of these irrational thoughts, the fifth step in the CBT process.

One woman drew herself in the “lower right corner as proportionately small and powerless” (p. 349) with a large eye looming over her. When asked to depict a more realistic scenario, she painted herself in the middle of the paper thinking about what others are thinking about her which she labelled, “them.” Her self-image was surrounded by smaller figures, who were, in reality, thinking about themselves and not her. The two drawings helped invalidate her irrational thoughts.

Morris again employed the concept of bipolarity to work on step six: *substituting irrational thoughts with rational ones*. In the first drawing (the desensitization drawing), the client is asked to depict an anxious situation. After discussion of the first drawing as an *in vivo* event, the client is instructed to create what Morris calls a “mastery image” (p. 350), one in which the client envisions a successful ending to an anxious event. To illustrate this process, the client drew a situation where she wanted to approach a classmate to discuss course-related materials. In the first drawing, she is shaken and fragile, with people on one side talking about her. In the mastery drawing, she is having a successful conversation.

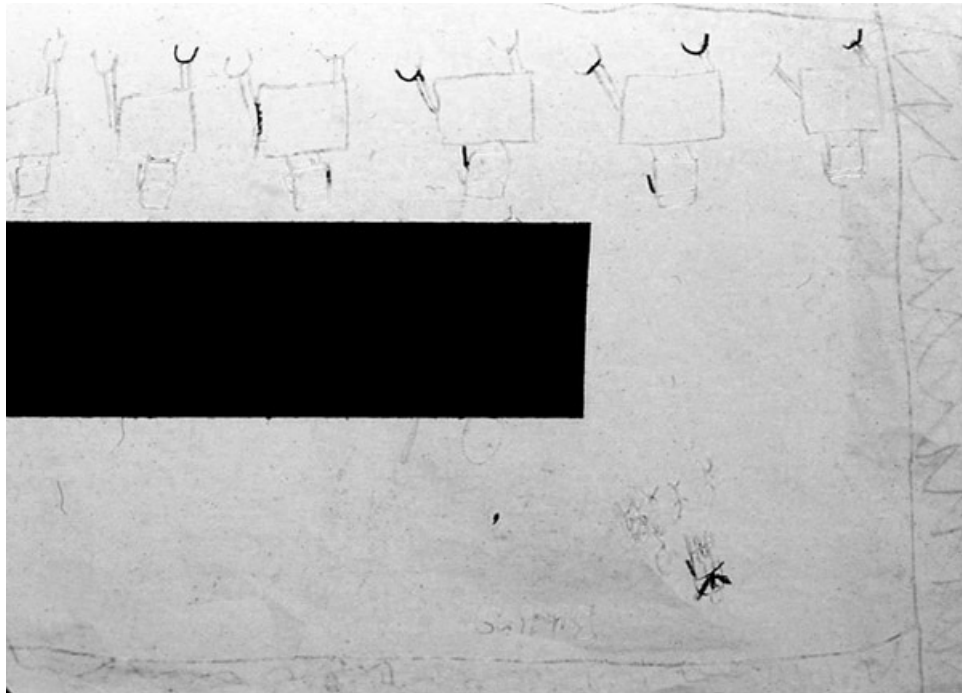
CBAT with Children

Art therapists working with troubled youth realize the need for behavior management as an important component of treatment. Sobol (1985), like Roth (2001) was one of the first to note that some behavioral interventions may be necessary in child art therapy, especially for antisocial or problematic behaviors.

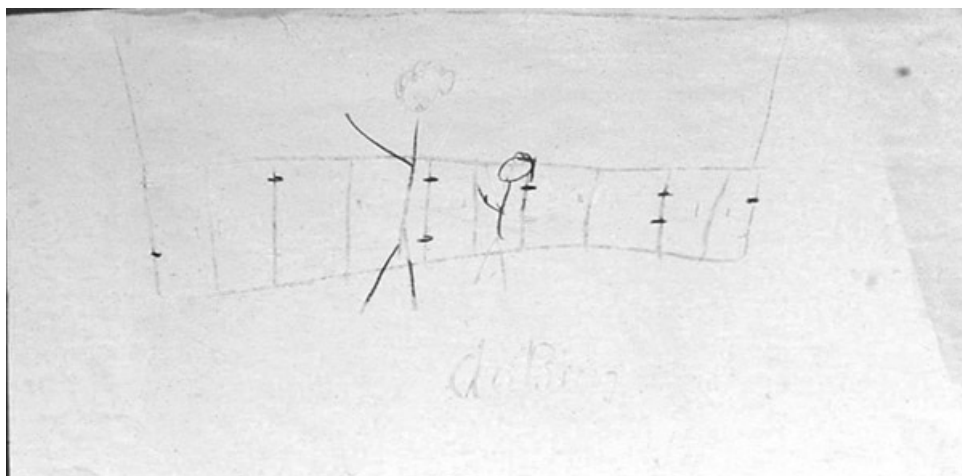
An example of CBAT was my work with Scott, a 12-year-old with behavioral and social deficits (Rosal, 1985, 1992, 1993, 1996). In a group with five other students his age, he learned how to relate positively to peers. After 20 sessions of art therapy, his teacher also noted major improvements in his behavior.

CBAT techniques used with Scott included relaxation, imagery, and problem-solving. For example, he was asked to identify and draw a troubling classroom situation ([Fig. 17.1](#)). In this drawing, he was put at a desk far from other students who teased him about this when the teacher left the room. Asked to draw what happened next, he drew himself telling the teacher that the others were teasing him ([Fig. 17.2](#)). The group members

helped Scott understand that telling how he was treated by other students would not help him connect with them. Scott and the group were able to explore other ways to deal with teasing. This session was so useful to Scott that during termination, he drew a picture of himself with a friend ([Fig. 17.3](#)), the first one he had.



[Figure 17.1](#) Scott in Classroom Sitting Away from Other Students



[Figure 17.2](#) Scott Telling the Teacher that the Other Students Were Teasing Him



[Figure 17.3 Scott Drew Himself with His First Friend during the Termination Session](#)

By the end of the year, he was chosen by the other children to host the final assembly!

Summary

Art therapy is particularly suited to CBT because making art is a cognitive process that uses thinking, sensing, and identifying as well as understanding emotions. When creating, the artist is uncovering mental images and messages, recalling memories, making decisions, and generating solutions. Whether drawing or sculpting, creating involves instant feedback systems and the ongoing reinforcement of satisfying behaviors. Each brushstroke can suggest or promote further action (feedback) as well as delight (reinforce) the artist. Art also provides a concrete record of inner processes that can be discussed and altered. It can also be used to recall past events, and as a reminder of positive emotional experiences, as will be described in the case study below.

Art Therapy and DBT

Although the use of art as a mindfulness-based treatment strategy is widely practiced, few describe dialectic behavioral art therapy (DBAT).

Acceptance and Change

According to Huckvale and Learmonth (2009), DBT is easily integrated with art therapy for patients with chronic mental illness. They posit that through art therapy, a patient might feel accepted, theorizing that pushing change invalidates the person. This is an important issue in DBT; Linehan found that acceptance of a patient's unique characteristics was necessary before pursuing any agenda of change.

In the case presented by Huckvale and Learmonth, the patient feared messiness and needed to wear gloves and have plastic under the art materials. The art therapist therefore provided these safeguards. Thus, "Acceptance was embraced in the session structure and the relationship. The possibility of change was explored through the art materials. A dialectic between them was opened up for reflection" (p. 56). This made it possible for the patient to return to the group art therapy provided on the open ward, and to let go of her fear of making messes.

Awareness and Mindfulness

Heckwolf, Bergland, and Mouratidis (2014) paired key art therapy principles with their counterparts in DBT, such as cultivating awareness in art therapy and mindfulness in DBT. Likewise, sublimation was paired with emotional regulation. By not acting out impulses, a client had more control over difficult feeling states and could live a life not ruled by outbursts.

They described DBAT with Anna, who experienced overwhelming anxiety and depression. A painting after her parents finalized their divorce exemplified the sublimation/emotional regulation pairing. It was of her childhood safe place—a tree in a park-like setting—yet the sky was fiery and threatening. Heckwolf et al. (2014) theorized that with both safe and frightful images on the same page, Anna became aware that opposing emotions could occupy the same space, and could problem-solve around while dealing with difficult mind states.

Creative Mindfulness

This model, developed by von Daler and Schwanbeck (2014), integrates art and other expressive modalities with DBT. They describe it as incorporating the creative, sensory, and playful aspects of artistic expression into skill-based sessions. As practitioners of DBT, they based their experiment on creative approaches with evidence-based thinking, turning to principles of neurological change.

Thus, if a creative response is paired with a maladaptive behavior, a new behavior is generated and a corresponding rewiring of neurological pathways occurs in the brain. The example that the authors offered was a person who, feeling lonely, uses food to self-soothe. If that person were taught to use an artistic response to the uneasy state of loneliness instead of reaching for food, a new behavior is learned and the brain begins to change as well. The assumption is that because neuroplasticity is related to experience, new experiences involving multiple senses, like art, can affect changes in both emotional and cognitive regions of the brain. Thus learning new modes of behavior is easier when all the senses are tapped. This point is crucial in DBT, a skill acquisition therapy.

They outlined a three-phase DBAT program: (1) distraction, (2) creating a new experience, and (3) applying new skills in vivo or daily life. Several arts therapies exercises exemplify their work. One that combines nonjudgmental and phenomenology skills is selecting a piece of art from a group member and describing all that can be observed in that artwork: colors, shapes, lines, etc. A second is to have clients, while holding a lump of clay, explore its tactile qualities by paying attention to all sensory aspects of that medium.

DBAT in Action

Art therapist Sheila Lorenzo de la Pena, uses DBT at a major state psychiatric facility (personal communication, November 19, 2014). She has practiced DBAT in three formats: (1) as part of learning skills-based DBT groups, (2) in DBAT groups, and (3) in individual art therapy sessions. Additionally, she has infused DBT work with art-based experiences as a means of having patients practice mindfulness, emotional regulation, stress tolerance, and nonjudgmental skills.

Techniques to induce mindful practice include blowing bubbles of liquids infused with colors and scents and experiencing materials with various textures and thicknesses. For emotional regulation, she encourages patients to pay attention to their breath while they move paint across large papers, and to use the whole body in swirling a drop of liquid to form a circle on the paper.

For both emotional regulation and stress tolerance, de la Pena slows down the art process, attends to the small steps in art making, and has the patient use lines to create patterns rather than pictures or specific images. To practice nonjudgmental acceptance, she uses layers of plastic sheeting with paint dribbled and dropped between the layers. Patients are able to move the paint around without getting messy and without the worry of being judged for making mistakes. If a patient finds an interesting design in the paint, they can use paper to make a mono-print of the pattern.

As a DBAT therapist, de la Pena encourages: (1) using one's self as a model for mindful practice and (2) acquiring a deep understanding of media dimension variables (Kagin & Lusebrink, 1978). After some missteps in her DBAT practice, she learned to attend to herself before sessions. She posted thoughtful quotes about nonjudgmental attitudes around her art therapy space. These served as cues or reminders for her to pay attention and be present and to prepare to model mindful actions for her clients. At times, she has done breathing exercises or her own art experiences before the session commences.

According to her, thorough understanding of color theory, media properties, and other tools of art practice are necessities for DBAT. She plans each session with a clear vision of how to use a particular medium. From there she thinks about how to convey handling of a material to the patients and teaches, in tiny increments, how to interact with the art. Since mixing colors may result in unwanted hues, she sets out only a few colors, reducing the risk of inducing overwhelming emotional responses. Preparation for each session includes planning from beginning to end. She thinks about the patient's involvement in set-up, in interacting with the media, and in clean-up. This thoughtful approach is at the heart of DBAT.

Art Therapy and MBCT

Two key components of MBCAT are enhancing a mindful understanding of moods and emotions and cultivating self-compassion. MBCAT is usually used with individuals suffering from depression (Hick & Chan, 2010), though it can also be employed for people with chronic psychiatric disorders (Chiesa & Serretti, 2011), debilitating pain like headaches (Day et al., 2014), and children with mental health problems (Coholic, 2011).

MBCAT Case Example

In the second edition of this book, I reported on the case of Karen, a 28-year-old computer programmer, who suffered from recurrent depression (Rosal, 2001). To work with Karen, I used components of MBCT like mindful attention to both somatic and cognitive emotional states. The goal of MBCAT was to help Karen become aware of her feeling states and to understand how they affect her ability to cope. In addition, she carried a great deal of guilt about her family situation and her own inability to cope with life circumstances; these feelings often led to increased depression. Thus, the second MBCAT goal was to have Karen acquire a sense of self-compassion.

During our first session, Karen told me the history of both her depression and her family. While hospitalized, she had learned that she had actually been depressed for several years without realizing it. After a good friend's suicide set off her own emotional turmoil, including suicidal thoughts, Karen decided to enter the hospital. Karen reported that she had a very stressful job and often found herself in arguments with co-workers and supervisors. Finally, she shared her sadness about not being in a relationship. She worried that her weight might be part of her difficulty in meeting and getting involved with men.

Karen's family of origin was troubled. Her alcoholic father had committed suicide when she was 10, and her mother had been unable to comfort herself or her three daughters about his tragic death. The family was left with few financial resources, and had become isolated from relatives, friends, and neighbors. Karen was the one who found her father, who had hung himself in their basement.

When asked what she would like to accomplish in art therapy, Karen stated that she wanted to better identify and understand her feelings, a major goal of MBCT. She added that while growing up, she was never asked how she felt. In the hospital, the other patients and caregivers were always asking her, and she found herself speechless. In art therapy she was also asked about her feelings, but was unable to come up with words or images to describe them.

During the first few sessions, it was clear that Karen suffered from many feelings associated with depression, including guilt, anger, anxiety, shame, hostility, sadness, and grief. A MBCT approach might be useful, since depressed clients were often assisted by the techniques outlined by Beck (1976) and his collaborators as well as Segal, Williams, and Teasdale (2002). Her wish to "understand" her feelings was particularly insightful, since Karen knew that she could easily "act them out." She often found herself in shouting matches at work or with her sisters, and she frequently cried uncontrollably at home. Yet she was not able to identify what she was feeling, nor its origin. What she knew was that overwhelming feelings led to unproductive interactions with peers and relatives. The first goal, then, was to meet her request.

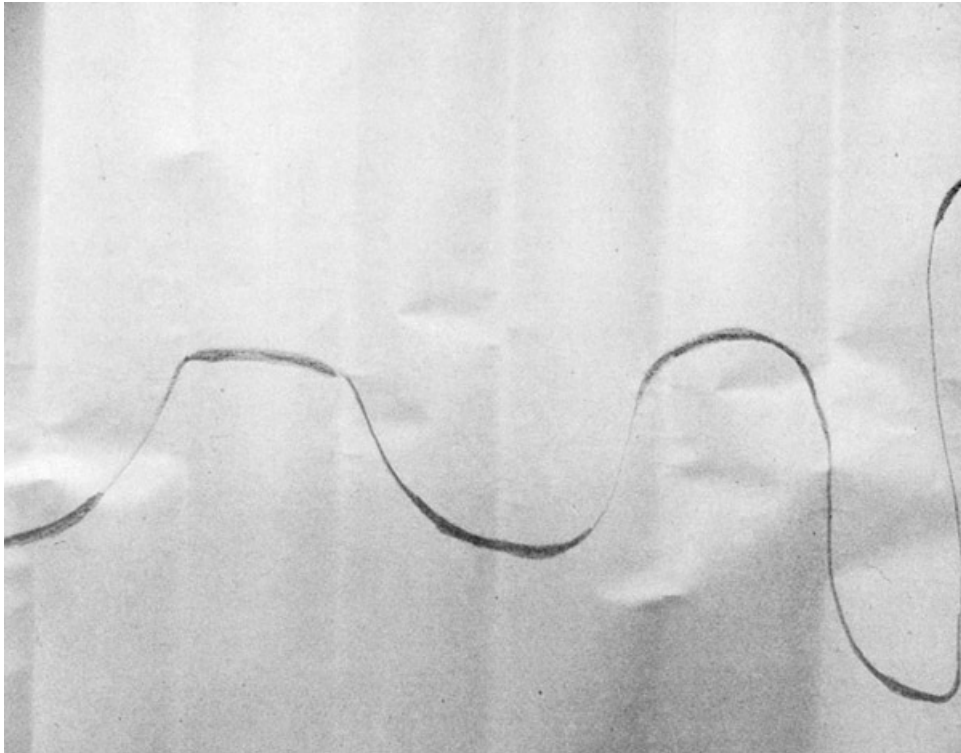
To begin, Karen was asked to complete three drawings: (1) Before: life prior to hospitalization, (2) During: events in the hospital that held meaning for her, and (3) After: what she hoped to achieve through outpatient treatment. For her first drawing, she chose a large piece of paper and, with craypas, drew a linear map of what she thought her life "looked like" so far (Fig. 17.4), illustrating its ups and downs. For each downward dip, Karen was able to cite an event that made her feel blue. The deepest and final dip on the right side of the paper was the recent depressive episode that had prompted her hospitalization.

The first drawing, her lifeline so far (Fig. 17.4), was then compared with the third, what she hoped to achieve (Fig. 17.5). Karen described this drawing as a landscape of rolling grassy hills with some "dips." Stating that she would like to be "steadier," she insightfully acknowledged that even the healthiest of people sometimes had "dips." Because she wanted warmth in her life, Karen had drawn the hills being warmed by the sun.

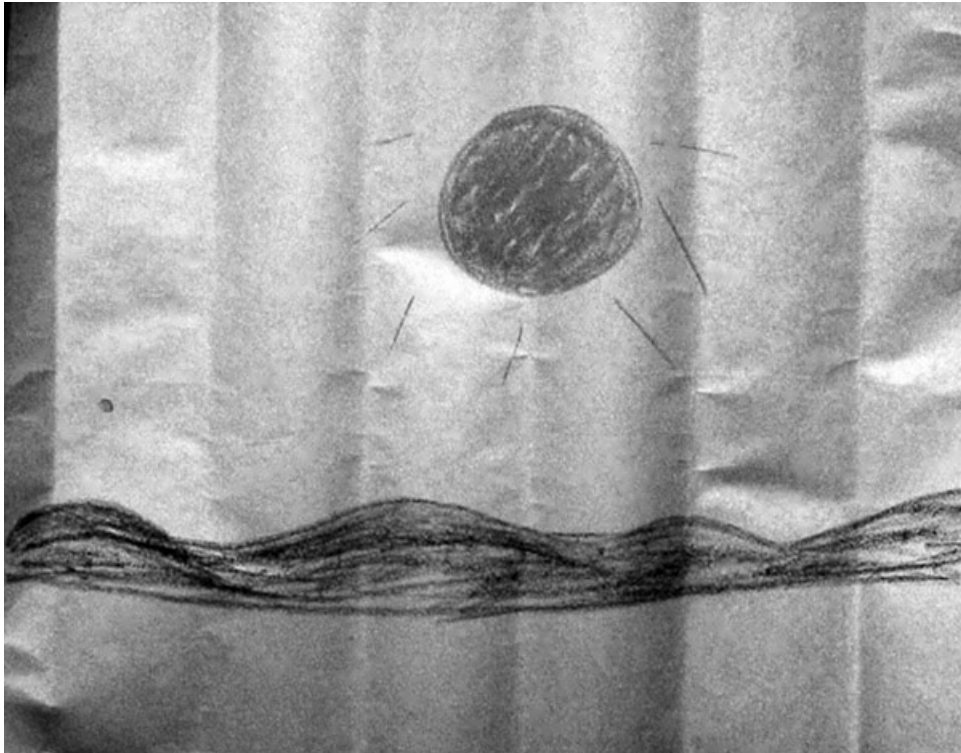
Based on Rhyne's work, Karen was asked to produce a set of personal construct "mind state" drawings. Viewing Rhyne's set of mind states, Karen was asked to produce her own list of those she wanted to explore. Karen developed a list of 12 feelings that included some of Rhyne's and some of her own. In six weekly

sessions, Karen reflected on and drew each of these mind states. At the end of each session, she meditated upon each mind state before discussing her images.

Once all of her mind state drawings were completed, Karen was asked to place them along her original lifeline ([Fig. 17.4](#)). After the feeling drawings were placed on the line, she had several insights. First, she realized that it was rare for her to feel peace and serenity ([Fig. 17.6](#)), and wondered if she would be able to do so more often in the future, describing what serenity might feel like, including feelings of wholeness, calm, light, and safety. Not finding a place on the lifeline for “serene,” she placed it outside the drawing on the left. That drawing was used for “homework” asking her to place this drawing by her bed, and to reflect on it and her descriptions of serenity before settling in for the night. Karen’s most surprising realization was that it was the feeling of anxiety that she feared most ([Fig. 17.7](#)). Although depression was heavy and dark ([Fig. 17.8](#)), anxiety was intense, prickly, painful, and unable to be contained. She also realized that periods of anxiety always preceded and triggered her depressions. Based on this awareness, and with the knowledge that the anti-depressant medication did not reduce her anxiety, she spoke with her doctor. The doctor prescribed anti-anxiety medication, teaching her when and how to take the drug. Karen reported immediate relief from the flood of negative emotions often experienced at work. Armed with her new insight and her new medication, she became less anxious about being anxious.



[Figure 17.4](#) Karen’s Drawing of Her Life’s Ups and Downs



[Figure 17.5 Karen's Drawing of How She Would Like Her Life Line to Look Like](#)

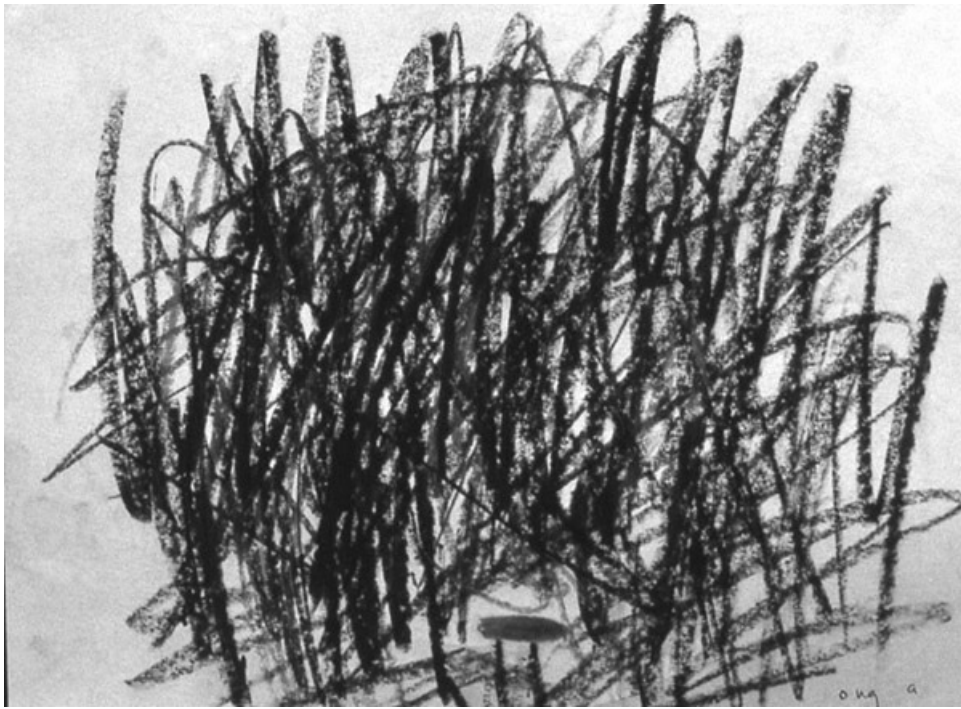


[Figure 17.6 Karen's Drawing of "Serenity"](#)

Summary

The Before, During, and After drawings assisted Karen in comparing and contrasting where she had been emotionally, and where she wanted to be eventually. Mind State drawings helped her to become aware and mindful of the feelings that had been unidentifiable and unmanageable. After about three months of such work, Karen continued for the rest of the year in art therapy focusing on other concerns, including

relationships with family and significant others.



[Figure 17.7 Karen's Drawing of "Anxiety"](#)



[Figure 17.8 Karen's Drawing of "Depression"](#)

Although her anxious feelings were not “cured” by her work in cognitive-behavioral art therapy, Karen became mindful when anxious feelings emerged and gained a good deal of control over her anxiety and thus, her depression. She was amazed that identifying and checking anxious states helped mitigate depressive ones. She began to use the *serene* drawing as a reminder to self-soothe, and to cultivate compassion for herself and others. If she became stuck when dealing with other matters during the course of treatment, Karen used the personal construct drawings to decipher how she was feeling. Although she continued to use art throughout her therapy, these particular drawings were kept at hand, and were often called upon by Karen or me during

our discussions of relationships and interpersonal strife.

As demonstrated by examples of both DBAT and MBCAT, art therapy is easily integrated into recent variants of CBT. Using art therapy interventions, such as drawing a situation from two mindsets can help a client become aware of cognitive distortions. *Acceptance*, a key component of how art therapists practice, is also an important principle in DBT. Juxtaposed with helping to create an atmosphere that embraces *change*, self-acceptance can move a client into a space where they may be willing to take steps to try new behaviors.

Encouraging clients to be aware of their surroundings, emotions, and thoughts, while creating is a major aspect of art therapy. Mindfulness must also include the practice of self-awareness by the therapist.

Conclusion

Tapping into the inherently cognitive essence of making art is at the heart of CBAT and its variants, DBAT and MBCAT. There is evidence that a wide range of visual techniques can enhance CBT. Mental imagery is one of the most common tools used by cognitive behavioral therapists, so the drawn image is a compelling addition. In addition, the art-making process helps patients focus and stay focused.

CBAT can aid quick and effective problem-solving as well as acquiring coping skills, and is especially useful in brief therapy. Even when additional work can enhance the life of someone like Karen, swiftly getting to the heart of the problem can provide immediate relief.

Helping a client of any age to develop an internal sense (locus) of control is the primary goal of CBT. Certainly clients engaged in any form of art therapy can quickly develop efficacy and mastery as they choose art materials, how to approach an art project, and how and what to discuss about creations. CBAT and its variations accelerates the acquisition of control by combining the inherent internal control-building aspects of art therapy with additional techniques such as (1) discovering, promoting, enhancing, and reconfiguring mental images; (2) comparing and contrasting drawings; (3) carefully choosing and portraying problem-specific situations and events; and (4) creating pictorial metaphors of feelings and mind states.

Note

- * Some portions of this chapter are from Rosal, M. L. (In press). Cognitive-behavioral art therapy revisited. In D. E. Gussak & M. L. Rosal (Eds.), *The Wiley-Blackwell handbook of art therapy*. London, UK: Wiley-Blackwell.

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18

Narrative Art Therapy in Trauma Treatment

Linda Gantt and Laura Greenstone

Talking therapy never worked for me. I had been in therapy since the age of 15. When I put it down on paper, I got it out of my psyche. I do not have flashbacks anymore.

—Katie

In this chapter, we present a method informed by neurobiology that uses art therapy as the principal means of processing traumatic events. We then illustrate the approach with the case of a young woman who survived domestic violence, sexual assaults, and being held captive. The approach is based on a theory encompassing the treatment of post-traumatic stress disorder (PTSD) and the dissociative disorders. The theory, developed over the past 30 years by Louis Tinnin and Linda Gantt (Gantt & Tinnin, 2007, 2009; Tinnin, Bills, & Gantt, 2002; Tinnin & Gantt, 2014) synthesizes recent research on brain mechanisms, decades of clinical observation, and an understanding of instinctual survival strategies. While the use of narrative therapy (White, 2007; White & Epston, 1990) and narrative exposure therapy (Schauer, Neuner, & Elbert, 2011) is not unique to contemporary approaches in trauma treatment, Tinnin and Gantt's work concentrates on identifying the universal stages of traumatic experience as processed in the nonverbal mind. We show that art therapy is fundamental to this specific type of treatment.

Trauma—A Major Public Health Problem

In the 1970s, it was rare for therapists to ask questions about a client's trauma history, let alone make a formal assessment for trauma symptoms. This climate changed significantly in the next decade with the publication of the third edition of the *Diagnostic and Statistical Manual (DSM III)* (American Psychiatric Association, 1980). According to Bessel van der Kolk (2014), a pioneer in modern trauma research,

The adoption of the PTSD diagnosis by the DSM III in 1980 led to extensive scientific studies and to the development of effective treatments, which turned out to be relevant not only to combat veterans but also to victims of a range of traumatic events, including rape, assault, and motor vehicle accidents.

(p. 156)

Currently, it is hard to find a client (especially in psychiatric hospitals or community mental health centers) who has not had at least one major trauma. However, it is still easy to find therapists who have not had any specific education about trauma, or are qualified in using art therapy as the core of trauma treatment.

Katie, whose case is introduced below, is an example of someone whose trauma history made a significant impact on her present-day functioning. Katie came to a domestic violence agency after suffering years of abuse by her boyfriend, the father of her four-year-old son, Brandon. She was a tall, attractive woman in her mid-20s who spoke in a soft tone. She described her three-year relationship with her boyfriend as being verbally, emotionally, physically, financially, and sexually abusive. Katie was forced into having sex throughout their relationship and was compelled to have several abortions before Brandon was born.

Katie's abuser often threatened to kill her and her family when he did not get his way. In the last incident before she came to treatment, Katie and Brandon (under 18 months at the time) were held hostage by gunpoint in their apartment. Katie was forced to sit in a chair for many hours, unable to comfort Brandon who was crying from hunger and pain after being thrown against a wall. An armed SWAT team ("Special Weapons and Tactics") rescued them after three days.

Katie had been out of the abusive relationship for over two years before coming to the domestic violence agency. At intake, she described being in a constant state of hyper-alertness, having flashbacks, and having difficulty managing her son's separation anxiety and aggressive behavior. Katie's goal for therapy was to improve her relationship with her son. She was returning to school and felt that her schedule kept her from spending quality time with him. She had full legal and residential custody of Brandon. The father had court-mandated supervised visitation that he had not used for over a month when Katie came to treatment. The possibility that he would exercise his rights to visit Brandon was a constant source of anxiety for Katie, as the thought of any contact with her perpetrator caused her considerable panic.

Katie came from a divorced family with a history of domestic violence. She had two siblings. Her parents separated when she was an adolescent, and she described feeling emotionally neglected by them. She described her current relationship with her parents as "shaky" and she tried to keep her distance. Katie was not currently on medication, but reported that she had seen a therapist and a psychiatrist when she was a teen, and had been diagnosed with bulimia. She enjoyed drawing and painting and was involved in tattoo art and culture.

Greater Recognition of Trauma

Over one hundred years ago, Pierre Janet, Sigmund Freud, Jean-Marie Charcot, Josef Breuer, and other pioneering psychiatrists who were working on the problem of hysteria recognized traumatic memories to be the central factor (van der Kolk, 2014). However, after Freud changed his theory to focus on drives and internal conflict instead of actual events, and the subsequent domination of psychoanalysis, the early attention to actual trauma disappeared.

In the 20th century, trauma was hidden for several additional reasons. People had been given the message, both overtly and covertly, that one does not talk about it. In addition, society generally denied that children could be maltreated in their own families. Furthermore, when one's verbal brain is compromised in response to a life-threatening event one *cannot talk* about it. This is why art and the other creative/expressive therapies should have a major role in trauma treatment. As art therapists Cohen and Cox state, "Artemaking gives

people...the opportunity *to tell without talking* [emphasis added], thus opening a window into their internal worlds” (Cohen & Cox, 1995, p. xix).

Today, we see advances in the general understanding of trauma as a result of major studies in both the laboratory and the larger society. The landmark Adverse Childhood Experiences Study (ACE) (Felitti et al., 1998) took an epidemiological approach, finding that negative events in childhood correlated with poor health outcomes in adulthood (such as heart disease, intravenous drug use, depression, chronic obstructive pulmonary disease, and suicide attempts). While it took some time for the results of this study to be appreciated in mental health circles, there are now training programs and websites devoted to spreading this crucial knowledge to public policy makers, educators, the judicial system, and mental health program directors (for example, see www.acesconnection.com). The United States government through the Substance Abuse and Mental Health Services Administration (SAMHSA) and its National Center for Trauma-Informed Care (NCTIC) now promotes trauma-informed and trauma-specific programs (www.samhsa.gov/nctic/trauma-interventions).

The Prevalence of PTSD

According to the National Comorbidity Survey Replication (NCS-R) the lifetime prevalence of PTSD for adults in the United States is said to be just under 7%, with women having a higher rate (9.7%) than men (3.6%). (Retrieved January 8, 2015, from <http://www.ptsd.va.gov/professional/PTSD-overview/epidemiological-facts-ptsd.asp>). For adolescents, the estimated lifetime prevalence of PTSD is 5% (Retrieved January 8, 2015 from http://www.ptsd.va.gov/professional/treatment/children/ptsd_in_children_and_adolescents_overview_for_prof). Given the prevalence of trauma-related disorders, there is a critical need for new and effective approaches that are time-limited, are adaptable to group settings, and that can be readily modified to be used with a wide age range.

The Theory

Over the last 30 years, Tinnin and Gantt refined their understanding of trauma and its effects in order to develop a means of treatment that is both brief and effective. Their clinical work has been with a variety of populations (including survivors of medical trauma, industrial and car accidents, domestic violence, and war, as well as childhood physical and/or sexual abuse). There are two major parts to their theory—the consequences of humans having a dual brain at birth and the universality of the Instinctual Trauma Response.

The Dual Brain

Humans are born with two brain hemispheres (the frontal cortices) that do not communicate with each other until the corpus callosum matures in early childhood (before age three). When this communication begins, something has to give:

When one hemisphere becomes dominant over the other, a compelling sense of unity develops. This is when the individual acquires “I-ness” and begins life as a unitary agent in the world of verbal communication. The dominant hemisphere (usually the left) becomes the verbal brain, with a mind that operates with the logic of language and imposes a sense of self as unitary agent with willed action in linear time (past, present, and future).

(Tinnin & Gantt, 2014, p. 9)

After the verbal brain becomes dominant the nonverbal brain works well in its subservient but nonetheless crucial role, all the while performing essential tasks such as recognition of faces, dealing with images and sensations, and visuospatial perception. As Siegel (2001) and Schore (2009) confirm, the right hemisphere develops more rapidly than the left during early childhood and is crucial in dealing with emotional material. The illusion of mental unity (that everything originates in the language areas of the brain) serves one well until a traumatic event throws the person into the Instinctual Trauma Response, in effect forcing the verbal brain offline. As a result, the traumatic experience “remains outside of verbal recall, unremembered in words but unforgettable in feelings and images” (Tinnin & Gantt, 2014, p. 9). When the trauma is over, the verbal brain is amnesic for much of the experience. However, as most art therapists can vouch, nonverbal material relating to traumas can be manifest in art, often much to the surprise of the artist.

The Instinctual Trauma Response (ITR)

Tinnin and Gantt (2014) postulate a universal response to trauma based on the hard wiring of the human brain that they call the Instinctual Trauma Response (ITR). It consists of a sequence of reactions when one is facing a life-or-death situation that includes:

- A startle
- An attempt to fight or flee
- A freeze
- An altered state of consciousness (ASC)
- Automatic obedience
- Efforts at self-repair

Body sensations accompany each aspect throughout the ITR.

The startle alerts the person to imminent danger. Often, the executive functions of the frontal cortex can avert a trauma by making a quick-witted decision for a plan of action. However, if there is no time for such action the person’s limbic system (a more primitive part of the brain that all mammals have) responds by fighting the attacker or running away. However, if such actions fail and the aggressor catches the person, or if he or she is physically in a trap (such as a crushed vehicle), then the limbic system is derailed and the most primitive part of the brain kicks in (Gantt & Tripp, in press). This part sustains heart function and breathing but little else, and certainly no conscious mental activity.

If an individual avoids the trauma, the experience can still be distressing and may need to be processed. However, there is no disruption of consciousness, so details about the event are readily accessible. Not everyone who experiences a life-threatening trauma develops PTSD. Some of the variables influencing the outcome include age, resilience, expectations, previous traumas, and available support. However, those who do go into the ITR and have peri-traumatic dissociation (that is, dissociation at the time of the trauma that is a manifestation of the altered state of consciousness) are the most likely to develop PTSD.

Origin of PTSD Symptoms in the ITR

During the freeze, the implicit and explicit parts of the experience are dissociated from each other:

Once a person enters the freeze, the rest of the ITR is recorded in the nonverbal part of the brain. However, this material is often inaccessible to consciousness; therefore, the experience feels unfinished. Because of the dissociation that occurs during the ITR, much of the nonverbal aspects of the experience have the potential to resurface as troubling symptoms such as intrusive flashbacks, nightmares, or body memories.

(Gantt, 2013, p. 237)

Later, when a person has PTSD symptoms, most (if not all) of those symptoms can be understood as being that which was experienced because of instinctual survival mechanisms but without conscious awareness. For example, a panic or anxiety attack can be a re-enactment of a thwarted attempt to fight or flee an attacker. Similarly, obsessive/compulsive behavior or a substance abuse problem developed after a trauma, might be an effort at self-repair gone awry. Knowing about the ITR helps trauma survivors to see that they are not “crazy” as many fear they are. We reassure them that their experience can be understood in terms of brain function.

“The hardest part was thinking back and remembering what happened...I tried to avoid it in the past...Making yourself replay those videos in your head was the best and worst part.”

—Katie

The Fundamental (Dis)organization of a Trauma Story

The core of much of psychotherapy is telling one’s story (Pearson & Marr, 2007; White & Epston, 1990). However, trauma stories are substantially different than simply reciting one’s history of relationships and key events in an unhurried and unstructured way. According to van der Kolk (2000), a major reason why trauma stories are fragmented is that “the part of the brain necessary for generating sequences and for the cognitive analysis of experience is not functioning properly” (p. 18).

“Finish the Story”

Realizing that trauma survivors could not easily tell their stories, Tinnin and Gantt began assisting the process by using the structure of the ITR. When comparing the merits of different pharmaceutical aids (sodium amyltal and nitrous oxide) versus hypnosis for telling a trauma story, Tinnin concluded: “Those [clients] whose narratives were unemotional but complete—that is, not interrupted because of painful reliving—did better than those whose stories were emotionally told but interrupted before the ending” (Tinnin & Gantt, 2014, p. 5). The mantra of any trauma treatment program should be “Finish the story”—that is, achieve narrative closure by putting the fragments of the trauma into the context of the ITR, and change the story from present tense to past with a definitive end.

Some therapists (as well as many clients) are concerned about whether trauma stories are an accurate account of what happened. We find it useful to employ Spence’s (1982) distinction between *narrative truth* (which gives an account of “Once upon a time...”) and *historical truth* (which is based on particular “facts” that give the who, what, where, and when of an event). We accept that capturing historical truth is impossible. However, constructing a story based on narrative truth can be done in such a way that it has a beginning, a

middle, and an end with a particular emphasis on how it fits into one's overall history. To this type of truth, we add the *nonverbal truth* of the Instinctual Trauma Response that gives the basic outline of those elements that are contained in every trauma.

The Application

The Graphic Narrative

The graphic narrative is the term Tinnin and Gantt use for their series of pictures used in trauma processing (Tinnin & Gantt, 2007). There are several trauma treatments that use drawings either routinely (Chapman, 2014; Steele & Kuban, 2013) or occasionally (trauma-focused cognitive behavioral therapy [TF-CBT] [Cohen, Mannarino, & Deblinger, 2006]), but this approach is unique in that it uses the ITR as the fundamental outline for the story. Clients receive psycho-educational material about the ITR and are shown a video in which an actor mimes the different aspects as a routine part of the treatment process.

It is best to use simple, clear drawing materials—thick and thin felt-tip markers, oil pastels—and large sheets of white drawing paper (12" × 18"). Colored pencils or regular pencils do not show up well when the story is videotaped. Since the drawings are stacked as the graphic narrative is assembled, pastels are also not advisable.

A basic graphic narrative has at least eight drawings. A “Before” and an “After” picture serve as bookends that set the story in time. Between these two are drawings that depict each aspect of the ITR, as well as the accompanying thoughts and feelings. Body sensations should be included in each drawing, but it is possible to do a separate one to show the response of various parts of the body, bringing the basic number to nine. However, to advance the account and to make it as complete as possible, other drawings can be added. For instance, during the trauma, the client may have been moved to another place (such as outside a building or to a hospital). This is a *transition* picture that serves to impose a linear sequence on the narrative.

Siegel (1999) points out that in the case of “split-brain” patients whose two hemispheres are surgically disconnected, “non-word-based ways, such as drawing a picture or pointing to a pictorial set of options to make its output known to the external world” (p. 327) can be utilized. He does not suggest any further possibilities for using art in clinical applications, but his description of what happens in a trauma accords with what we see as some of the components of the graphic narrative: While the explicit material is dissociated, “Implicit memory of the event is intact and *includes intrusive elements such as behavioral impulses to flee, emotional reactions, bodily sensation and intrusive images related to the trauma* [italics added]” (p. 51).

“Going back so far in my childhood was surprising. I remembered things that I knew but I did not think was part of what led me to abusive relationships. It gave me more power and control over my choices in life.”

—Katie

Generally, the graphic narrative depicts one event. However, in the case of repeated traumas at the hands of the same perpetrator such as physical beatings or sexual abuse, it is possible to do chapter stories as suggested by colleague Margaret Vasquez. Such a graphic narrative would start out with an account of the first time using the ITR for the basic outline, and then condense the repeated episodes.

Grounding

Often, the process of drawing is sufficient to keep a person grounded—that is, in the here-and-now and oriented to time, place, and person. The therapist watches to see if a pause in the drawing process is because the artist is either thinking about what to do next or is dissociating. The person’s eyes give the best clues about the capacity to be fully present. When the client is staring into space rather than looking intently at the drawing, the therapist should turn the drawing paper over and initiate a grounding exercise. For example, “You seem to have lost track of what is happening in the room. Let’s get you back in the here-and-now. Pick up your grounding stone and rub it in your hands. Now, look above eye-level and name three things you see...now, name three things at eye-level...now, name three things below eye-level.”

There are many simple grounding techniques involving the various senses that can be used (Tinnin & Gantt,

2014, pp. 88–90). At their core is the principle that the therapist temporarily acts as an auxiliary ego to restore the dominance of the client’s left (verbal) hemisphere. Practicing grounding techniques before they are needed is a crucial part of the preparation for trauma processing.

Helping the Process

Drawings are often made out of sequence. This is why separate sheets of paper are used for each part of the ITR. It is up to the therapist to get the pictures in order, and to see if additional pictures might be needed to make the graphic narrative logical. However, we mentioned earlier the story presents narrative—not historical—truth. We have had several clients who worked on traumas they experienced as four-year-olds. On the surface, the portion of the graphic narrative depicting the altered state of consciousness seemed almost psychotic, but when viewed from the perspective of a young child whose vocabulary was rudimentary to say the least, the pictures made exquisite sense.

Many beginning therapists feel compelled to make comments when a person is drawing, not knowing how they should fill the time. However, being relatively silent is the best stance to adopt, since this speeds up the process of drawing and helps the patient to focus on the primary task. This is especially the case when therapy sessions are an hour long.

It is imperative that the therapist give some parameters for each session. “To tell the story as completely as possible, you need to do a drawing for each of the elements of the ITR plus a ‘Before’ and an ‘After’ picture. You can do many of the drawings in one session. I will help by telling you how much time is left. If we are close to the end of the session, and you have not finished all of the drawings, I will ask you to do the ‘Self-Repair’ and the ‘After’ picture so that you can see with your own eyes that the trauma is over.” *Under no circumstances* should the therapist let the client leave a session without making certain he or she is grounded and fully oriented.

It is possible to do a graphic narrative in the space of one to three individual or group sessions. As in individual sessions, the therapists in a group session watch the process of drawing to determine who might need some assistance or is in need of grounding. It is helpful to have a co-therapist, in order to attend to all of the group members’ reactions.

The Re-presentation

Re-telling the story by the therapist is the crucial process that brings the event to a definitive close. By now, the details have been repeated several times as each of the drawings is done. Nonetheless, the therapist reviews the drawings with the client to see that the order makes sense. The therapist makes certain to know the name or designation (such a “next-door neighbor”) of each person, the age of the client at the time of the trauma, and the name he or she was called at that particular time.

The therapist puts the drawings on the wall or large cork board, and asks the client if the order is correct. The therapist stands beside the display and the client sits so he or she can see the pictures from a distance of four to six feet. Some people feel assured that the end can be easily seen, and others feel overwhelmed by the large number of pictures. However, we tell clients to approach watching the re-presentation as if they are going to a movie. One can be empathetic with the characters, but not be overwhelmed and totally immersed in the story.

At the end of the re-presentation, the therapist makes a point of bringing the narration to a definitive close “And now, we see that this very important story in the life of (client’s name) is truly over—and we can finally say, ‘The end!’”

“My brain was not repeating it anymore. The trauma felt over and I became aware that I wanted to make changes in my life.”

—Katie

It is ideal if at least one other person witnesses the re-presentation, but this cannot always be done.

Typically, the re-presentation is digitally recorded, making a review possible if needed. Some people dissociate momentarily during the re-presentation and benefit from such a review. The therapist keeps a close watch and stops the re-presentation if necessary, grounds the person, and determines when to resume the story. The video recording as well as the art becomes the property of the client, who can choose to show it to a family member or friend, or to destroy it.

If this approach is used in conventional once-a-week sessions the client can do the “Before” and “After” pictures along with the “Self Repair” one week, and fill in the middle events of the trauma during subsequent sessions. Under no circumstances should the person be left doing the pictures in the middle of the story. “You have done most of the story but we have 15 minutes before the end of our session. Let’s get out your ‘After’ drawing so you can see that the story really did end and you survived. And let’s go through that grounding technique we have used before so we can be certain you are back in the here-and-now before you leave the art room.”

Katie's Treatment

We have selected specific drawings from several of Katie's graphic narratives rather than show the entire series for a single event.

Katie was referred to the creative arts therapy program within the domestic violence agency. She received six months of weekly 50-minute art therapy sessions with Laura Greenstone, while Brandon received simultaneous filial play therapy sessions. The ITR method was adapted to fit the parameters of the program's structure.

The Trauma Symptoms Inventory (TSI) by John Briere, (Briere, 1995) and the Parenting Stress Index (PSI) by Richard Abidin (Abidin, 1995) were administered to Katie prior to treatment. "The TSI is used in the evaluation of acute and chronic posttraumatic symptomatology, including the effects of rape, spouse abuse, physical assault, combat experiences, major accidents, and natural disasters, as well as child abuse and other early traumatic events" (Briere, 2015; retrieved from <http://www.johnbriere.com/tsi.htm>). Katie's score on the TSI was clinically significant for trauma, with her highest scores on the subscales of Intrusive Experiences (nightmares, flashbacks, and memories of a previous traumatizing event), Defensive Avoidance—defined in DSM III under PTSD as "avoiding painful thoughts and memories from conscious awareness," and Sexual Concerns, that is, sexual distress, such as sexual dissatisfaction, sexual dysfunction, and unwanted sexual thoughts or feelings (Briere, 2012, Professional Manual).

The Parenting Stress Index (PSI; 2015), is "Designed to evaluate the magnitude of stress in the parent-child system, The PSI-4 is commonly used as a screening and triage measure for evaluating the parenting system and identifying issues that may lead to problems in the child's or parent's behavior"(Retrieved from <http://www4.parinc.com/Products/Product.aspx?ProductID=PSI-4>.) Her pre-treatment scores indicated that Katie was experiencing a high level of parenting stress related to the quality of the parent-child interaction, with her total scores falling in the clinically significant range.

Katie's sessions were held in a well-stocked, sunlit art studio. She said that she was looking forward to participating in art therapy. Her attitude was pleasant and calm as she described having flashbacks and out of body experiences, as well as, being constantly on guard. Laura asked Katie to draw her life as a line—including aspects of her life that she experienced as traumatic—to assess the number of graphic narratives to be done using the ITR treatment method.

Katie identified nine distinct traumatic experiences, including witnessing domestic violence between her parents when she was young, a motor vehicle accident, multiple incidents of domestic violence and torture by the abuser, and a recent sexual assault by an acquaintance at a party.

Katie was provided with psycho-education about trauma symptoms and basic neurobiological components of trauma. She expressed her willingness to participate in the ITR model and her desire to lessen her PTSD symptoms.

Laura worked with Katie before the ITR process began, in order to make sure that she had the needed skills to manage her anxiety throughout the process and between sessions. Katie did a "safe place" drawing and learned grounding techniques. Laura evaluated Katie's ego state by monitoring her symptoms before continuing with each stage of the narrative process. Katie also kept a log of her symptoms and triggers between sessions.

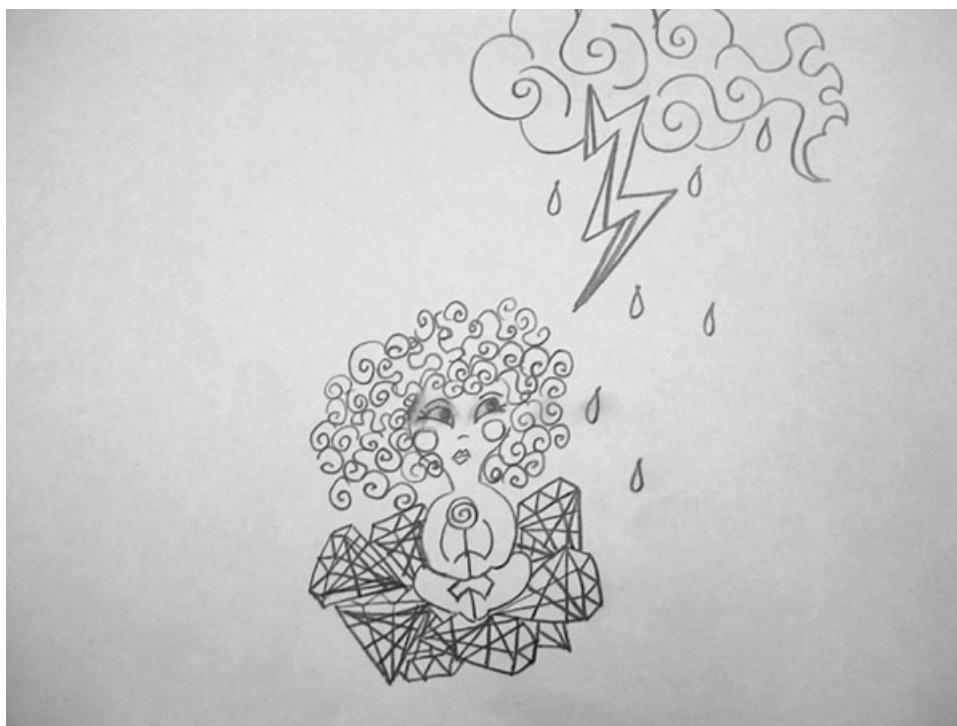
In the first session, Katie reported that she often experienced feelings of dissociation during her normal routine. Her "safe place" drawing was always on the table while she drew the components of the graphic narrative. She was reminded that she could look at it at any time or create another one if she felt the need to ground herself. Katie was given a handout about the Instinctual Trauma Response to guide her through the ITR process. She was instructed to start a narrative of "Something scary that happened to you as a baby, real or imagined." She was told to include her whole body in each of the drawings. The intention of this assigned narrative was both to teach the client the process, and to address any pre-verbal trauma that she might have experienced.

Katie drew quietly during the session. When she was done, she shared that she had an urge to get a tattoo in response to upsetting feelings she had been experiencing during the week. She stated that she was aware of her compulsion toward self-mutilation. Katie agreed to a verbal contract with the therapist to not act on her urge

to get a tattoo as a response to pain until the next session.

The imagery she used in the baby narrative for her Startle ([Figure 18.1](#)) of sitting on glass-like diamond shapes, seems to indicate the possibility of preverbal trauma. Laura recommended that Katie ask her mother if she had experienced any traumatic medical procedures either during her birth or soon after. Her mother said that Katie had a lumbar puncture (spinal tap) a week after her birth. This information gave Katie insight into her fascination with tattooing and needle-like images in her artwork.

The graphic narrative process continued with drawings of each stage of the ITR for the baby story. Katie's depiction of the Altered State of Consciousness ([Figure 18.2](#)) shows not only ongoing feelings of dissociation but also body sensations, mimicking her experience of bulimia.



[Figure 18.1](#) "Startle" from the Baby Story

In processing subsequent traumas, Katie reported only moderate increases in core posttraumatic stress symptoms. Her urges to mutilate herself in response to life-stressors lessened. In one session, she reported that she resisted urges toward bulimia and getting ear gauges.

She had some difficulty starting the graphic narrative of the domestic violence between her parents and had to create another safe place drawing. Ultimately, she was able to complete it and to have Laura re-present it with a witness. She also completed an "externalized dialogue" (Tinnin & Gantt, 2014) with the victimized child in the narrative, which she reported lessened her symptoms.

The multiple incidents of domestic violence with her abuser were treated as chapter stories within a single graphic narrative. Laura used grounding exercises throughout the process, as flashbacks of her torture increased slightly. Katie methodically drew the image for the Thwarted Intention ([Fig. 18.3](#)) and depicted the incident when she and Brandon were held captive. Katie drew herself begging the abuser to allow her to get medical attention for her son after the abuser had thrown the boy against a wall.

In [Figure 18.4](#), she depicted herself holding her son and feeling totally immobilized as she goes into the freeze, while the abuser holds a gun in his mouth, threatening suicide. She reported a decrease in anxiety as she completed each drawing. During the process she reported that she had a dream in which she stood up to the abuser and stated that she was generally feeling less victimized.



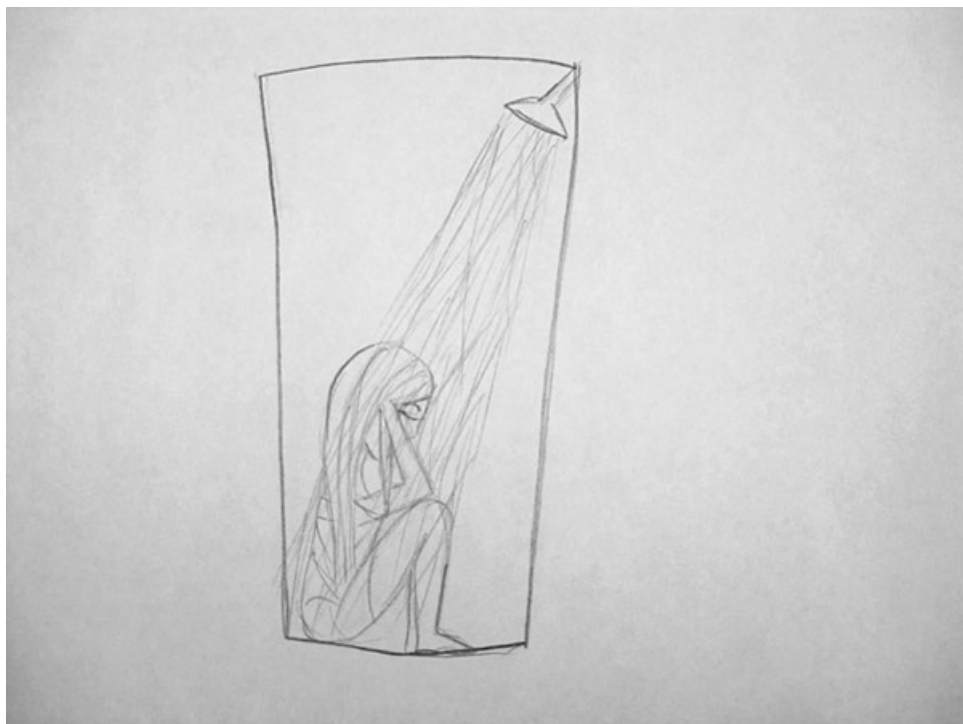
[Figure 18.2 “Altered State of Consciousness” from the Baby Story](#)



[Figure 18.3 “Thwarted Intention” from the Captivity Story](#)



[Figure 18.4](#) “Freeze” from the Captivity Story

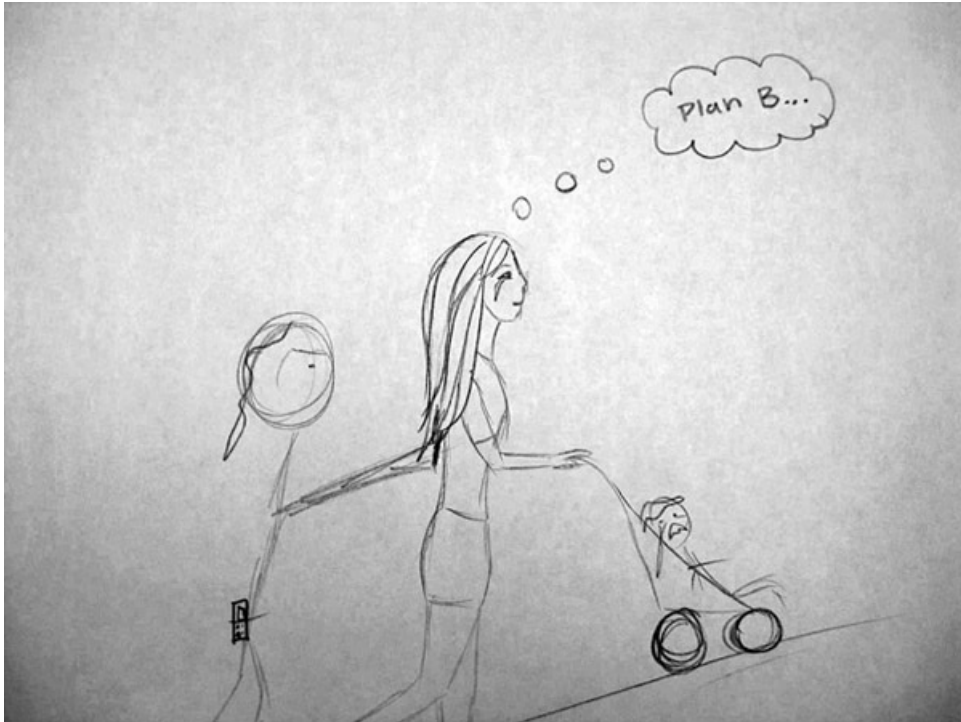


[Figure 18.5](#) “Self-Repair” from the Captivity Story

[Figure 18.5](#) shows Katie’s Self-Repair. After the graphic narrative of her captivity was completed, Katie reported a marked decrease in trauma symptoms. She completed an externalized dialogue with her frozen self, in addition to the re-presentation. Katie reported that she was no longer re-experiencing the incidents of torture and domestic violence with the abuser, and she went on to process the recent sexual assault. During her treatment, she initiated the completion of a police report that she had previously been unable to do because of her anxiety.

In [Figure 18.6](#), Katie shows herself in “automatic obedience,” as her perpetrator directs her every move.

When trauma survivors understand this aspect of the Instinctual Trauma Response, they often feel great relief that there is a brain-based explanation of a baffling behavior that does not seem rational.



[Figure 18.6 “Automatic Obedience” from the Captivity Story](#)

Outcome

Katie's post-treatment scores for both the TSI and PSI fell in the normal range within two weeks of the end of treatment. Five years later, she contacted the program. She had moved out of state, was successfully maintaining a full-time job, and her son was doing well. He had not been in contact with his father in years. She was in a healthy, committed relationship, and in regular communication with her mother and siblings. She continued to use art as a coping activity. Katie consented to the use of her drawings for this chapter and participated in an interview about the process, which we have quoted throughout this text.

Conclusion

In addition to contributing to the relief of posttraumatic stress symptoms, this case study and observation of numerous ones like it, suggest that the ITR method—in conjunction with child and family-focused trauma intervention—may contribute to the successful reparation of attachment difficulties in parents and children who suffer from neurobiological injuries due to domestic violence and trauma.

The ITR methods shares certain properties with other contemporary trauma treatments, such as psychoeducation, constructing a narrative, cognitive processing, and imaginal exposure. However, the special features of this approach are the re-presentation and the use of the ITR as a scaffold for the re-contextualizing of the memory fragments into a linear sequence. One can *see* the pictures at a distance and confirm that the event is truly over. Moreover, the troubling nonverbal avoidant, intrusive, and arousal symptoms have been targeted and thus eliminated.

The ITR method should be conducted by experienced, trauma-informed art therapists who have access to training and ongoing peer consultation in the field of trauma. Current research in mental health, psychiatry, and neurobiology present exciting opportunities for the field of art therapy. Since the beginning of the discipline, art therapists have had an intuitive understanding of the value of art making which is now being validated by science. This development should make possible opportunities for further funding, research, and application of art therapy as part of mainstream mental health delivery systems.

Resources

The ITR Training Institute: <http://www.ITRtraining.com>

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19

CREATE

Art Therapy Relational Neuroscience

Noah Hass-Cohen and Joanna Clyde Findlay

Introduction

The Art Therapy Relational Neuroscience (ATR-N) approach underscores the neurobiological underpinnings of art therapy interventions and change, assisting art therapists in fine-tuning their clinical, teaching, and research practices. ATR-N was developed by the first author, providing an interpersonal neurobiology model for the multi-modal expressive arts field (Hass-Cohen, 2008a). ATR-N is mapped by the following principles, referred to as CREATE, which stands for Creative Embodiment, Relational Resonating, Expressive Communicating, Adaptive Responding, Transformative Integration, and Empathizing & Compassion. CREATE explains how an integrated and attuned state of mind can emerge during the novel sensory experiences associated with creating art in the therapist's presence in the art therapy space. The interpersonal neurobiology of emotion, cognition, and action are expressed in the dynamic interplay of brain and bodily systems during art therapy. ATR-N CREATE based therapy activates integrated changes across brain areas, contributing to a sense of hope, well-being, flexibility, stability, and overall wellness (Figure 19.1).

The circular diagram indicates the main structures that each CREATE principle, Creative Embodiment, Relational Resonance, Expressive Communicating, Adaptive Responding, Transformative Integrating, Empathizing and Compassion is associated with. The chart on the right indicates four main interpersonal neurobiology pathways activated in CREATE. Transformative horizontal integration refers to right to left hemispheric connections, vertical integration includes bi-directional cortical-subcortical-bodily connections.

Across the six CREATE principles the therapeutic factors are (a) safety, including sensory grounding, relaxation, and affect regulation skills; (b) relationships, including the therapeutic relationships; (c) remembrance, including grieving, autobiographical memory processing, and internal locus of control development; (d) reconnection to others; and (e) resiliency development, including the development of empathy and optimism.

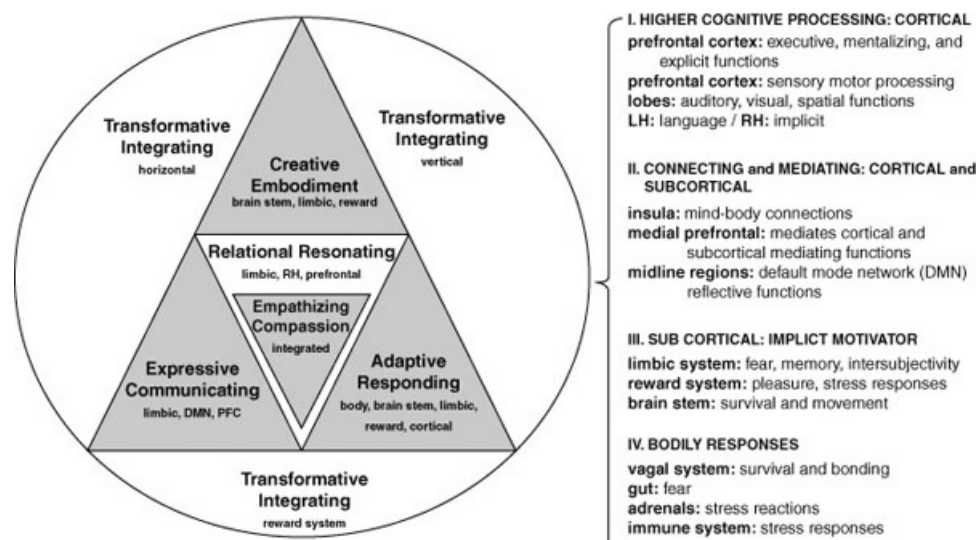


Figure 19.1 The Dynamic Interplay of Brain and Bodily Systems and Art Therapy Relational Neuroscience Principles

Creative Embodiment

Principle Description

Creative Embodiment represents the creative manifestation of human senses, perceptions, experiences, and relationships. These include implicit and explicit emotions, feelings, and thoughts, as well as seeing, touching, and verbalizing. Creative Embodiment highlights the therapeutic effects of kinesthetic art making expressed in the motor system functions. Embodied motion ranges from the micro-movements needed for art expression, pain relief, and bodily function, to the perceived, symbolic, and anticipated motions involved in intersubjectivity, attachment, adaptive responses, and empathic resonance. Movement also strengthens links between emotion and cognition and is central to social, cognitive, and emotional function (Koziol et al., 2013).

The motor system coordinates and reinforces the planning-cognitive and emotive-social systems (Stocco, Lebiere, & Anderson, 2010). The intersection of these three systems during the creative process supports freedom from constricting affect and increased understanding. Repeated embodied and expressed movement help clients solidify implicit learning and consolidate new memories and changes.

Therapeutic imitation of purposeful movement and action also forms a fundamental neural basis for social connections (Mukamel, Ekstrom, Kaplan, Iacoboni, & Fried, 2010). The client comes to recognize the therapist's offering of the media and her actions as familiar and meaningful. Movements, scratches, marks, and smudges inherent in clients' creation of an artwork elicit empathy and bodily involvement from the art therapist. A reiterative dynamic of interpersonal neurobiological responses to anticipated, actual, verbalized, and implied movement then inform and promote positive transference.

Relational Neuroscience: Motor, Visual, and Cognitive Systems

Involved in Creative Embodiment are the motor system (Hass-Cohen, 2006a), visual system (Hass-Cohen & Loya, 2008), reward-motivating system, default mode network (DMN) and mirror neurons (MN) (Hass-Cohen, 2007) associated with imagination and creativity (Hass-Cohen, 2016b). Creative Embodiment is further augmented by emotive (subcortical) and cognitive (cortical) interfaces (Hass-Cohen & Clyde Findlay, 2015).

The motor system and the cerebellum. The broad motor system includes the motor cortex and the cerebellum. The motor cortex is adjacent to Broca's language area, and thus "speaking" and creating with one's hands has been linked to communication and expression. The cerebellum plays an important role in motor control and is associated with regulating fear and pleasure responses (Koziol et al., 2013). Providing cognitive and emotive controls, it also receives input from sensory systems (Kalat, 2012). Furthermore, neurotransmitters such as dopamine (DA) released in the art making impacts the basal ganglia, activating voluntary movements. These are important contributions of movement and sensory manipulation to cognitive and emotive interfaces and well-being.

The visual system streams. Two streams help distinguish between attention to the content of the stimuli (*what*) and the relationships between stimuli (*how*) and their spatial location (*where*). The higher stream is survival oriented; it processes movement associated with visual-spatial inputs and guides action. The higher stream is sensitive to implied or explicit threat of movement by humans or the environment. The lower stream processes object recognition, texture, and meaning (Kalat, 2012). The ultimate integration of *how*, *where*, and *what* information is forwarded to the prefrontal cortex (PFC) executive networks. From an ATR-N perspective, creative embodiment represents how visual processing of motor action integrated with symbolic content contributes to cohesive interpersonal function.

The motor and reward system. The reward system produces neurotransmitters that aid in positive and negative emotions. Positive motivating emotions stimulate dopaminergic projections eventually diffusing DA throughout the brain (Carr, 2008). DA also has the potential to rebalance stress doses of cortisol and norepinephrine (Panksepp & Burgdorf, 2006). Triggered by creative arts interventions, movement stimulates DA, which increases positive emotions and motivation, affect processing and reduces inactivity (Baizer, 2014), and negative emotions (Konarski, McIntyre, Grupp, & Kennedy, 2005). Thus, reward system activation helps counteract the primary activation of the fear-amygdala and memory-hippocampal areas during negative emotions (Gray & McNaughton, 2003). Activation of the reward system has also been implicated with

processing in the creative mid-brain neurocircuitry, dubbed as the default mode network (DMN) (Jung, Mead, Carrasco, & Flores, 2013).

Mirror neurons functions. MN function assists in implicit identification of purposeful mouth expressions and hand gestures (Rizzolatti, Fadiga, Gallese, & Fogassi, 1996). As the grasping and handling of the art therapy media, tools, and art become familiar, the anticipation of purposeful interpersonal interaction increases. For example, the quality of therapeutic mirroring will depend on the client's familiarity with the crayons in comparison to other media. It is also likely that the client's MN firing will increase if the therapist's gestures are perceived as goal oriented (Hass-Cohen & Clyde Findlay, 2015). Therapists and clients also have a mirroring reaction to familiar and purposeful content transmitted in the art. For example, dual drawing gestures facilitate embodied attachment, as they echo early infant imitative dyadic learning associated with reciprocal movement. Subsequently, encouraging the use of care-giver infant images will help integrate interpersonal mirroring.

Sophia's Paper Trailing

Sophia is a 35-year-old Caucasian graphic designer who is expecting her first child. Sophia came to therapy reporting that she has been alternatively quarreling with her husband or avoiding him, and has not been sleeping well. She is contemplating leaving her husband and moving to another city. Historically she has frequently “run away” from her problems across the state and abroad. Sophia was asked to “Use the materials and explore a map of where you have been.” After finding a space for a large piece of paper on the floor, she was encouraged to move around the paper and connect her “places” ([Figure 19.2](#)).

The tearing, taping, winding, and circling of her “paper trail” embodied Sophia’s integration of her experiences, cognitions, and emotions. Struggling with how to make the image into a three-dimensional form facilitated the creation of a hopeful symbol of change. Micro, macro, and symbolic movements supported her work. Following the therapist demonstration, she taped and connected her trails, contributing to dyadic imitation and interpersonal neurobiological mirroring. In doing so, both Sophia and her therapist circled her art. As the art making progressed, Sophia shared that before settling down with her husband, she had found that moving helped resolve some of her family issues, in particular her mother’s death in a car accident when she was 11. As a result, she had parented her three-year-old twin sisters. After her father’s remarriage, Sophia left home at 16, returning again and leaving for college and work at 18.



[Figure 19.2](#) *My Paper Trail, My World, My Nest*

Making an art piece that symbolically and kinesthetically connected the places she had lived in helped Sophia to narrate a coherent autobiographical story connecting her past and present life, while creating a nest which she labeled as “safe.” Her novel experience emerged within the intersubjective therapeutic relationship.

Relational Resonating

Principle Description

Relational Resonating embraces co-consciousness, co-regulation, and expressive meaning making. Within attuned art therapy relationships, these positive co-experiences can transform relational insecurity to security. Such attuned therapeutic relationships and communication promote stable internal and flexible psychobiological states, as well as interpersonal interactions. In therapy, social art based exchanges entrain mental representations that have the potential to activate and mend attachment wounds, stabilize affect regulation, update autobiographical memories, reduce the effects of trauma, and contribute to earned attachment.

The Relational Resonating principle underscores that fluid, and stable self-other alignments give rise to self and relational compassion. These rewarding social affects facilitate change, making attachment bonds inherently pleasurable, reducing distress, and attenuating responses to social separation (Machin & Dunbar, 2011; Sbarra & Hazan, 2008).

Imagining, creating, and sharing the art supports a non-threatening emergence of a strong therapeutic relationship (Moon, 2008). Non-verbal expressive communication, innate to art therapy, provides easier access to working with internal implicit working models of attachment. This form of right-to-right hemisphere non-verbal communication is reminiscent of early caregiver-child relationships (Schorre, 2000), and provides a foundation for self-regulation and contingent relationships (Chapman, 2014). Clients with secure relational histories can use past positive relationships for comfort, while those with less secure or traumatic internal models learn to lean on the therapeutic art making and the relationship with the art therapist.

In order to achieve cognitive and emotional flexibility, the art therapist also encourages clients to describe their art. Language engages the left hemisphere (LH), which functions in the middle range of affect and is biased toward prosocial emotions (Schorre, 2000). Thus, across the hemispheres, image making accesses the social-emotional self. As art therapy progresses, recalling, projecting, and altering images of the self and others in the past, present, and future, support the development of current and future relationships and consolidate autobiographical memory.

Relational Neuroscience: Attachment, Affective Systems and Supportive Art Making

The neurobiology of relational resonating and regulation involves the functions of the PFC, the limbic system which includes the fear center (the amygdala, AMY), the memory center (hippocampus) and the mind-body connector (insula) (Hughes et al., 2012). The reward system's neurochemistry, oxytocin (OXY) and the right hemisphere self-functions, primarily the right medial prefrontal cortex (mPFC) and the right orbitofrontal cortex (OFC) are also critically involved.

The AMY. The amygdala, which is responsible for the rapid fear response, is also directly connected to the visual cortex, and thus prioritizes social-emotional cues received from that source. The AMY also automatically coordinates affective interpersonal learning experiences, processing facial expressions, and gazing (Schupp et al., 2007). Connected to the hippocampus, the AMY alerts individuals to memories of fear, aroused by emotional triggers such as color, texture, and shape. The PFC acts to evaluate such potential threats (LeDoux, 2003) and art making can assist in such evaluations (Hass-Cohen & Loya, 2008).

Oxytocin. It is likely that sensory pleasure and pride in the art product stimulate the secretion of the brain's natural reward hormone, oxytocin (OXY), which can then continue to generate positive responses. Serving as a neurobiological feedback loop, OXY strengthens the connections between such cues and rewarding outcomes (Vanni-Mercier, Mauguier, Isnard, & Dreher, 2009). Within the therapeutic relationship, these connections contribute to bonding, and alleviate stress (Diamond, 2001; Machin & Dunbar, 2011). OXY and endogenous opioids increase social behavior, strengthen the internal working models (IWM) of attachment, and attenuate separation distress (Sbarra & Hazan, 2008).

Right hemisphere self-functions. The RH holds the physical-emotional-social self. Accordingly, attuned RH-to-RH communication allows access to implicit emotions and assists in the development of affect regulation (Schorre, 2000). The RH is dominant for intuition, fantasy, and associational and holistic processing

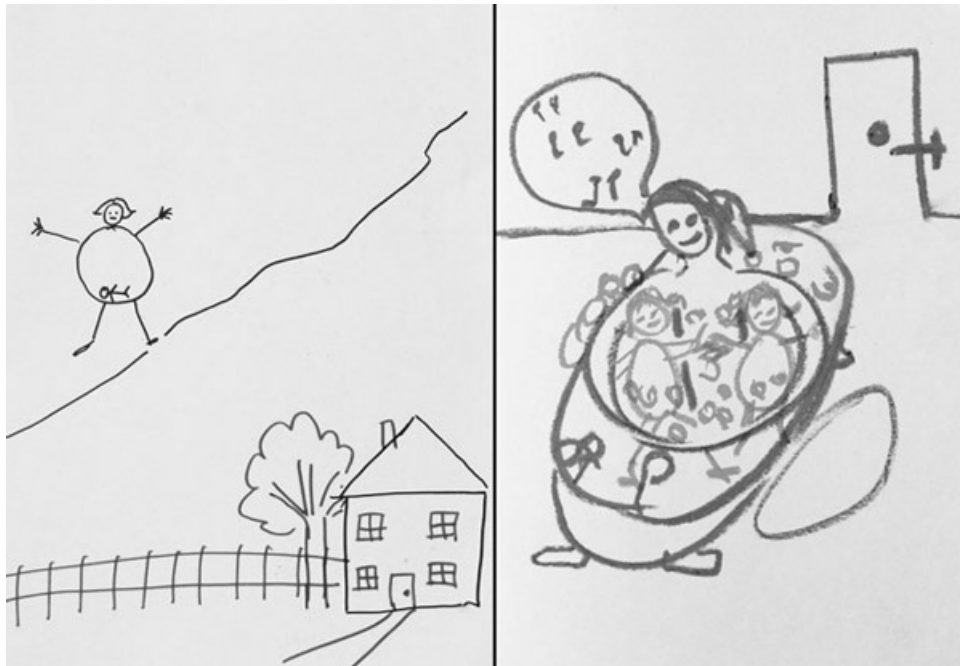
and it responds to both internal and external stimuli. The RH's extensive connections to midbrain circuitry, which is associated with fear and joy, make the RH more immediately responsive to survival-based danger cues than the LH.

RH-based interpretations of the world also form the basis of our social experience throughout the life span (Schore, 2000). Thus, it holds the frontal structures integral to the interpersonal sense of self, particularly in the right OFC and medial PFC. In fact, face-to-face caregiver-infant transactions directly affect the imprinting of the OFC. This structure is also shaped by stressful misattunement, stress-regulating repair, and re-attunement. It is central to the ability to empathically understand the states of others and interpret their intentions. This social circuitry contributes to co-regulation and is activated by left-to-left eye gaze (Chapman, 2014).

The RH also coordinates an organized sense of the body-in-space, a function needed to effectively engage in art-making. Attuned non-verbal empathic exchanges during art making directly access and support such right hemispheric regulation. Explicit left hemispheric functions, that is, actions and cognitions, are also implicated in dampening fear responses and in promoting relational connectivity. Connectivity between the right and left hemispheres is critical to integrated relational functioning (Lieberman, 2007). For example, verbal processing seems to involve a cortical shift from the RH to LH, further modulating affect (Hass-Cohen & Clyde Findlay, 2015). Connectivity between the right and left hemispheres is critical to integrated relational functioning. CREATE ATR-N practices routinely employ a sequence of invitation to art making, creation, titling by the artist and narration by the artist.

Sophia's Stitch in Time

As therapy progressed Sophia expressed fears that her issues would actively harm the well-being of her unborn child. The therapist asked Sophia to divide her page into two, and to draw on one side her fears about the baby and on the other a supportive relationship. The purpose was to align a positive relationship with the new relationship. Such alignment would hopefully help her access an internal working model of relational security ([Fig. 19.3](#)).

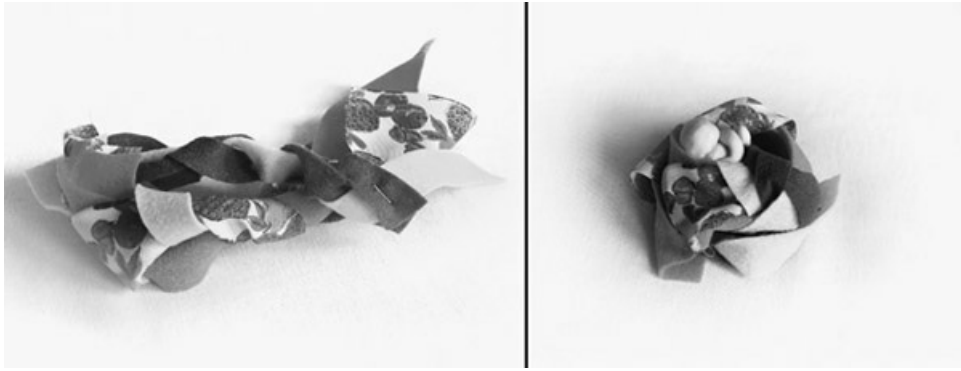


[Figure 19.3](#) On the left: Right Now. On the right: A Safe Relationship, Me, and the Twins

When looking at the art, the therapist and client were struck by the floating and fragile representation of the baby in the left-hand image. The small baby is lying in Sophia's large empty stick figure abdomen, although the upward gesture of the mother's arms suggests a secure attachment base (Fury, Carlson, & Sroufe, 1997; Hass-Cohen, 2006b), the details suggest anxiety. Furthermore, Sophia's form floats above the house, perhaps indicating fear based dissociation that is overriding her cognitive functioning. This is in contrast to the more grounded drawing of the house, door, pathway and tree, which give rise to hope.

In comparison, the image of Sophia and her sisters on the right is in saturated blue, pink, and yellow colors and thus expresses positive affect. The oil pastels Sophia chose leave thick, confident lines easily expressing a positive memory of love, hugging, and safety. Talking with Sophia about the two images soothed her and inspired her good mothering hopes; taking care of her baby now would not deplete her as when she was an adolescent parenting her twin sisters. Thus the autobiographical exploration helped her generalize a felt sense of love and softness.

In support of bonding, the therapist then invited Sophia to explore her cache of fabrics, and to pick fabrics that reminded her of the closeness with her sisters. Spontaneously she combined them into a braid that she later tied to her car keychain, which she would be likely to touch every day. The process would remind her of her love for her sisters and hopefully bind positive childhood memories with current relationships. The visual-tactile reminder could stimulate and reconfirm Sophia's positive internal models of attachment. Associated with warmth, covering, clothing, protecting, and touch, manipulating the fabric gave access to implicit memories of bonding, perhaps encouraging not only affect regulation, but also supporting cortical executive mastery. Later, Sophia wrapped a small polymer clay figure representing her baby with the braid.



[Figure 19.4](#) [A Stitch in Time on the left. All Wrapped Up on the right.](#)

These reiterated symbolic processes may have stimulated OXY release. Research also suggests that there is a four-to-six hour window for the updating and consolidation of recalled memories with new, similar yet different information (LeDoux, 2003). The key-chain braid serves to extend the session time into this window of opportunity. After the session, as Sophia drives home, the keychain continually reinforces the link between Sophia's positive IWM with her sisters and her current relationship with her unborn child ([Figure 19.4](#)).

Intentionally using cloth, which stimulates early sensory pathways of touch, increased Sophia's access to implicit memories of positive attachment with her sisters, which was then transferred to the soft wrapping and holding of the unborn child. These directives demonstrate ATR-N sequencing; making implicit information explicit, integrating emotional and cognitive functions, reworking imagery to move toward change, finally consolidating coherent narratives.

Expressive Communicating

Principle Description

The vivid and sensory qualities of art media alongside the inherent ambiguity of the art-making processes evoke strong emotions and present an opportunity to express, communicate, and regulate. Expressivity supports creativity, allowing for the development and emergence of a repertoire of diverse solutions. Expressivity and creativity charge the reward circuitry and help maintain a dynamic balance between excitation and tranquility. Such balancing facilitates affect regulation and increases the cognitive capacity to tolerate emotional frustration and to experience joy, satisfaction, and relational security.

Therapeutically, positive emotions have been associated with safeness, self-mastery, pride, gratitude, and love (Seligman & Csikszentmihalyi, 2000). Happiness and pleasure are supported by attitudes and behaviors such as curiosity, playfulness, and creativity. Positive emotions, which are part of instinctual survival based reactions, contribute to creating physiological equilibrium and homeostasis (Panksepp & Burgdorf, 2006), as well as to developing and maintaining resiliency. Over time, this broadening of affect (Fredrickson, Mancuso, Branigan, & Tugade, 2000) can become habitual. It contributes to adaptive responding and to the development of critical personality traits such as optimism, insight, self-confidence, and an interest and capacity for meaning-making (Linley & Joseph, 2004; Maddi, 2006).

Relational Neuroscience: Co-Existing Positive and Negative Activation, and the Dual Influences of the Default Mode Neuro-network

There are several models of emotions (Demaree, Everhart, Youngstrom, & Harrison, 2005). Dimensions of emotions include: (a) emotions associated with arousal, hypoarousal, and calm, which are mediated by the interface of subcortical and cortical structures; (b) motivational and pleasure biased emotions, which are supported by the reward system; (c) basic emotions expressed by facial expressions (Ekman, 1992), which are modulated by the brain stem and connections with the polyvagal complex; and (d) left hemispheric positive feelings versus right hemispheric negative emotions. Positive affect has been linked with the striatum, a limbic region that includes the caudate nucleus and putamen. This region helps coordinate motivation with body movement. More specifically, the striatum facilitates and balances motivation, taking into consideration higher-level and lower-level motor functions (Wise, 2008). Positive emoting may undo the influences of negative emotions that remain following trauma; positive emotions act to bring about positive outcomes as well as to negate negative outcomes. Under therapeutic conditions, art making can start to provide motivational and pleasurable experiences that counteract negative lifecycle events and the impact of trauma.

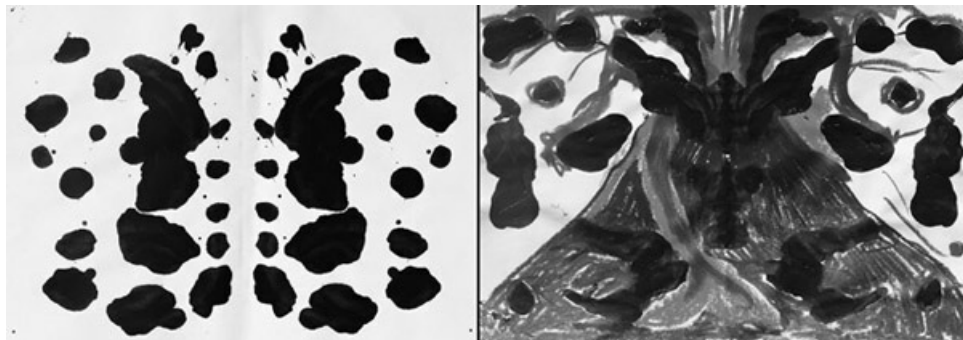
Expressive communication includes the DMN functions, which are involved in reflective and divergent thinking (Raichle & Snyder, 2007) and in creativity (Jung et al., 2013). The DMN is involved in reflection and generation of divergent solutions during resting states. Resting or default states occur when we disengage from external cues or triggers. The DMN includes the mPFC, midline frontal and lateral parietal structures, and the medial and lateral temporal-limbic regions (Spreng & Grady, 2010). The higher-executive areas of the PFC and the sensorimotor strip are engaged in art making, as well as in any life solutions brought by such creative reflective thinking.

In art therapy, we take advantage of daydreaming and rumination to create tangible solutions in the form of art products. This is in essence creativity: the generation of divergent possibilities followed by an expression of a solution. Thus, ATR-N therapeutic interventions can be designed to take advantage of the neural linkages between intersubjectivity, autobiographical memory, executive function, and creativity. This means that the retrieval of memories and executive functions associated with the PFC, when combined with imaginative processes associated with the DMN, are then linked to positive outcomes of creative expression (Beatty et al., 2014).

My Volcano

Throughout therapy Sophia complained about not knowing how to express or talk about her anger. She is reminded of her mother's angry attacks and does not want to be like her. She was therefore invited to playfully try a dribble/Rorschach painting using black paint on folded paper. The therapist, mindful of the advantage that engaging the DMN may provide, asked Sophia to rest for a couple of minutes with her eyes closed while the black paint dried. Then she asked Sophia to further elaborate on the image ([Fig. 19.5](#)).

Sophia developed her 'volcano' image on the right with saturated colors of orange, yellow, brown, and green, suggesting sensory arousal. The anger she described getting in touch with, through the explosive movement, colors, and sound, was dynamic and invigorating rather than overwhelming. The richness of the green base and fertile brown hill also suggested growth and containment. Sophia described how shifting from a sense of dread toward her anger to perceiving it as an orange fiery energy was empowering.



[Figure 19.5](#) Splat (left) and My Volcano (right)

Adaptive Responding

Principle Description

To assist clients in developing adaptive coping skills, art therapists use demonstrative therapeutic interventions that balance and support optimal arousal, safety, and expressivity. The simultaneous experience of these states helps to contain the tangible representation of stress and trauma, de-sensitize difficult emotions and intrusive memories, and generate new solutions. The CREATE ATR-N practices are intended to foster optimal neural firing—repeated synchronized activation of neural networks with repetitive coping and success.

As such, the approach is active, involving simultaneous art-making, meaning-making, and contextual memory processing. A juxtaposition of stress and excitation can elicit clients' expression of conflicting feelings and increase their tolerance levels for strong affect. Making art can safely support a nonverbal, felt, and sensory discovery of one's past and current attachment strategies and style. The creation of art provides for emotional relief and self-regulation through tangible and concrete distancing. The complexity of the art directives described above lays a foundation for clients' adaptive coping, as well as for resiliency and relapse prevention.

Relational Neuroscience: The Neuroscience of Resiliency and Vulnerability

Governed by the nervous system's checks and balances, adaptation to stress requires a stabilization of basic life functions and protective resiliency (McEwen, 2013). Adaptive Responding involves functions of the (1) polyvagal complex (Porges, 2001); (2) short-term sympathetic noradrenaline stress axis; (3) long-term endocrine stress axis; and (4) reward, catecholamine, and serotonergic systems.

The stress response involves several complex responses: (a) a freezing and shaking response (Levine, 1997); (b) a flight-or-fight response, for example, a protective in-control response such as running away (Henry & Wang, 1998); (c) a turning to safe others and places (Tomova, von Dawans, Heinrichs, Silani, & Lamm, 2014); (4) and a long-term hibernation process (Sapolsky, 2004). Over time, a chronic stress response may have a severe impact on a person's sense of well-being, contributing to immune system dysfunction and other health issues (Clyde Findlay, 2008).

The first response, freezing, is a primitive immobilizing reaction, associated with the hyperactivation of the parasympathetic nervous system. The second, flight-and/or-flight responses, are masterful and excitatory sympathetic nervous system reactions. They are mediated by the AMY and the sympathetic/adrenal medulla axis (SAM). The sympathetic nervous system response also involves the secretion of noradrenaline (NE), released by the adrenal glands. The third, a social response, involves a parasympathetic, calming reaction.

The fourth, the long-term stress response, represents a state of endocrine endurance; reacting to events that are perceived as uncontrollable, and arousing feelings of helplessness and hopelessness (Henry & Wang, 1998). It is mediated by the hypothalamic-pituitary-adrenal (HPA) axis and the secretion of cortisol. Cortisol shuts down all functions that are not immediately needed, conserving energy to deal with the situation at hand. Cortisol is very efficient in coping with stress as it allows us to forget, and in so doing, ideally assists in turning off the stress response and increasing protective coping. However, an unrelenting secretion of cortisol representing a failure to hinder the stress response can have detrimental effects (Sapolsky, 2004). These include comprised immune as well as cognitive, memory, and executive functions (Popoli, Yan, McEwen, & Sanacora, 2011). Unless resolved, such long-term stress may result in mental health, cognitive, and physiological disruptions (Sapolsky, 2004).

In contrast, benign stressors can trigger a search for pleasure and proximity, thereby promoting the rebalancing of altered physiological and psychological states (Esch & Stefano, 2005). Because of neuronal plasticity, this can result in changes in internal representations of attachment (Roisman, Padrón, Sroufe, & Egeland, 2002). Psychologically, using the art to balance avoidant or negative and helpless responses with assertive or positive ones allows clients to regain their sense of being in control.

Sophia's Box

Sophia struggled with negative self-judgment, stress, anger, and unresolved long-term grief and oscillated between feeling irritable or numb. These reactions were compounded by her expressive avoidance, which contributed to a mismatch between her inner and outer worlds. To decrease her stress by matching internal experiences with external responses, the therapist asked Sophia to decorate the inside and outside of a box. She chose collage; those images she glued on the outside were to show how others see her coping with stressors, and those on the inside were to show her internal perception of her stress ([Figure 19.6](#)).



[Figure 19.6](#) *My Inside-Outside Box*

Sophia used the same symbols that had once represented negativity, an oceanic volcano and the color orange, to represent coping, indicating a growing sense of mastery and ability. She also chose friends to represent coping; this is interesting, as women are more likely than men to turn to others at times of distress (Tomova et al., 2014). After the therapist shared this information with her, Sophia added some additional images of women. She wistfully stated that she now understands why her husband tends to leave the house when they have a fight, while she would like to come closer to him.

In the following session, Sophia's inside-of-the-box revealed two opposing states: vulnerability expressed in an image of a young child, and a beautiful softness of a younger inward-looking contemplative self ([Figure 19.7](#)).

Sophia talked about the challenges she faced, given that she had lost her mother at such a young age. Together with her therapist, they reflected that unlike a volcano, the lid on the box can be shut or opened, thus developing a sense of mastery and control over the jittery activation of her nervous systems. Sophia experimented with closing and opening the lid, commenting that as she takes a breath between the inside and outside, she is able to take the outside imagery inside and the inside imagery outside. She was particularly intrigued by what the creative curiosity of the child from within could bring to her day-to-day coping. She also placed another image of a woman in the box, explaining that this symbolized herself mothering her internal personhood and completing the mourning of her mother. To her therapist's surprise, she also placed her baby and fabric piece "All Wrapped Up" inside her collage box ([Figure 19.8](#)).



[Figure 19.7 Inside My Box: Peekaboo](#)



[Figure 19.8 My Sculpture in My Box: Feeling Little](#)

Sophia's newfound plan, to hold her baby safely, represents increasing self-identification and attunement, as well as her dynamic capacity for finding adaptive and resilient solutions. Within the therapeutic relationship, these isomorphic expressive and contained events can provide corrective emotive experiences, along with a promise of altered physiological and psychological states.

Transformative Integrating

Principle Description

Transformative integrating of images and autobiographical memories occurs over time. This requires repeated associations of successful and supportive mentalizing, attuned and sensory expression, and secure affective relational experiences. Thus the exploration of kinesthetic expression and visual conveyance of meaning, accompanied by non-verbal and verbal affirmation, allows for functional integration of the emotional and cognitive centers of the brain. Then, a negative memory may be reinterpreted as a positive experience through comprehension, action, and acceptance. The formation and maintenance of memories is labile, meaning that consolidated and established memories, if recalled and destabilized, are susceptible to change and reconsolidation (Schwabe, Nader, & Preussner, 2014). Through ATR-N-based therapy Sophia's remembered, established and difficult memories of her mother's outbursts and loss were updated with newer experiences of friendships, bonding, stress reduction, growth, and hope.

Relational Neuroscience: Vertical and Horizontal Integration

ATR-N-based directives and the narrations of the client's art further concretize the integrative functions of self and social mentalizing processes. This transformative integration synthesizes cognitive functions, such as attention and insight, with somatic experiences, tactile experiences, emotion, motivation, and motor control. Furthermore, synchronized client and therapist psychobiological attunements promote various directions of neurological integration.

Emotional expression and sharing, which entail bottom-up information processing, can link subcortical awareness with cortical cognitions, contributing to increased awareness, acceptance, and interaction. Naming, and discussing the art process and product further deepens awareness and understanding. Such vertical integration is promoted by coping with the arousal of self-exposure to others, while negotiating relationships and moving in space. Another key function involves the cortical embracing of reactivated autobiographical attachment memories.

Expressing and explaining the art can integrate right hemisphere holistic forms of thinking with left hemispheric analytic language based processing. Hence, art-making requires the activation of right hemispheric visuospatial perception and non-verbal imagery, along with left hemispheric linear processing of verbal and written reflections. This horizontal integration, is also cued by theory of mind relational representations, such as a dual drawing.

Integration also occurs within midline brain pathways that hover on the borders of the cortex and the limbic system. Midline brain pathways and executive prefrontal functions are involved in effective integration of autobiographical memories, theory of mind, mentalizing functions, and creativity. Creativity is associated with the DMN generation of alternative perspectives or imagined scenes (Beaty et al., 2014). This integration involves activation of regions anterior to the visual center, underscoring the critical role of the expressive arts.

Empathy and Compassion

Principle Description

Mindfulness, empathizing, and empathic attention provide a gateway to compassion and nurture the desire to relieve self and others' suffering (Neff & Germer, 2013). Empathizing is about compassionately putting oneself in one's and the other's "shoes." Pro-social empathizing involves deliberately monitoring one's shifting thoughts, feelings, and perceptions, as well as adopting kindness-based values. These mindful actions promote secure attachment and can positively transform the self-other dialectic. These activities and skills are particularly important for individuals with whom utilizing the advantages of creative embodiment, relational resonating, and expressive communication can be a challenge at the beginning of treatment (Hass-Cohen, 2016a).

The art therapist's empathy, including sensitivity to embedded relational transactions, is associated with the offering and sharing of art media, and the unconditional acceptance of the art product. The therapist, with her third hand, third eye, or second mind, overtly and symbolically empathizes with what the client needs. Holding a client's page, mending a fragile piece, carefully wrapping a finished object and safely storing art works conveys deep relational care. Mirroring, echoing, and imitating clients' hand gestures convey understanding and empathy. Different types of touching of the art or references to its tactile qualities convey relational interest and caring. The client also has the opportunity to mimic the therapist's hand gestures and work, conveying understanding and empathy. Such reciprocal implicit dialogue moves the client toward experiences of anticipated and experienced aid.

Relational Neuroscience: Functions of Mirroring Systems, Appreciative Joy, and Creativity

The capacity for empathy is a reflection of the functioning of integrated neuropathways, and includes activation of norepinephrine (NE), OXY, and DA. Empathizing has also been linked to MN's responses to familiar movement, and to the firing of mirror neuron systems' (MNS), which is evoked by familiar familial relationships. MNS activate in response to another's suffering (Rizzolatti & Craighero, 2004). For example, when pain is inflicted upon a loved one, one's own pain circuitry is also activated (Singer, 2004). Although we do not actually feel the physical pain inflicted on our beloved ones, we cringe as if we do. The understanding of these mirroring responses embodies and brings to life empathic reactions to art. An earned state of empathy and self-compassion is an intersubjective experience, which only happens because we have experienced it ourselves.

My Compassionate Past, Present, and Future

Often times, it is very hard for people who have experienced long-term stress and traumatic events to make progress in therapy. This can be due to engrained modes of being as well as neurochemical alterations (Lanius, Frewen, Vermetten, & Yehuda, 2010). Individuals who have experienced chronic unrelenting stress or trauma will often self-blame and feel guilt, which contributes to their depression and alienation from others. This lack of self-empathy also presents a risk for relapse. Sometimes it is easier for clients such as Sophia to access positivity through conjuring and imagining support and empathy from others.

To support Sophia's compassion for her herself, her unborn child and budding family, the therapist suggested that she make three images of her past, present, and future—as someone who loved her would see it. This directive also has the advantage of stimulating anticipation for a positive future, thus strengthening autobiographical functions.

Drawing this sequence helped Sophia lean on kind, loving images of connection to others. The drawings elicited Sophia's emerging visual, symbolic, and relational strengths. Compared to the first drawing of her fears for her pregnancy ([Figure 19.3](#)), the drawing here is elaborated, detailed, and made with confident lines. Discussion of the first image, representing the places where Sophia had traveled and worked, no longer caused her memory or representation to be fragmented, as in the "Create a Map of Your World" directive ([Figure 19.3](#)). The request to experience another's compassionate empathy conjured up a vital relational resource for Sophia

that she could call on in the future, and confirmed her collage images identifying friends as a coping resource.

The second image of Sophia's pregnancy is striking in its fullness and appeal. Compared to her initial see-through, floating initial drawing, this figure sits solidly and centrally on the page, with a more detailed face, wearing a smile and lovingly touching her pregnant belly. The third image, of Sophia's future, reveals an integration of her previous imagery; her torn paper nest and her baby wrapped in fabric, which now include her husband and child, in a nest-like embrace ([Figure 19.9](#)).



[Figure 19.9](#) [My Compassionate Past—My Adventures \(left\)](#), [My Compassionate Present—Me and My Belly \(middle\)](#), [My Compassionate Future—My Nest \(right\)](#)

The orange color, which first emerged in her volcano painting, was used by Sophia to highlight her drawings, also suggesting her integration of a sense of energy and mastery. The appearance of the orange sun in the top right hand corner of the middle image, and its continuity across to the third image, implies integration of right and left hemispheric functioning. The recurring nest-like image of a compassionate future suggests increased security. This “nest” became symbolic of her intentions for her future; her ability to connect with trusted others, and her deepening connection with her baby. As demonstrated by Sophia's change the ATR-N CREATE principles of Creative Embodiment, Relational Resonating, Expressive Communicating, and Adaptive Responding serve as doorways to Transformative Integrating and to pro-social Empathizing and Compassion.

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Part VI
Systemic Approaches

20

Family Art Therapy

Barbara Sobol and Paula Howie

Our lives begin and unfold within the context of families that shape and, in most instances, support our development. However, only since World War II has family therapy come into prominence as a viable treatment modality, with many recent adaptations. The focus is increasingly moving beyond the closed system of the self and his or her conflicts to an open, larger system or systems of which the person is a part. "The individual patient is being viewed from a relational perspective, in terms of the early contacts with important others in his or her life and the emotional roles the patient has assumed within the family" (Singer, Klein, & Bernard, 1992, p. 16).

History of Family Therapy

Family therapy has roots in social work, anthropology, and psychoanalytic psychotherapy. Sigmund Freud, in renouncing his own seduction theory at the beginning of the century, effectively shifted the focus of the psychoanalytic community away from actual events and relationships in families and toward the study of the individual's developing internal mental life (Masson, 1984). The relevance of actual ongoing family life did not recapture the imagination and scrutiny of most psychotherapists until mid-century. In 1950, child psychiatrist and psychoanalyst Nathan Ackerman urged the treatment of whole families in child cases (Ackerman & Sobel, 1950). Around this time, John Bowlby (1988) and his colleagues were beginning to conceptualize the importance of early child/mother attachment and its significance for normative development. Elsewhere in the 1950s, other prominent analytically trained psychiatrists were engaged in clinical research on the etiology of schizophrenia. Among them were Murray Bowen at the National Institutes of Mental Health in Bethesda, Maryland, Lyman Wynne, Bowen's successor at NIMH, and Don Jackson at Chestnut Lodge Hospital. The study of individual patients expanded to include observation of their families. Family communication—rife with denial and distortions—was studied to determine to what extent it might contribute to, if not sustain or cause the symptoms of schizophrenia.

In 1959, Don Jackson joined anthropologist Gregory Bateson, psychiatrist John Weakland, and sociologist Jay Haley at the Mental Research Institute (MRI) in Palo Alto, California, an organization with a grant to study the broader issue of the nature of communication itself. From this early eclectic collaboration, a new theory of family systems began to take shape, driven by Jackson's research interest in schizophrenia, Bateson's study of cybernetics (the science of closed information systems and their self-correcting properties), and Haley's fascination with psychiatrist Milton Erickson's techniques to effect change through paradox and hypnosis.

While Bowen and Wynne remained committed to exploring a family's history as a way to shed light on the current emotional system, the MRI group made a radical conceptual and methodological shift, focusing solely on the here-and-now operations of the family system (Kerr, Hoshino, Sutherland, Parashak, & Mc-Carley, 2008, p. 32). Leaders in the family therapy movement developed treatment interventions to interrupt, amplify, or otherwise disturb the ongoing operations or organization of a family system as first steps toward introducing new and healthier patterns of interaction. Jay Haley (1991) and Cloe Madanes (1981), proponents of *strategic family therapy*, believed that families could get stuck in interactional patterns that maintained problem behaviors, no matter how well-intentioned the desire for change. Strategic therapists made use of dramatic paradoxical directives and other creative behavioral prescriptions to jolt a family system stuck in repeated and unsuccessful attempts at solving a specific presenting problem.

Salvador Minuchin (1974) formulated *structural family therapy* in his work with socially and economically disadvantaged families. Minuchin believed that problems are maintained by dysfunctional family organization. "Structural treatment is designed to alter the organization of the family" so that families could develop more competence in solving their own problems. "The goal of therapy is structural change" (Nichols, 2011, p. 129).

Much of the new therapy was outspokenly anti-psychoanalytic. Little or no value was placed on insight; a high value was placed on short-term treatment, on maintaining the therapist's objective and expert stance, and on behavioral interventions—either straightforward or paradoxical—intended to stimulate change across the whole family system.

Throughout the 1960s and 1970s, analytically based family treatment and the new systems paradigm developed along mainly separate lines and were often treated as incompatible. However, both schools of thought benefited from an inevitable cross-fertilization and from an influx of new ideas. Early systems theory was rocked and revised by feminist principles (see e.g., Luepnitz, 1988; Walters et al., 1988) and by the ideas of social constructivists (see e.g., Anderson, 1992), resulting in a partial return of subjectivity and a higher level of personal engagement and collaboration between therapists and families. Psychoanalytically based family therapy acquired a new richness through the influence of object relations theory and the willingness of some in the analytic community to acknowledge the value of a systems approach, particularly strategic and structural formulations (Cf. Slipp, 1984).

Core Concepts

From among the evolving concepts and principles of family therapy, a number have endured over time, and to a greater or lesser degree underlie all schools of systemic thought, no matter how diverse. Each of these core concepts describes a key aspect of family life; they have been organized by the authors into a family art therapy observational tool, the “Eight Ways of Looking at a Family” (Howie, Prasad, & Kristel, 2013). The “Eight Ways” model creates a useful lens through which the art therapist can observe a family and develop a fuller understanding of family dynamics. Later in this chapter we will use the “Eight Ways” to organize information gleaned from our observations of drawings made in a family art session.

Each conceptual category described below reflects essential theoretical viewpoints of one of the major approaches in family therapy: a developmental approach; a strengths-based, resilience approach; the impact of culture; communications and behavior theory; structural theory; a range of theoretical approaches dealing with the unconscious underpinnings of family life (psychodynamic; object relations; attachment); an art-as-therapy approach; and a recognition of “the self in the system” (Nichols, 2008).

“Eight Ways of Looking at a Family”

Life Cycle

Every family has a natural developmental *life cycle* with identifiable and predictable phases and crisis points (Carter & McGoldrick, 2004). Events and dynamics of preceding generations powerfully influence how a family handles the critical transition points in its development. A family that is comfortable in one phase of the life cycle (for example, caring for an infant) may not necessarily be comfortable in a subsequent phase (for example, dealing with an adolescent). Therapists from different systems-oriented schools, from Bowenian to strategic, incorporate life cycle concepts, making use of the *genogram* (a three-generation family map) that invites a family to recognize and explore its own development and history.

Resilience

Every family has its strengths or qualities of resilience that can sustain the family and its individual members through difficult times (Walsh, 2002). Family resilience can be a resource even in the most trying of circumstances, and can help to protect family members from recurring traumatic influences such as poverty, mental illness, and physical illness. A strengths-based approach can help the family to identify the resources they possess, such as humor, caring relationships, and an ability to work together.

Family in the Culture

Every family operates in a culture and society, and both influences and is influenced by the society that surrounds them (McGoldrick, Giordano, & Garcia-Preto, 2005). The influence of culture on the family cannot be underestimated. The family lives within a context that can add to its resilience, or can be a source of constant strain and conflict. Ethnicity is a consideration, as it may have a profound influence upon the family members' identity development.

Communication/Behavior

In every family, *all behavior*—verbal and nonverbal, active or passive—*is communication* (Watzlawick, Beavin, & Jackson, 1967). Within the family system, communication unfolds in a circular or recursive manner, rather than in a linear or simple cause-and-effect fashion. Families tend to respond to uncomfortable or unacceptable deviations from their habitual circular (and possibly dysfunctional) patterns of behavior by initiating interactions, often non-verbal signals that pull the “deviant” member back into compliance with the familiar ways of relating. A crisis may occur when a family's automatic signaling fails to correct the deviant behavior.

Structure

Every family has a discernible structure. that is, “its members behave among themselves in an organized, repetitive manner and...this patterning of behaviors can be abstracted as a governing principle of family life” (Jackson, 1965, p. 116). For example, both physical and emotional boundaries within a family are a part of its structure, and in part determine which behaviors or interactions are acceptable and which are not within the family's unwritten rules or norms. In order to observe family structure *in vivo*, a family therapist may invite a family to create a *reenactment*, that is, to interact during a session as they would at home (Nichols, 2008).

Unconscious Life of the Family

Every family member has a largely unconscious, subjective life of attachments, thoughts, emotions, and representations of self and other that are experienced internally. This unconscious activity profoundly affects the here and now. It may largely determine how particular structures evolve within a family, how emotions are expressed and relationships experienced. The network of internal projections, expectations, and wishes can bind a family together in healthy or unhealthy ways. Therapists who utilize this principle are likely to be exploratory and interpretive in their work with families, with the intent of bringing unconscious aspects of

family process into awareness for contemplation or reflection (Nichols, 2008).

Themes and Metaphors

At a level beyond words and behavior, every family may express its emotional life in the themes and metaphors it creates through its use of expressive arts. Metaphors and themes may be conscious ideas and wishes that are important to the family; they may also be unintended communications from the unconscious interior life and longings of family members, and as such can be a surprise to the artist or to others. Themes which may be apparent are those of alliances, protection of a smaller or more impaired member, differences in focus, and otherwise unexpressed secrets, such as a desire by a member of a divorced family to return to an earlier time. When powerful yet unintentional themes arise in the imagery during an art therapy session, the artist may acknowledge, deny, or alter the apparent meaning.

The Individual within the System

Every individual may be seen both as part of the whole system and as an individual self (Nichols & Schwartz, 1991). It is often a symptom of an individual family member that overwhelms the family's coping resources and brings the family into therapy (Nichols, 2008). When we consider the system as a whole, keeping in mind its unique character, we must not overlook the influence of the individual upon the family. Does the individual rebel, support, or become dragged down by the family? Conversely, does the family assist in its member's individual development or impede it in subtle or overt ways?

Development of Family Art Therapy

Family art therapy most certainly began with the work and writings of Hanna Yaxa Kwiatkowska (1978), who was an art therapist at NIMH from 1958 to 1972, and who worked in close collaboration with Lyman Wynne. As part of Wynne's research on schizophrenic adolescents, she developed the *Family Art Evaluation (FAE)*, a modification of Elinor Ulman's (1996) diagnostic assessment for individuals. She also created models for adjunctive art therapy and art therapy as a primary treatment for families. Kwiatkowska trained a number of art therapists at NIMH and at the George Washington University, including those who established family art therapy at the Walter Reed Army Medical Center, where her family art evaluation was used as a model for family intervention until 2002.

Following Kwiatkowska, other art assessments were developed, for whole families (Landgarten, 1987), for couples (Wadeson, 1987) and for families with young children (Rubin & Magnussen, 1974). Others, including Consoli (1994), modified the use of the Kwiatkowska FAE. In 1989, The American Art Therapy Association (AATA) recognized family art therapy with a plenary session at its annual conference. By the mid 1990s, AATA had also established a regional symposium on family art therapy, in recognition of its importance for training art therapists across the United States.

Family Art Therapy Today

Family art therapists blend a commitment to the use of graphic expression to promote psychological healing and growth with a commitment to thinking *systemically*. Understanding a client's symptoms as inextricably related to the current ongoing dynamics in his or her most intimate environment, the family art therapist engages some or all of a client's family in artmaking with the therapeutic objective of *creating change* throughout the family system.

In tracing her own evolution as a family art therapist, Shirley Riley (Riley & Malchiodi, 1994) suggested that art therapy is a fluid modality that may be adapted to support any number of theoretical approaches to family therapy (p. 17). Given the proliferation of ideas and techniques in both family therapy and art therapy, the precise "look" of a course of family art therapy may vary widely in both rationale and methods.

For example, "family art therapy" may describe Kwiatkowska's (1978) 18-month treatment in which she used art to explore feelings and relationships and made analytically based interpretations to the family (pp. 137–175). It may also describe Carol Cox's (1992) brief treatment in which she used art and strategic therapy directives to address the painful aftermath of sexual abuse within a family. Similarly, it can refer to a model for short term crisis intervention (Linesch, 1993); a model that follows a social constructivist or narrative therapy framework (Riley & Malchiodi, 1994, pp. 17–36; Kerr et al., 2008, pp. 193–219); a model that uses the principles of paradox (Kerr et al., 2008, pp. 87–118; Sobol, 1982); a model of ongoing artwork within the context of play therapy (Gil & Sobol, 2005); a model combining case management and art therapy with inner-city African-American families (Doby-Copeland, 1999); and a model using family landscapes to describe a symbolic distance between family members' experiences (Arrington, 2001). All fit comfortably under the broad umbrella definition of family art therapy.

Using Kwiatkowska's Family Art Evaluation (FAE) for Assessment & Treatment

Hanna Kwiatkowska's (1978) theoretical approach and assessment procedures continue to provide a strong foundation for treating family systems with adolescents as well as families with younger children. Used as either an assessment procedure or as a series of clinical interventions, the FAE allows the art therapist to gain an understanding of a family along all eight core dimensions of family life described earlier in this chapter.

As a family moves through the series of tasks in the FAE, a multidimensional "portrait" emerges that elucidates this family's unique relational experience. The series of drawings may also be understood as a metaphorical reenactment of family patterns, a visual narrative of a family's response to the stress of an unfamiliar situation, or even as an unfolding "conversation" spoken through imagery among family members. Additionally, a receptive art therapist can locate the "emotional center" of the session—a defining moment, image, or set of images that have captured a deep, but usually unarticulated truth about the emotional

relationships within the family.

The authors use a modified form of Kwiatkowska's original FAE, both as a teaching model and in clinical practice. Modifications include combining Kwiatkowska's original two procedures—the representational and the abstract family portraits—into a single procedure, and shortening the time given to complete the “individual scribble” before going on to the “joint” family scribble. The changes were made primarily to reduce the length of time needed to complete the session. Completion of the entire modified FAE with a small family may take one and one-half hours or less. During that time, family members are drawing in response to their own inner promptings as well as to the constant communication evolving within the whole family group.

The information yielded by a careful reading of an FAE can help the art therapist design clinical interventions that can aim for a range of outcomes, from behavioral change to deep insight. The family art therapist may use a non-directive approach or may draw from a wealth of techniques created or adapted for use with families, including a family mural (Rubin, 1978), magazine collage (Landgarten, 1987; Linesch, 1993), family book (Junge, 1985), construction projects (Riley & Malchiodi, 1994), or work in clay (Keyes, 1984; Kwiatkowska, 1978; and Kerr et al., 2008) to support the clinical goals. The following case illustrates how images drawn in an FAE may illuminate the relationships within a family and point toward a direction for the art therapy treatment.

Case Illustration: Darrell

(Note: Darrell is an adolescent seen originally by author B. Sobol. Later, both Sobol and Howie reflected on this case in their teaching at the George Washington University. The descriptions and comments, written here in the first person, reflect the thoughts of both authors.)

Darrell was referred to my child and adolescent public health clinic twice in one year. As the art therapist, I was expected to balance individual therapy, family therapy, art therapy, and case management in my treatment. At the time of the initial referral, this bright, gifted 16-year-old African-American boy was on the verge of expulsion from high school for disruptive and oppositional behavior and poor academic performance. Darrell was the only child of his single mother, who had given birth to him when she herself was 16. At the time of the referral, she was in recovery from cocaine addiction and was working as a secretary.

When not in school, Darrell spent most of his time during the week alone at home. On weekends, he spent a great deal of time at his maternal grandparents' home in a neighboring county. His father was only peripherally involved in his life. Darrell's family on his mother's side had a strong connection to their church community; as a gifted singer, he was often a soloist in the church choir. Darrell also had a history of attention deficit disorder. After one brief, unsuccessful trial of Ritalin in the sixth grade, his mother declined further trials of medication.

Only three family therapy sessions were held before Darrell broke his most recent behavioral contract at school and was expelled, then swiftly transferred to an alternative public school. In the only session in which the full family was present (Darrell, mother, grandmother, and grandfather) a painful dynamic between the mother and grandmother was exposed. As the family discussed making plans for Darrell, the grandmother appeared exasperated and critical toward her daughter. Darrell's mother, unable to contain her resentment at her perception of a lifelong experience of rejection, deflected the session away from problem-solving and directly toward her own pain.

As soon as Darrell was transferred to the alternative high school, the mental health team at the new school took over the individual and family treatment. They used a structural model of family therapy intended to empower the mother as the main authority figure for Darrell, and to require the grandmother to play a more minor role. Although there was a great deal of optimism at the outset, within three months Darrell was permanently expelled from the alternative school and soon after, he was permanently and legally "withdrawn" from the county public school system. The family was again referred to my clinic, by now the only available venue for therapy in the county system.

In reviewing the second referral for therapy, I read that although the mother had seemed enthusiastic about her newly empowered role, she had not been able to sustain her commitment. As she fell away from the required family sessions, Darrell increasingly flaunted the most basic rules of his school program. With the absence of Darrell's mother, it seemed that while "solutions" to "problems" were being tried, a critical level of information was missing about the emotional dimensions of the family relationships. Because of this, perhaps, all attempts at behavioral problem solving were destined to fail.

I recalled the raw and bitter emotions that had nearly derailed the early family sessions at my clinic. In deciding to do an FAE, I hoped that the family would use the art to reveal more about their feelings, while containing them in symbolic form. The family understood that the FAE would be taped and would be observed by my graduate art therapy students. On the night of the FAE, both Darrell's mother and his grandfather phoned separately to say they would not attend the session. The mother's absence fit my hypothesis that any further exposure of her feelings might be experienced by her as too painful to tolerate. Moreover, an extra layer of observing eyes (the students, in addition to her own family) may have affected her decision not to attend.

The FAE was administered primarily by Cheryl Doby-Copeland, then an art therapist in postgraduate study, and me. In the Modified FAE session, family members work at adjacent easels, each making five drawings, using chalk pastels and black markers on white drawing paper. The drawings are, in order: a free drawing; a family portrait done in either representational or abstract style; a "warm-up" individual scribble drawing; a jointly developed family scribble drawing; and a final free drawing.

The FAE Session

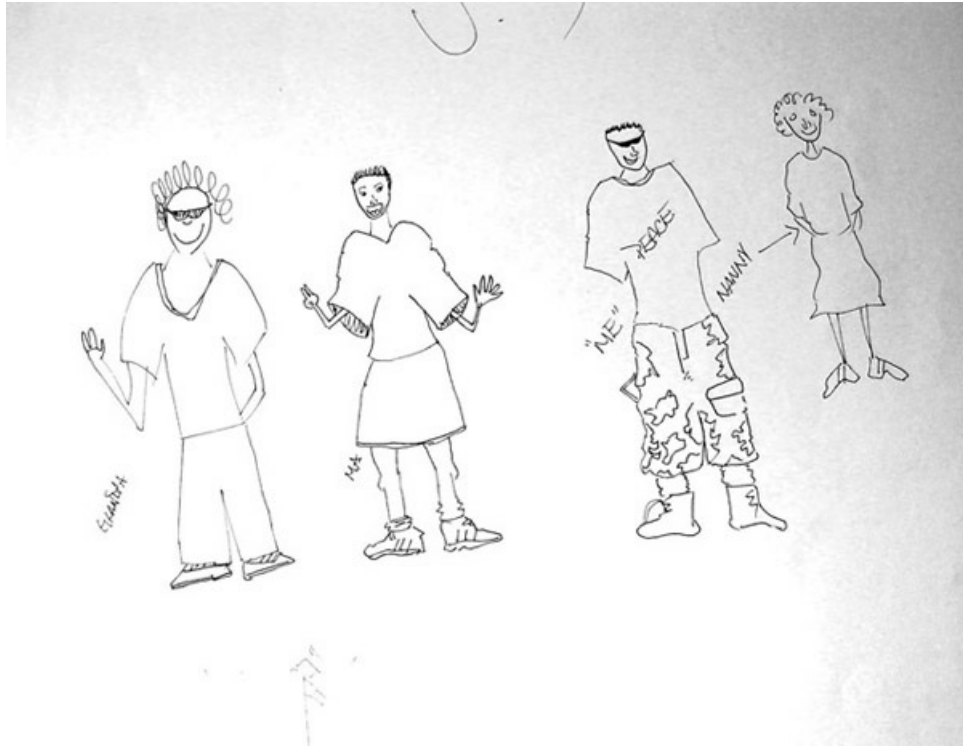
Throughout the session, there was an easy banter between Darrell and his grandmother, often at a low pitch so that one could hear and experience the light tone but not hear the words. For the first task, the grandmother, an articulate woman, drew simple stick figures with a surprisingly weak hand. Darrell drew vigorously and in a bold style. His sardonic and mocking attitude was striking, and he communicated an emotional distance through his banter and his imagery. His drawing was of a male cheerleader, a boy in a skirt with spiked hair, a “Wacky Guy.” ([Fig. 20.1](#))

In the second task, the family portraits drawn by Darrell and his grandmother continued the styles and, to some degree, the themes of the first procedure. Grandmother’s family portrait, done in a light, shaky hand, again had floating stick figures that barely distinguished one family member from another—except for her daughter, who was shown smoking a cigarette. Darrell’s family figures ([Fig. 20.2](#)) were detailed and highly individualized cartoons; his comments again had a mocking or self-mocking tone. He drew himself in hip-hop clothing—baggy pants, sunglasses, baseball cap. Next to himself he drew the smaller figure of his grandmother in a simple, unadorned dress. Spatially, they formed a pair. Separated from them by a few inches was a second pair, Darrell’s mother and his grandfather, both in hip-hop clothing. The Darrell figure, all bravado in its dress and stance, had no arms.



[Figure 20.1](#) “Wacky Guy”

The joint scribble, requiring family members to work cooperatively at close quarters, often raises the level of anxiety in a family. Instead, as Darrell and his grandmother worked together to develop her scribble, he lost his sardonic edginess and seemed notably less anxious than before. Although he continued to banter, he grew visibly invested in the drawing. He teased, then guided his grandmother into developing the scribble into a full page profile of a horse’s head ([Fig. 20.3](#)), bent down to nibble grass, but looking out at the viewer with a strong, frontal eye and a half-smile. For the title, he wrote “Grazing” at his grandmother’s request, then signed both his “baby name” for her and hers for him: “Nonny and Pookie.”



[Figure 20.2](#) Darrell's Family Portrait

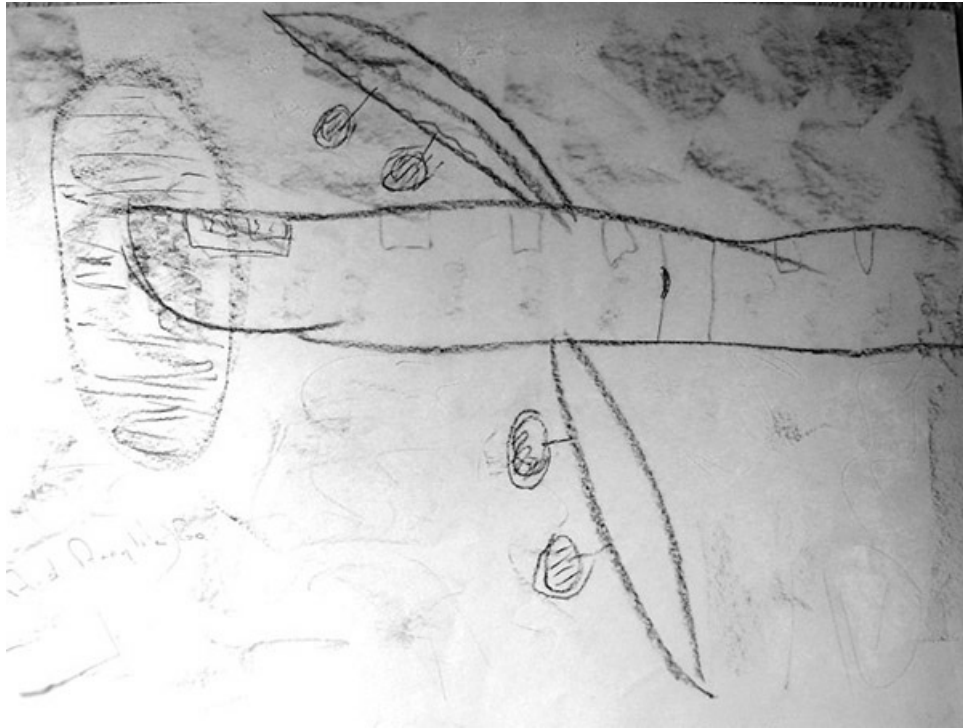
The change—the drop in the sarcasm and the concomitant rise in investment—continued into the last drawing. This final drawing task often acts as a “recovery drawing,” affording family members time back at their individual easels after the anxiety of working together. Grandmother attempted the difficult task of depicting an airplane ([Fig. 20.4](#)) revealing yet more of a possible cognitive or age-related problem. Darrell positioned himself so that he could watch her work, then drew a realistic, accurate, and detailed portrait of her at her easel ([Fig. 20.5](#)).

Drawing Inferences from the Artworks

Following the session, the art therapist may find it useful to put the entire set of drawings up on a wall, in a grid formation according to the task, where they can be viewed as a whole rather than as discreet sets of individual drawings. She may begin to discern relationships between or among the pictures and to track how these relationships evolve during the session. A few images may stand out and may evoke a strong subjective response in the therapist. Working toward a hypothesis about the family relationships requires both the subjective response and a careful objective observation of both the drawings and the interactions. The art therapist's objective descriptions uncover formal, thematic, or metaphorical connections between or among the drawings; her subjective emotional responses may help her form a bridge to significant emotional issues in the family.



[Figure 20.3 Joint Scribble](#)



[Figure 20.4](#) Grandmother's Final Drawing of an Airplane

The student and I used the “Eight Ways” paradigm as a framework for organizing both our subjective and objective responses to the art. The drawings suggested issues pertinent to each of the core concepts about family life, as discussed below. Using our subjective responses to the art as a guide, we paid particular attention to the family portraits and the horse drawing, both of which held great evocative power.

Darrell's Family's FAE Seen through the “Eight Ways” Paradigm

Life cycle: Darrell's image of his mother (family portrait) depicts her as an adolescent similar in age and attitude to his image of himself. In the life cycle of this family, it seems that the mother's adolescence and transition into adulthood are, in Bowenian terms, *unfinished business*. Repeating some of his mother's history, Darrell himself—if he is not allowed to finish high school—may be launched prematurely into adult life. The family may need to slow down this transition for him; they may need to revisit the mother's premature launching and renegotiate the mother's entry into adulthood.



[Figure 20.5 Darrell's Portrait of His Grandmother at Her Easel](#)

Resilience: Resilience was felt more in its absence than in its presence in this particular session.

All who were present were aware of the last minute cancellations by Darrell's mother and his grandfather. We were aware of Darrell's glib, defensive posturing and the formal weakness (thin, wavering line quality) of his grandmother's drawings. Later, we would wonder about the intergenerational bond between Darrell and grandmother. This could be seen as an obstacle to his growth—a compensation for the losses he had experienced, keeping him from experiencing their magnitude. Early classic structural theory would be wary of such a cross-generational alliance. However, later iterations of structural theory would allow for this level of flexibility in family structure as a possible healing element, a healthy compensation for his absent parents.

Cultural considerations: As with Resilience (above), there was a dearth of cultural information in these FAE drawings. We knew from the family's presentation that Darrell grew up in the culture of an urban working class single parent family. From the family history, given when they made a genogram in their first session, we knew that Darrell's family had strong ties to their Baptist church. The church was integrated into their life in the community and was also central as their spiritual support and connection. With no explicit references to church or religion in the drawings, we could only speculate about the impact of the church culture on their lives. Was there a spiritual or cultural crisis for Darrell that underlay his sardonic posturing?

Were his friends and peers drawn from among other church families, or did he find friends—and norms—outside the boundaries of his faith community? Were religion and church a refuge and support for Darrell's mother? Did Darrell and his grandmother *not* draw about their church because it was too personal a subject to be explored or exposed with these therapists who were essentially strangers?

Communication/Behavior: Darrell kept up a defensive, distancing posture for the first three art tasks, not only with his bantering humor, but also with his images of posturing caricatures, several of whom wore sunglasses that kept the viewer at an emotional distance. During the joint scribble, this attitude seemed to dissolve. His use of “baby names” suggested that being physically close to his grandmother may have helped him to drop some of his posturing. This felt closeness seemed to allow the emergence of the horse image, with its direct and open gaze, and Darrell's subsequent guileless watching of his grandmother during the last procedure. While he never stopped joking, during the last drawing his banter took on a poignant quality in a joke about the passage of time.

Structure: The change in the nature and style of the images as Darrell and his grandmother moved from the family portrait to the horse suggests something about the structure of the family. Darrell drew mother, grandfather, and himself as adolescents, with the grandmother figure quite close to him, in the background. This placement, followed by an even closer and literal alliance with grandmother in the horse picture, suggests that Darrell can move close to grandmother—to bask in her watchful care—as he demotes his mother to adolescent status, then eliminates her presence altogether. Yet their similar dress and body posture also suggests Darrell's identification with his mother. The lack of clarity about mother's position in the family may be contributing to Darrell's confusion and acting out.

Unconscious life of the family: The horse image and the obvious comfort in the process of creating it suggest a *secure attachment* between Darrell and his grandmother, and a sense that grandmother provides, in object relations terms, a *holding environment* for her grandson. Mother's absence from the session suggests that grandmother may not provide, in Winnicott's terms, a *good enough* holding environment for her. The depictions and somewhat derogatory verbal characterizations of mother also raise questions about possible *projective identification*. If Darrell's mother experiences herself within the family as a “bad daughter” and an outcast, one wonders if this self-image is a projection she has received and internalized from her mother. Darrell's images (directly or indirectly of himself)—from open and guileless, to wacky, confusing, cool, and even bizarre (his warm-up scribble)—suggest that he is struggling and uncertain as to whether he is a “good” or a “bad” child within the family. Are there different and conflicting projections coming from mother and grandmother?

Themes and metaphors: For the art therapists, the image of the horse with its benign smile and direct gaze, was surprising. Until that drawing, Darrell had shown that he had a talent for caricature and was an astute observer of hip-hop culture. His themes had been drawn from the externals that surrounded him—the clothing, the swaggering postures, the sunglasses that shielded him from real connectedness with others. He also depicted himself (the “wacky guy”) as a clown-like character—where the externals were out of conformance with the surrounding culture and seemed dissonant, confusing, and even confabulated. However, the image of the horse, so close to the viewer and so different in its soft line and color, suggested a less brittle and less guarded boy, perhaps less well-formed in the identity that he allows others to see. His visual metaphor of the gaze carried over to his final drawing and suggests an underlying emotional connectedness or longing for love that might be explored through individual art therapy more easily than in the family setting.

The Individual within the system: As a 16-year-old, Darrell was struggling within his family environment and within himself as an emerging young adult. His drawings suggested confusion; his behavior signaled that he was failing to find his place in the social and academic world. Our therapy team felt he needed individual sessions in addition to the critical family work, so that he could safely begin to talk about his most personal feelings. We asked for an evaluation for depression. Darrell's mother, herself depressed and angry, was isolated from the family system and was possibly a good candidate for individual therapy prior to or concurrent with family therapy.

The Follow-Up Session

Before the FAE session, it was clear there were unexplored emotional issues in this family that were getting in the way of finding good behavioral solutions to Darrell's expulsions. After the drawing session, it seemed clear

that before a good behavioral plan or any attempt to restructure the family roles could be made, the emotional life of the family needed to be addressed.

The shift in the mood of the session, with the appearance of the horse, suggested that therapy should explore the feelings and thoughts the horse image evoked for both Darrell and his grandmother. When asked to talk about the horse, Darrell leaned forward in his chair, abandoning the laid-back posture he had assumed until then. Darrell said that the horse “is strong, a free spirit, and peaceful, out in nature...when I am with my grandmother, I’m usually happy and peaceful. The eyes and the smile...are...aspects of her because she is always watching over me. When I do something good, she smiles at me. My grandmother is like my guardian angel.” Referring to his watching her in the last picture, he said “...she’s the main one I focus on for her wisdom. I always keep her somewhere where I can see her, somewhere in my mind.” After this moment of reverie, Darrell fell back into his “cool” and guarded stance. Looking at the portrait he had done of his mother, he slumped in the chair, shrugged, and said, “that’s just the way she is; I can’t change her, so I don’t worry about it. I just let her go and get on with my life.”

From FAE to Clinical Treatment

Psychologist Ellen Wachtel (2004) suggests that in an integrated approach to family therapy, a psychodynamic formulation, rather than serving to pathologize a child or family, “enhances the ability to make good sound behavior and systems interventions.” (Wachtel, 2004, p. 153). In Darrell’s case, images from the FAE allowed the art therapist to understand the family from both an analytic and a systems point of view, providing a great deal of flexibility for treatment.

The Family Art Evaluation session provided an environment that was emotionally safe enough for Darrell to relax his guarded stance and let his imagination produce the smiling horse of the joint scribble. We wondered if he would have been as open if his mother and grandfather had participated. Later, in the follow-up session, the act of looking at the image of the horse seemed to evoke in him the same reverie he showed while drawing that picture. He was able to allow himself to express a vulnerable dependency, as well as a striving for manhood. Amazingly, this cool teenager found the words to describe the extent to which he had folded an internal image of his grandmother into his image of himself.

But it also seemed that this peacefulness was gained at the expense of his mother, who may have been emotionally unable to join the session, or had been somehow barred from joining. Both grandmother and Darrell seemed to minimize or avoid a sense of loss. Darrell’s laconic rejection of his mother as someone to “let go of,” while in some ways mature, seemed a poignant echo of his grandmother’s rejection of her daughter. Darrell’s ability to bask in the glow of his grandmother’s care left an area of family pain which remained unaddressed.

Using this understanding as a jumping off place for the family art therapy, we were able to formulate two basic goals and a direction for treatment. The first goal was to create a safe therapeutic space—a holding environment—that could include Darrell’s mother. An invitation to the mother to find her own graphic language in art could be extended to her at first within the safety of her own individual sessions, then later in the presence of the other family members.

The second goal included structural and behavioral components—to ensure that Darrell, who was “chomping at the bit,” would be competently managed and guided through this stormy part of his adolescence. It would be foolhardy for the art therapist to ignore the behavioral crisis in favor of an exploration of dynamics; it would be equally unwise to ignore the network of emotions underlying and supporting the dysfunctional behavior. The subsequent family art therapy, therefore, used both frames of reference, shifting gears as both need and opportunity arose. For examples of other cases treated with art therapy within a systems framework, see Riley’s work with an adolescent schizophrenic girl (Riley & Malchiodi, 1994, pp. 67–86), Arrington’s work with a family prone to violence (Arrington, 2001), and Sobol and Howie’s work with an acting out adolescent (Howie, Prasad, & Kristel, 2013).

Conclusion

Family art therapy is inherently paradoxical. First, although families assemble for therapy to alleviate the distress within the system, there is usually a focus on one member who is seen as having “the problem.” One task of the art therapist is to achieve or create a balance between the pull to make one member “the sick one,” and the goal to treat all members within a system with equal respect and dignity. From the earliest days of our profession, we know that making art in any group creates an equality of conditions, wherein the least verbally articulate, or the youngest, or the one who is thrust forward as “the sick one,” is given the same opportunity to speak through his art. Yet even within the intended safe space of family art therapy, there is both opportunity and danger in each drawing. The creator risks both the hope that he will be heard and respected and the fear that he will be exposed or shamed.

Second, while each member is invited to draw from his own deeply personal motivation or experience, each may also be affected profoundly by drawing in the presence of those who are closest to him.

When all the FAE drawings are hung side by side, to be contemplated intentionally as a whole, the art therapist can often see how a drawing made by one family member can stimulate a strong emotional response in another member or cause an emotional shut-down—all of which may be manifested in the evolving images.

Third, while the art therapist will never see the family in operation in its natural setting (that is, at home and without scrutiny from an outsider), successful treatment rests on knowing that the family will bring their relationships—both the overt and the hidden—into the therapy room, accepting scrutiny in order to be understood and changed. As in all therapy, the relationships are altered from the very moment the therapist joins the system.

The process of making art invites the development of a graphic language and an emerging graphic “conversation” that may contain both familiar elements and something quite new and surprising. Art may at times help participants to create distance among one another, but it can also titrate relationships, allowing some families to tolerate being together in uncustomary ways. As we observed in Darrell’s case, creating images in the presence of family and viewing the images created by significant others can manifest a deep sense of connection (Darrell and his grandmother) and can also reveal vast silences and emptiness (the painful absence of Darrell’s mother in the family dialogue). Through a variety of interventions, from broadly expressive to specifically focused, the art therapist gains a rich understanding of family dynamics that can help her guide a family toward change.

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21

Group Art Therapy

Katherine Williams and Tally Tripp

Group therapy became an accepted mode of treatment largely because of the putative efficiency of treating many patients with only one or two therapists in one room at one time, and these features are salient reasons for its continued use. Aside from its practicality, however, the efficacy of group treatment lies in the opportunity it offers for a unique kind of learning that can contribute significantly to personal growth and change. While group experience is not a re-creation of the members' family, participants arrive bearing and wearing their history. Members' customary ways of seeking comfort and viewing the world are described variously as introjects, organizing principles, pathological accommodation, or learned attachment strategies, to name a few. No matter what terms are used, however, it is clear that being in a group elicits each member's idiosyncratic patterns of thinking, feeling, and behavior and offers possibilities for experiencing new ways of being in the world. The opportunity to observe and facilitate this process widens the group clinician's diagnostic and therapeutic armamentarium.

A Brief History of Some Approaches to Group Therapy

Even though Freud wrote about group process, he did not engage in group treatment, and it was the sheer numbers of traumatized servicemen returning to England and the United States during and after the Second World War that brought about a focus on group as a useful modality. Bion (1959) initiated the social systems approach to group treatment. He saw the individual as inextricably a part of a group, even though the task of relating to the group of which he is a part is a formidable one, fraught with hope and fear and resulting in regression. One of Bion's major contributions is the way he characterized these regressive beliefs which he described as three basic assumptions: *fight/flight*, *dependency*, and *basic assumption pairing*. These beliefs can be experienced by one person, by some people, or by all members at any given time. They may hold sway for a series of groups, or any or all may appear within a single group meeting. When a member assumes a prominent role and acts *as if* any of these assumptions were true, that individual may be given great power, through the accumulated force of the split-off parts of other members being projected onto him or her. It is the leader's job to shed light on such covert and unconscious processes that get in the way of learning about the self in relation to others.

Bion's work became combined with the theories of social scientists like Lewin (1951) and Rice (1969), who applied systems theory to group attributes and activities. The value of this perspective is to heighten the leader's awareness of the place of the group in the larger system, as well as the leader's responsibility to manage the boundaries between the group and the system, noticing the effect that activity at the boundary has on the group. This provided the group leader with a wider lens through which to view group process, and emphasized the importance of group members' effect on each other to bring about change. However, the group leader was still seen as the primary formulator of meaning in the group experience.

Another meta-theory is that of Yalom (1983; Yalom & Leszcz, 2005), who describes the helpful processes that inhere in groups in a way that can be applied to various theoretical approaches. He lists 11 therapeutic factors that he believes comprise the basic mechanisms of change in all group therapies. These are "instillation of hope, universality, imparting of information, altruism, the corrective recapitulation of the primary family group, the development of socializing techniques, imitative behavior, catharsis, existential factors, cohesiveness, and interpersonal learning" (p. 1). He maintains that therapists with different theoretical perspectives will emphasize differing groups of these factors and that different patient populations and the resulting goals will also highlight some factors over others.

Rather than being a leader-focused approach, like early systems theory, this is a group-centered approach, in which the leader's goal over time is to recede from centrality, making interventions that encourage members to do the work of the group. Yalom acknowledges that the leader who works in a short-term setting with severely disturbed patients must be much more active than the leader of an ongoing group of healthier individuals. However, to whatever extent is possible in any given group, he believes that wisdom resides in each member, a belief embedded in his roots in existential therapy. Even though leaders and members are dealing with the anxiety that emerges from grappling with these issues (consciously or unconsciously), they are all a part of the group, not apart from it, all engaged as "fellow travelers" (Yalom & Leszcz, 2005, p. 106).

The leader's task is not to interpret, but to illuminate the process that is unfolding in the here-and-now. This involves focusing on the interactions occurring in the group at any given moment, stopping the process and asking the group to observe what has happened; and helping members to understand and integrate this knowledge, while developing curiosity about their own and fellow members' process. Issues of timing (within the particular session as well as within the life of the group), level of stability of group members, the goal, and the setting will determine how this unfolds. For inpatient groups, the life of any group may well be a single meeting, so the goals would be to help patients become engaged in therapy so that they may seek it later, help them spot patterns of relating to others that could be areas to focus on in subsequent therapy, and help them to reduce the anxiety caused by being in the hospital.

Relational and intersubjective theories are based on the idea that we are hard-wired for relationship and that all relationships and learnings are co-created. Hence, our lives are essentially lived in, from and through groups. Mitchell (1988) writes of the continual human thrust toward connection and the attendant danger, vulnerability, and loss that are inherent in that seeking. Stolorow, Atwood, and Orange (2002) speak of the co-

creation of all human behavior.

The impact of post-modern theories on systems theory has widened the focus to include the embeddedness of all life experience in a system or systems. Cohn (in Grossmark & Wright, 2014) maintains that a systems theory lens provides a sense of equalization and empathy—as members of one or many larger systems, we are not alone, even in our distortions. Not only the leader but any “observer” may change the focus, and thereby be engaged in finding and offering meaning. This is consistent with Riley’s (2001) comments on this chapter in the second edition of this book, where she states that a post-modern take on systems theory frees the leader from needing to be the holder of knowledge within the system, and allows him or her to collaborate with patients in a state of creative “not-knowing.”

Group Art Therapy

The foregoing models of group therapy do not involve art making, although it could be integrated within any framework. But what about group art therapy? How is it distinct? Ranaken (2014) writes that the relationships among the therapist, the patient, and the art work itself add a unique, triangular dimension to the process. The experience of making art in a group and the enduring nature of the artwork also add complexity. Many articles—including some chapters in this book—describe art therapy with individuals against the background of the groups in which they were treated, without noting the impact of the group in which the art was made. We contend that no matter what the group structure is, the introduction of art making will have a reciprocal effect on both the group and the art.

Surveying the literature, one finds basically three types of art therapy groups: the *studio or community based* group, the *theme or task focused* group, and the *process oriented* group.

The Studio or Community Based Art Therapy Group

In the studio based group, people come together to make art and are influenced in some way by the presence of others, but the focus is on the process of the individual's art making and the final art product. The group leader does not typically provide a specific theme or task, but functions more as a "collaborator," working with the client in a kind of partnership (Moon, 2002). The leader maintains the studio space to keep it organized and safe, makes decisions about the way materials are stored and made available, and may provide emotional support or technical assistance for the art making. The first art therapy groups that were conducted in hospitals, like those led by Ulman in the 1950s (1975), were of this sort, while more recently Allen (1995), C. Moon (2002), and B. Moon (2010) espouse this approach within community based studio settings. Such groups may take place in a wide variety of settings with clients who share a common background, issue, or task, like people with medical illnesses, teens with learning challenges, or community groups gathered to produce a mural. The art therapist can create a therapeutic studio environment, even in a setting normally used for other purposes (C. Moon, 2002).

In the studio setting, art making can facilitate self-expression while providing social interaction in a growth-enhancing environment. Czamanski-Cohen (2010) describes art therapy with adolescent Israeli girls evacuated from their homes and relocated. Working collaboratively on models about the trauma of forced relocation, the girls explored issues and feelings that would have been difficult to discuss. They referred to the group as a "class" rather than "therapy," highlighting how a studio art approach may circumvent the potential stigma of a traditional therapy group.

Lark (2005) facilitated community-based workshops for groups of adults from differing social, cultural, racial, and political backgrounds. The participants used a variety of materials and found objects to paint and collage panels on the theme of "experiences with racism." Creating and witnessing the placement of these panels along a steel wall promoted awareness and, for some, a resolve to try to address the problem. Shifting back and forth between art making and verbalization helped the group manage the tension arising from cross-cultural and interracial encounters. Lark's imposition of a theme provided more structure than in many studio groups, but since the topic arose organically from the ethnic backgrounds and conditions in which members lived, it offered an invitation and permission that enabled them to struggle with it together.

Structured/Task Focused Groups

In this country, the theme or task-based group seems to predominate, particularly in inpatient settings, day treatment programs, or special schools where much of the literature describes working with a particular population. In a structured group, a leader, like Liebmann (1986) in the United Kingdom, might come up with a task, group directive, or theme that members can respond to, or choose not to respond to (which, in itself, is a response that may help someone focus on what is important for them). A directive can calm anxiety in group members or the leader, thereby reducing management challenges and creating an environment where both leader and members are able to feel a sense of agency.

Task-focused directives are often suggested to groups dealing with similar issues, like mothers following perinatal death (Speert, 1992). The mutuality of constructing a torn-paper collage about loss provides support and a sense of shared grief. In inpatient settings, trauma survivors may be given a theme because the maintenance of a safe, stable environment is paramount for affect regulation. Rankin and Taucher's (2003) approach is a phase-oriented model in which the therapist titrates requests for creative expression, to keep the client within what Siegel (1999) calls the "window of tolerance"—that amount of arousal consistent with being able to process new information. Pifalo (2009), working with women caretakers following the disclosure of sexual abuse within their families, helps group members create trauma narratives through a visual mapping exercise exploring family transactional styles and patterns.

Adlerian art therapists like Sutherland (2014) use a protocol to model group cooperation and respect, with the goal of generalizing this experience into social consciousness and the capacity to interact democratically. After greeting group members individually as they enter the room, the leader employs activities such as working together on the same sheet of paper or in a directed manner. While the art experience itself is valued, there is also structured focus on the process—like the multiple ways members heard the directions, or the experience of feeling included and understood—because the art tasks are selected to give members a taste of what it feels like to belong to a group and to have compassion for others.

Vick (1999), as leader of a short-term art therapy group, actively links observations of ongoing processes during the session. Rather than a theme, he offers pre-structured images (photos, collage images, papers, etc.) as a stimulus for art making with adolescent inpatients. The structure for the group is determined by the choice and use of these art materials, affording each member great flexibility of self-expression. In processing the resultant artwork, connections are made by looking at similarities and themes in the stimulus elements.

Riley (2001) discusses working in short term groups with severely burned, latency-age children whose emotional scars were addressed through action-oriented art therapy techniques to strengthen resiliency, restore social confidence, and manage distress. She uses tasks that are relatively easy to perform, in order to minimize pressure, to maintain each child's interest, and develop connection and cohesion. One example is the creation of a mural where group members "put the bad feelings and memories in a jail," helping the group express intense feelings while gaining mastery and creating some distance from the trauma (p. 74).

Noble (in Riley, 2001), working with small groups of autistic children and adolescents in a school, sees the art as functioning like "a glue for both verbal or nonverbal social interactions..." (p. 91), breaking through the barriers of isolation and frustration. She incorporates turn taking, non-competitive games, and simple art directives, providing an opportunity for connection and a unique experience of social pleasure.

Sometimes a group has an initial structured agenda, yet the session evolves into something more deeply interpersonal. An example is a recent activity one of the authors (Tripp) conducted at an Air Force Warrior Camp for veterans with physical or psychological wounds. After a brief introduction to art therapy, with soft music playing, the participants were invited to paint or draw freely inside a circular outline. Despite some skepticism, hesitancy, and a dash of defensive humor, each was able to experiment with the art materials and create a mandala. Even though some offered concrete or superficial responses to the directive ("I painted with blue and gold because they are my team colors"), one special operations warrior represented his traumatic experiences in Afghanistan in a visual timeline that encircled his mandala. After his moving narrative, others began to talk more deeply about their own difficult memories and their current focus on healing. At the end of the session, an officer who had been observing the process stood up and said that he found these wounded warriors to be "the bravest of the brave," and expressed appreciation for their courage in sharing their stories.

Process-Oriented Groups

Much of the early literature on process-oriented groups comes from England, where Waller (1993) writes about group interactive art therapy and Skaife and Huet (1998) speak of group analytic art therapy, although in the United States, Wadeson (1980) and Riley (2001) also describe process-oriented groups. In groups where process is paramount, the focus is on members' interaction with one another and the leader. Moon (2010) describes art making in groups as a "sensual" process that evokes and intensifies feelings in the present moment. Statements such as "it is curious that no one has responded to Jane's dramatic image" are made to move the group to relational engagement. Such groups are often long term, with membership changing only as members terminate; others have constant membership for a considerable time with a set termination date. While anything may be discussed, members are often engaged with each other through the content or the process of the art expression itself.

For example, a member of an art therapy group led by one of the authors (Tripp) became agitated as she worked alone in the corner of the studio, stabbing aggressively at her paper. Other members responded in their own way: one by being resentful of the noise, another by retreating and feeling fearful of the energy, and yet another by reaching out to comfort the member who was afraid. Speaking about such an experience brings immediacy to the discussion that can be generalized to members' ways of being in the world. The therapist helps the group members look at their own and others' responses, encouraging members to respond to one another in the moment, through what is expressed and not expressed, in art or in words. It is difficult to ignore the torn up paper, slashing red marks, or pastel dust—the by-products of emotional art making.

McNeilly (2006) states that one of the most important functions of the analytic art therapist is to promote ongoing sharing and linking among members where the group as a whole is the primary focus of attention, with the interpretation of individual experiences being secondary. The art group contains the "visual evidence" that can help move the process between imagery and verbal language, or between micro- and meta-perspectives within sessions.

Contributions from All Approaches

The division into three approaches to group art therapy is quite arbitrary. In reality, the art therapist usually blends approaches. For example, in a hospital, it is possible to run a studio group in which process elements are noted, even as the leader takes a strong role in the management of the group in order to ensure physical and emotional safety. In community studio groups, there are times when strong guidance and directives are needed. While it is often felt that apparently homogeneous populations—like those in medical settings, homeless shelters, or trauma treatment centers—benefit from groups centered around shared themes; it is also important to remember that there will always be diversity of race, socio-economic status, age, and sexual orientation, which must all be considered in every aspect of group process.

Overall, however, there is an increasing interest in systems and process issues as one moves from the studio group to the themes group, to group interactive art therapy. The groups also become less leader focused and more group focused, as one moves from studio to interactive approaches. This is not a hierarchy, but is rather one way of categorizing what happens in art therapy groups, in order to highlight the fact that each choice the therapist makes entails a sacrifice. Looking clearly at these choices helps the therapist “be awake,” as the Buddhists say, rather than blindly following accustomed practice.

Benefits and Challenges Arising from the Integration of Art Making into Group Therapy

The advantages are significant. Images are generated from and processed by areas of the brain not necessarily accessed by verbal expression; art making may uncover feelings and themes that had not been in conscious awareness. A group working together on a mural exhibits interactional patterns ripe for exploration, like members' comfort level with each other and the art materials, the need for personal boundaries, or responsiveness to non-verbal cues. Another advantage of making art in a group is that all members can express themselves simultaneously, whereas in a verbal group, members must speak serially. The images endure and can be returned to, holding a metaphorical space for each member and elucidating the group process, sometimes connecting a single group to its previous and subsequent group sessions, giving expression to group themes (Harris & Joseph, 1973).

In any group, the therapist needs to consider such issues as whether it is to be long or short term, with which population, for how long, in what space, for what goal, and using which theoretical approach. The art therapist has additional considerations, such as clients' developmental level or their ability to use materials safely and with approval in that environment (the prohibition of chalk dust in hospitals, or the limitation of sharp objects for clients struggling with self-harm or suicidal thoughts, for instance). These and other variables affect decisions that are part of a complex process that “requires the capacity to hold in mind many disparate elements simultaneously and to recognize the effect that an action in response to one element will have on the other elements” (Deco, in Skaife & Huet, 1998, p. 105).

In verbal therapy groups, multiple processes occur simultaneously, but in group *art* therapy, those processes are greatly increased. Art therapists have to consider whether—and if so, how—to structure the group for individual and group art expression, and must think about what impact the art making process and product will have on group members. Individuals may be creating artworks in separate areas of the studio space, may be working side by side at one table, or directly with one another on a single project. One of the first tasks of the group is to determine how it wishes to use the space and time. The art therapist can be prominent in directing this activity or, as Skaife and Huet (1998) describe, can thoughtfully but parsimoniously guide the transitions in “sonata form” as the group unfolds. A predominant theme usually emerges in the initial discussion, perhaps augmented by another, and these leitmotifs become elaborated in the art experience, then revisited in the discussion. The art therapist who is attuned to this sonata will direct her interventions to the transitions from movement to movement, while restraining herself from commenting on process during the art making. In the final segment, the group will discuss the process of art making, the response to others in the room, and the content of the imagery that is produced.

Each of these elements of the group has many aspects. For instance, focusing on the process of creation involves each member exploring his or her experience while making the art, what it is like to have her artwork representing herself in this moment, and what others' reactions are to her piece. The experience in which one

member finds satisfaction in expressing anger through aggressive use of materials, while another finds this disruptive to her need for a safe place, is fertile ground for group process. Can both perspectives on the process be held? Can one member experience empathy by realizing the impact of her actions on another? Can one member experience the mastery of providing a safe place for herself in the midst of what she experiences as chaos? And how does the art therapist leader decide to work with these potentialities?

Further Considerations for the Thoughtful Art Therapist

There are many reasons why an art therapist might provide a theme. She may do this because the patients are not at this time in their lives capable of generating a productive idea and are, because of their illness or their lack of exposure to therapy, dependent on her to provide structure and education. She may want to create an atmosphere that promotes some of Yalom's therapeutic factors such as universality, interpersonal learning, and group cohesiveness. In groups in acute psychiatric settings, where patients often arrive late or are suddenly pulled out for other treatments, the therapist may decide that the only way to keep any continuity is to work around a common theme, so that new group members may more easily join or others may leave without disrupting.

A self-psychologist might select a theme or project based upon the developmental need of the group members to idealize the leader—providing a self-object function for members as they bring their narcissistically fragile selves to the group. A relational therapist might use an “assignment” at a vulnerable moment in the group's life, in order to protect herself and group members from becoming embroiled in a confusing enactment, fueled by their unacknowledged dissociated parts.

However it is conceptualized, a group that opens with an assigned task is one in which both the art therapist and the group see change for members coming about through complying with a directive, rather than from grappling with the uncertainty of relating to each other. The latter may be as uncomfortable for the art therapist as for the members, and may be a more accurate reason than her stated purpose. Or she may feel pressured to come up with significant diagnostic material more quickly than other clinicians in order to prove the efficacy of art therapy or to promote her authority within the system, without taking into account McNeilly's (1983) caution that a theme may actually evoke powerful feelings before the patient is ready to deal with them. All in all, recognition of the art therapist's heretofore unconscious fears may allow her to bring them into consciousness, where they will have less power over her and afford her more resilience as leader.

While some write convincingly of incorporating Yalom's approaches into art therapy groups that remain quite structured (e.g., Sprayregan, 1989), fully opening up the group to allow its interactive power raises many issues. The art process affects and mediates all that happens within the group, posing challenges that verbal groups do not have to confront. Skaife and Huet (1998), writing about group analytic art therapy, ask “What are the implications of the therapist taking [an apparently] passive role in a group which has an activity in it, which needs structuring at least in so far as when, and for how long, it takes place?” (p. 24). They echo Yalom who asserts that without the leader providing initial structure, the group may disintegrate, so they do offer enough to help the group get started. However, they leave the time allotted for art making and the content of the art making up to the group, believing that “the group makes use of the tensions around the change in activity to play out issues of power and authority” (p. 25).

Clearly, the members of some groups are not able to deal with this amount of tension and uncertainty. And while the elucidation of group members' roles and their relationship to early familial patterns can be beneficial, it can also take away from the art-making process. If discussion goes on for too long, there will not be enough time to make art; in fact, any discussion takes up time that could be used to create; and the art products that emerge from any single session of group interactive art therapy are rarely fully realized. The art therapist therefore must choose whether to place some structure on the use of time like McNeilly (1990), or to allow the group to come to terms with setting or not setting those limits itself like Skaife and Huet (1998), and sometimes Waller (1993).

However, with appropriate group membership and enough time for trust to develop, a relational process-oriented art therapy group can be an agent of change. One of the authors (Williams) led such a group, which was gradually able to understand the management of their time and the development of their curiosity around their own process as important tools for growth. A significant moment in the life of the group came when an angry group member stated indignantly that she was leaving the group because she never got a turn to talk about her art and the leader and the group members didn't help make space for her. This group member had been important in the group because of her ability to be helpful to others—albeit while withholding her own thoughts and concerns—and the members were shocked at this outburst. Out of the silence that followed, another group member finally said, “That's just like in your family, where you felt no one was interested in

you and your mother never protected you. Don't leave—let's figure out what we're doing to silence you and what you are doing to make us into the same, disappointing family.” The emergence of this level of understanding comes from the slow accretion of knowledge that arises from moment-to-moment observation of and immersion in the relationships in the group—experienced through words, tone, bodily reactions, and of course, the art itself.

Processing the Art

As noted earlier, the artwork can contain messages not yet available to awareness, and these images are multiply displayed; so that even when a member is not speaking, his or her image communicates to other members and is a symbolic embodiment of the existence of its maker. This can enrich the life of the group or, at times, overwhelm the group with the sheer amount of stimulation emerging from a roomful of images. One remarkable occurrence in many interactive groups is the frequency with which images spontaneously emerge as symbols for the group process. Of course, if the group process is contentious, the symbols will reflect this; so our hypothetical art therapist must be able to contain the anxiety around the resultant tension and conflict, and still function in the midst of it.

But, assuming the art therapist decides to talk about the art, how best to add words to the image once it is made? Speaking about the artwork offers a real challenge to the interactive group therapist, who must be aware of all the assumptions implicit in this task. For instance, do she and the members believe that everyone should get a chance to speak about their picture? If so, this diminishes the depth of the discussion, and inhibits spontaneous group interaction around issues raised by a group member's image. If not, there can be a sense of frustration that an image has been made but not discussed.

If the art therapist wants to provide equality, is she offering a container that is sufficiently stable and comfortable that group members feel safe enough to speak or not to speak, thereby offering a chance to build a more vital sense of themselves? Or is she colluding with the members in fleeing from the group task of relating to each other through the art by promoting a discussion style that mitigates against real connection? In group interactive art therapy, the art therapist would almost always make the choice to comment on the process rather than to structure the process, but every time she comments, she is encouraging the group to move to a verbal mode, which involves moving away from the art process.

Moreover, whenever an artist discusses a picture, the artist is describing what she drew and thought in the immediate past. This can be beneficial in affording some distance from which to discuss difficult material, thereby toning down the activity of the sympathetic nervous system and creating an opportunity for patients who have been driven by the sequelae of a traumatic history to develop the capacity to mentalize. On the other hand, focus on discussing the patients' artwork can remove the immediacy of group interaction, and the group can revert to a dry show-and-tell format unless the art therapist guides members to attend to the experience of speaking of this material at this moment in this group. These are only a few of the ways art therapists of all persuasions might use the systems or process orientations to scrutinize the design and experience of their groups.

Yet once the art therapist has thought carefully about the above variables, it is a relief to remember that the art itself communicates strongly, often directing the group to deal with issues that may not have been evident in a more verbal or intellectual interaction. The art pieces may pique our attention or call out to be seen, understood, or challenged. What is hidden inside the box? What does this symbol mean? Why is the figure so tiny? Why is there so much black in this piece? In each case, the art is representative of the artist, but is also a place for projection of the group members' thoughts, fantasies, and feelings. Assumptions and associations to the tangible art product may move the process along more quickly or dramatically than might have happened in a group where verbalization is the primary means of communication.

For example, in an early session in the life of an ongoing outpatient trauma-focused art therapy group conducted by one of the authors (Tripp), members were invited to put their artwork together for processing. The resulting collection of art works created by the six women provided a metaphorical representation of the group, reflecting common themes of fear, unresolved trauma, fragmentation, and dissociation ([Fig. 21.1](#)).

One piece, however, stood out because it was a bright paper sculpture that, on the surface, appeared to reflect happier themes. This piece also demanded attention because when placed on the table with the other pieces, it stood up.

One member had expressed curiosity about this *different* piece, implying that it—and potentially by association its maker—was “not the same as the rest of us.” The member whose art was being discussed, in fact, had experienced a recent traumatic loss, and was not entirely comfortable with the group's openness in focusing on details of unsettling events or sharing their traumatic histories. When the group's attention was

directed to her colorful piece, this member appeared uncomfortable and chose not to participate in the discussion.



[Figure 21.1 Artwork by Group Members](#)

One piece stands out and becomes the focus, resulting in a discussion of differences.

In the following week's session, this previously silent artist admitted that she had been hurt by the responses to her artwork, which had triggered a re-experiencing of her history of feeling shunned. She stated she had been ambivalent about sharing these feelings, and had even considered not returning to a group where she felt she didn't "fit in."

The ensuing discussion, using the art as metaphor, allowed members to address themes such as integration into group membership, accepting or embracing diversity, dealing with conflict, expressing needs, understanding others' feelings, and establishing cohesion. It is doubtful that these women would have been able to engage so deeply without the metaphor of the *different* art piece and the artist's feelings about the group's reaction to it. Exploration through art allowed all of the members to express their appreciation of one another's uniqueness, and to notice that when concerns around these issues were shared, conflict and fears could be diminished.

Conclusion

While it is clear that *art therapy in groups* and *group art therapy* are two different but related experiences, there are areas of commonality. Group members gather together and to varying degrees are able, however briefly, to enter into a dialogue with the self from which emerges an image that in some way represents that self—even when the representation is expressive of the manner in which the self is hidden. The art making is an experience of “being alone in the presence of another” (Winnicott, 1958), a very different experience from being merely alone, and one that many patients missed early in life. Even in a studio group there are times it is possible to see the resonance of images—a convergence of symbols that show that there is some relationship among the group members, even though no common theme or materials have been dictated. Art therapists in more structured groups attempt to create conditions in which this is likely to occur by offering a common theme or task, and art therapists in interactive groups use the similarity and dissimilarity of images to explore group process.

Art making within a group offers group members an opportunity to experience both pride and shame (Wadeson, 1980) within a context in which it is possible to live through the shame and live into the pride in the presence of attentive witnesses. The anxiety attendant upon being in a group pushes group members to show themselves writ large, with their habitual patterns of thinking and behaving highlighted further by their interactions with the art materials, and the images that issue from this process. Paradoxically, the group also offers comfort, as members project intrapsychic material into the artwork where (in some) it is symbolized, “acknowledged and explored,” and related to the self and other members of the group. The material can then be owned and accepted as part of the self, bringing about change (Greenwood & Layton, 1987, in Waller, 1993, p.17).

There are also instances in which group members can appear to be minimally involved in the art process or are merely contained within the group in the presence of the images. Allen (1983) writes of establishing an observer role for patients who are new to the group or who are at the time unable to participate. It appears that she sees this as an initial phase of group participation. One patient on an inpatient unit where one of the authors (Williams) worked came regularly to group but never drew. He was severely depressed, unshaven and in his bathrobe, although he always arrived on time and usually helped her wheel supplies back to the closet on his closed ward. Eventually, he was discharged, without ever having participated verbally or artistically.

About eight months later, a well-groomed young man greeted her in the hall. When she clearly did not recognize him, he identified himself as the sad man in her art therapy group. Remarkably, he thanked her for the group, mentioned how much he had gotten out of it, and described in detail the other patients’ pictures that had meant the most to him. It appeared that in his depressed state, the images were able to speak to him and linger in his mind, although he did not have the resources to interact with the group members at that time.

For the conditions to exist in which all of the foregoing processes can take place, art therapists must subject every aspect of the design of the group, their behavior in group, and their understanding of what occurs within the group, to the same intense scrutiny with which they would critique a piece of artwork. The systems and process perspectives are helpful tools in this endeavor and can be applied, with varying intensity, to understanding groups of any theoretical orientation. The art therapist who is open to learning about herself and her patients through participation in group art therapy is one who realizes that we all co-create our relationships with each other as we co-create an image or shape in relation to the intrinsic properties of the materials we choose. Since our curiosity about materials is less charged than our curiosity about each other, art can often open up possibilities for connection that have been occluded by our own histories. At best, creating images, and viewing the images of others, can provide a deep sense of connection, and a rich understanding of the dynamics that propel or inhibit relationships. Making art together develops a graphic language that enables people to speak to each other in ways that are often unattainable by words alone.

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Part VII

Integrative Approaches

Developmental Art Therapy

Susan Aach-Feldman and Carole Kunkle-Miller

Our developmental approach to art therapy is based on various perspectives, including analytic ideas about psychosexual (Freud, 1905) and psychosocial (Erikson, 1950) development, especially observations of the separation-individuation process (Mahler, Pine, & Bergman, 1975). We also use studies of cognitive growth (Bruner, 1964), especially Piaget (1951, 1954); and of normal development in art (Di Leo, 1977; Golomb, 1974; Harris, 1963; Kellogg, 1969; Lowenfeld, 1957; Rubin, 1978). Normal development is our framework for understanding and intervening with clients whose development is not proceeding according to normal expectations. (See [Table 22.1](#))

It is critical to think developmentally when working with those at the earliest stages of artistic expression, Piaget's "sensorimotor" and "preoperational" phases, 0–7 in the normally developing child. For those with severe cognitive, physical, and emotional impairments, a detailed understanding of this period is required. We meet their needs by using both traditional media and "pre-art" materials (Lonker, 1982). We also analyze art behaviors according to levels of functioning, as in the "expressive therapies continuum" (Kagin & Lusebrink, 1978), which describes media interactions for each level in terms of "media dimensions variables" (Kagin, 1969), as well as criteria for assessing and selecting materials.

Assessment

The presymbolic client may have a limited ability to make choices, to express affect, or to use traditional art media appropriately. While one might assume that he or she would profit from a structured interview; we recommend that the assessment follow a progression from nondirective to structured. Specifically, we suggest an interview that combines two or three of the following: (1) *non-directive work with traditional and pre-art media*, (2) *structured work with traditional art media*, and (3) *structured work with pre-art media*. With some, the assessment can be conducted in an hour; others may need several sessions. At the end of treatment, the assessment interview can be readministered to evaluate progress.

Table 22.1 Summary of Major Theories in Developmental Art Therapy

Age of Expected Attainment of Skill			
Theorists	0–2 Years	2–4 Years	4–7 Years
Erikson	Trust vs. mistrust consistency of experience separation	Autonomy vs. sharing (2–3) learning to control and let go	Initiative vs. guilt (3–5) develops right and wrong internalizes prohibitions from parents
Piaget	Sensorimotor exploration through body trial-and-error process object permanence	Preoperational (2–7) egocentric substitutes learns to classify	
Lowenfeld		Manipulative random scribble controlled manipulation named manipulation early shapes	Preschematic representation of a person cephalopod houses/trees/animals no particular schema
Hartley, Frank, and Goldenson	Exploration and experimentation Manipulation water play, block play	Product-process phase process of manipulation without intention creation of accidental form product itself important, not the representation	Representation of image with intention, beginning of fantasy
Golomb	Delight in action interest in how material moves and feels	Romancing stage use of media as if it had form Reading off stage looks for forms, names parts	
Rubin	Manipulation mouthing materials Forming more conscious control	Naming associating to the form Representing qualities of object Containing creation of boundaries	Experimenting exploring different ways of doing
Williams and Wood	Stage 1—Responding to the environment with pleasure sensory arousing art media as a means of motivation learning to trust	Stage 2—Learning skills that bring success able to use basic art tools and supplies shapes beginning to emerge	

During the *nondirective segment*, the therapist offers a wide selection of materials, including both art and pre-art media (i.e., water, shaving cream, beans, rice). During this phase, the art therapist allows the client to select the media and to determine activity, theme, and content, if at all possible (Rubin, 1978). The amount of time assigned to this phase may vary, and will be determined by the initiative and responses of the client.

In the *directive segment*, the therapist presents traditional art media, along with specific instructions. In

designing tasks, their purpose is to identify the client's place in the hierarchy of skill development. Activities presented with clay, for example, range from requesting manipulations (pressing, pounding, pinching), to forming shapes, to modeling a person.

Another option is a *structured assessment of the use of pre-art media*, observing the client's media involvement in terms of *orientation, manipulation, and organization*. To evaluate *orientation*, we present a variety of qualitatively different (fluid, solid) media and note the response (i.e., aversive, positive). Other tasks examine *manipulative* (i.e., scooping, pouring, banging) and *organizational* skills (i.e., combining, containing) relevant to the material. Throughout the assessment, we gather information about the client's developmental level in the use of materials; response to media properties; use of structured vs. nonstructured formats; and capacity to express affect.

Use of Structured and Nonstructured Formats

To evaluate the degree of organization required for optimal creative activity, we compare the client's efforts during "high-" and "low-project structure" phases of the assessment (Kagin, 1969). We look at differences in regression vs. organization, dependency vs. initiative, attention span, and motivation—to determine "project structure" for the initial phase of treatment.

Capacity for Expression of Affect

Levels of affective expression are assessed verbally and nonverbally. Some can talk about their art. Even presymbolic clients can be asked what a scribble “might be,” what it “looks like,” or what manipulating the material reminded them of. Since mentally impaired adults can produce “named associations” related to age-appropriate issues like sexual fantasies (Kunkle-Miller, 1978), we assume the same potential exists in other developmentally disabled individuals.

Nonverbal behaviors also provide significant affective data; and with some may be the *only* source of information. The client’s closeness or distance from the art therapist, facial expressions, gestures, and the position and muscle tone of the body are uncensored affective responses that reveal much about anyone, especially those who do not speak.

To identify the preferred modality, we present visual, auditory, tactile, kinesthetic, olfactory, and gustatory experiences, and then note responses—to develop treatment strategies that will attract the client’s attention and sustain interest. For instance, a client who uses an auditory form of self-stimulation (i.e., making inarticulate sounds, talking to himself) may respond positively to auditory stimuli by the art therapist (i.e., pounding clay, tapping markers on paper, or clapping hands). With the disabled, one or more sensory avenues may be impaired; so it is essential to identify which are “open” to therapeutic intervention.

Treatment: The Sensorimotor Phase

This first phase of Piaget, normally 0–2, includes the essentials of motor, cognitive, and emotional growth upon which all later development is based. During this phase, the normally developing infant evolves, from a totally undifferentiated state, to one with greater clarity of sensations and perceptions, as well as a refinement of reflexes and movements. By the end of the phase, the child can differentiate between self and other, has a variety of simple schemas, and a basic understanding of cause and effect.

Differentiation of self and other emerges from a close attachment and trusting relationship. Understanding cause-and-effect relationships also emerges from interactions with the primary caretaker, and with objects like toys. Understanding cause and effect and actively investigating the environment signal the end of this phase (Williams & Wood, 1977).

Clients of different ages may demonstrate characteristics of this phase, functioning in part at a developmental age of 0–2. The normal sense of curiosity leading to investigating the world, as well as the pleasure from that exploration, are often lacking in the developmentally delayed client. Motivation of clients at this stage is a difficult task, one which must take into account functioning level, interests, and chronological issues.

Materials

In the beginning of the sensorimotor phase, the child's primary interest is in his own body, followed by mother's body; Freud called the body "the first toy." These early experiences enable the child to learn differentiation of various kinesthetic and sensory inputs, as well as a basic definition of self—"me vs. not me" (Winnicott, 1971). Somatic experiences provide a necessary conduit to establishing a basic tolerance, comfort, and familiarity with various sensations and movements for clients of all ages. Movements that are first practiced *without materials* (opening and closing hands, squeezing) can subsequently be used for manipulating materials.

Development of play on a *kinesthetic* level can be a catalyst for the exploration and manipulation of materials. This process may need to begin with pre-art media. (Fig. 22.1.) The primary objective is to "expand sensory, perceptual and motor horizons" (Wilson, 1977, p. 87). Many clients at a sensorimotor level of development demonstrate "resistance to external stimuli," and need simpler steps "to more complex stimuli" (p. 89).



[Figure 22.1](#)

Lonker (1982) believes that such materials decrease resistance by providing *successive approximations* to traditional art media. Pre-art materials include safe (digestible) and manipulable items like "flour, cornstarch, salt, scent extracts, cornmeal, oatmeal, pudding, Jello, shaving cream, crazy foam, sand paper, fur, feathers, beans, noodles, spaghetti, sand, water, etc." (p. 14). For those with severe deficits, the use of pre-art materials may need to be restricted. For example, a severely retarded individual may not be able to understand why

smearing pudding is permissible during therapy, but not at mealtime.

Interest in traditional art media usually begins near the end of the sensorimotor phase. The interest in sensation and movement noted in earlier efforts with materials is evident in the initial use of crayons and paints. Since some clients may still have a tendency to mouth and ingest media, evaluation of their safety is essential. Materials should be introduced in limited quantities, as some may not be able to tolerate too many novel stimuli at once. The therapist may consider the full range of simple 2- and 3-dimensional art materials in selecting appropriate media.

To Foster Attachment and Differentiation of Self, Other, and Object

A client at the sensorimotor phase is similar to a young infant; but due to a variety of factors, resolution of the developmental tasks of infancy may be limited. The capacity for attachment and for the differentiation of a sense of self, other, and object may be impaired. Poor differentiation is evident in poor awareness of people (severely limited responsiveness and initiative, verbally and nonverbally); and of objects (no boundaries in using media).

In order to develop appropriate therapeutic interventions, even with older developmentally delayed clients, emotional development in infancy provides useful guidelines. Mahler et al. (1975) describe a progression from a time of complete dependence (*normal autism*), to parallel functioning (*normal symbiosis*), to relative independence (*separation-individuation*). We have identified three phases of work with art materials, from *extreme dependency* to *autonomous functioning*, each requiring different interventions.

With a client who demonstrates *extreme dependency and disorientation*, the therapist provides the impetus and functions as the agent for the play process with materials. He or she might physically direct and prompt the client through the investigation of a natural material, like beans or leaves. Exploratory movements could include touching, smelling, listening, observing, and perhaps even tasting the material.

With a client who can *respond to interpersonal cues*, the therapist fosters reciprocity (i.e., mirroring, imitation) in the play process-engaging the client to anticipate and repeat behaviors. To establish reciprocal play, use of each sensory modality should be prompted. For example, the therapist might “mirror” the direction (i.e., forward, backward, sideways) of the client’s hand movements, or of his rhythm while pounding clay.

With a client who demonstrates *initiative and reciprocity* in play, the therapist alternates directive and reflective roles, functioning minimally as agent and model, while continuing to be facilitating. For example, with a client using a crayon, the therapist could facilitate attention to the mark-making process, reinforce initiative, or promote the selection of colors.

The client at the sensorimotor phase requires intensive and ongoing intervention to facilitate involvement with materials. Although very impaired, he or she can explore and learn about the world, but the art therapist must “join into the play” (Rubin, 1984, p. 237) and “be more than usually active in helping the client learn to use...materials” (Wilson, 1977, p. 87).

The therapist needs to modify many elements of media presentation, in order to promote exploration for such a client. To increase the range of movement of a cerebral palsied individual, the art therapist might present shaving cream or finger paint in a tray. The medium’s fluidity increases the potential range of stroking movements, as the tray provides containment. We consider *motivation*, *prompts*, *practice steps*, and *reinforcement*. Lonker’s (1982) use of “inherent structure” is helpful in facilitating investigation at this level.

To Acquire a Positive Sensory Orientation and Simple Motor Schemes

The integration of basic sensory information, and the refinement of simple motor schemes normal for the sensorimotor phase, is inhibited with presymbolic clients. Lonker suggests that the art therapist operate as a “guide of the senses,” “introducing materials which are less obtrusive to his or her touch...[and being aware of the client’s] sensory limitations in order to develop a trusting relationship.” She also recommends the “gradual introduction of each texture or material along with ‘talking through,’ adding affect to the voice, and gestures” (1982, p. 13). The art therapist thus begins a process of “emotionally desensitizing” the client to initially aversive tactile experiences. The eventual goal is to establish a positive orientation to a variety of qualitatively different media.

To promote independent manipulation and the refinement of a variety of simple motor schemes, the therapist may first need to evaluate various aspects of motor functioning, using toys and natural substances. Motor schemes typically demonstrated at a sensorimotor level include batting, shaking, banging, mouthing, pushing, turning, etc.

To Discover Cause-and-Effect Relationships

As the awareness and coordination of sensation and movement develop, through repeated practice, an interest in cause and effect emerges in art activity, as elsewhere. With persons with disabilities, sensory systems may not provide enough information, or physical impairments may inhibit exploratory movement. The art therapist therefore needs to provide art experiences with “sequence” and “order,” where the client can “discover” relationships between cause and effect, like mixing colors of paint (Silver, 1973).

Case Study Sensorimotor Phase: Matthew

Matthew was a totally blind, developmentally delayed four-year-old, in individual art therapy. He was “tactile defensive” (aversion to touching and being touched), and had problems in language (elective mutism), cognition (severe mental retardation), and mobility (semi-independent ambulation). His mental age was 20–35 months (Stanford Binet). His emotional development was at the earliest phase, with poor individuation of self and other, and lack of independence in self-care and exploring the environment. Higher functioning seemed possible, since Matthew’s delays reflected not only organic impairments, but also emotional difficulties.

Matthew’s behavior during early sessions reflected his emotional problems. There were a variety of self-stimulating behaviors (hand flapping), and no verbal or nonverbal interaction. In response to media, Matthew screeched, cried, and withdrew his hands. Since self-directed activity was minimal, the art therapist used a structured approach.

Temporal boundaries were defined by songs at the outset: “This is Art Time,” and at the end: “Goodbye Art Time.” Also using song, Matthew and the therapist were physically indicated and named. The goal was to foster identification and differentiation of the event (art) and the individual (therapist). Over 9 months, Matthew progressed from screeching and hand flapping, to rocking in rhythm to the songs, to verbalizing segments of the “temporal” songs. For example, the therapist would say, “This is...” and Matthew would respond, “art time.”

Following the greeting, the therapist initiated playful activities to stimulate positive affect and to encourage trust, for example, hugging, stroking, tickling, knee bouncing, touching, etc. Sometimes music was used too, like singing “Eentsy, Weentsy Spider” while making gentle tickling movements on Matthew’s leg, trunk, and arm (Fig. 22.2). The focus was on movement and touch, not materials. Though the therapist was the agent, Matthew’s initiative was invited by waiting for a response after each play trial.

After about 3 months, Matthew began to show enjoyment. Soon after, during the “pause period,” he began to make movements or sounds that seemed to be a request to repeat the activity. Next, the therapist would wait for Matthew’s “request” before repeating a game. The emergence of this “requesting behavior” was seen as a major step toward beginning reciprocal play, and comprehending cause-effect relationships.



Figure 22.2

Efforts to reduce Matthew’s tactile defensiveness used pre-art media. Over time, the therapist introduced varied materials, including water (fluid), shaving cream (moldable), and seeds (particle). Through hand-over-hand direction and song, exploratory movements were encouraged, like batting, stroking, and patting. Over 9

months, Matthew began to engage in self-directed exploration of fluid media, like water. He also began to tolerate exploration of other types of media. A decrease in screeching and crying was noted, though resistance continued in efforts to withdraw his hands when the therapist was not directing his efforts.

Matthew needed a structured approach to increase awareness of self and other, to develop understanding of cause-effect relationships, and to promote self-directed sensory/motor exploration. Matthew gradually assumed some of the role as “agent” for the play. As reciprocal play and exploration of materials increased, self-stimulating behaviors decreased.

Treatment: The Preoperational Phase

The client at this phase functions between ages 2 and 7. It is signalled by a change in the approach to materials, showing discrimination and the organization of sensorimotor responses. There is also progress toward representation and egocentric symbolism, representing the individual's subjective reality. Language is developing, with labeling of thoughts and feelings facilitating the therapy. As these skills develop, the individual is becoming capable and desirous of more autonomous functioning.

Materials

A wider variety can now be introduced, though sand and water continue to provide important opportunities for exploration, and outlets for the expression and release of tension. Also, the fascination with devising routines for organizing and controlling the world generally, and materials specifically, can be successfully initiated on pliable media like sand and water. Activities with these pre-art materials can serve as precursors for organization and composition with traditional art media.

A broad range of media (crayons, paint, clay) is now appropriate; though redirection of inappropriate responses (e.g., mouthing), modeling, or directed practice may be necessary to facilitate stage-appropriate use. Growth is also facilitated by imitation and the emergence of dramatic play, so that art materials can first be investigated through play, before they assume importance for their representational potential.

To Promote Autonomy

Physical maturation provides individuals with the ability and desire to perform increasingly complex tasks with more autonomy. "Muscular maturation sets the stage for experimentation with two simultaneous social modalities: holding on and letting go" (Erikson, 1950, p. 251). Hartley, Frank, and Goldenson (1952) note that children's play reflects a fascination with such sequences as pouring water or sand in and out of cups, a culturally acceptable manner of exploring curiosity about the elimination process. The individual at this stage is attempting to work through separation from mother, with crying and clinging (i.e., holding on), negativism, and pushing away (letting go). A preoperational individual who is chronologically older may not be so concerned with toileting, but control and separation issues remain important.

Even severely and profoundly impaired individuals desire some level of independent functioning, so promotion of autonomy is important. Previously an agent for the play process, the art therapist now encourages the client to choose alternatives, and reinforces initiative. For a person with disabilities to use materials independently, adaptations may be needed, like attaching a broad piece of foam rubber to the handle of a paintbrush.

A carefully devised project can result in a successful experience, and build confidence. To facilitate the finding and selecting of materials with maximum independence, the storage and presentation of supplies must be consonant with sensory and motor skills. We consider the proximity of work surfaces and storage areas, the accessibility of supplies (open or closed containers, high or low shelves), and the quantity of materials.

To Promote the Expression and Differentiation of Feelings

As individuals move through the preoperational phase, they become more cognizant of feeling states, differentiating between affects and their antecedents. Such feelings as anger, sadness, and fear, which were previously generalized as “painful” or “bad,” become separated and clarified. Since this is no simple task, the therapist often needs to promote awareness of specific feeling states. This requires developing a sensitivity to affective expressions, from a joyful shriek to an angry punch, so that he or she can name the feeling.

For example, the client aggressively punches the clay and the therapist comments, “You are really mad at that clay today.” Language-impaired clients may require very specific and concrete examples of feeling states. Photographs, especially of the client, showing different kinds of feelings (anger, sadness, happiness, fear, loneliness) may be useful in labeling, for example: “Point to the picture that shows me how you are feeling today.”

The Development of Sensory Discrimination and Percept Formation

Activities with both pre-art and art media can promote sensory discrimination and percept formation. The client can be guided to note and identify characteristics like “full” and “empty,” using materials like water or seeds and containers. Using clay or flour and water, characteristics such as “wet” and “dry” can be examined. The client can also be encouraged to perform actions that promote a change in properties.

By describing and labeling the client’s efforts, the therapist reinforces identification of these concepts. Providing such feedback in a playful manner enhances attention and motivation. For example, the therapist can improvise songs with lyrics that reflect and accompany the client’s efforts. Skills in observation, interpretation, and identification are developed through such an empirical approach to sensory discrimination, as the client plays an active role in the discovery process.

The therapist needs to first identify motor skills necessary for the use of various media; and then to analyze the series of actions required for specific activities. For example, to glue blocks on cardboard, the client must reach for the glue, spread it on a block, turn the block over, and press it down. He or she can help clients to practice by providing verbal cues, such as “touch the glue, spread it on the block, etc.” Or he or she might present such cues in a musical way, in a “Gluing Song” to the tune of the “Hokey Pokey:” “You put your finger in, You take your finger out. You put your finger on the block, And you rub it all about. You turn the block over, And you press it down. And that’s how you make it stick!” Planned, consistent arrangements of materials on the work surface also helps, the spatial order guiding the client in the correct performance of the sequence.

To Develop the Capacity for Symbolization

For the presymbolic client, the development of *symbolization* is dependent on *imitation*, *association*, and *approximation*. *Imitation* requires the perception of physical or behavioral characteristics, and the invention of simple forms of equivalence through enactment (discovery of similarities). These perceptions must be “linked up” or *associated* with the art process, in order to transform them into symbolic expressions. *Approximation* of the features of people and objects becomes possible, once there is an association of feelings and ideas with created forms. The presymbolic client has difficulty with abstract thinking processes like imitation and association. Producing symbolic forms and articulating features is often complex, frustrating, and confusing, because of deficits in coordination, ego development, or intellect.

To develop skills in *imitation*, the therapist can promote *simulation* of life experiences in the manipulation and use of materials. Using dramatic play, the therapist may help the client to imitate events (eating), objects (car), or people (mother). Through imitative play using gesture and sound, the client can practice simulating ideas, events, and objects. The client can connect a “form” with an experience or idea, and begin to understand the process of representation and abstraction. *Imitation* thus provides a mechanism for relating form and idea, the first step in symbolization.

The presymbolic client may also need direction and support to *associate* feelings, objects, and events with art media, processes, or products. The therapist can focus on visual, tactile, or kinesthetic aspects. For example, crayon taps may remind the client of raindrops, or the colors brown and red may be associated with peanut butter and jelly. A focus on lines or shapes can also elicit associations, like faces, objects, or animals.

Finally, it is necessary to foster skills at *approximation* in order to promote symbolic art production. Underlying such approximation is the discrimination of characteristics of significant items. To assist emotionally disturbed, mentally retarded clients, Roth ([Chapter 12](#)) provided three-dimensional models as “conceptual references.” She used models to define specific attributes of objects the client showed an interest in representing.

Approximation also depends on knowledge of *techniques*. The presymbolic client is often inexperienced in creating particular shapes and forms. To encourage representing features and properties, teaching of specific techniques may be required. When a blind child wanted to make a puppet, he needed to learn simple techniques for construction using papier-mache. When skills are limited by motor impairments, the therapist should evaluate media and modify project structure. If modeling a figure of plasticine clay is too hard, the therapist could show how to assemble a figure with play dough. The wedge could be sliced into six segments, and distinct body parts identified by the client. Then, using even gross movements, the connections and placement of parts could be attempted.

Case Study: Preoperational Phase—Henry

The story of Henry demonstrates interventions appropriate for a preoperational child, while tracing his transition from presymbolic play to symbolic expression. Henry, a developmentally delayed five-year-old, was admitted as an inpatient to a psychiatric hospital. His presenting problems were failure to develop speech, delayed self-help skills (encopresis), and a high level of anxiety in strange situations and with strange adults. Although his mental age was 3–11, his emotional issues were typical of a younger child, like separation anxiety, negativism, and battles for control. Henry demonstrated potential, but his language and emotional disabilities seemed to be preventing development.

Henry's behavior during the initial sessions reflected his emotional difficulties. He ran away from the art therapist, avoided eye contact, refused to look at the materials, and laid on the floor, covering his face with his hands. Although the first step in any therapy is establishing trust, with Henry it was even more vital. Respecting his need for distance, the art therapist backed away and began painting at the easel; to act as a role model, and to assess his ability to imitate and reciprocate nonverbally. Henry gestured toward the easel, then began to paint. He smeared brown paint, then overlapped additional colors in shapeless forms (Fig. 22.3). His motor schemes were those of controlled scribbling. And he reflected some emotional issues related to the encopresis (smearing the brown paint).

Once Henry felt comfortable enough to make eye contact, the art therapist used a “total communications” approach—voice, gestures, sign language, and singing. Sign language communicated without words at his level, facilitating the development of trust. Singing was used as a minimally threatening way of getting his attention and giving direction.

The communications were also aimed at teaching language and the concept of associating or “naming.” The therapist reinforced whatever Henry was “doing” and “making.” “You are making circles. What else could you add to the circle?” The intention was to promote both creative behavior and the development of the next level of graphic skill. The ultimate goal was Henry's expression of emotional problems, which would probably be facilitated by the development of symbolic schemas.



[Figure 22.3](#)

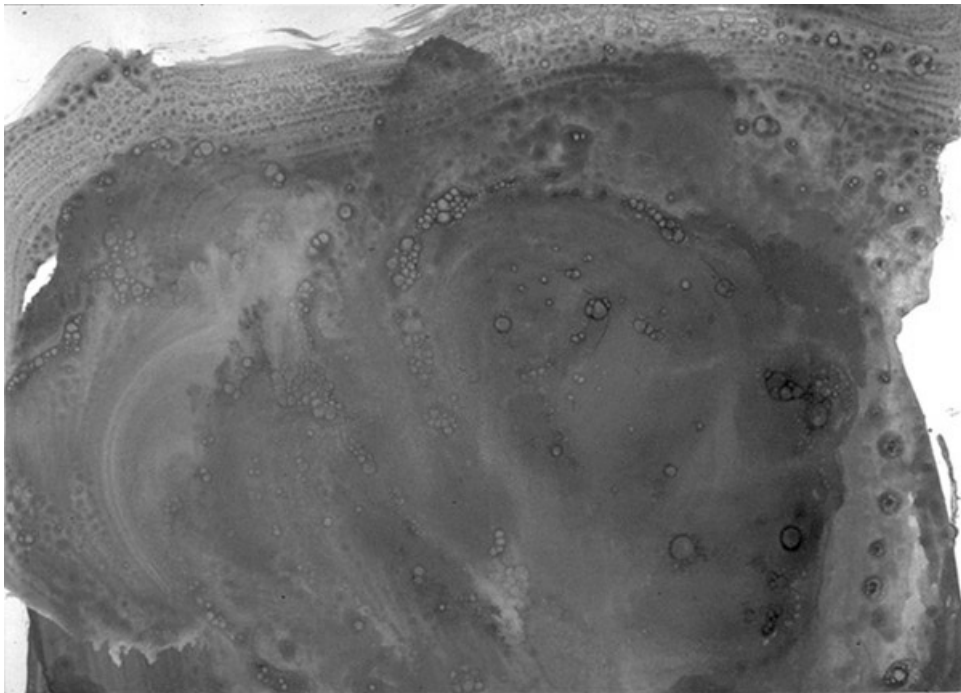
Because of Henry's difficulty in establishing relationships, the ability to represent a human face schema seemed critical. To promote this idea, the therapist created a primitive mask, which was then used in “peek-a-boo” games. The focus throughout therapy was on the development of skills that would permit the expression

and resolution of emotional conflicts. An emphasis on manipulative and cognitive skills, as well as affective expression, was necessary in order for progress to occur.

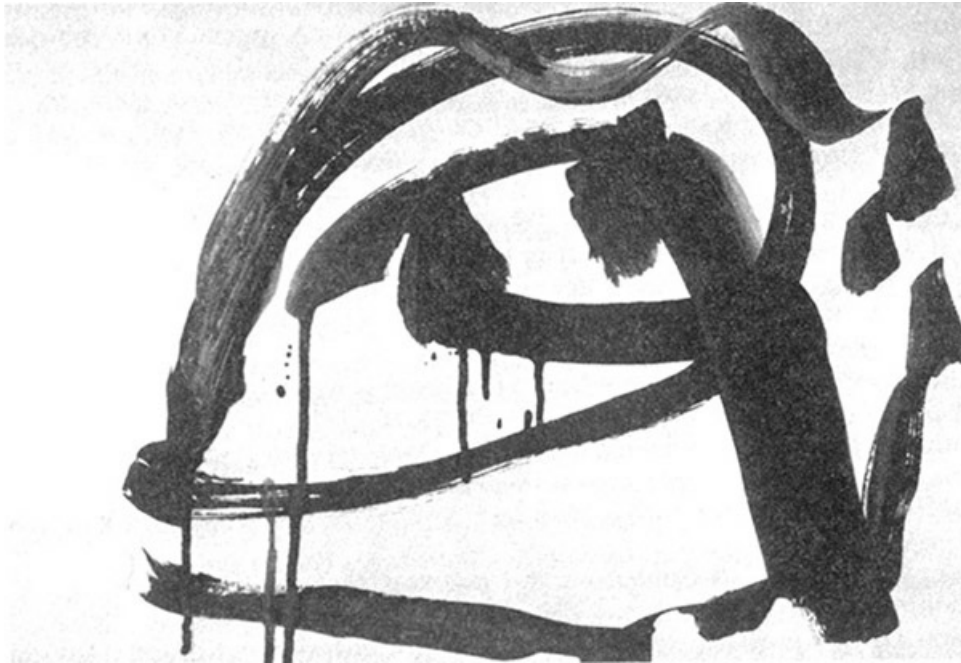
After three months of weekly art therapy, Henry began to make paintings with more distinguishable forms and cleaner colors. He made graphic shapes, from a circle to the letter “H” (which he identified with his name), to a house, to a human face ([Fig. 22.4](#)). During one of his last sessions, Henry painted the outline of a face with a large black mouth, which he then pounded aggressively with markers. For a child who cannot speak, the mouth is a reminder of his frustration. ([Fig. 22.5](#)). The pounding was probably Henry’s way of symbolically expressing his feelings about his disability.

Henry’s interactions with the therapist also changed dramatically, from extreme avoidance to reciprocal interaction. The number of “signs” and other communications increased, and Henry’s ability to express basic concepts through art improved (see [Fig. 22.6](#)). His graphic skills went from controlled scribbles to preschematic representations (Lowenfeld, 1957).

Henry used art as a language for expressing himself. Developmental art therapy enabled him to make the transition—from exploring without any intent to create a form—to creating basic representational images, which he associated with himself and his environment—to symbolic imagery representing his concerns. By differentiating feelings, developing motor schemes, and learning to create a basic symbol, Henry was able to improve his ways of handling feelings and of interacting with others.



[Figure 22.4](#)



[Figure 22.5](#)



[Figure 22.6](#)

Conclusion

A developmental approach to art therapy, based on understandings of cognitive, emotional, and artistic maturation, has been found especially useful with clients at a presymbolic level of expression. The case studies illustrate applications of this approach with two children—one operating at a sensorimotor level and the other in the preoperational phase.

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23

Lessons in the Images

Art Therapy in Creative Education

David Henley

Learning prospers when we reinstate the vague and inarticulate to its proper place in our mental life.

—William James

One morning, in a school for disturbed teenagers, 16-year-old Mel was reading *The New York Times* as part of current events and latched onto an article on the bombing of Dresden in World War II. Although the city had no military value, the allies fire-bombed this medieval architectural treasure purely to terrorize and break the will of the German people. The firestorm annihilated thousands of civilians and is one of the few war atrocities perpetrated by American and British forces. The article covered a recent candlelight peace march, commemorating the 50th anniversary of the terror-bombing.

Disturbed by the story, Mel said that “history is always written by victors who retain power” and that he himself is often wrongfully attacked by adults who are “always right, only because they’re in charge.” He described his “own war” against those who wield power, who “never have to worry about the consequences of being wrong”—like the allies, and like his teachers.

These adolescent issues of power and authority were expanded upon when, as part of the current events activity, I suggested making some images about the article. Mel created a colored pencil drawing (Fig. 23.1) of a flaming candle, featuring a cloud of smoke and dripping red wax. Though reluctant to talk about it, Mel did point out the split in the image: the mushrooming cloud representing the ever-present threat of world war, and the candle symbolizing a gesture toward world peace.

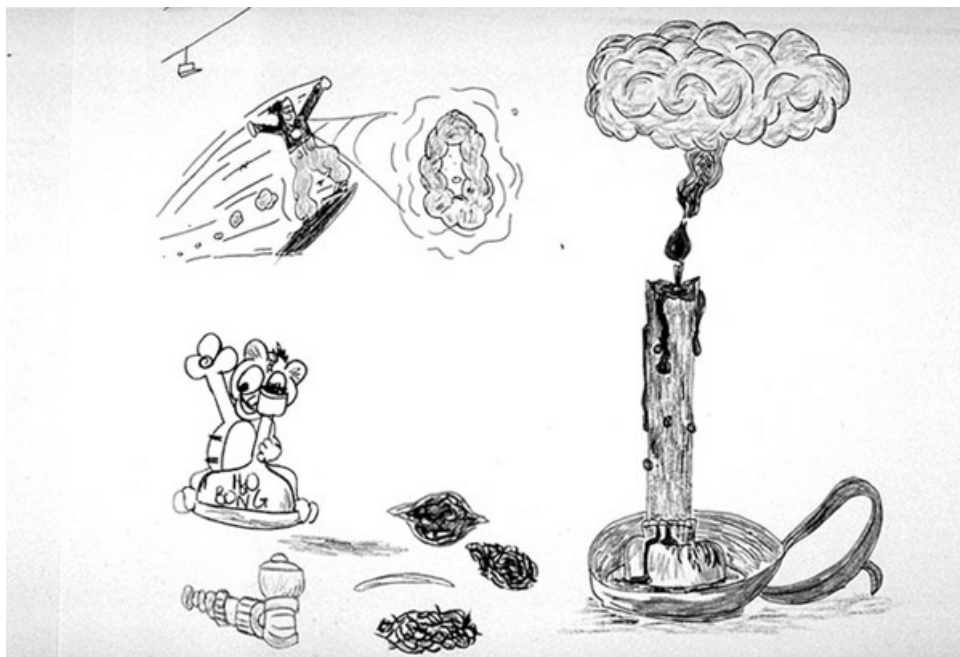


Figure 23.1 A free associative response-drawing to Mel’s reading on the Allied bombing of Dresden. Rich contextual references abound with the centerpiece being the candle, denoting the actual remembrance ceremony as well as a spectre of future “melt downs,” both personal and

[global.](#)

As he spoke, he continued to doodle in his characteristic style, adding some cannabis references, along with a snow-boarder blowing a smoke ring of the “peace weed” toward the boiling clouds. These drug references were received with the same seriousness as the candle image, since they were an integral part of the metaphor. While discussing the topic, we were able to explore Mel’s sometimes explosive hostility to authority, and its relationship to his engulfing, infantilizing mother and absentee father.

As this vignette illustrates, almost any meaningful learning experience can become a vehicle for therapeutic growth. The mission of education is usually the acquisition of academic skills, but it is expanding to include increased therapeutic support; as violence, substance abuse, and other problems reach epidemic proportions in the schools. Believing that academic work can be a springboard to emotional problem solving, I have developed both a “therapeutic curriculum” and methods for a “therapeutic critique” (Henley, 1997, 1998, 1999, 2004, 2012a).

The key to such a curriculum is tailoring educational work to the children’s own interests, no matter how negative or inappropriate they may be. In disturbed adolescents, these include negativity, anarchy, drugs, and violence, all of which find impoverished expression in contemporary media. Yet Shakespeare, too, conjured up as much graphic violence, sexual perversity, lawlessness, and psychedelic imagery as any contemporary video or computer game! Like therapy, this curriculum “goes to where the child is” by using any content that engages him or her in learning. Just as Shakespeare was able to transform graphic descriptions of maternal incest and rape into Hamlet, so too can the disturbed child transform his own negative perceptions and feelings into something poetic and powerful.

A Brief History of Therapeutic Education and Art

In 1799, a young physician named Jean Itard (1802/1962) took on the challenge of taming and educating a “wild child.” The boy, probably autistic, was found naked and scarred, roaming the forests of France in a primal state. With highly developed animal senses, void of language or habituation to people, he was approached by Itard with sensitivity and empathy. His methods of educating and civilizing the feral child paved the way for humanitarian therapeutic approaches.

Over a century later, educator John Dewey (1916) stressed the importance of personal involvement in learning: “When excitement about subject matter runs deep, it stirs up a store of attitudes and meanings derived from prior experience. As they are aroused into activity they become conscious thoughts of emotionalized ideas” (Dewey, 1934, p. 65). Dewey also recognized the role of the unconscious in creative education: “New ideas come to consciousness only when work has been done in forming the right doors by which they may gain entrance. Unconscious maturation precedes creativity in every line of human endeavor” (p. 65).

Psychoanalytic ideas were implemented in Margaret Naumburg’s progressive school, Walden. Naumburg (1917), who had studied with Dewey at Columbia and later founded the field of art therapy in America, put into practice her ideas about fostering learning through spontaneous creative expression. To help accomplish this mission, she hired her sister, Florence Cane (1951), to teach art in a uniquely empathic fashion.

In the 1930s, art education pioneer Viktor Lowenfeld (1939) began his seminal work with blind children in Europe. Influenced by the child-centered teacher, Franz Cizek, he stressed motivation as the core of creative expression. Lowenfeld stimulated self-expression by bringing feelings, bodily sensations, memories, and ideas, into greater sensory proximity (1957). And he fostered a therapeutic alliance, enhancing the children’s investment and their willingness to take creative risks (Ulman, 1987). Henry Schaeffer-Simmern (1948) also emphasized sensory involvement:

Even the simplest drawing, so long as it is the result of visual conceiving, always points to the producer’s relationship to the subject represented. It is this innermost connection between subject matter and artistic form which assures the organic unfolding of one’s inherent creative capacities.

(p. 154)

Art therapy in educational settings began in earnest with the work of Edith Kramer, who documented her “art as therapy” approach at the Wiltwyck School (Kramer, 1958). Her pioneering work with these disturbed children centered upon harnessing the drives in the service of the ego, in order to achieve maturational growth and sublimation through the art process—ideas that are central to the therapeutic curriculum.

Case Background and Setting

In order to illustrate the therapeutic curriculum, I return to Mel, and a composite of one day of programming in a public school envisioned as an alternative to behaviorally based special education programs. It was designed for children 5–21, whose emotional and behavioral issues made it difficult for them to function in regular programs. A bright, creative, and fascinating teen, Mel's intractably negative behaviors had led to a series of failed placements in both public and private schools. His was a complex clinical picture, with symptoms associated with ADHD and immature forms of both borderline and bipolar disorders. Emotionally, Mel functioned at an arrested level of development, with frequent regressions.

His ADHD symptoms included hyperactivity, impulsivity, inattention to tedious or low-reward tasks (most school work), and frequent mood swings. Mel also suffered from a body-ego disturbance, impulsively invading the personal space of his teachers and peers, who complained that he was "always in their face." There were also bouts of self-injurious behavior, particularly when his bottomless need for attention was rebuffed. At times, Mel would become verbally abusive, turn his aggression toward himself or others, or withdraw.

Like many troubled teens, Mel often attempted to self-medicate with recreational drugs. The after-effects of these binges ranged from nasty, groggy moods to hair plucking, skin picking, and cutting. Like others with similar disorders, Mel possessed "islands" of ability; with unusually strong world knowledge (he read and watched the news avidly), and a capacity for insight. His precocious drafting ability was complemented by a ferocious sense of sarcasm. His hard-hitting caricatures and cartoons of teachers and administrators revealed astute powers of observation and criticism. This ability to lampoon others awarded him special status in the social hierarchy of his peers.

In this program, I was a "teacher/therapist," meaning that I was to implement both educational and therapeutic initiatives as part of an interdisciplinary support team. Since this was an alternative progressive school, I was free to write curricula that infused the arts therapies into every facet of the school day. Treatment approaches were also eclectic—behavioral, cognitive, object relations, psychodynamic—implemented when appropriate to the situation, as I shall now illustrate.

The Therapeutic Curriculum Illustrated

The opening moments of the school day were, like any time of transition, marked with high anxiety and low productivity. The students filtered in huddling and chatting, recounting “war stories” about the night’s adventures, and exchanging social gossip. To allow for—yet contain—such discharge, a morning ritual of hot drinks, snacks, and taped music videos served to ease the transition. Eventually, the students were called to order, and told the plan of the day.

First Hour: Generating Ideas and Issues

Each academic day began with current events, with the entire class perusing the *New York Times*. Sipping tea and thumbing through the paper, we resembled a large family in the midst of a morning routine. Beyond cementing community ties, this ritual helped to contain distracted, unsettled, or agitated behavior. For those who were bleary-eyed, staring at the paper—even if only at sports scores or TV listings—camouflaged inactivity through appropriate means.

The *Times* also provided content they could relate to, since the news is full of lurid but compelling material involving sex and violence. The stories served as conduits for their own projections and anxieties, through real life factual material. The *Times* also offered a model of how to transform provocative content in an understated and poetic way. The vocabulary sets a standard, particularly since the writing style in the *Times* has become more casual.

In the opening vignette, I described how Mel latched on to the article on the anniversary of the Dresden bombing. His self-selected topic may have acted as a metaphor for his own anxieties—over fears of annihilation and the ultimate authority of those in power. Like his peers, Mel did not always reach such high levels. Emotionally disturbed children typically oscillate between different modes of functioning, depending on inner resources. More often than not, the child's weak ego leads to aborted attempts or chaotic discharge of drive energy, which may preclude the culmination of the process into a product (Kramer, 1971).

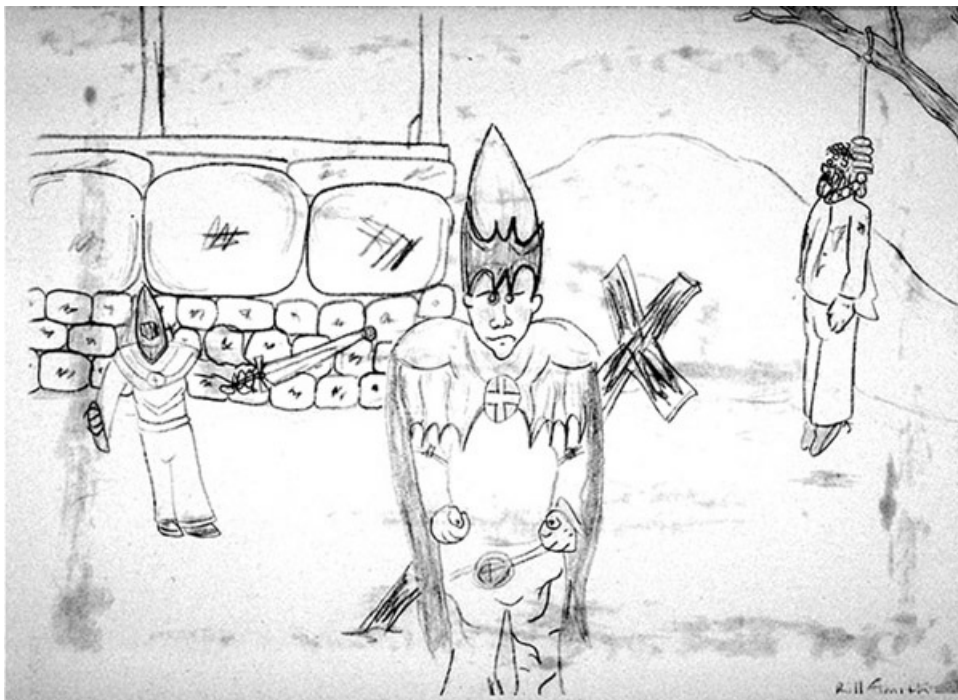
Second Hour: Finding Issues in the Classics

The second hour involved bibliotherapy, in which the students read literary classics; works chosen for their relevance to teens, as well as for their academic content. Often issues were projected onto the characters, especially through identification with the aggressor or the victim.

One day the group viewed a video of the play they had been reading—Shakespeare’s *Henry V*—a sprawling historical epic of violence, loyalty, and political intrigue, as the young man struggles to mature into a King. There is a moment in the play when King Harry has to confront a childhood friend, Bardolph, a loving but hopelessly alcoholic character, brought to him on charges of looting a French church during the battle of Agincourt. Despite affection for his old friend, Harry had to put his kingly duty before personal loyalty, and Bardolph was sentenced to hang. Mel took his turn to read: “...we will have all such offenders cut off. For when lenity and cruelty play for a kingdom, the gentler gamester is the soonest winner.”

As the old man was strung up, the King made tearful eye contact, and memories of their lives together flashed before his eyes. A few students, including Mel, were clearly moved by this passage. Most related it to times when they too had to decide whether or not to expose a guilty friend, in order to protect themselves or their peer group.

Invited to write or draw about this issue, Mel produced [Figure 23.2](#), in which King Harry faces his audience with clenched fists, choked with emotion, but resolute in his actions. To his left, the executioner wields his broad sword to show support for the King. Poor Bardolph is shown hanging, left as an example to others to abide by their society’s code of ethics. A cross seems to bear down upon the King’s back as it slants toward the corpse, as well as another on the King’s cloak—symbols referring perhaps to hopes for redemption or salvation, though it is not clear whether it is sought for the victim, the king, or both. Whatever its symbolism, Mel had engaged a metaphor of archetypal proportions and defended against pressures exerted by the primary process.



[Figure 23.2](#) A misconception that teens with severe emotional disturbances cannot embrace high-level literature is put to rest as Mel contemplates the complex issues of King Henry’s personal loyalties pitted against his responsibility to the crown.

Despite the urgency and evocative nature of the theme, Mel maintained an intact narrative and realistic drawing style. Although drawing the death of the King’s childhood friend might have sparked his own self-destructive tendencies or fears of annihilation; these seemed neutralized in his academic yet evocative treatment of the subject. The choice of colored pencils may have also supported the containment of his

emotions and conflicts. Since both intellect as well as emotion were simultaneously engaged, this activity probably bolstered his tenuous ego.

The drawing represented higher-order defensive measures indicative of sublimation, wherein drive energy is partially neutralized. The vignette exemplifies one aspect of this approach, as the ego is supported in its bid to relieve strong internal pressures, through a form that remains personally powerful yet socially meaningful. For the piece was not only a document of personal insight; it was also valued by the group. Like all powerful art, it stood as a collective truth for Mel's peers to share.

Third Hour: Focusing Ideas

During the third hour, students were encouraged to develop ideas stimulated by individual readings or group activities. One day, Mel decided to follow up on another article from the *Times* about the re-introduction of wolves to Yellowstone Park after 70 years of extirpation. During the class discussion, Mel had taken the position that nature should take precedence over short-term human economic needs. He declared that “a bounty on the skins of offensive people might provide a lesson in tolerance.” I encouraged him to direct his passion to several resources on hand in the classroom, like Lopez’s study (1978) of wolf/human behavior.

Perusing this book, Mel became interested in wolf mythology, particularly the story of Romulus and Remus, the Roman wolf children. I directed him next to Candland’s (1993) study of reported instances of wolves actually raising human babies along with wolf siblings. Engrossed in these tales of feral children (like the wild boy of Aveyron), Mel lifted an image from the Lopez book. From a medieval manuscript, it shows a werewolf carrying off a boy ([Fig. 23.3](#)). Mel joked about

whether this odd couple might be accepted by the Yellowstone pack. Turning serious, Mel lamented that adopted cubs were often ostracized or even killed by the pack.

Using the book’s illustrations, Mel sketched a series of postures (tail raising, teeth baring, bowing), any of which might signal acceptance or rejection. He then drew parallels to life in the classroom, where the “alpha” or dominant males influenced whether he—who was overweight and unattractive—was considered fair game for teasing or acceptance as a peer. Mel observed how the alpha male was sometimes challenged by other aggressors, creating an atmosphere of uncertainty and tension in the class until the hierarchy was again stabilized—just like in the wolf-pack. Mel then referred to his drawn she-wolf as an “alpha” in her own right, capable of vigilant protection and tender nurturance.



[Figure 23.3](#) Lifted from a medieval manuscript Mel expresses his own and the creature’s relational ambivalence: Will he be devoured and consumed or protected?

Perhaps he used this topic as a way to work out his own position in the class, always a source of anxiety. Given Mel’s abandonment issues and continued neediness for parental attention, his image also speaks clearly of an all-powerful mother. Note the special care with which he modeled the alpha she-wolf, who firmly yet gently holds him in her jaws. For Mel, there was a fine line between maternal engulfment/annihilation and maternal “holding,” nurturance, and care. Judging from the figure’s grin, the quality of attachment seems to be

one of bliss rather than fear.

Although the material had stirred anxiety over social status and maternal care, in researching the subject Mel seemed to gain a measure of mastery. Naumburg (1947, 1966) wrote that the image fixes in time and space unconscious material that would otherwise remain evanescent—hence, insight and maturational growth become a possibility during such an art therapy experience. In this case, mastery came in the form of marshaling powers of reason via the cognitive domain (Silver, 1978), to neutralize potentially overwhelming unconscious forces.

Fourth Hour: Overcoming Resistance to Writing

In language arts, writing of any kind can be agonizing for students with emotional or learning difficulties. Faced with assignments like journaling or critical essays, compliance often declines, with the barest effort being expended. Even creative writing requires extra stimulation in order for disturbed students to stay on task. Lowenfeld (1982) taught that students can often overcome resistance when given a novel motivation to fuel their efforts. Phototherapy was such a stimulus, introduced to help the class compose visual ideas, which could then be translated into prose.

The first task was to learn to truly “see,” using the camera’s lens as a viewfinder. I showed them the work of artists, like painter Georgia O’Keeffe and photographer Alfred Steiglitz; who used devices such as cropping, framing, and magnifying images. Small supervised groups were then allowed to explore the school with cameras, in search of suitable material to photograph.

Most of the students handled the freedom well, but even with close monitoring, Mel barged loudly into the general office where he found the principal. He then thrust the camera into the principal’s face, and began to shoot. Although he followed the requirements, cropping the portrait in an interesting way, the print ([Fig. 23.4](#)) accurately captures the principal’s distressed feelings about having his personal space invaded.



[Figure 23.4](#) Phototherapy can unleash a raw expressive response. Mel’s confrontational yet effective cropping of a figure of authority can be viewed as succumbing to a overpowering stimulus. His “shot” cunningly violates the glaring principal’s own personal boundaries.

After the contact sheets were developed and enlarged, Mel composed a prose poem about the mask-like portrait. His choice of the principal alluded, once again, to issues of power and authority. But this loaded subject precipitated more incursions of primary process material, as his writing took on a delusional, even paranoid, quality. In the flowing free-verse of his poem, Mel described the principal as “a restroom spy with unnatural hearing and smell, who knew everything one did in there, yes, you could hear him laughing and whispering through the toilet stall,” etc.

Upon reading the draft of his wild verse, I offered some suggestions intended to tone down its exaggerated quality. The next version was not only unchanged, but had escalated to include sexual obscenities. Mel was soon out of control, brashly reading his work aloud to the class. I cautioned him that he was now in violation of the “private expression rule” (Henley, 1992, 1995), which stipulated that creations of a graphically obscene or violent nature could exist only in privacy. No form of exhibition would be permitted, since such work might disturb others or be detrimental to the school community. Therefore, I calmly stated, the work in its present

state needed to be censored. Disregarding this warning, Mel continued to perform the poem, ad libbing in different voices, to the delight of his peers.

As part of Mel's individualized education plan (IEP), he was subject to a mutually agreed-upon behavioral contract, which spelled out the contingency plan for dealing with out-of-control behavior. After several cues to regain control himself went unheard, Mel was asked to relocate to the time-out area. In defiance, he stood inches from my face, mimed blowing smoke at me, and again refused. A "code" was called (as per school policy), and reinforcements arrived to escort him to time-out (a cubicle in the hallway). Mel's passions had been aroused to the point that he lost self-control, bringing into question the stimulation of the activity.

Fifth Hour: Behavioral Consequences

Because Mel was able to relocate without becoming assaultive, his contract permitted him to take his pen and sketchbook into time-out. He drew quietly for most the hour's "cool-down" period. After convincing me that he could handle returning to the group, he was welcomed back to class. During his period of seclusion, Mel had produced several images alluding to our confrontation (Fig. 23.5). He drew himself looming over me, about to flick an ash in my face, as his shirt exclaims "No Life!" His broad stance, threatening gesture, and troubled expression all capture his defiant posturing. Again, Mel was able to show some ego strength: the form of the drawing remains remarkably intact, despite conveying strong emotion. This extraordinary caricature was drawn in one continuous, elegant contour line. His confident drafting, the dramatic perspective, and its complex layers of meaning, all contribute to the work's expressive power.



[Figure 23.5](#) Masterfully drawn in one contiguous line, this foreshortened ash-flicking, in-your-face self-portrait sums up Mel's suffering.

Typically, Mel presented the drawing to me without comment, yet his demeanor suggested that it was meant to be a conciliatory gesture. In using a drawing to express his contrition, he was able to bypass authority issues and "save face." By using the language of art to communicate the depths of his suffering, Mel was able to accomplish a "supreme act of integration" through a work which fits Kramer's (1971) definition of "formed expression." The drawing possesses an economy of means, a sense of inner consistency and truth, as well as conveying an emotional charge and power that others can identify with. The sum of these successful elements suggests that sublimation had been achieved. (Henley, 2012b)

The second picture of the series (Fig. 25.6) is more regressed, with the mood of defiance deflating into resignation and self-pity. References to childlike self-soothing surround him: a ring toss, blocks, a walkman, all co-exist with an inventive use of descriptive text. While the content of the work is more raw, this takes nothing away from the image as a form of cathartic release and a further achievement of formed expression.

It was perhaps the resilience of our therapeutic alliance that allowed these contradictory feelings to be fully expressed, as they were "held" in the Mahlerian sense, without my judgment or placing blame. Indeed, it was I who had overstimulated Mel with the photo project. With all of us taking some responsibility for the meltdown, Mel was welcomed back with a clean slate, and encouraged to take his rightful place in the class.



Figure 23.6 Behavioral consequences are rarely processed with such a degree of aesthetic sophistication and emotional turmoil. Months of consistent therapeutic support and superior draftsmanship enables Mel to achieve a degree of sublimation.

Discussion

In a 1917 paper titled “A Direct Method of Education,” Naumburg wrote: “Up to the present time, education has missed the real significance of the child’s behavior, by treating surface actions as isolated conditions. Having failed to recognize the true sources of behavior, it has been unable to effectively correct and guide the impulses of human growth.”

In the case vignettes, we see an illustration of Naumburg’s tenet. Throughout each of the activities, Mel’s issues were recognized as an integral part of his overall learning experience. The themes stimulated both fresh ideas and long-standing conflicts, which sometimes provoked Mel into losing control over his behavior.

Yet this provocative process is also at the center of the therapeutic curriculum—to take creative and therapeutic risks, in order to elicit impassioned participation and ply the depths of causation, as Naumburg had urged. At the same time however, there is an emphasis on self-control, self-monitoring, and social responsibility. The dynamic tension that exists between these two is an integral part of the approach. An expected outcome of the “personal relevance” component is that disturbing responses are likely to be elicited. And one must use caution when using themes as motivational stimuli that may tap into a child’s issues.

A tragic example is the case of Kip Kinkel, who in 1999 murdered his parents and several classmates after years of emotional suffering. Just prior to his killing spree, Kinkel’s high-school teacher had taught Shakespeare’s “Romeo and Juliet” using an MTV-style film version, in addition to reading the play. Set in contemporary Los Angeles, the rival families are shown as barrio gangs, whose unbridled gunplay and violence captured the students’ imaginations—and becoming an obsession for Kinkel. When police entered the home and found the slain parents, their grim search was set to music. Kip had left the film’s soundtrack on continuous play at top volume. The eerie music enveloped the officers, its themes creating a dramatic backdrop to the crime. As an educational intervention, the teacher had chosen a powerful stimulus—one that engaged this student’s interest in ways that had unforeseen and tragic consequences.

Acknowledging the potential power of such stimuli, we need to utilize children’s capacity for reason as a way to cope with provocative themes. By engaging the intellect, cognitive therapeutic approaches can be used to bolster self-reflection while objectifying potentially disturbing material. Distorted belief systems, irrational worries, skewed perceptions can all be tempered through intellectual inquiry. Hence, when Mel became worked up over current events, world history, or literature, he was drawing upon his intellect to process and defuse his own issues as well.

When intellectual approaches fail to neutralize the overwhelming emotions of children with weak egos, however, we can expect regression and breakdowns of impulse control. Behavioral approaches may then need to be pressed into service. As with Mel, this might take the form of a mutually agreed upon contract, spelling out contingency plans for dealing with acting out behavior. He understood that we would negotiate and accommodate acting out for only so long, before action would be taken. Because of his problems with limits, their parameters needed to be crystal clear. Only then could Mel anticipate the consequences of his actions and feel secure, even when out of control. With limits set, we could do our work with fewer regressions and a strengthened therapeutic alliance.

A solid alliance with Mel enabled me to set limits when necessary, while not doing fatal damage to our rapport. As he tended to vilify me as the all-bad “mother,” it was critical to absorb this negative transference and to convey a sense of forgiveness after each incident. Emphasis was always placed on his returning to class with a blank slate and a fresh start.

Yet, even with this response, Mel’s splitting defenses often remained mobilized. [Figure 23.7](#) reflects what a strain it was for him to maintain our alliance, especially when we were in conflict. This image was presented to me the morning after a particularly bitter confrontation. In Mel’s dream I loom over him, imperiously gesturing, while he sweats out the nightmare under the covers. I declare that Mel is in a “no cue situation,” meaning that his behavior had escalated to the point that no further warnings would be given before he would be removed from the class.



[Figure 23.7 The Teacher/Therapist as an imploring, even hounding figure lives on in Mel's unconscious as he invades his dreams. It is extraordinary how ego-ideals can become integrated with id-derived parts of the dream-narrative.](#)

I was represented as the voice of the auxiliary ego and the superego. That Mel carried our behavior contract with him into the realm of primary process, attests to the gravity of these struggles, as they fully engaged his psyche. The program had become internalized for this child, which I believe contributed to its therapeutic efficacy.

Conclusion

The approach described in this chapter is not simply a matter of practicing art therapy in educational settings as a clinical support service. (Cf. Bush, 1997) In the therapeutic curriculum, work is not separate from the academic experience, but is an ongoing process integrating a range of expressive modalities: art, photography, poetry, and bibliotherapy.

The mission of the therapeutic curriculum is to support a child within the “least restrictive environment” as stipulated by the mainstreaming law. My interpretation of this statute is that the content of academic courses should include elements of emotional problem solving. Only then can the school experience address the whole child on a sustained basis. Given that school lasts for 12 years (up to 16 in special education), long term therapeutic work can be accomplished. This stands in stark contrast to the “revolving door” that characterizes profit-driven HMO’s.

The therapeutic curriculum can also be adapted to assist the “normal” school child in coping with life’s stresses and transitions, without diluting academic rigor. For children whose problems remain at sub-threshold levels and do not require IEP accommodations, a more empathic approach may also enhance their adjustment and motivation. Rather than being a means of damage control after symptoms of maladjustment appear, the therapeutic curriculum can be proactive and preventive. And the work goes on all the time as part of normal school activity.

I have also used it in a summer camp setting with ADHD children, who became adept at utilizing metaphors during ordinary group activities (Henley, 1999). For example, after leading a fishing expedition with a group of bright seven-year-olds, I asked them whether they’d ever felt “like a fish out of water.” They immediately grasped the connection between their own anxieties and those of the fish—which they had caught and put into the camp’s aquarium. They were able to project their feelings onto the fish, and to explore instances where they felt alienated, isolated or abandoned. They made pictures about being afraid to be left overnight at Grandma’s, having to move to a new house, or having new step-siblings when their parents remarried. Expressions of great profundity were generated by an otherwise unremarkable summer camp activity.

Ideally, the therapeutic curriculum intervenes during formative stages of development, wherein we hope to promote healthy coping capacities that will endure into adulthood. For it is our children who will inherit and define the future health of our culture and, indeed, the world.

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24

Pandora's Gifts

Using Imagination and All of the Arts in Therapy

Shaun McNiff

The Integrating Realm of Imagination

The idea of using all of the arts in therapy provokes fear in some and excitement in others. Perhaps this discrepancy is connected to the way in which the reputation of the mythic figure Pandora, the “all-giver,” changed from being the source of bounteous gifts to the cause of pandemonium (Gaskell, 1960; Walker, 1983). Pandora’s “many things” came to be perceived as “too much.” The word *pandemonium* (pan, demonium), meaning the universal release of daimons/spirits, became associated with a state of being overwhelmed.

The linear mind does not respond favorably to the stream of images and sensations flowing from Pandora’s original vessel, a honey vase from which blessings were poured. The vase became a box “only in the late medieval period” due to a misunderstanding of the original image (Walker, 1983, p. 767). When Pandora, the first woman, “out of curiosity for new experience” (Gaskell, 1960, p. 558) opened the vessel she was forbidden to touch, all of the evils of the world were released. By the time she was able to shut the lid, only Hope stayed within the enclosure. Pandora became a symbol of chaos, and her many blessings were lost.

Within general culture, the Pandora image has developed into a reminder of what “we do not want to do.” Don’t open the lid and let everything out; keep it all under control, and so forth. However, those who are stimulated by a creative interplay of diverse elements are more apt to welcome the endless possibilities suggested by the original image of Pandora. Negative assumptions about the Pandora aspect of conscious can be altered by an understanding of how the creative imagination is an integrating intelligence, which actually *requires* a fluid mix of ingredients. The ills of Pandora’s many things become necessary elements of a creative integration that does its best work with a rich variety of ingredients.

In the mid-1600s, the empirically minded philosopher Thomas Hobbes viewed imagination as a connecting power that functions organically, in contrast to mechanistic chains of thought. The formative power of imagination integrated all faculties and ways of knowing—the arts, science, reason, perception, memory, and emotion. From the radical empiricism of Hobbes to the more transcendent Romantics, imagination was viewed as a mediating intelligence. In 1744, Mark Akenside described the imagination as a “middle place” between perception and reason, and Samuel Taylor Coleridge (1907/1817) emphasized imagination’s role as an “intermediate faculty.”

The identification of imagination as a middle realm suggests a state of consciousness where the different elements in a situation can meet, influence one another, and create new patterns of interaction. The release of Pandora’s many things will find its way to order and creative transformation, within an environment that understands and protects the natural movements of the integrating imagination.

In 1804, Jean Paul Richter described the imagination as the “faculty of faculties,” which he likened to the process of pollination: “In genius all faculties are in bloom at once, and imagination is not the flower, but the flower-goddess, who arranges the flower calyxes with their mingling pollens for new hybrids” (1973, p. 35). Imagination, as Richter suggested, is the “conductor” of creative action, a force that operates by making fresh links between previously separate entities, always open and receptive to new possibilities while forever seeking out opportunities. It would be sheer folly for the creative imagination to arbitrarily declare any aspect of inquiry off limits. As a “conductor” of the complex of forces and thoughts moving within a person, the imagination functions as an inner leader.

During the 20th century, the intelligence of the imagination has been overlooked by education and psychology, in spite of the testimony of great thinkers like Albert Einstein, who declared that “imagination is more important than knowledge.” Our multi-dimensional lives give a new relevance to the idea of imagination as the power capable of gathering and fusing infinitely variable materials and ideas.

Using All of the Arts in Therapy

Paolo Knill, who has created a method called “intermodal expressive therapy,” repeatedly refers to the use of all of the arts in therapy as a “discipline” that can be compared to a more singular focus on painting, piano, poetry, or theater. He emphasizes how we need to pay more attention to “the basic human need or drive to crystallize psychic material; that is, to move towards optimal clarity and precision of feeling and thought” (Knill, Barba, & Fuchs, 1995, p. 30). Stephen Levine’s (1992) approach to using all of the arts in therapy trusts that in the sometimes difficult and disintegrating movements of creative imagination “lies the cure” to our psychic ills (p. 69). In *Foundations of Expressive Arts Therapy* Stephen and Ellen Levine (1999) note that, even though the “multidimensional approach” to all of the arts has been “accused of eclecticism in the sense of an incoherent collection of approaches” (p. 11), the process of creative imagination unifies the multiplicity of experiences that often cause our emotional fragmentation.

The idea of using all of the arts in therapy consistently raises concerns that those who work in this way will be dilettantes—“jacks of all trades and masters of none.” I do not deny these worries about quality. But are not our goals in both creation and therapy focused on the integration of the varied elements of our lives? Are we better served by keeping Pandora’s discoveries securely locked inside a box, or by learning how to move with them in creative and ever changing ways? Is the most complete exercise of intelligence and creation possible without accessing all of our resources?

One way of responding to the dilettante challenge is by training therapists who are skilled in the process of integrating the arts.* In 1974, I founded the first graduate program with the goal of achieving this outcome. Paolo Knill’s intermodal expressive therapy and other ways of integrating the arts grew from our community. We studied traditions in the West and within all of the world’s indigenous cultures where different expressive media are used to further healing (McNiff, 1979). However, the potential of integrated arts training will be limited if the only goal is the creation of yet another mental health specialization and “brand name.” The more intriguing task is the exploration of how all therapists—and artists—can open their work to a more complete process of expression.

In this chapter I hope to demonstrate how work in art, as in all creative modalities, requires multi-sensory activity. In *The Arts in Psychotherapy* (1981), I also suggested that the natural “integration of the senses in artistic expression” restores a “forgotten balance” that is the basis of healing (p. ix). So rather than getting caught in arguments about dilettantism, eclecticism, and professional association guidelines for a discipline, I will try to show how the practice of art therapy is enhanced by—indeed, “requires”—a more comprehensive understanding of expression through all of the senses.

I have always been comfortable encouraging these approaches in the “art therapy” community not just because I am a painter, but because the word “art” in English includes all of the arts and artists. As Susanne K. Langer (1957) said: “there is only one concept exemplified in all the different arts, and that is the concept of Art” (p. 14). Arguably, if art therapy is to exclude the other arts, it should consider changing its name to Visual Art Therapy.

Can we learn to approach multiplicity—whether in Pandora’s Box or in the therapy room—as an opportunity rather than as a plague? In environments that support the expression of creative imagination with both children and adults, there is typically a mix of different modalities. We find repeatedly that the ecology of different sensory expressions not only increases the creative vitality of the whole environment, but also furthers imaginative expression within a particular medium. I have always chosen to use different arts in my studio practice, because the breadth of resources and materials enriches the creative process and is more satisfying for participants.

I have increasingly observed that the healing effects of the art therapy experience are connected to a successful activation of creative “energy.” Consequently, a primary objective of my practice has been the creation of a space that generates expressive energies, which then act upon the people within it. In keeping with Asian healing practices based on the healthy circulation of ch’i (qi) in the body, I have found that within a free and safe environment, the creative medicines of the artistic process find their way to conditions in need of transformation (McNiff, 1998).

In constructing this environment I am concerned with the overall feel of the studio. I strive to create an

atmosphere which fosters access to the realm of imagination, which acts upon us through its transformative forces. I often drum and play other percussion instruments as participants paint or work with visual art media. There is a high level of emotional release and relaxation connected to the drumming that helps people move more spontaneously. Participants describe how the drum enables them to work in a bodily way; how it stimulates a flow of imagery; and how it helps them connect to the forces of creation.

For example, I have discovered that drumming helps people make bolder and more expressive gestures. When we encourage spontaneous expression on large surfaces with wide brushes or oil sticks, for example, the drum furthers the use of the whole body. Percussive music has a similar effect on artistic expression on small surfaces and with precise tools. In big and small paintings, rhythm supports movement.

Repeatedly, I have seen how a person who at first timidly moves with a paint brush, becomes an “expressionist” with the help of the drum. Others who fear expression, can let go of restrictive thoughts. Faint or tight lines and other signs of inhibition are often caused by feeling that we have nothing of value within ourselves to express. People are also blocked by feelings of technical ineptitude. Moving with the drum beat, we realize that expression can be more than what we initiate alone. Paintings can be created in response to, and in synchrony with, the expressions of others.

The drum helps to sustain expression within the painting, just as the rhythmic element provides continuity for a musical composition. The person who lacks self-confidence or a clear sense of where to go with a painting, simply makes strokes, taps, and marks in synch with the drum beat. Images take shape through the natural flow of incremental gestures. Rhythm enables us to appreciate how the painting process, like music and dance, involves a sequence of expressive gestures that occur within the context of space, time, and kinesis.

The painting itself can be viewed from the perspective of rhythm. Visual patterns, repetitions, ascending and descending lines, and other features are related to elements of the music. When multiple art forms are used, we may be even more apt to experience ourselves making gestures within a supportive environment of expression. I believe this use of different artistic media creates an environmental energy, what I call a creative space, that truly acts upon the individual. It counteracts the common problem of a person feeling pressure and inhibition, because of a belief that expression comes completely from within themselves. When we feel empty and blocked, the environment itself can be a source of stimulation.

My work with all of the arts in therapy began in response to the way people in the psychiatric hospital to whom I was offering opportunities to make visual art, spontaneously expressed themselves with poetry, drama, voice, and movement as well. Was I to say that these communications were off limits? Was I to close Pandora’s Box or was I to allow the different expressions to emerge, trusting that they would find their way to creative integration? Did I have to be an expert in these different media in order to welcome what was expressed naturally in the studio environment? Could I open myself and the art studio to a natural multimodal flow of expression? The different art forms introduced a broader spectrum of expression, and they were clearly manifesting needs for communication that could not be met exclusively by the visual arts.

Stories, poems, creative writings, and imaginal dialogue have always played an important role in my work as ways of engaging visual art imagery (McNiff, 1992, 1993). But from my first art therapy experiences, I discovered how limiting verbal explanations can be. I explored ways of responding to art with art, and in keeping with Jung’s practice of “active imagination,” I found that we can amplify and focus our engagement with an image by imagining it further (McNiff, 1998). Explanation certainly has its place in art therapy, but I have also experienced how it can arrest the ongoing flow of the creative process. The exclusive use of verbal language as a mode of relating to images tends to keep us within the realm of what I call “explanationism.” Even my experimentation with imaginal dialogue was restricted by the linear structure of narrative (McNiff, 1992, 1993).

In my studios we explore using movement, vocal expression, and performance to more completely access the creative energies manifested by images. While other colleagues who engage all of the arts in therapy give relatively equal focus to all media (Knill, Barba & Fuchs, 1995; Levine 1992; Levine & Levine, 1999), I have always used the visual arts as what I call the “trunk of my tree.” I introduce the other arts in order to more completely perceive and express the energetic qualities of images. Sound and bodily movement, for example, help us to resonate more closely with the vibrational qualities of images approached as energetic fields of interacting colors, movements, and forms. There is as much physics to a painting as there is psychology, and the energetic medicines have healing powers that are not accessed through verbal explanation.

Pandora's many ingredients can be released in such a studio atmosphere, and in keeping with the dynamics of the creative process, they are allowed to find their way to areas of need. The healing process of creativity corresponds to the ecological forces of nature. Outcomes cannot always be planned in advance, and I am usually surprised by what a person does and how a problem is resolved.

Talking about paintings will always be an essential feature of art therapy. But I have found that it can sometimes be more helpful to respond to a painting of swirling lines with movements that correspond and mirror, amplify, diminish, or re-direct the expression of the visual art work. Vocal improvisations add yet another dimension to our experience of a painting. These multi-media engagements expand the sensory interplay. We can respond to any visual configuration, scene, or combination of colors through sound and movement. The simplest and most elemental figurative and non-figurative compositions often elicit the most direct and spontaneous artistic responses in other media. Body movement and vocal improvisation deepen our relationships to paintings, and actually augment our understanding of them. This expansion of the process of interpretation and communication reminds us that pictures can evoke more than verbal explanations.

My role is one of keeping the space safe and creative. This process is similar to D. W. Winnicott's attempts to create a "holding environment" that supports the person in finding understanding. Winnicott was dismayed when he realized "how much deep change" was "prevented or delayed" by his interventions. He concluded that the analyst's role is the creation of environments that act upon people: "If only we can wait, the patient arrives at understanding creatively and with immense joy, and now I enjoy this more than I used to enjoy the sense of having been clever" (Davis & Wallbridge, 1981, p. 25).

This method of using all of the arts in therapy establishes an environment of creative energy that influences people, in contrast to an emphasis on linear treatment plans for individuals. The creative atmosphere is an agent of therapeutic transformation. However, such "process medicines" complement, but certainly do not replace, the conventional treatment plan. Within the overall environment of the studio, I adjust and plan according to the unique needs of individuals. One person might need to warm up with body movement in order to paint with more fluidity, whereas another might need to sit down and meditate in order to benefit from stillness and quiet focus.

From the beginning of my art therapy practice, I have focused on the healing effects of groups of people working together in studios (McNiff, 1973). Maxwell Jones's (1953, 1982) practice of the therapeutic community and Rudolf Arnheim's (1954, 1972) interpretation of Gestalt psychology helped me to understand that the structures of environments generated therapeutic forces. Where others might use specific systems for integrating the arts, I am more interested in an open-ended "ecology of imagination" (Cobb, 1977) that happens in a therapeutic community of creative expression encouraging infinitely variable processes of expression.

Even if an art therapist chooses to work only with visual media, there is a need for a deeper appreciation of the interplay among different sensory modalities within the creative process. In the following section, I will focus on how an understanding of the kinetic basis of painting furthers expression within visual art therapy. Hopefully this illustration will show how the different arts inform and enhance one another, and how even the most focused practice in a particular medium is advanced through an understanding of how all of the faculties work together within the process of creative expression.

The Primacy of Movement

I will typically introduce painting and drawing activities by encouraging people to move in a relaxed way, without thinking about what they are going to do next. I urge them to move freely while they paint, without an initial regard for results. As they become immersed in the painting activity, they also see that the movement will "start to direct itself." It helps to demystify painting and drawing when we approach them as movement. When we paint, we are dancing. When we dance, we sculpt fleeting forms and create fleeting images. Neither kinesis nor touch can be separated from the process of creating a picture. In my experience, the expressiveness of a painting is furthered by improving a person's ability to move with greater spontaneity and grace.

I try to keep people focused on elemental gestures. I encourage repetition and simplicity, knowing that structure and other forms of communication will emerge from basic motions, if we can stay with them and let go of the need to plan everything in advance (McNiff, 1998, 2015). We avoid inhibiting ideas about what a painting or poem "should be" by approaching it as movement.

We have all heard the child or adult say, "I can't think of anything to draw." The same poverty of ideas

tends to apply to the other arts when they are approached through mental or even visual planning. Movement offers a guaranteed starting point. Rather than focusing on the quality of the visual image, I recommend concentrating on the character of the movement and the creative energy it generates. When the person says, “I can’t think of anything to make,” I reply, “That’s fine. You don’t have to think of things in advance. Just move with the materials. Close your eyes if it helps, and feel the movement and the way the art materials make contact with the surface. Imagine the painting as a dance. Focus on the quality of the movement. Don’t be concerned right now with the visual appearance of the picture.”

As I drum and use other percussive instruments to create rhythms, people begin to let go and move more spontaneously in their paintings. Not only does the accompanying music further the painting, but I find that people will often move with their brushes and oil sticks in synchrony with the rhythms. In some cases, the paint is applied percussively and rhythmically through striking motions, slaps, taps, rubs, and other gestures evoked by the music. There are also clear variations in the visual marks and patterns which emerge, in keeping with changes in the music. Painting, movement, and tactile sensibilities are naturally integrated in the making of a picture. Music and sound tend to energize the painting process, and I have never observed them controlling or in any way interfering with the artist’s freedom of expression.

By approaching painting as a multi-sensory activity we benefit from a more complete circulation and ecology of expressive energy. It is helpful to view every gesture as part of an ongoing flow of movement. A particular stroke emerges from the one that went before it, and then becomes the source of yet another gesture.

People need to learn how to move from within themselves, from the particular place where they are at the moment. Many find it difficult to act creatively, because they attempt to be in a place other than where they are at the moment. They lose balance, and the ability to move with the forces of the environment that will ultimately support expression. They expect something other than what they are doing at that particular time, or they think that what they are doing is inadequate. They become blocked, and caught up by negative and confusing thoughts.

The movements of any person on the surface of a painting can become truly fascinating, when they are made with total concentration and abandon. If people need guidance after making their first gestures, I encourage them to simply build upon what they are already doing. When we begin to move in a more relaxed way, the movements not only emerge from one another, but even seem to perfect themselves. The improved quality comes from within the movement itself.

Simple experiences with movement help us to see how we frequently overdo it with plans in other parts of our lives. I might say to a person in need of direction, “Try to keep moving, don’t stop, and trust that a new movement will always come out of the one that went before it. Put everything you have into the movement. Even if you make a slow and delicate gesture with your arm, fill it with all your energy and with total concentration. Identify completely with it. Be aware of your breath and view stillness as a pause between movements. Let another gesture come forward and yet another one from it. If you can keep moving in a relaxed way, without thinking about what you are going to do next, you will discover that the movement will start to direct itself.”

If we are able to let go of the need to mentally direct expression, we discover that the movement “happens” to us. When we reach the state of being moved by a force that is more than our conscious mind acting alone, we have entered the realm of *imagination*. It is our body which is moving, yet it is propelled by forces outside of ourselves as well as within ourselves. As Ahab said in *Moby Dick*, “Is Ahab, Ahab? Is it I, God, or who, that lifts this arm?”

Nothing will happen, however, unless there is sustained movement from one moment to another. The direction is not always clear, and the outcome rarely known at the start of an expressive act. What matters most is the commitment to beginning, and the acceptance of what will emerge. By focusing on the movement basis of painting, the mind follows the lead of elemental gestures.

Letting Go While Staying Focused

Those who have encountered the powers and gifts of the creative imagination know firsthand that it is usually the overly controlling mind, excessive effort, and narrow expectations that restrict access to the middle realm of imagining—which requires a paradoxical discipline of letting go while staying focused, and allowing the creation to emerge.

Children's play can teach us so much about the creative process. As Hans-Georg Gadamer insists, the fulfillment of play requires the player to become lost in play (1994, p. 102). The fear of losing control is the primary reason why many people are reluctant to open themselves to unplanned expression. This fear may be magnified when making art is accompanied by other forms of expression.

Free movement can evoke a sense of primal isolation or coming apart at the seams, and spontaneous drama may trigger the paralysis of stage fright or the dread of being exposed. These fears can be motivating forces for expression, if the space is safe, and if participants are convinced that their expression will be welcomed and respected. Lifelong fears of being rejected and judged can be reversed, if every gesture is witnessed with a sense of appreciation and even sanctity. This is the most distinguishing characteristic of the art therapy studio.

Rather than letting ourselves go within the creative process like a child at play, we initially guard ourselves against "pandemonium." Our defenses are constructed on the basis of real life experiences of being overwhelmed and confused. Opening to the gifts of Pandora is not without challenges. Creative exploration can be difficult, and it is sometimes painful and disruptive.

Nevertheless, the experience of making art consistently suggests that what disturbs us the most may also have the most to offer. In medicine, the toxin can become the anti-toxin. Similarly, engaging and knowing the power and the pain of rage, fear, and ecstasy, allows us to harness their energy in our lives. Over and over again, I have found that the images and expressions we create never come to harm us. Indeed, even when full of pain, they instruct and strengthen us. The goal of this approach to art therapy is the creation of a space where we can open ourselves to the complete spectrum of human expression, trusting in the intelligence of the creative imagination.

Creative vitality can be viewed as a condition in which all of our resources are simultaneously engaged. The process of transformative integration is the basic dynamic of health, as well as creation. This approach to art therapy, then, relies on the making of a space where these creative powers can be activated, and where we in turn can be healed by them.

Note

- * If we think in terms of more universal access to all of the arts in therapy, then we are subject to the valid criticism that therapists are using the media of other professional groups without proper training. However, there are many Registered and Board Certified art therapists who do not have highly developed skills with all of the media they use with clients. Are they to be restricted to offering only materials in which they are proficient?

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An Eclectic Approach to Art Therapy

Harriet Wadeson

In responding to the editor's invitation to contribute to this book, my secretary typed that I would be happy to write a chapter on "The Electric Approach to Art Therapy." I didn't correct the letter, but added in the margin that this is indeed highly charged work. And so it is. The power of an eclectic approach is the personal nature of its development. Nothing is taken for granted. It is not simply because I believe that many theories have something to offer, nor that any one theory may be too limiting—although I find both to be true—that I choose to be eclectic and encourage my students to be so as well. My rationale is far more fundamental, intrinsic to my convictions of what therapy is and what it is about.

The instrument of the therapy is the self of the therapist in concert with the self of the patient. Our basic tools are not paint or brushes any more than they are words. Whatever happens in art therapy occurs within the container of the transference relationship (psychoanalytic theory: Moore & Fine, 1968). Margaret Naumburg (1966) was particularly emphatic in making this point. I also believe that the therapeutic endeavor is a creative enterprise. Since the selfhood of each therapist is unique, each clinician's creative work in this realm will bear the imprimatur of that self, with all its life experience influencing each moment of the therapeutic relationship. Just as my painting will be different from yours (even though we may have attended the same art school), so we will practice therapy differently, each according to our own style, even though we may share similar views of psychodynamics and treatment objectives.

Each existing theory orients us somewhat differently. No doubt these theories were developed in consonance with the unique needs and life experiences of their authors. It follows, therefore, that if we are to make the most of our unique potentialities, it is up to us to select and synthesize from among the many theories and treatment models available to us in accordance with our needs and worldviews.

It is important to note that this is an active and ongoing process. Being eclectic does not mean slipping into a ready-made garment and going to work. The process requires far more creativity. We may select a hat from one store, a sweater from another. We hope the shoes won't clash with the rest of the ensemble. We might outgrow them or discard a style that pinches for one that is more comfortable. It is in this way that we create ourselves as art therapists. Nevertheless, it is not necessary for us to weave our own garments. We can select ready-made slacks and shorten them only if they are too long. To switch metaphors, we don't have to reinvent the wheel.

When we look at the theories that we wear, however, we must recognize them for what they are. They are not skin or blood or bones. They are made up to serve a purpose. For example, there is no such thing as an id. (Have you ever seen one?) There is only a concept. If that concept helps us to organize our understanding, then it is useful. On the other hand, if we are referring to "repressed" aspects of the "self" that are more encompassing than "basic drives," we may find the Jungian "shadow" a way to express our understanding.

An eclectic approach is a more difficult road. It requires choices. There isn't a unified system into which the complex data for understanding and changing human dynamics can fit. Nevertheless, for me it is the only way. It is consonant with my belief that therapy is growth, and that growth is a mystery. The art therapist participates with the client in the client's growth. And the art therapist must grow as well. An aspect of that growth is the continuing search for understanding, the ongoing refinement of one's thinking. This is an active process of attending to all possible influences, including new ideas and theories.

And the mystery? Ultimately the process of growth is a mystery to us. It is a continuation of the process of creation. As an art therapist, I am in awe in relation to that process. As a searcher and seeker in understanding human creation and growth, I must be open to new possibilities.

My Eclectic Layer Cake

In a brief chapter such as this, it is not possible to present a full description of the eclectic synthesis that informs my view of art therapy at this time. The best way to summarize it appears to be an historical review of the layers of my own theoretical development.

As I have stated elsewhere (Wadeson, 1980), I began with Father Freud during teenage baby-sitting stints at the home of my-uncle-the-psychiatrist. I had never dreamed dreams could be so illuminating (Freud, 1900). When I began working at the National Institutes of Mental Health (NIMH), the neo-Freudians who reigned supreme were being joined by the systems folks who were studying family dynamics, which they later published (Bowen, 1961). I read Jung (1959), but found him too spiritual. Later, I was ready for him. I was working with adolescents at NIMH then, and leaned on Erikson's (1950) developmental model.

During the mid-1960s, I began venturing forth from NIMH and the medical model into more humanistic realms. I read existential philosophy (Heidegger, 1962, 1964; Jaspers, 1952, 1963; Kierkegaard, 1957) and began to replace the idea of psychic determinism with the notion of individual responsibility for creating one's life. I began to see perception as an active, selective process. This view was more hopeful, and therapy took on new dimensions and possibilities for me. I suppose I was always a closet phenomenologist, but in conjunction with existentialism it took on new validation (Boss, 1958). When I changed projects at NIMH and moved from affective disorders to acute schizophrenia, my immediate interest was to try to understand what it was like to be schizophrenic. There are plenty of observations by others of acute schizophrenics, but I wondered what it was like for *them*. So I directed my research to the phenomenology of schizophrenia (Wadeson & Carpenter, 1976). Art therapy was a natural channel for the expression and reification of the inner experience.

Consonant with an existential view was a shift from viewing the patient as object. It became increasingly apparent that the patient was not a constant with a fixed symptomatology. There were patients who behaved very differently in their art therapy sessions with me than they did with their psychiatrist or in the dayroom. Since most of the patients with whom I worked were diagnosed psychotic and were free of medication for research purposes, the shifts in their behavior were often quite dramatic. I began to see how much influence the therapist has. It became clear to me that I could not understand my sessions with patients without exploring my half of the equation. I began to scrutinize the therapeutic relationship.

From a practical standpoint, I found Fritz Perls' (1969) Gestalt therapy helpful. Attending to the messages my body was sending me, I became more self-aware in this endeavor. This was particularly useful during art therapy sessions. For example, I began to notice that at times my eyes would go out of focus. I came to recognize that this signaled boredom or apathy on my part, and was almost always related to the patient's enacting some distancing maneuvers. Now, the moment my eyes go out of focus, I interrupt the patient and inquire about what's going on.

I find Gestalt therapy's concept of "disowned parts" an interesting companion piece to the concepts of "projection" in Freudian theory and of the "shadow" in Jungian psychology. Taken together, these three constructs round out a significant area of psychopathology or malfunctioning. The three ideas do not contradict one another, but rather are complementary, each adding a dimension to our understanding of what happens to those aspects of ourselves we find difficult to accept.

Of the major triumvirate of psychoanalysis, humanistic psychology, and behaviorism, I find the latter the weak sister. Yet I borrow from that approach too. I believe that there is never a session in which I do not use positive reinforcement. Particularly around sexual issues with couples, I am likely to use behavioral approaches for restructuring the interaction.

More recently I've focused on group dynamics. I find art expression especially valuable in both reflecting and advancing group process. The art activity makes everyone a group participant. Yalom's articulation of group therapy theory and practice has been especially clarifying for me (1975, 1983). Promoting experiences of universality through the commonality that can be readily viewed in the content of the art productions, and the exploration of the here-and-now through art expression, make the marriage of group therapy and art therapy a dynamic union.

Finally, there are two significant influences that form the matrix of human experience and are sometimes overlooked in theories of psychotherapy. One is the physiological. Much of the research at NIMH with which I

was affiliated resulted in significant correlations between biochemical variables and psychopathology. Given this information, coupled with epidemiological studies pointing to genetic links for certain clinical syndromes, the possibility of hereditary predispositions in mental illness is a very strong one.

The second influence is societal. It is so pervasive that it is difficult to define briefly. Hopefully, two examples will suffice. It seems to me that most emotional problems stem from feelings of inadequacy or unworthiness. In our society, children are usually raised in an isolated nuclear family, are often pushed to achieve, and are seldom cherished just for being who they are. Child rearing is different in many other cultures where an extended family, as well as parents, dote on the growing child. In our culture, therefore, child-rearing patterns along with economic pressures and rapidly changing social values may contribute to emotional disturbance.

Whereas the first example deals with etiology, the second deals with disposition. No matter what the treatment, the proof of the therapeutic pudding must come later, in the world in which the patient lives. In some instances, a child may have to return to hostile parents or an adult to the unemployment line. So it does seem obvious to me that both physiological and societal factors must be recognized in our understanding of the people we treat, and the treatment we undertake with them.

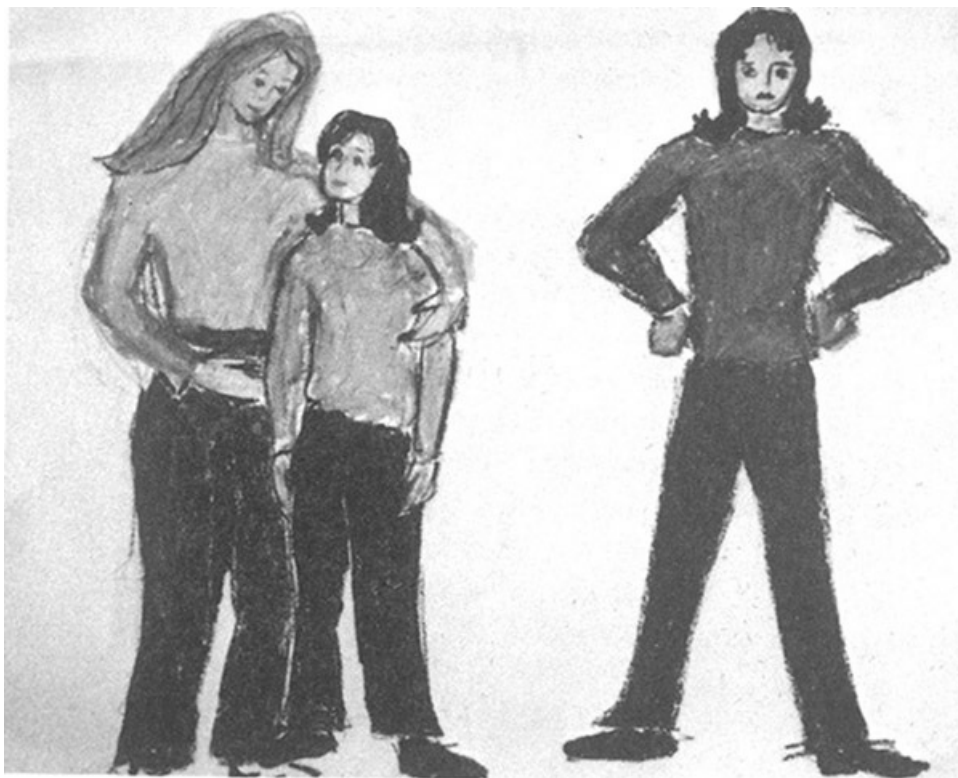
In sum, I have only alluded to the sources for the content of my eclecticism. Hopefully, the following examples will provide a view of how they come into play in the clinical situation. Please bear in mind, as you view them, that an eclectic approach is not a fragmented one. The pieces that come together from diverse sources must integrate as a whole, if the art therapist is to have a basis for understanding the therapeutic process and directing it in a meaningful way.

An Art Therapy Example

Susan, a bright, capable teacher, was a member of a private practice art therapy group of eight women. In the third month of treatment, the group was discussing their feelings toward me, spearheaded by Susan, who at 34 was amazed by how childlike she felt in relation to me. Others were also animated in expressing their feelings, so I suggested that they all draw pictures of their relationship with me. [Figure 25.1](#) is Susan's.

She spoke of feeling very young, wanting my protection, affection, and approval, and represented herself as a child close to me with my arm around her. The figure on the right came as a surprise and represents her defiance and anger at being a dependent child. I am no longer with her, and she is larger. I asked her if she was willing to act out her picture and she agreed. First, she assumed the position of the child, and I put my arm around her. Then I sat down and she assumed the position of her larger self. She commented that she felt nervous and sort of frightened in the first position; that the second position felt much better.

Fundamental to understanding the theoretical frameworks that I used in conceptualizing and dealing with this event in Susan's therapy is a recognition of the facilitating function of art expression. Although Susan had recognized uncomfortable feelings in relation to me prior to her drawing, it was the pictorial image formation process that brought into awareness an unexpected side of her feelings. Therefore, it is important to bear in mind, as a foundation to the approaches to be discussed, the power of art expression as a ladle for dipping into the unconscious soup. With that as a basis, I will discuss the theoretical frameworks from which I approached this episode in Susan's therapy:



[Figure 25.1](#)

1. *Freudian Psychoanalytic*. The subject is transference. In her reaction to me, Susan recognized the parallels to childhood relationship to authority and the adaptations that evolved. The therapeutic situation plunged her into feelings of dependency that she had not experienced in some time.
2. *Gestalt Therapy*. The technique I used in asking Susan to "enact" her picture is drawn from Perls' dreamwork (1969). His view is that the objects in a dream are all self-representations, and clients can best process their dreams by "becoming" the objects in them and thus reown "disowned" parts. I believe art expressions may be viewed and worked with in the same way. In Susan's case, the

enactment deepened the “owning” of her feeling states, forming a synergy between the imagistic and the kinesthetic.

3. *Jungian Analytical Psychology*. Both the dependent child and the angry defiant adult bear elements of the concept of the “shadow” (Jung, 1964). Both these aspects of “self” were unacceptable to Susan and were usually repressed, causing her difficulty by being unacknowledged. By bringing these shadow elements into the light, Susan was able to work with them, rather than to be unconsciously subverted by these denied aspects of self.
4. *Developmental*. In Susan’s picture and its processing, we see her move from dependent child to defiant adolescent. By working with her shadow, she was able to grow into an adult in relation to me, no longer dependent on my approval or angry. She was also able to see me more realistically.
5. *Existential*. Susan recognized her responsibility for her feelings. She was quick to see that they emanated from her perception of me, rather than from anything I was doing. Recognizing herself as the creator of many life experiences, she also recognized her power to change them.
6. *Group Therapy Theory*. In Yalom’s view (1975, 1983), group therapy should be based on a theory that postulates that humans learn and develop in the context of interpersonal relationships (Sullivan, 1953). It follows, therefore, that individuals can best learn about themselves by examining their relationships with others. There is no better place than group therapy for obtaining this sort of feedback in the here-and-now. Often history-taking is not necessary, as the group becomes a microcosm in which members display their relationship patterns in the ongoing group interactions. The group often provides an awareness of the universality of experience; members feel less negatively unique, less isolated, less alone.

Such was the case for Susan in this instance. The pictures made by other group members at this session also displayed dependency and/or anger toward me. The social microcosm aspects of Susan’s behavior were represented in her risk taking. It was she who opened the sensitive subject of feelings about the therapist early in the group’s life. This was the first time anyone had enacted a picture. Not everyone was willing to be as open or risk as much during this session as Susan did. She demonstrated some of her very significant interpersonal strengths.

Locked into Theory

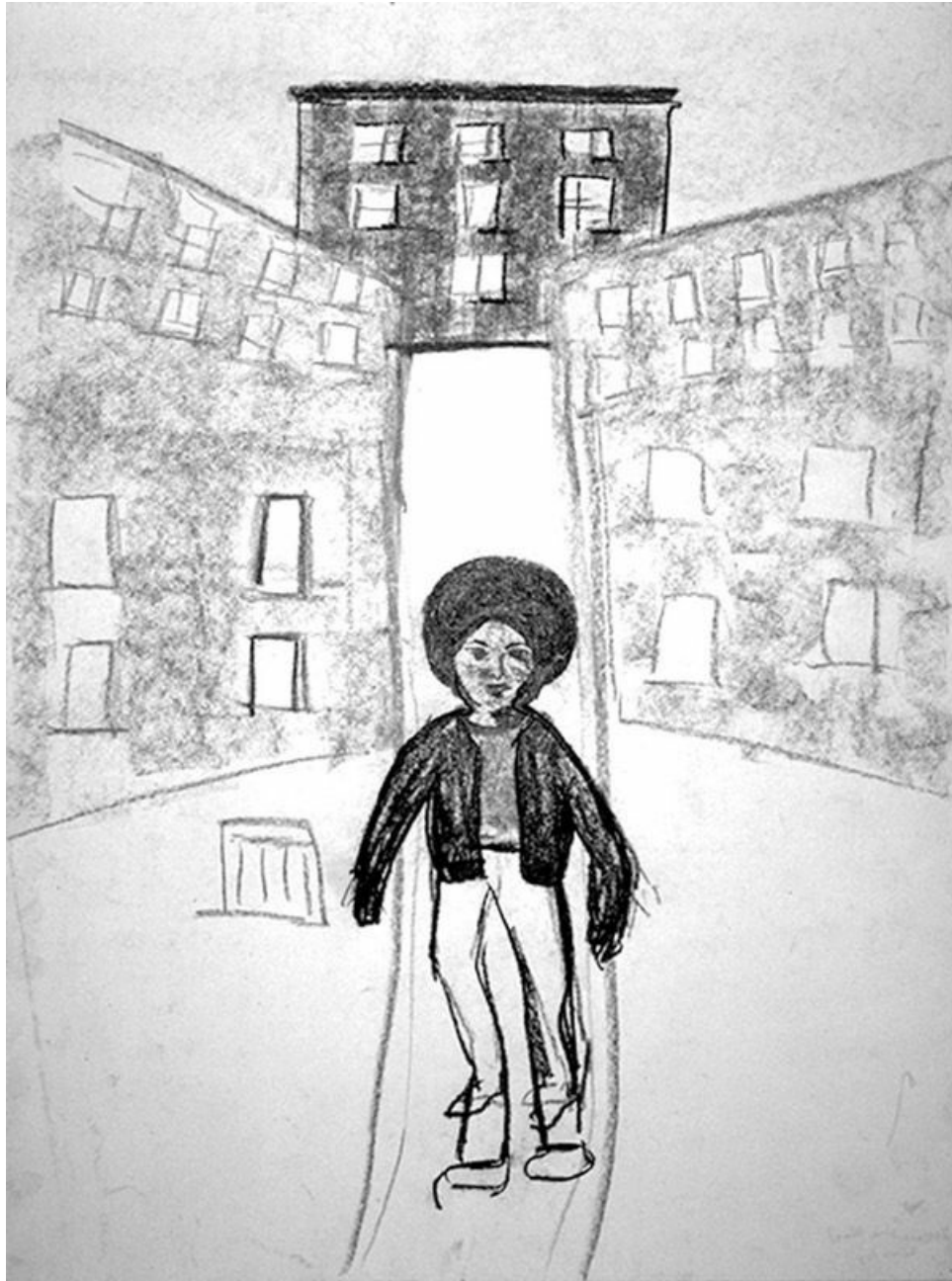
In the next example, my intention is not to erect a straw man to knock down, but to present a somewhat extreme example of the problem of being theory-bound. Please bear in mind that the purpose here is not to disparage the use of a well-integrated theory, but rather to point out the problem of narrow adherence.

I was giving an art therapy presentation to a staff unfamiliar with art therapy. The senior psychiatrist was particularly impressed by [Figure 25.2](#), a depiction of a delusion drawn by Vickie, a young woman diagnosed as acute schizophrenic. Prior to entering the hospital, she had the repeated experience of a “big black man, a killer” stalking her in a back alley.

By drawing a picture of him, she was able to explore her delusion more fully and make more sense out of her confusion over what was real and what was not. And the drawing communicated an experience that had previously remained private for this withdrawn young woman. Its expression in imagery, and our subsequent discussion of the picture and the experience markedly undercut the isolation of this patient who, prior to hospitalization, had remained shut in at home alone for several months.

But the senior psychiatrist had other ideas about the picture. He saw it as a penis within the vaginal canal. It seemed to me that his classical analytical training influenced him to seek out only sexual symbolism. Is this really the picture’s deeper meaning? How do we know? I believe these questions confront us with larger issues of how we approach our work: How we understand the imagery presented to us, the understanding we gain of our clients, and what outcomes these understandings shape in the way we develop treatment goals and the way we relate to our clients. The psychiatrist who interpreted [Figure 25.2](#) as an image of sexual intercourse probably would have had a different sense of the patient’s dynamics than I did. Perhaps he would have conducted the treatment differently and would have related to her with a wish to uncover repressed sexual conflicts.

I believe it is important to meet clients where they are (fundamental to social work theory and others), and to build an empathic bridge (Kohut, 1959) between the patient and myself. In Vickie’s case this bridge served to reach the island of isolation she had created. Bridging this sort of isolation is particularly important for psychotic patients whose delusional, idiosyncratic ideation separates them from the basis of a consensual reality to which others ascribe. Furthermore, the empathy of the art therapist often provides the “corrective emotional experience” (Alexander & French, 1946) that is one basis for a humanistic approach to therapy.



[Figure 25.2](#)

But suppose the psychiatrist's interpretation is correct? An important foundation of my commitment to an eclectic approach is that I have found no single theory that can fully explain unconscious processes. There are no indisputable answers. We can no more claim that his interpretation is erroneous than we can say that it is correct. So how do we find out?

As a phenomenologist, I would rely on the patient's experience, first through imagery, then through fantasy. I would utilize free association (Freudian), active imagination (Jungian), perhaps enactment (Gestalt and psychodrama), and so forth. I would use tools from many therapeutic approaches, capitalizing on those to which the client responded most readily. Ultimately I would probably recognize that some areas would still remain shrouded in mystery; but my experience as an art therapist has taught me that there is so much that the art expression provides, that it is not necessary to make speculative leaps into insubstantial interpretations.

This conclusion leads me into another concern about being locked into theory. The internal consistency of a theory enables the clinician to arrive at a relatively neat and comprehensible formulation of a client's psychodynamics. Of course, the problem is that sometimes the client is made to fit the theory rather than vice

versa. Having a dynamic formulation may relieve the therapist's anxiety, and can serve as a platform on which to erect therapeutic work. It is more difficult to remain open to many possibilities, and to recognize that the data are never all in.

This sort of openness to possibilities, this working with hunches rather than more solid formulations, may be easier for art therapists than other clinicians. As artists, we may be characterized by some of the attributes Frank Barron (1968b) found in creative people, particularly a tolerance for ambiguity and a preference for complexity.

Therefore, with a recognition of the essential complexity in every human existence, and a tolerance for the ambiguity in a situation in which we are presented with an abundance of data (images, statements, behavior), my hope is that my anxiety will not push me to premature closure in an attempt to fathom my client's problems. I believe an eclectic approach encourages me to cast my net widely for the many sources of knowledge that may inform my understanding, and to take the time to weave a synthesis of ideas. Hopefully, an eclectic approach also prevents me from coming to premature formulations based on what I may have found to be a tried and true theory.

Toward Future Art Therapy Theory

Art therapists have utilized various theories of human development, psychopathology, and psychotherapy to inform their work. We adapt our work to these theories or we adapt these theories to art therapy. Many recognize a need for a theory of art therapy that would integrate human psychology, creative art expression, and the meaning of visual imagery.

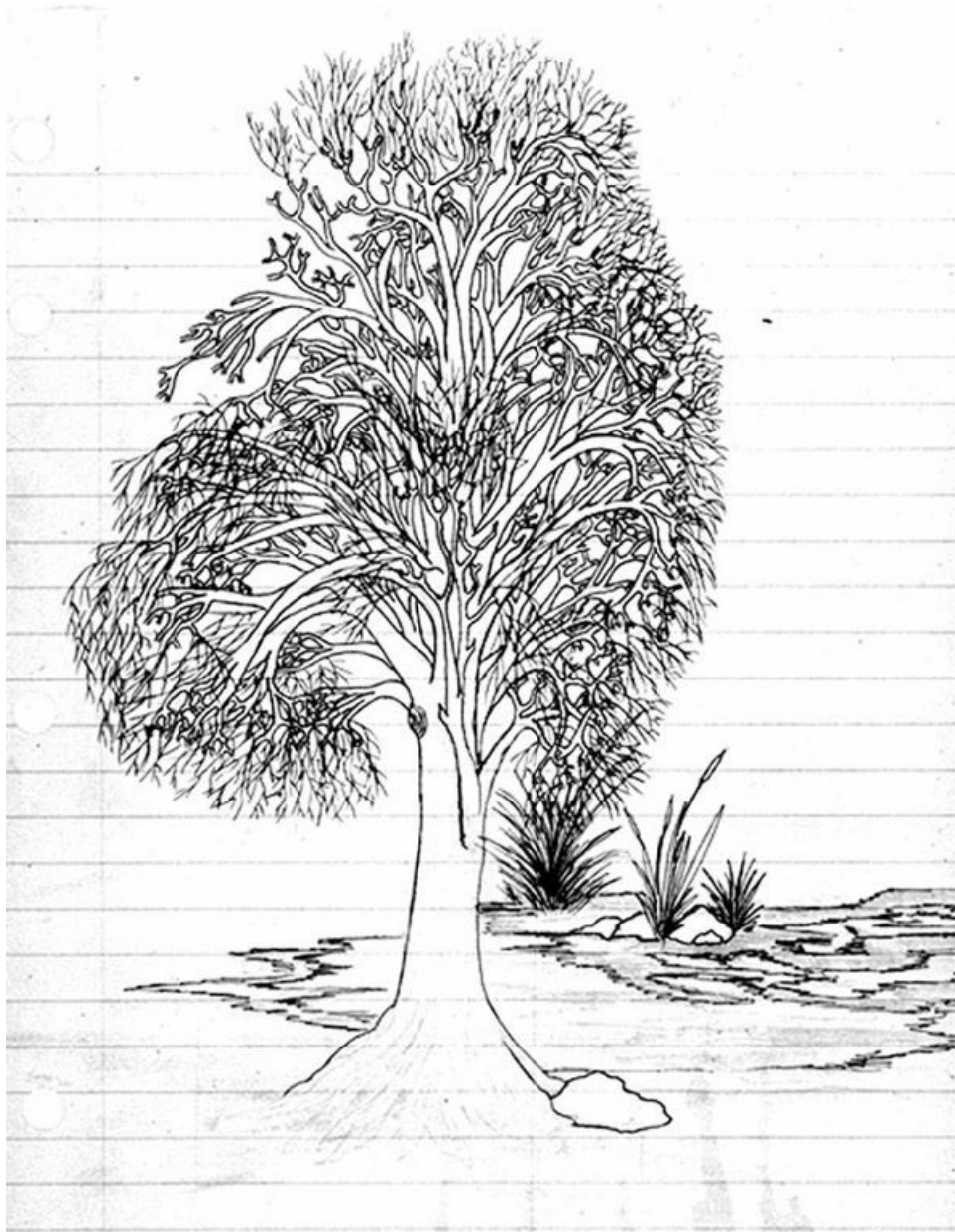
A brief glimpse of artwork by a psychiatric patient may indicate some of the directions for future theory. [Figures 25.3](#) and [25.4](#) were drawn by Craig, a young paranoid schizophrenic hospitalized at the National Institute of Health's Clinical Center, where I saw him. He had been dragged into the hospital by seven policemen, and was considered dangerous by the staff. His shaggy appearance and suspicious, menacing glances added to the effect. Artwork was an important outlet for him. Although his pictures expressed "secrets" he feared revealing, his love of drawing and the communication it afforded lessened the isolation his idiosyncratic ideation created.

The two pictures reproduced here were made prior to Craig's hospitalization. He stated that [Figure 25.3](#), delicate tracteries on notebook paper in pencil and blue ink, was drawn "in a shit house" when he was working at a factory. [Figure 25.4](#) was also drawn on notebook paper with pencil and blue ink. He described it more fully, saying that it was himself. The underneath part is "strong and grasping," the sphere is "selfless" and represents his "mind." He explained that the roots are holding the sphere and that the underneath shows "control" of the body over the mind. "In order for the mind to exist, the body controls or comforts it," he said.

An art therapy theory would be able to account for many aspects of Craig's art-making activity. First, there would be an understanding of why and how a very psychotic patient did not decompensate further as so many others did upon hospitalization. It was clear that making art, in and of itself, was a stabilizing process for Craig.

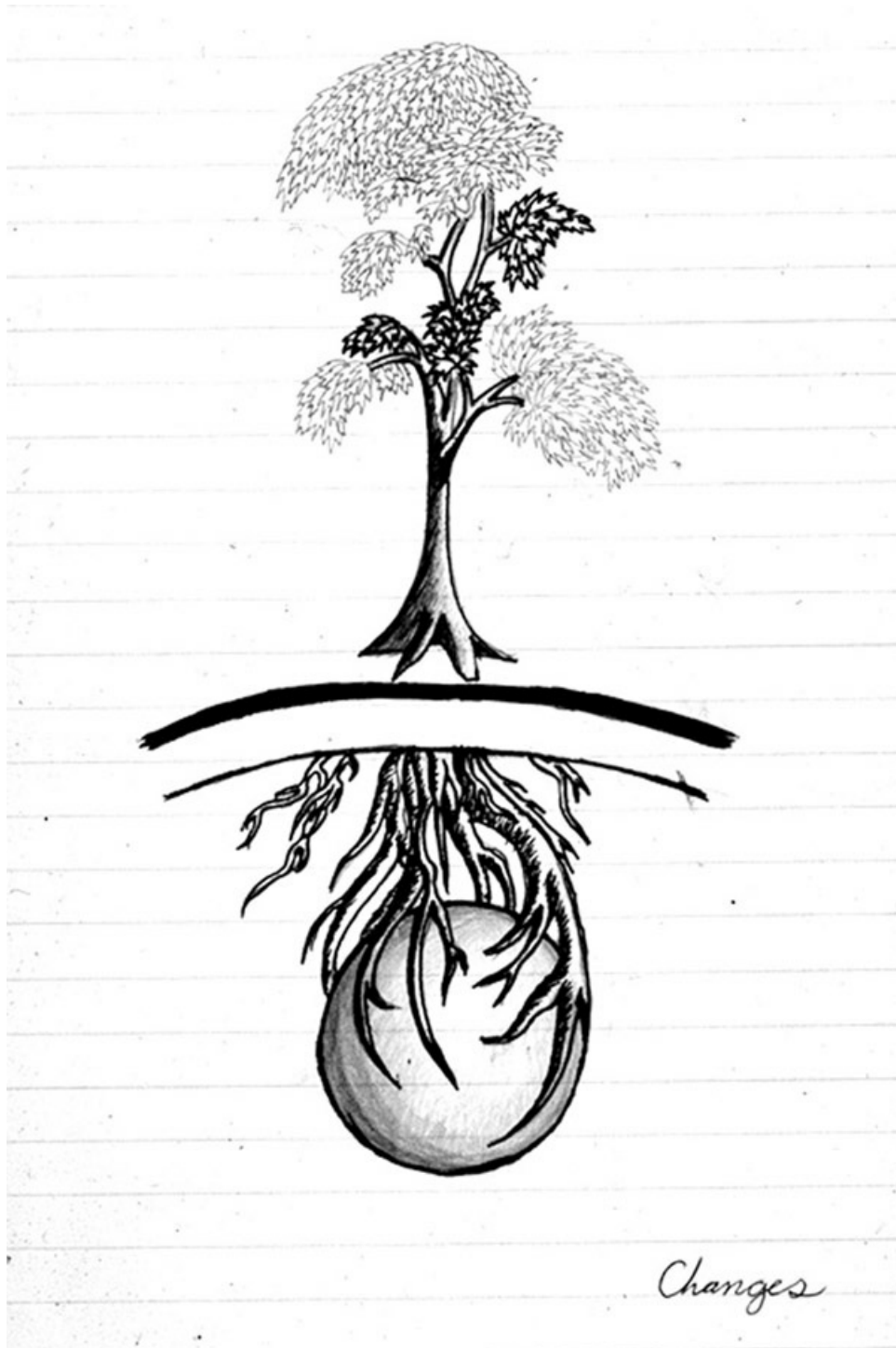
Second, Craig's frightening physical aspect, his fear that people would take his "secrets" from him, and his elaborate delusional system alienated him from others. But his art created a bridge for him. Staff and patients were intrigued by his pictures, showing their interest, and often admiration. But even more significant was the opportunity art therapy sessions provided. It was there that he began to build trust, through my interest in the meaning of his imagery. In his pictures he portrayed an elaborate inner world of strange beings and unearthly landscapes. The isolation experienced by delusional patients cannot be overemphasized. An art therapy theory would note art's potentiality for bridging.

Most obvious, of course, an art therapy theory would facilitate the understanding of imagistic expression. There would be recognition of the delicacy and loving care that this fearsome, often wild-looking young man devoted to [Figure 25.3](#). Evident also in this picture is some of the control of which he spoke in reference to [Figure 25.4](#). This latter drawing is an interesting contrast to the former. The upper tree is quite truncated in comparison to the more conventional tree of [Figure 25.3](#) and the unusual underpart of the second tree in [Figure 25.4](#). This underground aspect is original, creative, bizarre. The artistry in art therapy is the ability both to encourage art expression, and to help the patient relate to it. In this case, although Craig had been fearful of disclosing his private meanings, sufficient trust had developed between us for him to associate to his picture quite freely.



[Figure 25.3](#)

But even with his somewhat unclear explanation, how do we understand such an image? Hopefully, an art therapy theory might provide direction. For the present, we note the power and importance of what is underground, what is hidden from view. Craig has related this portion of the picture to control. He has spoken of mind and body, but the locus of control is unclear from what he says. The roots appear to grasp and to be quite separate from the portion of the tree above ground. We gain a sense of Craig's struggle for control, both from the content of this picture and from the style of all his pictures. We see the separation, both graphically and thematically, between the upper and the lower.



[Figure 25.4](#)

We see a young man with a highly original creative energy who has had difficulty getting along in the world, who has managed to frighten almost everyone—family, employers, hospital staff—almost everyone except his art therapist. Even a famous psychiatrist renowned for his writings on schizophrenia, who served as consultant to our ward, was afraid Craig wanted to kill him and would not see him alone. I found Craig gentle, sensitive, a very caring human being. What might an art therapy theory tell us about this discrepancy?

Finally, there is the question of creativity. How does it move us? What is the healing nature of art making? Certainly it operated for Craig. And what is the nature of a therapeutic relationship that has creativity at its center? Perhaps this phenomenon allowed me to know an aspect of Craig that others didn't see.

The Selectric Electric

I have strayed from “An Eclectic Approach...” only to return to it. My hope is that as we develop our profession, and gradually build what will come to be art therapy theory, we will learn from and integrate whatever wisdom we may. There are many paradigms, more than one lens through which to view our complex world. They enable us to see a number of different relationships within the “reality” we attempt to understand.

I hope this chapter has made clear that I believe theory to be an essential foundation to our work. An eclectic approach respects the contributions of many theorists, and enables the clinician to draw on many sources of knowledge. It places a great deal of responsibility on the therapist to form a functional synthesis, integrating theories with one another and applying them to practice in the most efficacious way.

For those who feel a need for art therapy to have its own theoretical base, I believe this book begins a process for developing and drawing together various strands that can be woven into an art therapy theory. We look to the articulation of knowledge of human growth and behavior, to metapsychological viewpoints, to formulations of psychopathology, to treatment rationales. We have a rich heritage for a foundation. To that we must add an understanding of what is unique to art in therapy: expression in images, working with art materials, the client–therapist relationship around art making, the place of creativity in art therapy. It is an exciting challenge.

For starters, I would like to return to the thoughts of my typist. I highly recommend her Selectric-Electric approach to art therapy.

If I were to update *An Eclectic Approach to Art Therapy* in 2015, I would add to the focus of this chapter an extended view that would cover issues that have received critical attention more recently:

- (1) Trauma, as both a cause of mental illness and as a problem in itself, and the physiological effects of trauma as shown in studies of brain changes;
- (2) Community treatment of many different kinds, including local groups as well as large scale interventions, such as occurred following 9/11;
- (3) Multicultural issues in which the therapist must have not only awareness of cultural differences, but also multicultural competence to work with a range of populations whose values and lifestyles may be very different from the therapist’s.

Finally, it is important that the art therapist use his or her own art to process the therapeutic encounter to further understanding not only of the client(s), but also of the self in relation to the client(s).

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Conclusion

Judith Rubin

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 (1985)

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.”

—Bernard Levy (1974)

It is all well and good to read about different theoretical approaches to art therapy and to be stimulated by different styles of thinking and of working. But what is the practitioner to do with all this information? Is it best to select one primary orientation? Is it wiser to use whichever one seems right at any particular moment? Or is there a way to integrate more than one approach into a workable synthesis?

Elinor Ulman’s contribution in the Psychodynamic Section ([Chapter 6](#)) reminds us of the dilemma faced by early art therapists, who felt a need to choose between *art as therapy* as espoused by Edith Kramer, and *art psychotherapy* as developed by Margaret Naumburg. Given these two approaches, both grounded in Freudian theory—one with the emphasis on art and one with the emphasis on therapy—which direction should the clinician take? Unlike those who saw them as incompatible, Ulman insisted that they were not, and integrated them into her own theory of art therapy.

Harriet Wadeson, who entered the field a little later, described her dilemma, as she gradually learned about the many different ways of viewing human beings and psychotherapy. In her chapter on an *eclectic* approach to art therapy ([Chapter 25](#)), she gives a clear account of how she came to know and to value diverse theories, and how she solved the problem of *which one to use when* in her clinical work.

Many art therapists, perhaps a majority, approach their work in the fashion described by Wadeson, shifting gears as the situation seems to require. In fact, it seems to me that most art therapists are primarily *pragmatic*, selecting the approach that best fits the therapeutic moment. In a film he made, Bob Ault described four different approaches, each to be utilized *depending on the needs of the patient(s)*, an appealingly client or person-centered point of view (Ault, 1986).

Most people are attracted to art therapy because they like both art and human beings; and they tend to be curious, as well as compassionate and creative. For some individuals, their curiosity extends beyond understanding the people they see and the art that is made, to the creative process that seems to work so well in healing. This very combination can make theory-building endlessly fascinating for those so inclined. Indeed, it has been fortunate that restless thinkers, like the authors in this book, enjoy the challenge of theorizing. All of them have worked out ways of applying theoretical constructs—by synthesizing what they know about the therapeutic power of art, with what they understand about one or more theories of psychotherapy.

Most art therapists yearn to find meaning in their work and to do it well, without abandoning their own creative core. For most, regardless of orientation, creativity is synonymous with mental health; in that both reflect the capacity to be freely in charge, whether of materials or of the self. In fact, it was a playful psychoanalyst named Donald W. Winnicott who wrote in *Playing and Reality* (1971a) that “it is only in being creative that the individual discovers the self.”

Winnicott’s elegant concept of the “holding environment” is one that is referred to by many contributors to this book, since it describes the kind of space essential for authentic creativity as well as growth. His appeal to

non-analytic art therapists is probably based on the fact that he was so creative as a therapist himself, as in his invention and use of the “Squiggle Game,” a graphic way to communicate with his young patients (Winnicott, 1964–1968; 1971b).

Jung, like Winnicott, is cited by many contributors who are not analytically trained or oriented. Jung’s understanding, however, of what I would call the “creative unconscious,” and his reverence for the *image* have a powerful appeal for art therapists. Jung, who built, drew, and painted as part of his own self-analysis, was also an artistic theorist. A minister’s son, he stressed the mystical and spiritual elements in analytic therapy; whereas Freud, a rationalist, was determined to prove the scientific validity of the radical new depth psychology.

Ironically, both polarities are more important in mental health than ever before. Neuroscience dominates contemporary psychiatry, while cognitive-behavioral therapy currently dominates psychology as the approach with the greatest number of evidence-based studies to demonstrate its effectiveness. At the same time, in a digital world of virtual realities and rapidly changing modes of communication, where human values often seem to have been lost, the hunger for meaning and for deep connection has intensified. As a result, spiritual and contemplative approaches have also grown in popularity among healers in all disciplines, and are evident in the self-help materials hungrily lapped up by the public.

Art therapy, drawing as art has from time immemorial on the human spirit, offers a wonderfully appropriate and 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. And although we operate from many 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. I believe that art is indeed the signature of the soul, and that what we create are *Soul Prints*, the title of an unpublished manuscript.

Yet, as you have seen, each of the art therapists in this book has a slightly different idea of how to go about using art to help human beings to free their souls and to live more fully. In addition to the virtues of the theories themselves, two major variables in theory selection have been identified: the patient and the therapist, both of which play a role in the theoretical equation developed by each of us.

Arthur Robbins (1981) felt a need to look beyond analytic theories stressing sublimation, largely because of his experiences with psychotic and borderline patients who were unable to sublimate. Mildred Chapin was drawn to the special relevance of self psychology for work with those whose problems began in the earliest months and years of life. In contrast, Janie Rhyne noted that the confrontational and demanding approach of Gestalt art therapy is not for those whose psychological state is too fragile. The same could be said for Shaun McNiff’s highly stimulating workshops.

There is a parallel in the history of how different theories evolved. “One source of difference between schools of psychotherapy that is often overlooked and which needs to be made explicit is the difference in types of patients on which the founders of the different schools based their initial observations” (Stein, 1961, p. 6). After citing some well-known examples (like Freud seeing hysterics and Sullivan schizophrenics), the author went on to draw the logical conclusion: “With these differences in basic data and sources of observation, it is not surprising that each school should develop its own special theory and technique.” It therefore also makes sense that “one school might well have a good deal more to say about one specific type of patient than another” (p. 7)—or, one might add, about one aspect of a patient rather than another.

Many therapists believe that there is a “need for different theories to deal with different sets of empirical data [and that]...no single theory is fully sufficient to order even one set of clinical observations” (Gedo & Goldberg, 1973, p. 172). The idea is that different models of the mind fit different patients, as well as the same patient functioning at different developmental levels at different times (cf. Rothstein, 1985).

Listening Perspectives in Psychotherapy (Hedges, 1983) clarifies the importance of being able to hear a patient’s communications in terms appropriate to their etiological source. The author defined *listening perspectives* as different “clinical frames of reference,” which provide a “backdrop” for hearing patients’ verbalizations. Another book on “learning to listen from multiple perspectives” (Frederickson, 1999) also articulates different ways of listening, based on different aspects of psychoanalytic theory. The basic idea is simple but powerful, and I believe that such shifting frames of reference often occur automatically for experienced therapists, in response to what is being said, done, or created.

In addition to understanding what is being *said*, art therapists need to develop an appropriate set of “looking

perspectives,” so that we can look each time in a way that truly fits the process or product in front of us. Indeed, just as the same behavior can have different meanings depending on the theoretical filter through which it is perceived; the same painting, sculpture, or creative process can have different meanings, depending on the theoretical lens through which it is viewed.

In the two chapters explicitly dealing with the problem of selection among different theories (Ulman and Wadeson), both authors stress the related importance of the *style* of the individual therapist. Just as theoreticians develop ideas that fit their personalities and ways of working; so anyone’s way of being an art therapist must be synchronous with one’s authentic self. It is really impossible to “put on” any approach that does not comfortably “fit.”

In finding a “goodness of fit,” however, we need to be careful that the theory and methodology we espouse does not conceal unrecognized needs or conflicts within ourselves. It is all too easy, especially if one is articulate, to find or create a theoretical rationale for almost any therapeutic stance. And, to the extent that our theory, as well as our practice, is determined by forces of which we are unaware, then it is no more than an externalization of our own intrapsychic issues. Insofar as we have, usually through our own therapy, come to know and to accept these forces; we can hopefully be in charge of them.

We can then try to evaluate them objectively, in the light of what we know and understand about the human and artistic needs of those with whom we work. Only after this step of self-analysis, are we ready to think or talk about the mature and creative use of the self in art therapy. The next step toward that goal is to be open-minded—about how one perceives what is happening, how one approaches the patient, and what one does in response. However, an *open* mind is not an *empty* one. It is a mind truly open to seeing and hearing what being presented, perhaps through some of the various theoretical lenses in this book.

It makes sense that the more familiar one is with different possible ways of seeing and hearing, the more likely it should be to truly see and hear what is actually there. Of course, there are times when we simply cannot perceive the signal, like the pitch of animal sounds that are beyond the range of human hearing. More often, however, we *could* see and hear what is there, but are unable to do so because we do not *know* a frame of reference (a theory) that would make it possible. One goal of this book is to increase the number of “lenses” art therapists are able to put into their clinical “frames,” to multiply the number of “listening and looking perspectives” potentially available to each clinician, so that he or she can receive, perceive, and conceive as well as possible.

In addition to allowing the art therapist to *see* more, different approaches allow the patient to *say* more, to make a wider variety of statements about themselves. This is powerfully demonstrated in a film used extensively in the training of psychotherapists, *Three Approaches to Psychotherapy* (Shostrom, 1965). In it, a woman named Gloria is interviewed successively by three clinicians with very different perspectives and technical approaches—Carl Rogers (client centered), Fritz Perls (gestalt), and Albert Ellis (rational-emotive/cognitive). The different personalities of the three men are, as one would expect, consonant with their theoretical views. But what is most fascinating is that each of them evokes a somewhat distinct aspect of the client. While clearly the same person throughout, Gloria expresses different facets of herself in response to each of the three interviewers. That this happens with art as well was demonstrated when both Edith Kramer and I interviewed the same child within a month at Walter Reed Army Hospital in 1977. It is clear in the videotaped interviews that, like Gloria, Lisa showed different facets of herself and her art with each of us.

So there is a lot to be said for having access to different ways of thinking about and doing therapy through art. Yet paradoxically, in spite of the multidimensional value of multiple lenses, there is also much to be said for the enthusiastic embrace of at least one well-known and well-digested approach...

The notion of a general synthesis or integration usually communicates to the student the need to be cautious, take all points of view into consideration, and to avoid emotional involvement with a particular, one-sided position.... Contrary to this conception, we recommend strongly that students should, once they have surveyed available theories of personality, adopt a vigorous and affectionate acceptance of a particular theoretical position without reservation. Let the individual be enthusiastic and imbued with the theory before beginning to examine it critically.

(Hall & Lindzey, 1977, p. 705)

Not only does such an embrace of one theory make sense logically, it makes even more sense psychologically,

in regard to each art therapist. The importance of finding a way of working that suits the individual has been noted repeatedly, and cannot be emphasized too strongly...

A person must find a theory which is sympathetic to his best talents, whether they be interpretive, poetic, directive or such. If he doesn't do so, he will be inept, or more likely, phony.... The primary question about the "rightness" of a style is whether one accepts responsibility for the consequences he evokes and is skillful in facing them...Certainly, [one] should be aware of the unlikelihood of discovering *the* single [best] technique.

(Polster, 1966, p. 5)

As for the search for the single best "technique" in art therapy, I think family art therapy pioneer Hanna Kwiatkowska, said it best: "My strong conviction is that *the only technique of art therapy is the technique of relating to a patient through art*" (1974, p. 17, emphasis in original). Kwiatkowska felt that the numerous "technical maneuvers" or "directives" that continue to explode on the art therapy scene stemmed largely from clinicians' anxiety about what would happen if things were left more open. Whatever the cause, the reader would do well to look carefully at the approaches described in this book. Regardless of theoretical orientation, even the most prescriptive are carefully designed to promote the patient's own creative participation in the making of his or her own art.

There have always been and will always be individual art therapists who enjoy thinking theoretically, like Aina Nucho (2003), Vija Lusebrink (1990), Diane Waller (2014), and Paolo Knill (2004), all of whom have devoted substantial time to that effort. Nevertheless, there has also been considerable resistance within art therapy to theorizing, perhaps because those who think visually are less comfortable thinking verbally.

No doubt there are also "transferences" to theory—both positive and negative—based on experiences with therapists, teachers, or supervisors in the individual's past. If the transference is positive, the theory espoused by that person might be idealized, but if it is negative, a specific theory—or even all theories—may be viewed in an agnostic or atheistic fashion.

Whether an art therapist openly espouses a theoretical stance or insists that he or she is atheoretical; whatever is done (the "technique" employed) implies some underlying theoretical assumptions. There is always a theory beneath the practice, even if it is unacknowledged and unknown. Or, to put it another way, "Clinical judgments and activities flow organically from conscious or preconscious theoretical premises, rather than the other way around" (Deri, 1984, p. 218).

Moreover, regardless of the therapist's orientation, the patient comes to therapy

with a theory of pathogenesis of his symptoms. With his words and speech [and art] the patient conveys not only a description of what he suffers, but his own diagnoses and explanatory theories of his [problems]...These explanations, the patient's theories, are not to be ignored but to be used as data, which not uncommonly go some distance toward insight.

(Rangell, 1985, p. 81)

Although none of the authors in this volume specifically addresses the patient's "theory," all stress that a person's associations to and ideas about their own art be taken very seriously.

In this generalization about something common to most chapters, I have been what psychoanalyst Arnold Cooper would call a "lumper." During a discussion on the relation of theory to technique, Cooper referred "to the distinction between 'lumpers' and 'splitters' [and] noted that we can at any moment, and with a particular end in view, decide whether we are interested in differences in technique or in how all techniques are at bottom the same" (Richards, 1984, p. 600). Whether "the search for common ground" is really more useful than "the examination of differences" (p. 600) is not clear to me. I am a "lumper" by inclination, tending to see commonality more than distinctions among different approaches. That is probably what has led me to see important learnings in a variety of theories and techniques, like those in this book.

In any case, I believe it would be appropriate at this point to briefly identify some commonalities, in addition to those already noted. Perhaps most important is that all the authors agree on the power of art to help and to heal. Their investigations of different theoretical worlds center on the search for an explanation of this power. In fact, one way to look at the "red thread" that runs through all of the chapters is that all represent an attempt

to answer the question: *Why and how does art heal?*

Although unique for each one, all of the contributors to this volume have found a way to integrate their previous training and experience with their chosen approach to art therapy. Elinor Ulman, in tracing the personal roots of three art therapy theorists, makes this point in considerable depth. Another kind of independence is evident in the fact that many of the contributors to this volume have gone beyond their primary theoretical resource. Kramer, for example, long after her initial statement of the theoretical importance of sublimation for art therapy, explored its origins in ethology.

In addition, all of the contributors seem to agree on at least three things:

1. The importance of the image
2. The need to create a therapeutic space in which people can safely create
3. The complexity of both person and process in art therapy

However, there are important differences too. Some of the approaches are quite intellectual and logical, some are more emotional and intuitive; but all attempt to integrate both feeling and thought in the art therapeutic process. And, whatever the relative emphasis on art and therapy in any author's conception, all include a consideration of both. Some also make explicit their conviction that any viable theory of art therapy that might eventually evolve ought to include both elements of this hybrid discipline, as well as the special relationship between them.

Despite the fact that imaging techniques and a massively improved understanding of how our brains work has influenced all therapies in recent years (as evidenced in the new chapters by Hass-Cohen and Gantt and their co-authors), there remains an ineffable component to art therapy that is vital and powerful. To put it another way, our "medicine," while it may indeed be connected to neurobiological evidence, is not chemical, but is rather closer to alchemical, that is, the special *miracle* of art. We still draw, as in societies from time immemorial, on the "magic power of the image," regardless of how we understand its origins or its functions. Similarly, while we are alert to the effects of trauma or cultural dislocation, we offer not a verbal "debriefing," but a way of "telling without talking," a new and potentially "corrective" kind of experience—no doubt at the level of the brain itself. Indeed, as the new chapters on neuroscience-based approaches suggest, we are just at the beginning of understanding how creating works to alter the brain which, we have discovered in the last several decades, is infinitely more plastic than we ever supposed—a hopeful finding for all kinds of therapy (Kandel, 2012).

Art in therapy is much more than the provision of a place for the inherent healing possible through an authentic creative process, however we conceptualize it. It is also art in the presence of another, whether we think of ourselves as teachers, guides, witnesses, companions, collaborators, containers, objects of transference, or any of the many possible ways identified in this book.

But no matter how we explain what happens during the art therapy process, we have a responsibility to those whose journeys we support to have some clear notion about what's wrong and how to help. 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 he or she does can the art therapist make fully available the healing powers of art. I believe that to effectively integrate a synthesis of art and therapy requires an internalized frame of reference. Theory helps an art therapist to sharpen both thinking and clinical skills. In fact, it is only when we have truly mastered some theory of psychological functioning and of psychotherapy, when it is "in our bones," that we can use our creative intuition in the most helpful way.

I also believe that it is essential to have a solid grounding in some coherent notion of how people function and how to help them to get better, before exploring any modifications or alternatives. It's similar to the need to learn to draw, paint, and model reality, before attempting alterations, abstractions, or other variations. In the same way, the enthusiastic embrace and deep understanding of one primary frame of reference provides a necessary matrix for the possible adoption and adaptation of others. One reason for a book like this is to familiarize the "becoming" art therapist with many different orientations, so that he or she can select intelligently from the many options available, according to what suits each individual's personality and values.

And, as stated repeatedly, there are very good reasons for having more than one way to look at the infinitely complex phenomena of people and their art. Simply put, the more extensive any art therapist's understanding of different approaches, the more clinical lenses he or she has with which to see. Like a stain on a microscopic

slide, a theory can enable a therapist to literally see something that would otherwise be invisible. And if he or she can look at a problem from a different angle, he or 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, like the authors of these chapters, have struggled with the difficult questions of how to understand, and do art therapy—in order to help the people they serve as much as possible through art.

It is my hope that this book—with its many “maps” of different ways to explore, to find, to create, and to help—will enable art therapists to begin their search for what suits them best. I hope, too, that it will increase the number of listening and looking “lenses” they can comfortably put into their clinical “frames.” Each approach offers a potential “door” for both therapist and patient, a new avenue for exploration and discovery.

Just as any theory needs to be understood and integrated through practice over time; so well-developed “technique” is not so much a collection of ideas, as it is something deeply ingrained and easily available. Elinor Ulman made this point in 1971 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 & Levy, 1981, p. 28). A good art therapist strives to have both theory and technique “in her bones” so that “relating to a patient through art” can be truly spontaneous, flexible, and artistic.

This book is meant to help all art therapists to be thoughtful about what they do, so that they can do it even better. I hope it will also help people to be humble, to know what they don’t know, and to be open to new ways of thinking, no matter how many years of experience they may have. In fact, I believe that being the best art therapist one can be is a lifetime task. Happily, it is also as wonderfully creative as the thrilling work of helping patients to find their true selves through art.

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Index

Note: figures and tables are denoted with italicized page numbers; end note information is denoted with an n following the page number.

acceptance

in cognitive-behavioral art therapy [341–2](#), [349](#)

in Gestalt art therapy [220](#), [223–4](#), [225](#), [225](#)

Adverse Childhood Experiences Study (ACE) [355](#)

aggression *see also* [anger and hostility](#)

sublimation of [87](#), [88](#), [99](#)

American Art Therapy Association [34](#), [402](#)

analytic therapy approaches *see* [Jungian art therapy](#)

anger and hostility *see also* [aggression](#)

discovery and insight in art therapy addressing [83](#)

Gestalt art therapy expression of [220](#), [221](#), [221](#), [225](#)

sublimation of [90–1](#)

anxiety

discovery and insight in art therapy to address [76](#), [80](#), [83](#)

mindfulness-based cognitive-behavior art therapy for [347–9](#), [348](#)

sublimation of [89](#), [90–1](#)

archetypes [178](#), [179–81](#), [180](#), [183](#), [185](#)

art therapy

cognitive and neuroscience approaches to *see* [cognitive and neuroscience approaches](#)

contemplative approaches to *see* [contemplative approaches](#)

foundations of *see* [foundations of art therapy](#)

humanistic approaches to *see* [humanistic approaches](#)

integrative approaches to *see* [integrative approaches](#)

overview of [1–12](#), [493–501](#)

psychodynamic approaches to *see* [psychodynamic approaches](#)

systemic approaches to *see* [systemic approaches](#)

third edition of book on [1–12](#)

ArtWorks project [57–63](#), [58](#), [61](#), [63](#), [64](#)

Asclepion [318](#)

Ault, Bob [34](#)

Baynes, H. G. [170](#)

Bhagavad Gita [317–18](#), [318](#)

British Association of Art Therapists [33](#)

Burks, Jason [323](#), [325](#)

Cane, Florence [33](#), [80](#), [111](#), [169](#), [170](#), [274](#), [454](#)

catharsis vs. sublimation [89](#)

Champernowne, Irene [170](#)

Chapin, Mildred [34–45](#), [59](#)

cognitive and neuroscience approaches

cognitive-behavioral art therapy as [333–50](#), [482](#)

CREATE as [371–90](#)

narrative art therapy for trauma as [5–6](#), [353–69](#)
 overview of [10](#)

cognitive-behavioral art therapy

- acceptance and change in [341–2](#), [349](#)
- with adults [338–9](#)
- awareness in [342](#)
- basic CBT steps [335](#), [338–9](#)
- case example of (Karen) [344–9](#), [346–7](#), [348](#)
- with children [339–41](#), [340–1](#)
- as cognitive and neuroscience approach [333–50](#), [482](#)
- current CBT models [334–6](#)
- current status of [338–41](#)
- development of CBT [333–4](#)
- dialectical behavioral therapy for [335–6](#), [341–4](#)
- early thinking about [336–8](#)
- eclectic approach to art therapy including [482](#)
- irrational thought challenging in [335](#), [339](#)
- irrational thought identification in [335](#), [338](#)
- mindfulness, generally, in [335](#), [336](#), [342–3](#), [344–9](#)
- mindfulness-based cognitive-behavior therapy for [336](#), [344–9](#), [346–7](#), [348](#)
- overview of [333](#), [349–50](#)
- personal construct system in [337](#), [345](#)
- problem focus in [335](#), [338](#)
- prompting in [337–8](#)
- rational thoughts replacing irrational in [335](#), [339](#)
- reality shaping in [337](#)
- reinforcement in [337](#)
- testing thought validity in [335](#), [339](#)
- therapeutic relationship in [335](#), [338](#)

collective unconscious [74](#), [171](#), [172](#), [174–5](#), [178](#), [179](#), [181](#), [182](#), [186](#), [233](#)

community-based arts [8](#), [275–84](#), [314](#), [315](#), [316](#), [316–17](#), [319–26](#), [320–2](#), [324–5](#), [420](#)

complexes [168](#), [175–6](#), [176](#), [177](#), [179](#), [183](#), [185](#)

contemplative approaches

- contemplative wisdom traditions in art therapy as [308–26](#)
- Focusing-Oriented Art Therapy as [286–306](#)
- overview of [9–10](#)
- spiritual path and art making as [271–84](#)

contemplative wisdom traditions in art therapy

- Buddhist traditions as [308](#), [309–10](#)
- community-based arts in [314](#), [315](#), [316](#), [316–17](#), [319–26](#), [320–2](#), [324–5](#)
- as contemplative approaches [308–26](#)
- Dharma Art in [310](#)
- Four Immeasurables (loving kindness, compassion, joy, equipoise) in [309](#)
- future developments in [326](#)
- Hindu-Yoga-Tantra traditions as [308](#), [310–13](#)
- karma yoga in [308](#), [314](#), [317–18](#)
- material and imaginal cultures of studio sanctuary in [313–26](#)
- mentoring in [321](#), [325–6](#)
- Naropa Community Art Studio for [319–26](#), [320–2](#), [324–5](#)
- overview of [308–9](#), [326](#)
- Prakrti* or three *gunas* in [312](#), [312](#)
- relational aesthetics in [317](#)

residencies programs for [322](#), [322–5](#), [324–5](#)

Samkhya [311](#)

sangha in [308](#), [313–26](#)

service aspects of [317–18](#), [318](#)

spiritual and cultural bypassing in [309](#)

studio as healing environment in [318–19](#)

Yoga Sutras of Patanjali in [312–13](#), [313](#)

CREATE

Adaptive Responding in [372](#), [382–6](#)

Art Therapy Relational Neuroscience (ATR-N) as foundation for [371](#), [373–4](#), [376–7](#), [380–1](#), [382–3](#), [387](#), [388](#)

case example of (Sophia) [374–5](#), [375](#), [377–9](#), [378](#), [379](#), [381](#), [381–2](#), [383–6](#), [384–6](#), [388–90](#), [389](#)

as cognitive and neuroscience approach [371–90](#)

Creative Embodiment in [372](#), [372–5](#)

Empathy and Compassion in [372](#), [388–90](#)

Expressive Communicating in [372](#), [379–82](#)

overview of [371–2](#), [372](#)

Relational Resonance in [372](#), [375–9](#)

Transformative Integrating in [372](#), [386–7](#)

creative education with art therapy

behavioral consequences in [461–2](#), [462](#), [463](#), [464–6](#)

bibliotherapy (finding issues in the classics) in [456–8](#), [457](#)

case example of (Mel) [452–3](#), [453](#), [455–66](#), [457](#), [459](#), [460](#), [462](#), [463](#), [465](#)

current events (generating ideas and issues) in [456](#)

discussion of [464–6](#), [465](#)

history of therapeutic education and art [454–5](#)

individual readings or group activities (focusing ideas) in [458–9](#), [459](#)

as integrative approach [452–66](#)

overcoming writing resistance in [460](#), [460–1](#)

overview of [452–4](#), [466](#)

therapeutic curriculum for [456–63](#), [466](#)

depression

discovery and insight in art therapy to address [76](#), [80](#)

mindfulness-based cognitive-behavior art therapy for [344–9](#), [346–7](#), [348](#)

developmental art therapy

acquiring positive sensory orientation and simple motor schemes in [441](#)

affective expression capacity considered in [437–8](#)

assessment prior to [435](#), [437–8](#)

case example of (Henry) [447–50](#), [448–50](#)

case example of (Matthew) [442–3](#), [443](#)

developing capacity for symbolization in [446–7](#)

developing sensory discrimination and percept in [445–6](#)

discovering cause-and-effect relationships in [442](#)

eclectic approach to art therapy including [484](#)

fostering attachment and differentiation of self, other, and object in [440–1](#)

as integrative approach [435–50](#), [484](#)

materials used in [438–40](#), [439](#), [443](#), [444](#)

overview of [435](#), [450](#)

in preoperational phase [443–50](#)

promoting autonomy in [444–5](#)

promoting expression and differentiation of feelings in [445](#)

in sensorimotor phase [438–43](#)

structured vs. nonstructured formats in [437](#)

- theories underlying [435](#), [436](#)
- dialectical behavioral therapy (DBT) [335–6](#), [341–4](#)
- discovery and insight in art therapy
 - background of [71–5](#)
 - case example of (Mrs. L.) [75–83](#), [77](#), [79](#), [81](#), [82](#), [84](#)
 - dreams in [74](#)
 - framework for freedom allowing [84](#)
 - free association in [74](#), [76](#)
 - interpretations role in [75](#), [78](#), [81–3](#)
 - least restrictive environment for [84](#)
 - overview of [83–5](#)
 - as psychoanalytic approach [71–85](#)
 - scribble drawings for [78](#), [79](#), [80](#), [84](#)
 - transference and countertransference in [74–5](#), [78](#), [85](#)
 - unconscious in [73–4](#), [80](#)
- displacement, sublimation and [94–5](#), [95](#), [96](#), [102](#)
- dynamically oriented art therapy [73](#), [74](#), [109](#)
- eclectic approach to art therapy
 - case example of (Craig) [488–91](#), [489](#), [490](#)
 - case example of (Susan) [483](#), [483–5](#)
 - cognitive-behavioral art therapy in [482](#)
 - current issues to be addressed in [491–2](#)
 - developmental art therapy in [484](#)
 - existential art therapy in [481](#), [484](#)
 - future art therapy theory and [487–91](#), [489](#), [490](#)
 - Gestalt art therapy in [481](#), [484](#)
 - group art therapy in [482](#), [484–5](#)
 - as integrative approach [479–92](#)
 - Jungian art therapy in [481](#), [484](#)
 - layers of theoretical development to form [480–2](#)
 - locked into theory vs. [485–7](#), [486](#)
 - overview of [479–80](#), [491–2](#)
 - physiological and societal influences in [482](#)
 - psychoanalytic approaches in [480–1](#), [484](#)
 - therapeutic relationship in [479–80](#), [481](#), [485–6](#)
- education, therapeutic *see* [creative education with art therapy](#)
- empathy
 - in CREATE [372](#), [388–90](#)
 - in mentalization-based art psychotherapy [148–9](#), [157](#)
 - in person-centered expressive arts therapy [232](#), [240](#)
 - therapist as artist communicating [46–8](#), [47](#)
- existential art therapy [205–11](#), [481](#), [484](#)
- Expressive Therapies Summit [2](#)
- family art therapy
 - case example of (Darrell) [404–14](#), [406–10](#)
 - clinical treatment following [413–14](#)
 - communication/behavior considered in [400](#), [411](#)
 - core concepts of [399–401](#)
 - cultural/societal influences considered in [400](#), [411](#)
 - current status of [402–3](#)
 - development of [401–2](#)

- drawing inferences from artwork in [407–9](#)
- “Eight Ways” model of [399–401](#), [409–13](#)
- Family Art Evaluation (FAE) as [402–15](#)
- history of family therapy [397–9](#)
- individual within the system considered in [401](#), [412](#)
- life cycle considered in [399](#), [409–10](#)
- overview of [397](#), [414–15](#)
- resilience considered in [400](#), [410–11](#)
- structure considered in [400](#), [411](#)
- as systemic approach [397–415](#)
- themes and metaphors considered in [401](#), [412](#)
- unconscious life of family considered in [401](#), [412](#)
- Fish, Barbara [34](#), [45–8](#)
- Fleming, Mari [34–5](#)
- Focusing-Oriented Art Therapy (FOAT®)
 - asking felt sense questions in [288](#), [293–4](#)
 - basic step (beginning) in [290–1](#)
 - choosing an issue to address in [288](#)
 - Clearing a Space with Art in [288](#), [294–8](#), [296](#), [297](#)
 - client example of (Alissa) [298–300](#), [299](#)
 - client example of (Brianna) [293–4](#), [294](#)
 - client example of (Cindy) [300–1](#), [301](#)
 - client example of (group) [300](#)
 - client example of (Jenn) [295–7](#), [296](#), [297](#)
 - client example of (Kristie) [302–4](#), [303](#), [305](#)
 - client example of (Shannon) [291–2](#), [292](#)
 - clinical sensitivity in [289](#)
 - as contemplative approach [286–306](#)
 - experiential listening in [289](#)
 - FOAT Check-In in [290](#), [292–4](#), [294](#)
 - FOAT Psychotherapy Process [301–4](#), [303](#), [305](#)
 - Focusing Attitude in [289](#), [291–2](#), [292](#)
 - Focusing roots of [286](#), [287–8](#)
 - foundational principles of [288–90](#)
 - grounding in [289](#)
 - history and development of [287–8](#)
 - mindfulness in [286](#), [289](#), [293](#), [294](#)
 - mirroring in [290](#)
 - overview of [286–7](#), [305–6](#)
 - presence in [288–9](#)
 - receiving in [288](#)
 - reflection in [289–90](#)
 - resonance in [288](#)
 - symbol/handle in [288](#), [290](#)
 - Theme-Directed FOAT in [290](#), [298–301](#), [299](#), [301](#)
- foundations of art therapy
 - overview of [6–8](#)
 - relational aesthetics as [7–8](#), [50–65](#), [317](#)
 - symbolizing and seeing as [6–7](#), [17–32](#), [181–2](#), [446–7](#)
 - therapist as artist as [7](#), [33–48](#), [59](#), [111–14](#), [189–91](#), [273–4](#), [276–7](#)
- Freud, Sigmund *see also* [psychoanalytic approaches](#)
 - eclectic approach to art therapy influenced by [480–1](#), [484](#)

- family therapy impacted by [397](#)
- Jung and [168–9](#), [190](#)
- on object relations [102](#)
- on sublimation [101](#)
- on tripartite (id, ego, superego) division of mind [73](#)
- on visual images [71–2](#), [73](#)

Gestalt art therapy

- acceptance expressed in [220](#), [223–4](#), [225](#), [225](#)
- anger and fear expressed in [220](#), [221](#), [221](#), [222](#), [225](#)
- anticipation and surprise expressed in [220](#), [222](#), [223](#), [224](#), [225](#), [226](#)
- art and Gestalt approaches [214–17](#)
- case example of (Wendy) [217–27](#), [221–6](#)
- contempt expressed in [224](#), [225](#), [226](#), [226](#)
- eclectic approach to art therapy including [481](#), [484](#)
- Gestalt assumptions and applications in [214](#)
- Gestalt psychology and Gestalt therapy as basis for [212–14](#)
- as humanistic approach [212–28](#), [481](#), [484](#)
- overview of [212](#), [227–8](#)
- present state expressed in [220](#)
- self-awareness in [214](#), [215](#), [226](#)
- structured approach to [217–27](#)

grounding

- in Focusing-Oriented Art Therapy [289](#)
- in narrative art therapy for trauma [360](#), [361](#), [362](#), [363](#)

group art therapy

- amount of structure and group dynamics in [425–6](#)
- benefits and challenges of [423–5](#)
- contributions of all approaches to [423](#)
- eclectic approach to art therapy including [482](#), [484–5](#)
- history of group therapy approaches [417–19](#)
- overview of [417](#), [429–30](#)
- Pandora's gifts in [473](#)
- processing the art in [426–9](#), [428](#)
- process-oriented [422–3](#), [426](#)
- structured/task-focused [420–2](#), [426](#)
- studio- or community-based [420](#)
- as systemic approach [417–30](#), [473](#), [482](#), [484–5](#)
- triangular dimension of (therapist, patient, artwork) [419](#)

Hartmann, Heinz [101](#)

Hill, Adrian [33](#)

Hinkle, Beatrice [169](#)

humanism in art therapy

- case example of (Lorraine) [203](#), [206–11](#), [209](#)
- existential art therapy as [205–11](#), [481](#), [484](#)
- as humanistic approach [203–11](#), [481](#), [484](#)
- mindfulness in [205](#), [210](#)
- overview of [203](#)
- roots of humanist psychology for [203–4](#)
- self-awareness in [204](#)
- therapeutic relationship in [4](#), [204–5](#)

humanistic approaches

eclectic approach to art therapy including [481](#), [484](#)
 Gestalt art therapy as [212–28](#), [481](#), [484](#)
 humanism in art therapy as [4](#), [203–11](#), [481](#), [484](#)
 overview of [3–4](#), [9](#)
 person-centered expressive arts therapy as [230–47](#)
 positive art therapy as [249–63](#)
 Huntoon, Mary [33](#)

imagination
 imaginal culture and imaginal mindfulness [316](#)
 integration of, in therapy [468–9](#), [471](#), [472](#), [475](#), [476](#)
 Jungian active imagination [171](#), [182](#), [191–8](#)
 mentalization based on [144](#)

integrative approaches
 creative education with art therapy as [452–66](#)
 developmental art therapy as [435–50](#), [484](#)
 eclectic approach to art therapy as [479–92](#)
 overview of [11–12](#)
 Pandora's gifts (imagination and all of the arts) as [468–77](#)

internalization [140](#)
 International Expressive Arts Therapy Association [2](#)
 Itard, Jean [454](#)

Jones, Don [34](#), [59](#)

Jungian art therapy
 active imagination in [171](#), [182](#), [191–8](#), [192–7](#)
 analytic attitude and [185–6](#)
 as analytic therapy approach [74](#), [167–87](#), [189–98](#), [273–4](#), [481](#), [484](#)
 archetypes in [178](#), [179–81](#), [180](#), [183](#), [185](#)
 case example of (Christina) [191–8](#), [192–7](#)
 complexes in [168](#), [175–6](#), [176](#), [177](#), [179](#), [183](#), [185](#)
 directed and nondirected thinking in [171](#), [181](#)
 eclectic approach to art therapy including [481](#), [484](#)
 foundations for analytical psychology and [168](#)
 Freud and Jung [168–9](#), [190](#)
 image and symbol in [181–2](#)
 individuation in [183](#)
 Jung as artist [189–91](#), [273–4](#)
 Jung as art therapist [170–1](#)
 mandalas in [172](#), [177–8](#), [177–80](#), [183](#), [274](#)
 map of psyche in [174–5](#)
 Naumburg and [169–70](#)
 overview of [167–8](#), [186–7](#)
 psychic energy in [168](#), [174](#), [175](#), [176](#), [176–9](#), [177–80](#), [185](#)
The Red Book on [168](#), [170](#), [171–2](#), [274](#)
 self in [172](#), [181–2](#), [183](#), [185](#)
 self-regulating aspect of psyche in [183–5](#), [184](#)
 shadows in [172](#), [174–5](#), [177](#), [178](#), [183](#), [185](#), [481](#), [484](#)
 transcendent function in [182](#)
 as transformative process [172–4](#), [174](#)
 unconscious in [74](#), [168](#), [169](#), [171](#), [172](#), [174–5](#), [176](#), [178](#), [179](#), [181–2](#), [185–6](#), [190](#)

Kinkel, Kip [464](#)

Klein, Melanie [140–1](#)
Kramer, Edith [33](#), [35](#), [109](#), [111–12](#), [455](#)
Kwiatkowska, Hanna [33](#), [401–2](#), [403](#), [498](#)

Lachman-Chapin, Mildred [34–45](#), [59](#)

libidinal energy *see* [psychic energy](#)

libido, sublimation of [87](#), [88](#), [99](#); *see also* [sexuality](#)

Little Hans [72](#)

Lombardi, Carmine [96–7](#), [98](#)

Loveless, Richard [315](#)

Lowenfeld, Viktor [454](#)

mandalas

in contemplative wisdom traditions in art therapy [311](#)

in group art therapy [422](#)

in Jungian art therapy [172](#), [177–8](#), [177–80](#), [183](#), [274](#)

in positive art therapy [253](#), [253](#)

Menninger, Karl [33–4](#)

mentalization-based art psychotherapy

affect consciousness in [148](#), [157](#)

case example of (Dora) [157–60](#), [158](#)

case example of (Harmonie) [150–3](#), [151](#)

case example of (Harriet) [145–8](#), [146](#)

conceptual dimensions of mentalizing [148–50](#), [157](#)

curiosity in [145](#), [147](#), [156](#), [157](#), [157](#), [161](#)

empathy in [148–9](#), [157](#)

epistemic trust in [157](#), [160](#)

mentalize, defined [144](#)

mentalizing use in art therapy [153–4](#)

mindfulness in [149–50](#), [157](#)

non-mentalizing vs. [152–3](#)

overview of [144–5](#), [161](#)

parenting analogous to [155–6](#)

as phenomenological process [156–7](#), [157](#)

as psychoanalytic approach [144–61](#)

psychological mindedness in [149](#), [157](#)

Socratic inquiry in [158–9](#)

transference-countertransference and [154–5](#), [160](#)

mental retardation

developmental art therapy in cases of [435–50](#)

retarded ego development in [18–20](#), [20](#)

sublimation despite [89–90](#), [100](#)

mindfulness *see also* [self-awareness](#)

in cognitive-behavioral art therapy [335](#), [336](#), [342–3](#), [344–9](#)

in contemplative wisdom traditions in art therapy [309](#), [316](#)

creative [342–3](#)

in dialectical behavioral therapy [335](#), [342–3](#)

in Focusing-Oriented Art Therapy [286](#), [289](#), [293](#), [294](#)

in humanism in art therapy [205](#), [210](#)

in mentalization-based art psychotherapy [149–50](#), [157](#)

in mindfulness-based cognitive-behavior therapy [336](#), [344–9](#), [346–7](#), [348](#)

in spiritual path and art making [273](#)

mirroring

- in CREATE [374](#)
- in developmental art therapy [440–1](#)
- in Focusing-Oriented Art Therapy [290](#)
- in object relations and art therapy [131–2](#), [133](#), [137](#)
- by therapist as artist [36](#), [41–2](#)

mother

- family art therapy addressing issues of [404–14](#), [406–10](#)
- Gestalt art therapy addressing issues with [218–19](#)
- mentalization-based art psychotherapy addressing issues of [145–8](#), [146](#), [159–60](#)
- object relations and art therapy in relation to [130](#), [133](#)
- sublimation of sexuality of [92](#), [92–4](#)
- symbolism for [18–19](#)
- therapist as artist addressing issues related to [36–7](#), [38](#), [40](#), [41–2](#), [45](#)
- transitional object representing [19](#), [36–7](#)

Naropa Community Art Studio (NCAS) [319–26](#), [320–2](#), [324–5](#)

Naropa University [272](#), [274–5](#), [310](#), [323](#)

narrative art therapy for trauma

- application of [359–62](#), [364–8](#)
- case example of (Katie) [353](#), [354–5](#), [358](#), [360](#), [362–8](#), [364–8](#)
- as cognitive and neuroscience approach [5–6](#), [353–69](#)
- dual brain consequences considered in [356–7](#)
- “finishing the story” using [358–9](#)
- fundamental (dis)organization of trauma story and [358](#)
- graphic narrative in [359–60](#), [361](#)
- greater recognition of trauma [355](#)
- grounding in [360](#), [361](#), [362](#), [363](#)
- helping the process in [361](#)
- Instinctual Trauma Response considered in [357–9](#), [361](#), [363–4](#), [367](#)
- overview of [5–6](#), [353](#), [368–9](#)
- Parenting Stress Index administered prior to [362](#), [363](#)
- prevalence of PTSD [355–6](#)
- re-presentation in [361–2](#)
- theory behind [356–9](#)
- trauma as public health issue [353–9](#)
- Trauma Symptoms Inventory administered prior to [362–3](#)

Naumburg, Margaret [33](#), [71](#), [72](#), [73–4](#), [80](#), [107–9](#), [111–12](#), [169–70](#), [275](#), [454](#), [464](#)

New Place [315](#)

Oaklander, Violet [216](#)

object relations and art therapy

- creativity and play in [134–6](#)
- definition of [139](#)
- developmental levels in, approaches for differing [136–8](#)
- developmental objects relations [133–4](#)
- discussion of [130–2](#)
- early life experience importance in [140](#)
- formation of self and [134](#), [140](#)
- mirroring in [131–2](#), [133](#), [137](#)
- overview of [138](#), [142](#)
- pathology of objects relations [134](#)
- patient’s inner world expression via [126–30](#), [127–9](#)
- points of agreement among theorists on [141–2](#)

- as psychoanalytic approach [102](#), [126–38](#), [139–42](#)
- role of art in [132–3](#)
- splitting and duality of self/object representations in [140–1](#)

Open Studio Process [275–84](#)

Pandora's gifts (imagination and all of the arts)

- creative space or environmental energy with [472–3](#)
- drumming and rhythm as [471–2](#), [474–5](#)
- group setting for [473](#)
- imagination integration as [468–9](#), [471](#), [472](#), [475](#), [476](#)
- as integrative approach [468–77](#)
- intermodal expressive therapy with [469](#), [470](#)
- letting go while staying focused with [476](#)
- movement and vocal expression as [472–3](#), [474–6](#)
- multi-sensory activity with [470–6](#)
- therapist training in integration of art forms [470](#), [477n](#)
- using all of the arts in therapy [469–77](#)

Perls, Fritz [213](#)

person-centered expressive arts therapy

- creative connection[®] in [232–4](#), [233](#), [242](#), [247](#)
- credo of [240](#), [242](#)
- cross-cultural understanding via [242](#), [243–5](#)
- empathetic listening in [232](#), [240](#)
- expressive art therapy, defined [230–1](#)
- healing power of [237–40](#), [238](#), [239](#), [241](#), [242](#)
- as humanistic approach [230–47](#)
- overview of [230](#)
- as path to wholeness [247](#)
- person-centered, defined [231–2](#)
- self-awareness in [247](#)
- self-direction in [231](#), [234](#)
- shadow in [245](#)
- social change through [242](#)
- transcending inner polarities in [245–7](#), [246](#)
- trusting client's path in [235–7](#)
- unconscious in [245](#), [247](#)
- use of, with clients [234–5](#)

Podvoll, Edward [319](#)

positive art therapy

- achievement in [260](#)
- engagement and flow in [256–7](#)
- engagement using strengths in [254–6](#), [256](#)
- as humanistic approach [249–63](#)
- meaning in [257–60](#), [259](#)
- negativity bias vs. [250](#), [257](#)
- overview of [249–50](#)
- PERMA (positive emotions, engagement, relationships, meaning, achievement) framework for [251–61](#)
- positive emotions in [252–4](#), [253](#)
- positive psychology as basis for [250–1](#)
- practicing [261–3](#), [262](#)
- relationships in [260–1](#)

post-traumatic stress disorder, narrative art therapy for *see* [narrative art therapy for trauma](#)

pseudonyms for case examples [12](#)

psychic energy [168](#), [174](#), [175](#), [176](#), [176–9](#), [177–80](#), [185](#)

psychoanalytic approaches

discovery and insight in art therapy as [71–85](#)

eclectic approach to art therapy including [480–1](#), [484](#)

mentalization-based art psychotherapy as [144–61](#)

object relations and art therapy as [102](#), [126–38](#), [139–42](#)

sublimation in [87–100](#), [101–4](#), [107](#), [311](#), [462](#), [463](#)

variations on Freudian theme in [106–25](#)

psychodynamic approaches

analytic therapy approaches as [74](#), [167–87](#), [189–98](#), [273–4](#), [481](#), [484](#)

discovery and insight in art therapy as [71–85](#)

Jungian art therapy as [74](#), [167–87](#), [189–98](#), [273–4](#), [481](#), [484](#)

mentalization-based art psychotherapy as [144–61](#)

object relations in [102](#), [126–38](#), [139–42](#)

overview of [9](#)

psychoanalytic approaches as [71–85](#), [87–100](#), [101–4](#), [106–25](#), [126–38](#), [139–42](#), [144–61](#), [311](#), [462](#), [463](#), [480–1](#), [484](#)

sublimation in [87–100](#), [101–4](#), [107](#), [311](#), [462](#), [463](#)

variations on Freudian theme in [106–25](#)

The Red Book (Jung) [168](#), [170](#), [171–2](#), [274](#)

regression, sublimation and [90](#), [91](#), [97](#), [99](#)

relational aesthetics

aesthetics, defined for [52](#)

aesthetic theory in contemporary art therapy [53–5](#)

artwork approach impacted by [62–3](#)

ArtWorks project using [57–63](#), [58](#), [61](#), [63](#), [64](#)

conceptualizing the work in [59](#)

considering context in [60](#)

contemplative wisdom traditions on [317](#)

contemporary aesthetic theory on [52–3](#)

contemporary art context for [50–1](#)

as foundation of art therapy [7–8](#), [50–65](#), [317](#)

history of art and aesthetics [52](#)

mistakes made by forgetting [60–1](#)

multiple aesthetics in [51–2](#)

overview of [7–8](#), [50](#)

practical implications of [56–65](#), [58](#), [61](#), [63](#), [64](#)

questions to consider about [64](#)

relational aesthetics in art [55–6](#)

relational aesthetics in art therapy [56](#)

therapeutic relationships and [61–2](#)

The Retreat [319](#)

Richards, MC [315](#)

Rogers, Carl [204](#), [231–2](#)

scribble drawings

or art as therapy [117](#), [118](#), [119](#)

for discovery and insight in art therapy [78](#), [79](#), [80](#), [84](#)

in family art therapy [406–7](#), [408](#)

self

developmental art therapy fostering differentiation of self [440–1](#)

in eclectic approach to art therapy [479](#), [492](#)

individuation of [183](#)

- internalization and formation of [140](#)
- Jungian art therapy on [172](#), [181–2](#), [183](#), [185](#)
- object relations theory and sense of [134](#), [140](#)
- self-awareness *see also* [mindfulness](#)
 - in cognitive-behavioral art therapy [342](#)
 - in eclectic approach to art therapy [481](#)
 - in Gestalt art therapy [214](#), [215](#), [226](#)
 - in humanistic approach [204](#)
 - in person-centered expressive arts therapy [247](#)
- self-direction [231](#), [234](#)
- self-objects [36](#), [37](#)
- self-regulation [183–5](#), [184](#), [343](#)
- sexuality
 - Gestalt art therapy addressing issues with [219](#)
 - objects relations and [126–7](#), [130](#)
 - sublimation of [87](#), [88](#), [89](#), [92](#), [92–4](#), [99](#)
 - therapist as artist addressing issues related to [39](#), [41](#), [42](#)
- shadows
 - in Jungian art therapy [172](#), [174–5](#), [177](#), [178](#), [183](#), [185](#), [481](#), [484](#)
 - in person-centered expressive arts therapy [245](#)
- Shaku, Soyen [272](#)
- social change/social action [8](#), [242](#)
- spiritual path and art making *see also* [contemplative wisdom traditions in art therapy](#)
 - art role in [273–5](#)
 - attention in [275](#), [276](#), [279–80](#)
 - case example of (Janet) [281–4](#), [282](#)
 - as contemplative approach [271–84](#)
 - intention in [275](#), [276](#), [278–9](#)
 - mindfulness in [273](#)
 - Open Studio Process as [275–84](#)
 - overview of [271–3](#)
 - service orientation in [276](#)
 - therapist as artist in [273–4](#), [276–7](#)
 - transpersonal orientation of [272–3](#), [276–7](#)
 - witness writing in [275](#), [276](#), [277–7](#), [280–1](#)
- sublimation
 - achieving [96–7](#), [98](#)
 - in art therapy [88](#), [101–4](#)
 - catharsis vs. [89](#)
 - contemplative wisdom traditions similarity to [311](#)
 - in creative education with art therapy [462](#), [463](#)
 - displacement and [94–5](#), [95](#), [96](#), [102](#)
 - failure of neutralization via [89](#)
 - identification fostering [104](#)
 - inducing and supporting [89–90](#)
 - other defense mechanisms and [90–2](#), [102](#)
 - overview of [87–8](#), [97](#), [99–100](#)
 - in psychoanalytic approaches [87–100](#), [101–4](#), [107](#), [311](#), [462](#), [463](#)
 - therapeutic relationship supporting [89–90](#), [94](#), [99](#), [102–4](#)
- suicide/suicide ideation, sublimation of [91](#)
- symbolizing and seeing
 - aphasia/organic brain disease impacting [21–3](#), [22](#), [23](#)

- developmental art therapy to develop capacity for [446–7](#)
- as foundations of art therapy [6–7](#), [17–32](#), [181–2](#), [446–7](#)
- intentionality and meaning in [24–32](#)
- Jungian art therapy image and symbol for [181–2](#)
- overview of [17–18](#)
- pathology of symbolic process [18–24](#)
- phenomenological description in [26–7](#)
- phenomenological integration in [31](#)
- phenomenological intuiting in [25–6](#)
- phenomenological unfolding in [27–30](#), [28](#), [30](#)
- retarded ego development impacting [18–20](#), [20](#)
- seeing, specifically [24–32](#)
- symbolizing, specifically [18–24](#)
- transitional object shift from substitute to symbol [19](#)
- “What Do You See?” question in [26](#)
- systemic approaches
 - family art therapy as [397–415](#)
 - group art therapy as [417–30](#), [473](#), [482](#), [484–5](#)
 - overview of [10–11](#)
- teleology [168](#), [172](#)
- therapeutic education *see* [creative education with art therapy](#)
- therapeutic relationship
 - in cognitive-behavioral art therapy [335](#), [338](#)
 - in creative education with art therapy [465](#), [465–6](#)
 - in eclectic approach to art therapy [479–80](#), [481](#), [485–6](#)
 - Focusing-Oriented Art Therapy principles for [288–90](#)
 - in Gestalt art therapy [227](#)
 - in humanistic orientations [4](#), [204–5](#)
 - in person-centered expressive arts therapy [231–2](#), [234–7](#), [240](#), [242](#)
 - in positive art therapy [260–1](#)
 - postmodern or collaborative views of [4–5](#)
 - relational aesthetics and [61–2](#)
 - sublimation supported via [89–90](#), [94](#), [99](#), [102–4](#)
 - therapist as artist in (*see* [therapist as artist](#))
 - transference and countertransference in (*see* [transference and countertransference](#))
 - in transpersonal psychology [272–3](#)
- therapist as artist
 - Ault as [34](#)
 - Cane as [33](#), [111](#)
 - case example of (Mary) [36](#), [38–45](#), [39](#), [40](#), [43](#), [44](#)
 - case example of (Warren) [46–8](#), [47](#)
 - Chapin as [34–45](#), [59](#)
 - empathy communicated by [46–8](#), [47](#)
 - Fish as [34](#), [45–8](#)
 - Fleming as [34–5](#)
 - as foundation of art therapy [7](#), [33–48](#), [59](#), [111–14](#), [189–91](#), [273–4](#), [276–7](#)
 - Hill as [33](#)
 - Huntoon as [33](#)
 - Jones as [34](#), [59](#)
 - Jung as [189–91](#), [273–4](#)
 - Kramer as [33](#), [35](#), [111–12](#)
 - Kwiatkowska as [33](#)

- Menninger as [33–4](#)
- mirroring by [36](#), [41–2](#)
- mother issues addressed by [36–7](#), [38](#), [40](#), [41–2](#), [45](#)
- Naumburg as [33](#), [111–12](#)
- overview of [33–5](#)
- relational aesthetics work impacted by [59](#)
- response art by [45–8](#), [47](#)
- self-objects addressed by [36](#), [37](#)
- sexuality addressed by [39](#), [41](#), [42](#)
- spiritual path and art making view of [273–4](#), [276–7](#)
- transference and countertransference with [36](#), [38](#)
- Ulman as [33](#), [112–14](#)
- variations on Freudian approach based on [111–14](#)
- therapists
 - as artist [7](#), [33–48](#), [59](#), [111–14](#), [189–91](#), [273–4](#), [276–7](#)
 - Jungian approach to art impacting [186](#)
 - therapeutic relationship with (*see* [therapeutic relationship](#))
 - training of, in integration of art forms [470](#), [477n](#)
- Thompson-Taupin, Celia [216](#)
- Three Approaches to Psychotherapy* [497](#)
- transference and countertransference
 - in creative education with art therapy [465](#), [465–6](#)
 - discovery and insight in art therapy related to [74–5](#), [78](#), [85](#)
 - in eclectic approach to art therapy [479](#)
 - mentalization-based art psychotherapy and [154–5](#), [160](#)
 - therapist as artist issues of [36](#), [38](#)
- transpersonal psychology [272–3](#), [276–7](#)
- trauma, narrative art therapy for *see* [narrative art therapy for trauma](#)
- Trungpa Rinpoche, Chögyam [272](#), [310](#), [319](#)
- Tuke, Samuel [319](#)
- Ulman, Elinor [33](#), [109–10](#), [112–14](#)
- unconscious
 - collective [74](#), [171](#), [172](#), [174–5](#), [178](#), [179](#), [181](#), [182](#), [186](#), [233](#)
 - in creative education with art therapy [454](#)
 - discovery and insight in art therapy about [73–4](#), [80](#)
 - family art therapy awareness of unconscious life of family [401](#), [412](#)
 - Jungian views of [74](#), [168](#), [169](#), [171](#), [172](#), [174–5](#), [176](#), [178](#), [179](#), [181–2](#), [185–6](#), [190](#)
 - person-centered expressive arts therapy on [245](#), [247](#)
 - visual imagery communicating [73–4](#), [80](#)
- variations on Freudian theme
 - art as therapy as [109](#), [114–24](#)
 - case example of (Greta) [121–4](#), [122](#), [123](#)
 - case example of (Janet) [117–19](#), [118](#), [120](#)
 - case example of (Mary) [114–17](#), [115](#), [116](#)
 - consequences of therapeutic choice [119](#), [121–4](#)
 - features of Freudian thinking [107](#)
 - Kramer's theory as [109](#), [111–12](#)
 - Naumburg's theory as [107–9](#), [111–12](#)
 - overview of [106](#), [124–5](#)
 - in psychoanalytic approaches [106–25](#)
 - subjective factors in theory development [110–14](#)

three theories of art therapy [107–10](#)
Ulman' theory as [109–10](#), [112–14](#)
Vedanta, Advaita [311](#)

Walden School [33](#), [73](#), [111](#), [169](#), [454](#)
Wiltwyck School [455](#)
Windhorse Project [319](#)
wisdom traditions see [contemplative wisdom traditions in art therapy](#)
Word Association Experiment [168](#)

Zilzer, Vera [97](#)
Zinker, Joseph [215–16](#)