THIRD EDITION

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

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

Third edition published 2016
by Routledge
711 Third Avenue, New York, NY 10017

and by Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

First edition published by Brunner/Mazel 1987
Second edition published by Brunner-Routledge 2001

Library of Congress Cataloging-in-Publication Data
Approaches to art therapy : theory and technique / [edited by] Judith Aron Rubin. — Third edition.
pages cm
Includes bibliographical references and index.
ISBN 978-1-138-88455-7 (hardback : alk. paper) — ISBN 978-1-138-88456-4 (pbk. : alk. paper) — ISBN 978-1-315-71601-5 (ebook) 1. Art therapy.
I. Rubin, Judith Aron.
RC489.A7A67 2016
616.89'1656—dc23
2015024934

ISBN: 978-1-138-88455-7 (hbk)
ISBN: 978-1-138-88456-4 (pbk)
ISBN: 978-1-315-71601-5 (ebk)

Typeset in Bembo
by Apex CoVantage, LLC

CONTENTS

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 Ã 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

ACKNOWLEDGMENTS

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, 200l; 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 an intellectually disabled, 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.

References

Atkins, S. S. (2002). *Expressive arts therapy: Creative process in art and life*. Blowing Rock, NC: Parkway Publishers.

Ault, R. (1989). Art therapy with the unidentified patient. In H. Wadeson, J. Durkin, & D. Perach (Eds.), *Advances in art therapy*. New York, NY: Wiley.

Bateman, A. W., & Fonagy, P. (Eds.). (2011). *Handbook of mentalizing in mental health practice*. London, UK: Routledge.

Betensky, M. (2001). Phenomenological art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy* (2nd ed., pp. 121–133). New York, NY: Brunner-Routledge.

Burt, H. (Ed.). (2012). *Art therapy and postmodernism: Creative healing through a prism*. London, UK: Jessica Kingsley.

Casement, P. (2013). *Further learning from the patient: The analytic space and process*. London, UK: Routledge.

Chapin, M. L. (2001). Self psychology and art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy* (2nd ed., pp. 66–78). New York, NY: Brunner-Routledge.

Chapman, L. (2015). *Neurobiologically informed trauma therapy with children and adolescents: Understanding mechanisms of change*. New York, NY: Routledge.

Dreikurs, S. (1986). *Cows can be purple*. Chicago, IL: Adler School of Professional Psychology.

Eberhart, H., & Atkins, S. S. (2014). *Presence and process in expressive arts work: At the edge of wonder*. London, UK: Jessica Kingsley.

Edwards, M. (2001). Jungian analytic art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy* (2nd ed., pp. 81–94). New York, NY: Brunner-Routledge.

Fish, B. J. (2012). Response art: The art of the art therapist. *Art Therapy: Journal of the American Art Therapy Association*, *29*(3), 138–143.

Franklin, M.A. (2016). *Art as contemplative practice: Expressive pathways to the self*. Albany, NY: SUNY Press.

Garlock, R. (1987). A program of creative arts therapies based on the theories of Alfred Adler. In J.A. Rubin (Ed.), *Approaches to art therapy* (1st ed., pp. 139–148). New York, NY: Brunner/Mazel.

Hass-Cohen, N., & Carr, R. (Eds.). (2008). *Art therapy and clinical neuroscience*. London, UK: Jessica Kingsley.

Hass-Cohen, N., & Clyde Findlay, J. (2015). *Art therapy and the neuroscience of relationships, creativity, and resiliency: Skills and practices*. New York, NY: Norton.

Hinz, L. D. (2009). *Expressive therapies continuum: A framework for using art in therapy*. New York, NY: Routledge.

Hiscox, A., & Calisch, A. (Eds.). (1997). *Tapestry of cultural issues in art therapy*. London, UK: Jessica Kingsley.

Hogan, S. (Ed.). (1997). *Feminist approaches to art therapy*. London, UK: Jessica Kingsley.

Hogan, S. (2001). *Healing arts: The history of art therapy*. London, UK: Jessica Kingsley.

Hogan, S. (Ed.). (2002). *Gender issues in art therapy*. London, UK: Jessica Kingsley.

Howie, P., Prasad, S., & Kristel, J. (Eds.). (2013). *Using art therapy with diverse populations: Crossing cultures and abilities*. London, UK: Jessica Kingsley.

Jung, C. G. (1923/1971) Psychological types. *Collected Works* (Vol. 6). Princeton, NJ: Princeton University Press.

Junge, M. B. (2010). *The modern history of art therapy in the United States*. Springfield, IL: Charles C. Thomas.

Kagin, S., & Lusebrink, V. (1978). The expressive therapies continuum. *Art Psychotherapy, 5*, 171–180.

Kalmanowitz, D., & Lloyd, B. (Eds.). (2005). *Art therapy and political violence*. London, UK: Routledge.

Kalmanowitz, D., Potash, J., & Chan, S. M. (Eds.). (2012). *Art therapy in Asia: To the bone or wrapped in silk*. London, UK: Jessica Kingsley.

Kaplan, F. (2006). *Art therapy and social action: Treating the world's wounds*. London, UK: Jessica Kingsley.

King, J. (2016). (Ed.). *Art therapy, trauma and neuroscience: Theoretical and practical perspectives*. New York, NY: Routledge.

Knill, P. J. (2004). *Principles and practice of expressive arts therapy: Toward a therapeutic aesthetics*. London, UK: Jessica Kingsley.

Kossak, M. (2015). *Attunement in expressive therapy: Toward an embodied empathy*. Springfield, IL: Charles C. Thomas.

Levine, E. (2015). *Play and art in child psychotherapy: An expressive arts therapy approach*. Philadelphia, PA: Jessica Kingsley.

Levine, S. K., & Levine, E. (Eds.). (1999). *Foundations of expressive art therapy*. London, UK: Jessica Kingsley.

Levine, E., & Levine, S.K. (Eds.). (2011). *Art in action: Expressive arts therapy and social change*. London, UK: Jessica Kingsley.

Malchiodi, C.A. (Ed.). (2005). *Expressive therapies*. New York, NY: Guilford.

Moon, C. H. (2001). *Studio art therapy: Cultivating the artist identity in the art therapist*. London, UK: Jessica Kingsley.

Moon, C.H. (Ed.). (2010). *Materials & media in art therapy: Critical understandings of diverse artistic vocabularies*. New York, NY: Routledge.

Nachmanovich, S. (1990). *Free play: Improvisation in life and art*. New York, NY: Penguin.

Rappaport, L. (2008). *Focusing-oriented art therapy: Accessing the body's wisdom and creative intelligence*. London, UK: Jessica Kingsley.

Rappaport, L. (Ed.). (2014). *Mindfulness and the arts therapies: Theory and practice*. London, UK: Jessica Kingsley.

Rubin, J.A. (2008). "Children and the Arts." In *The arts as therapy with children* [DVD]. Pittsburgh, PA: Expressive Media.
Rubin, J.A. (2011). *The art of art therapy* (2nd ed.). New York, NY: Routledge.
Silver, R. (2001). *Art as language: Access to thoughts and feelings through stimulus drawings*. New York, NY: Routledge.
Simon, R. (1992). *The symbolism of style*. London, UK: Routledge.
Stevens, A. (1986). *Withymead*. London, UK: Coventure.
Stone, E. (1996). "The intrapsychic and the interpersonal in art therapy," Paper presented at the annual conference of Art Therapy Italiana, Rome.
Tinnin, L., & Gantt, L. (2014). *The instinctual trauma response and dual brain dynamics*. Morgantown, WV: Gargoyle Press [available through Amazon/Create Space].
Wallace, E. (2001). Healing through the visual arts. In J.A. Rubin (Ed.), *Approaches to art therapy* (2nd ed., pp. 95–108). New York, NY: Brunner-Routledge.
Wilson, L. (2001). Symbolism and art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy* (2nd ed., pp. 40–53). New York, NY: Brunner-Routledge.
Winnicott, D.W. (1971). *Playing and reality*. New York, NY: Basic Books.

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. . . .

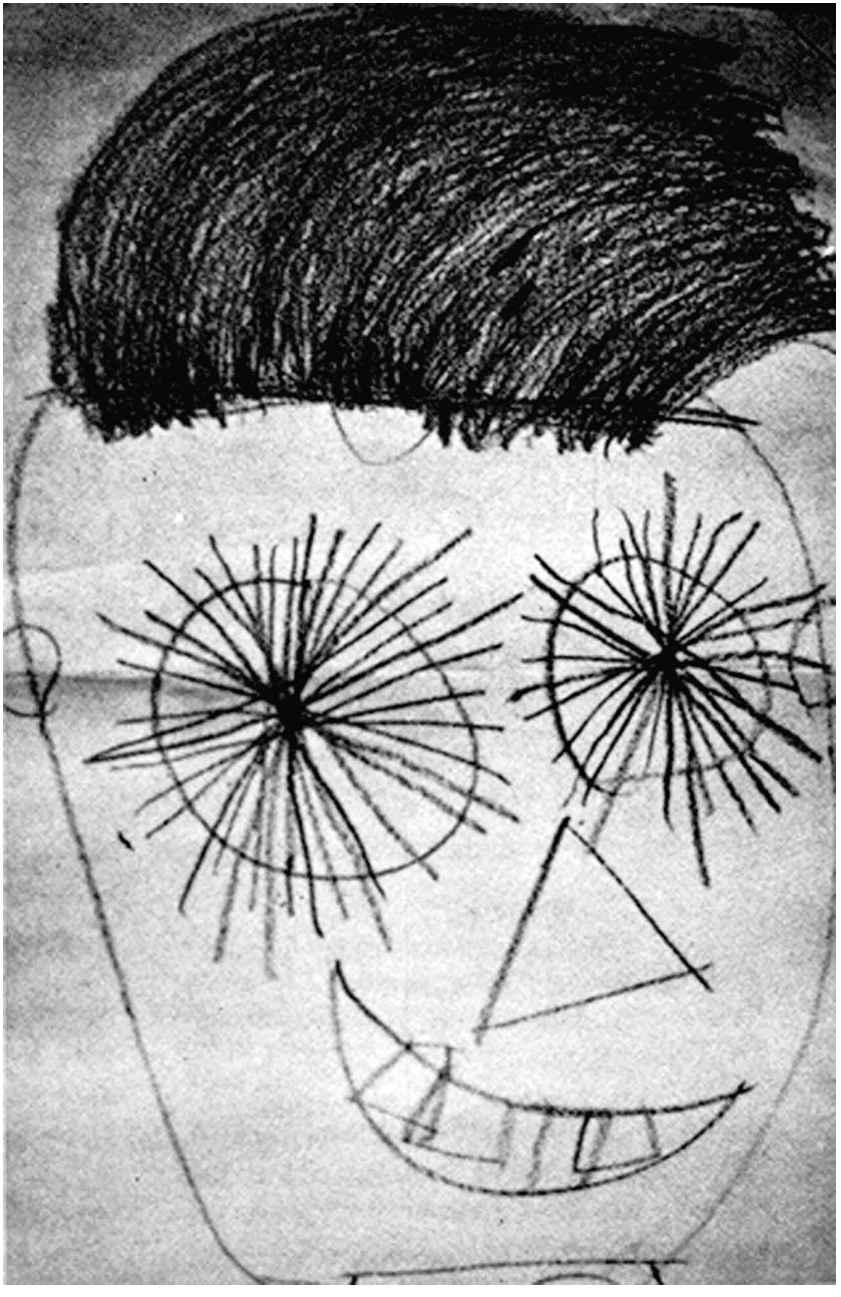

FIGURE 1.1

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

FIGURE 1.2

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.

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

FIGURE 1.3

to recover symbolic functioning in all areas, including language, through a similar development of visual images.

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.

FIGURE 1.4

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.

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

FIGURE 1.5

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.

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.

References

Beres, D. (1965). Symbol and object. *Bulletin of the Menninger Clinic*, *29*, 3–23.

Betensky, M. (1973). Patterns of visual expression in art psychotherapy. *Art Psychotherapy*, *1*, 121–129.

Betensky, M. (1995). *What do you see?* London, UK: Jessica Kingsley.

Betensky, M. (2001). Phenomenological art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy* (2nd ed., pp. 121–133). New York, NY: Brunner-Routledge.

Cassirer, E. (1974). *An essay on man*. New Haven, CT: Yale University Press.

Merleau-Ponty, M. (1962). *Phenomenology of perception*. London, UK: Routledge.

Wilson, L. (1977). Theory and practice of art therapy with the mentally retarded. *American Journal of Art Therapy*, *16*, 87–97.

Wilson, L. (2001). Symbolism and art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy* (2nd ed., pp. 40–53). New York, NY: Brunner-Routledge.

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