

Institute for Clinical Social Work

ART-MAKING AND TRADITIONAL PSYCHODYNAMIC  
TREATMENT OF ADULTS

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By

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## ABSTRACT

This qualitative study explored the experience of psychodynamic clinicians in private practice who have used art-making as a complementary modality of treatment within the context of verbal treatment of adult patients.

The study aimed to understand why traditionally trained clinicians made an intervention of art-making in their verbal treatment with their patient, when in the treatment process clinicians decided to make use of an art-making intervention in their treatment, and how the use of art-making within the context of verbal treatment impacted the clinicians' understanding of their adult patients.

The findings of this study indicate that these clinicians turn to art-making, in conjunction with their verbal treatment, because they have felt that the spoken word limited the scope of expression and self-disclosure of their patients' inner reality. Clinicians decided to make use of art-making, (a) when seeking to provide their adult patients with a way to disclose traumatic events, feelings, emotions, and the recovery of memories in relation to the trauma experienced, (b) when observing their patients struggling to bring out their inner experience via words, (c) when the treatment seemed to be stagnant, and (d) when they were in need of further information obtained via the intake process.

Clinicians' observations of their patients' creative process and its challenge increased their empathic understanding of their patients' inner struggles.

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## CHAPTER I

### INTRODUCTION

In 1988 I graduated from the School of the Art Institute of Chicago with a master's degree in art therapy. At that time very little was known about the use of art therapy in the psychotherapy treatment of adults here in Chicago. I remember the days when I hosted special meetings with psychiatrists and social workers at Chicago's Ravenswood Hospital to introduce them to the benefits of utilizing art-making with talk therapy. That have changed since then and talk therapy clinicians, many of them traditionally trained, have begun to incorporate complementary modalities of treatment, either singularly or in various modality combinations.

I became curious about what moved traditionally trained clinicians to open themselves to complementary nonverbal modalities of treatment such as art-making. This research study is about those clinicians, their motivations, their decisions to incorporate art-making into their traditional verbal approach, and the positive and negative aspects of utilizing such modality of treatment.

The primary concern of analysts and psychotherapists has always been to understand their patients. The therapeutic interaction is filtered by the clinician's own "inner reflections of the patient" as much as by what the patient is saying. (Basch, 1980) From the first interview with the patient the clinician looks for clues regarding what the patient wants, in what manner they are verbalizing and why that manner was chosen and

how they appear and present themselves to the clinician. (Basch, 1980) Verbal communication has been accepted as the primary modality toward therapeutic engagement of a patient. It has been given a certain level of authority as the main, and sometimes the only modality to depend upon when doing psychotherapeutic work.

While the literature on insight-oriented psychotherapy is filled with references to the verbal mode of communication and its importance and development within the frame of a session, there are some practitioners who have begun to integrate other modalities in order to more fully access the inner worlds of their patients.

In reference to this, Edna O'Shaughnessy writes:

It is now generally accepted that the interchange between the analyst and patient is wider than verbal; as well as words there are other transmissions by projections: feelings like anxiety, sexual excitement, hatred; mental images; sensations of drowsiness or rigidity; and so on. (1988, p. 138)

O'Shaughnessy reminds us that the interchange between the analyst and the patient is wider than verbal (1988), and that words are limited in their capacity to explain what is happening at the non-conscious level in our patients. This leads to the belief that nonverbal communication via images can work as the communicative bridge between the conscious and unconscious worlds of our patients.

Out of this primary concern to understand the patient, and in order to help patients gain a clearer sense of themselves, nonverbal modalities of treatment or "complementary therapeutic modalities" have begun to make their appearance in the consulting room. This wave of complementary modalities appears to come at a time when the scientific world is beginning to look at the mind-body connection; that is, the impact that the mind has upon the body and vice versa. (Moyers, 1993)

In 1989, French psychoanalyst Joyce McDougall gained widely acclaimed recognition for her psychoanalytic investigations of psychosomatic illness which shows how the body acts out the mind's distress, "tracing the drama's origins to highly emotional preverbal trauma." (1989) This has influenced the way we view traditional modalities of treatment such as verbal psychotherapy.

It is clear that most clinicians gather information about their patients primarily visually and through the spoken word. The way that patients relate their stories to the clinician, the pressure of speech, the tone of voice and the words used depict a partial view of the patients' sense of their own histories. They are expressing an internal image in the form of a verbalized thought that represents their perceptions, memories and/or fantasies. (Lusebrink, 1990) These internal images carry with them a visceral intensity that evokes in the patient and the therapist both emotional reactions and psychophysiological changes. Emotions and images together create the meaning of words, offering detailed information about past situations and/or preverbal memories. (Lusebrink, p. 9)

The spoken word as a tool, its "ability to generate an unlimited number of meaningful novel messages that are not bound to the here and now, combined with the cognitive capacity to exploit these properties, allows human communication to be extraordinarily effective and versatile." (Krauss, 2002) and is available, with few exceptions, to every human being.

Despite its obvious contributions, verbal communication also has limitations. Kodakos & Polemikos state that "verbal communication also has innate difficulties that can be marked at the level of transmission as well as the level of message

comprehension.” These researchers reflect on the way people make use of the spoken word to “... cover their thoughts and feelings at some degree, either to protect their self-image or to be agreeable to social conventions.” Another difficulty with the spoken word, according to Kodakos and Polemikos, is its limitation to verbally express experiences and feelings in a precise manner as there is always “the possibility of misinterpreting the words of an individual ...” since even the same word may have different meaning for two individuals. (Kodakos & Polemikos, p. 131)

Books on in-depth psychotherapy are filled with references to the verbal mode of communication, its importance and its development within the frame of a session, but these writings place little importance on communication through visual images as yet another modality for obtaining pertinent data about the patient.

Even though communication between the patient and the clinician has been a prolific topic of study within the field of psychotherapy (Leahy, 2004), the focus has mainly been limited to verbal interaction. Analyzing verbal communication between patient and clinician provides valuable information toward learning how the therapeutic encounter is constructed, developing awareness of the impact that the spoken word has upon the patient, and considering how the use of verbal communication shapes and influences the therapeutic interaction. (Leahy, 2004)

Some researchers consider verbal language to be one of the most important components of the therapeutic relationship characterizing it as “the main pathway for the mind to express itself.” (Favero & Ross, 2003) They state that it is through verbal language “that the therapist and patient touch each other’s mind. For the patient, verbal language brings conscious and unconscious material to life.... For the therapist, verbal

language provides form for the patient's material, creates a space to be held." (Favero & Ross, 2003)

However, words have a tendency to become abstract and are not always effective in uncovering the patient's difficulties or repressed material and defenses. (Sheikh & Jordan, 1983) Krauss (2002) provides an interesting discussion on the way information is conveyed via the spoken word with what he calls "four communication paradigms." (2002, p. 5) These communication paradigms are: encoding and decoding, communication intentions, perspective-taking, and dialogism. Each of these paradigms represents a different dimension of language use. According to Krauss these four paradigms characterize how "language functions as a medium of communication." (2002, p. 5)

For Singer (1978) external information, processed through ongoing thought, generates the formation of an internal schema. A schema, "consists of image-like representations, along with a verbal label of an event, object or person. Schemas... provide selection criteria for regulating attention and lend a focus to the encoding, storage, and retrieval of information in a domain." (Singer & Kolligian, 1987)

Among others analyzing the verbal modality of treatment, L'Abate (1999) writes on the usefulness of verbal communication that complementary approaches that utilize dance, music, or art-making have much to offer to the psychotherapeutic treatment in terms of cost effectiveness and behavioral change.

Additionally, it is already known by many clinicians that memories from childhood are often inaccessible to the adult via verbal communication but that such information can become accessible through remembered images. Horowitz (1971) points

to this fact by stating “the images that emerge through drawings are far more ambiguous than verbal descriptions and are thus far less likely to be censored, suppressed, or intellectualized.” (Horowitz, 1971) Naumburg (1966) pushes the emphasis further when she states that “the single and most important function of art production is as a vehicle for enriched communication.”

What words communicate does not necessarily explain what is occurring beyond words at the non-conscious level. Complementary modalities of treatment such as art-making can become the bridge to communication between the conscious and the non-conscious world of the patient. (Naumburg, 1966) In a recent research study on the use of drawings in organizations, Kearney & Hyle (2003) quoted Vince (1995) who points to the use of drawings as a “more specific and direct route to the emotions and unconscious responses underlying behaviors during change.” Furthermore, “imagery can bridge the gap between the apparently individual, private, subjective, and the apparently collective, social, political.” (Samuels, 1993, p. 63)

Within the history of psychoanalysis there have been analysts willing to incorporate art-making into psychoanalytic treatment to obtain further information about their patients. For instance, it is known that Carl Jung utilized drawings and paintings in his treatment as a way to access the non-conscious minds of his patients and that he also drew almost everyday. (Jung, 1964 & 1973)

For the purpose of obtaining useful therapeutic information about his young patients Donald Winnicott (1971) developed “The Squiggle Game,” a drawing game in which the child and therapist would engage in a series of back and forth drawings. The

“Draw-a-Story Game” by Gabel (1984) which is broadly used within the art therapy field, is an adaptation of the Winnicott technique.

The increased knowledge of the mind-body connection and the above-mentioned limitations of verbal communication have helped clinicians to become more open to utilizing other methods of approaching and gaining access to the patient rather than relying solely on the traditional spoken word. This awareness has motivated the clinician to pay closer attention to the patient’s nonverbal manner of communicating such as gesture, facial expression, body posture, and tone of voice.

Clinician and expert on learning disabilities, Joe Palombo (2006) writes extensively about the importance of nonverbal communication in relation to verbal communication and as “essential to successful social discourse.” (2006) He states:

Social communication deals with the medium, verbal and nonverbal language, through which relationships are conducted, whereas reciprocal social interaction deals with the way in which people relate to one another. Through language, whether verbal or nonverbal, we engage in what I call a form of “mindsharing”. . . the ability to ‘be with’ another through verbal and nonverbal communication.

Recent research conducted at the University in Beer Sheva, Israel, emphasizes the importance of utilizing complementary modalities toward the creation of meaning as a way to provide a framework for understanding in the therapeutic context. (Marlo & Kline, 1998) This research indicates also that nonverbal modalities within a therapeutic context contribute to the patient’s compliance in treatment. (Melamed & Szor, 1999)

## Problem Formulation

This qualitative research focuses on the use of the complementary treatment modality of art-making within the context of traditional talk psychotherapy treatment, in an attempt to learn why and when psychodynamic psychotherapists choose to make use of the complementary modality of art-making in addition to the verbal modality of treatment and exactly how the use of art-making within the context of verbal treatment impacts their understanding of their patient.

Modalities such as art, music, drama, sand-play, and dance are used in conjunction with verbal approaches as ways to access the non-conscious mind of the patient. The products of these complementary modality interventions are woven into the dyadic relationship of therapist/patient and become the marking points of meaningful revelations into the inner reality of the patient.

In recent years a new trend of thought and approach has been taking place in the outpatient psychotherapeutic treatment of adults. Clinicians are more willing to utilize complementary modalities of treatment such as art-making, within the context of their traditional verbal modality. This trend resonated with my experience, except that the interest led me in the reverse direction: from the partially nonverbal, as in art therapy, to the verbal approach.

Currently the most requested partial nonverbal modality by clinicians is art-making particularly drawing and coloring. Clinicians are becoming aware of the vast information that can be gathered from a drawing, and they seem to want to take advantage of such a modality. Malchiodi, in the introduction to the work of Oster and Montgomery (1996), points to the importance of every clinician becoming

knowledgeable about the use of drawings within treatment. She even goes as far as stating “it should be part of every clinician’s repertoire.”

Several writers have emphasized the contribution that art-making offers to traditional verbal psychotherapy through a “relief to excessive talking” (McNiff, 1988, p. 20) and an avenue to regain access to early memories that otherwise may be lost or unreachable.

### Significance of the Study for Clinical Social Work

Modalities such as art-making are used in conjunction with verbal approaches as ways to access the inner world of the patient. The products of these complementary modality interventions become the marking points of meaningful revelations into the inner reality of the patient.

In the study of psychotherapy, we have learned that patients need different approaches for different problems and at different times in their lives. A good psychotherapist must remain curious and flexible enough to draw from a broad repertoire of approaches to engage the diverse patient population that comes to therapy for help.

Complementary therapies offer exciting ways into our patients’ mysterious inner worlds that can expand the understanding found in more traditional verbal therapy. Art-making may be able to provide our patients with the possibility of both experiencing and expressing feelings that are less verbally accessible and to provide the clinician with an increased insight into their patients’ inner world.

## CHAPTER II

### LITERATURE REVIEW

This research study focuses on the creative process as experienced in the consulting room by the patient and the clinician in using art-making as the vehicle for the expression of the adult patient's internal process when words are not enough. It explores why psychotherapists decide to make use of art-making in their work with some patients; when do they determine that an art-making intervention would facilitate the therapeutic process; and how the use of art-making increases the clinicians' empathic understanding of their adult patients. The study assumes that verbal modes of communication provide limited access to some type of psychodynamic material and complementary modes of communication, such as art-making, can assist the patient in revealing those dynamics to the clinician.

Psychodynamic psychotherapy is creative work: as clinicians we assist our patients in "the process of decoding, deconstructing, and reconstructing data, guiding our patients by promoting self-awareness, making novel connections, and finding solutions, we can help bring into existence a new state of being." (Alfonso & Wellington, 2002) In his work on dreams, Freud (1900) identified the interpretation of dreams and their visual images as the bridge to the unconscious which could be accessed by his technique of free association.

The power of the imagination then becomes an essential part of the creative process that is amplified through the talk therapeutic treatment. Art-making aims to

facilitate the process of developmental growth, self-integration, and self-differentiation by allowing the patient to be in contact with dark parts of the self.

Kavaler-Adler (2000) proposes that the creative process can be used “to repair defects within the self and its inner world of object relations.” This is the perspective of object relations theory which is concerned with the exploration of “the relationship between real, external people and internal images and residues of relations with them and the significance of these residues for psychic functioning.” (Fonagy & Target, 2003) However, Kavaler-Adler wonders, if this could also be a “closed system of compulsive repetition” that can provide cathartic emotional relief but also “defensively wards off interpersonal life.”

Melanie Klein (1929) was one of the first object relations theorists to address the creative process. For her, the creative process was not simple sublimation but a complex process that encompasses reparation. This is the strongest element of the constructive and creative urges. In analyzing children, Klein observed their distress at the aggression that seems to be manifested in their creative playing. (Hinshelwood, 1991) For her there were different forms of reparation:

1. Manic reparation: based on the reversal of the child-parent relation;
2. Obsessional reparation which is a compulsive repetition of actions without much creative element;
3. Reparation grounded in love and respect for the object, a manifestation of true creative achievements.

Through creative expression the patient can create an illusion. For Klein (1929) adult symbolic language emerges from the need individuals have to safeguard objects

important to them. (Ambers & Burke, 2000) This function of symbols for a child, according to Klein, is to ease anxiety and guilt originating from the constant struggle with aggressive fantasies toward internal parental object. (p. 20)

Segal (1952) conceptualizes the creative process as a developmental mourning where the parental objects, having been damaged by the patient's own aggression, are recreated within the context of the art-making process and, in this way, repaired.

(Kavaler-Adler, 2000) From this perspective, the art-making process is a process of mourning which aims toward self-integration. (Loewald, 1962, in Kavaler-Adler, 2000)

Marion Milner (1969, 1981) is one of the few psychoanalysts who utilized the artwork that her patients painted as well as her own paintings and drawings to think insightfully about the content and function of those images. She encouraged her readers to think of the artwork as a map to the inner life of its creator. Pierides (1995) writes "the painter of the picture is externalizing onto the painting a major part of his own individual and unique sense of self . . . recreating internal reality in a reparative sense."

Art therapy is the therapeutic use of art-making within a professional relationship, by people who experience illness, trauma, or challenges in living, and by people who seek personal development. The use of a variety of media, such as watercolors, acrylics, color pencils, markers, clay, collage to create artwork to give expression nonverbally to material that is difficult to access verbally, and by reflecting on the art products and processing it with the clinician, people can increase awareness of self and others, cope with symptoms, stress, and traumatic experiences.

What art therapy offers particularly visual imagery and the art-making process is described as "distinctive" (McNiff, 1988) and because of this, many professionals in the

field of psychotherapy view art therapy as a nonverbal therapy. It is true that in this approach words are not always necessary. It may be more useful to believe that one of the main contributions of art therapy to the field of psychotherapy is that it provides “a relief from excessive talking.” (McNiff, 1988, p. 20)

The art process itself and the final art product are viewed and used among art therapists as a way for the patient to communicate and manifest his/her inner world. The drawing process itself is not viewed as the sole therapeutic agent. (McNiff, 1988; Dalley, 1984) The final product and the art-making process are verbally discussed with the art therapist, and it is generally during this processing time that “the patient can gain insight both intellectually and emotionally by connecting the meaning of the picture to her/his own internal/external life experience.” (Ledesma, 1996) The use of art as a therapeutic modality encourages a method of symbolic communication between patient and therapist. (Naumburg, 1966)

The task of the clinician is not only to acknowledge that the creative work is a reflection of the creative process and the internal representation world of the patient but it is also to determine whether “the developmental mourning process successfully consolidates and finds resolution within the creative work” or is a manifestation of an obsessive-compulsive recreation of destruction of internal objects without reparation.” (Kaveler-Adler, 2000)

Winnicott (1971) was also one of the few psychoanalysts who utilized art-making to engage difficult children in the therapeutic process. As a result, he developed the famous “Squiggle Game” where therapists engage the child in a drawing marks passed back and forth with the purpose of developing a therapeutic alliance with the young

patient and, in doing so, to obtain therapeutic data. He was interested in learning about their inner life and the way that their internal life impacted their relationships with others in the external world.

For Winnicott, (1971) the primary and most important relationship is that which develops between the infant and the mother. This relationship is internalized in the baby, and it will be used as the original matrix from which the baby begins to understand the world outside and his/her relationship with it. Within this realm of the “mother-baby unit” Winnicott devised his theoretical principles such as: true and false self, good-enough mother, playing and creativity, the importance of the development of illusion and disillusionment, potential space, and the transitional object. The notion of transitional object and potential space explains a “developmental progression from the early feelings of symbiosis to later perceptions of autonomy.” The infant realizes that a tangible world exists beyond his/her control; coming to this realization in turn can be traumatic and “to ease the transition toward acceptance of the independence of inner and outer existence, the growing infant imbues certain items with qualities of both internal fantasy and external reality . . . in the creation of the transitional object.” (Amber & Burke, 2000) Winnicott (1971) reminds us that the need for transitional objects does not end in childhood since the adult life constantly demands a balancing of inner and outer experience.

### Transitional Objects and Transitional Space

Winnicott's theory asserts that there is a transitional space between the child's developmental movements from absolute dependency on the mother to relative independence. In his schema, the child initially experiences himself and the mother as a whole entity. While to the outside world they appear as two separate beings, the infant sees no separation between the mother and himself; it is the mother-child or child-mother configuration that is the entire world. It is the mother who brings the world to the child, gradually and, ideally, non-forcefully.

Winnicott's concept of transitional space seems best suited to conceptualize the interactions between the clinician and the patient during periods when the patient becomes engaged in the art-making activity. The transitional space becomes a creative arena of nonverbal communication through which patients can express feelings and thoughts, and recover events that they cannot easily access verbally.

As the child begins to explore the world outside, or rather just beyond the mother-child unit, the child grows attached to objects such as a teddy bear, a blanket, or a doll. These objects are experienced as "transitional objects" on the way to the external world and thus are external manifestations of the child-mother unit. The child can make use of their transitional object to fill the mother's absence; it represents the object of the child's first relationship (Winnicott, 1971), putting the child on the path to becoming more independent, decreasing the absolute dependency on the mother-child experience. Transitional objects and the transitional space where the infant experiences them allow the child to navigate the "space" between internal and external realities.

In the movie “Hook” (Spielberg, 1991), which is based on the play “Peter Pan” (Barrie, 1904), the viewer is exposed to the life of an adult workaholic (Robin Williams) who returns to a place in his childhood as a way to re-capture what he has lost. It reminds the viewer of the innate need for an experience of illusion through play in order to obtain healthy development.

Peter’s adoptive grandmother asks him to remember infancy. She says to him: “Somehow you must go back; you have to remember Peter! Do you know who you are?”

With the help of a fairy character “Tink” (Julia Roberts), Peter is able to remember his childhood and embarks upon a journey to the land of “Neverland.” In “Neverland,” he faces a society of children who scream at him, “Play!, Play!”

Winnicott (1971) states: “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.” He emphasizes that only in playing is communication possible. (p. 54) For Winnicott, (1971) playing has a place and a time that is not inside nor is it outside. It is a space between the mother and the child that he calls “potential space.” (p. 41) It is in from which this space that play occurs. When Peter is able to acknowledge that specific space within his universe, he becomes able to play, to make use of his imagination, to fly.

Winnicott (1971) reminds us that playing is natural, that “...play is universal, and belongs to health: playing facilitates growth and therefore health; playing leads into group relationships; playing can be a form of communication in psychotherapy” (p. 41).

Peter is encouraged to fly. In congruity with his adult perspective, Peter responds, “I can’t fly.”

“Yes Peter, you can do it!”

And by having “happy thoughts” Peter is promised to be able to play and then to fly. The children are happy and in excitement they all scream, “You are doing it!”

“Doing what?”

“Using your imagination, Peter. You are playing, Peter!”

He finally comes upon his teddy bear, and it is in finding this teddy bear, Peter’s transitional object, that he is able to remember his infancy and to remember his mother.

In his 1953 paper, Winnicott introduced the concepts of transitional object and transitional space as important factors in the infant’s development. He defined these terms as “the intermediate area of experience, between the thumb and the teddy bear, between the oral erotism and true object-relationship, between primary creative activity and projection of what has already been introjected.” (p. 255).

Upon his return from “Neverland,” Peter becomes disillusioned when realizing that Tink will no longer be with him. The viewer sees Peter lying on the cold snowy ground at the foot of a Peter Pan sculpture.

He looks up and cries, “Tink, Tink.”

He sees Tink who in turn replies to him, “Say it Peter! Say it!”

And Peter responds: “I believe in fairies.”

Tink replies, “You know that place between asleep and awake, that place where we still are dreaming? That’s where I’ll always love you. That’s where I’ll be waiting.”

Tink is able to soothe Peter and remind him that there is a place between fantasy and reality (asleep and awake) where he can continue their experience.

This space “between asleep and awake” is what Winnicott (1971) called the intermediate space, the third space. (p. 11) Peter was able to re-experience and reclaim parts of his childhood through friendship, imagination, magical thinking, and play. Peter’s experience in Neverland enriched his capacity for self-healing, creative living, and self-discovery. (Galligan, 2000)

Winnicott (1971) emphasized the importance of the child’s first possession—or transitional object. This first possession (a teddy bear, a blanket), is imbued with maternal qualities and, “stands for the breast, or the object of the first relationship.” (p. 9) He also focused on the concept of transitional phenomena as that space between reality and fantasy. Both the transitional object and the transitional phenomena “are made possible by the mother’s special capacity for making adaptation to the needs of the infant, thus allowing the infant the illusion that what the infant creates really exists.” (p.14) All through life this infant’s experience is kept alive in the adult, “in the intense experiencing that belongs to the arts and to religion and to imaginative living, and to creative scientific work.” (p. 14)

Grolnick (1990) emphasizes the importance that Winnicott placed upon the early development of a person and how this early development “serves the therapist well when deciding how to help our developmentally disabled patients.” (p. 28)

According to Winnicott, (1971) for optimal development to occur, the caretaker must have the qualities of a “good enough provider,” to be attuned to the needs of the baby, providing “steadiness, love, empathy, enough frustration, and impact with reality and aggression.” (Grolnick, 1930, p. 28) The interaction with the caregiver becomes “gradually and increasingly internalized.” (Grolnick, 1930) in the child, and eventually

becomes a part of the internal world of that individual. This interaction between inner and outer worlds develops the concept of “transitional process” (Rose, 1978), a continuous interaction between inner and outer worlds, between perception and fantasy. (Grolnick, 1930)

In the therapeutic arena, the clinician provides the setting for new development to occur; the clinician becomes an “interpreter of insight” (Grolnick, 1930, p. 28) for the patient. In this way, the analytic process is not dissimilar from the creative one, both sharing a similar relationship to time and to inner and outer realities.

The creative process is one of self revelation. (Segal, 1991) Segal observes that “there is often a feeling, both in the artist and in the recipient, that the artist not so much creates but reveals a reality...part of the aesthetic experience has to do with a feeling of revelation of some half-perceived, apprehended truth, which is discovered not invented.” (Segal, 1991, pp. 94-95).

In the analytic process there is uncertainty as to how much relates to the present and how much relates to the past; it is in the experiencing of this ambiguity that the therapeutic interaction recreates a situation similar to the transitional phenomena experienced in childhood. (Adler, 1989) Adler writes, “Some of the most creative aspects of psychoanalysis (and some psychotherapies) may derive from the reactivation of transitional phenomena experiences which are tied to a child’s or an adult’s capacity for creative use of illusion and play.” (p. 81) In this way Adler makes reference to the idea that Winnicott’s concepts of transitional object and transitional phenomena apply to both creativity and adult issues. (p. 81)

Freud wrote extensively about the psyche (1949) and its agencies, the id, the ego and the superego. Within these agencies of the mind there is always a tension between the impulse to live and to create and the impulse to die, and to destroy. (Freud, 1949, Part II) In the analytic process and within the patient's relationship with the clinician these impulses become interwoven; there is a desire to create something new but also the simultaneous desire to destroy it. This interwoven process may be experienced through play or, similarly, through art making. This "play" process, in a sense, mirrors internal and external life events related to one's primitive instincts: life/death, reparation/destruction, love/hate in a constantly back-and-forth, pulling and pushing dialogue with oneself.

### Art Therapy

According to the American Art Therapy Association (AATA) art therapy is "the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma, or challenges in living, and by people who seek personal development. Through creating art and reflecting on the art products and processes, people can increase awareness of self and others, cope with symptoms, stress, and traumatic experiences; enhance cognitive abilities; and enjoy the life-affirming pleasures of making art."

Since the beginning of human existence, people have drawn images to describe their feelings, emotions, and activities. It is in large part through the early cave drawings, such as those of the Cave of Lascaux, the cave of Chauvet-Pont-d'Arc, and the Cave of

Altamira, that the world today has any understanding of the history of ancient civilization. (Clottes & Bahn, 2003; Burnham, 2003)

One of the earliest examples of the specific use of art in healing can be found in the Bible when David tries to cure King Saul's depression by playing the harp to him. (Samuel 16:14-23) Other examples include Navaho sand paintings and African sculptures which reveals the use of art in healing rituals. (Reichard, 1977; Meyer (2001)

Around the time of WWII, artists were taken to hospitals to assist and entertain the wounded and sick. Studies from that time began to demonstrate that patients exposed to some form of art and art making process developed a much more rapid and positive outcome than those who did not receive such exposure. (Dalley, 1984)

Art therapy encompasses with art, creativity, and psychotherapy. It differs from a traditional therapeutic use of verbal imagery by its direct use of art media to express internal images, feelings, thoughts, and sensations and to obtain feedback from the product. Lusebrink (1990) states, "the visual expressions produce a tangible, permanent record of the images that does not undergo changes and/or distractions through later recall from memory." (p. 10) It also differs from verbal imagery by the physical manipulation of art materials, the conscious thought process involved, and the level of control. The medium used becomes a symbolic agent within the patient's dialogue between internal and external reality. Finally, art therapy differs from verbal imagery in therapy by appealing to the creative side of the patient to create order out of chaos and give "an image or feeling a form. (pp.10-11)

The prolific works of educator, psychotherapist and mother of art therapy Margaret Naumburg (1890-1983) and others since the 1940s, including Edith Kramer

(1950's), laid the foundation for art therapy as a profession in the United States. Theories from psychoanalysis and art education became the foundation of two approaches in the field. The one stemming from Naumburg's position maintains that verbally processing a work of art with the clinician as a path to uncover one's inner reality is inherent in the therapeutic process—"art psychotherapy"—while Kramer's approach focuses exclusively on the specific act of creation as the sole force for healing and change ("art as therapy"). The framework of this study is based on Margaret Naumburg's approach.

Art therapy as a profession evolved out of the theory and techniques of psychoanalysis. (Borowsky Junge & Pateracki Asawa, 1994) Concepts such as the unconscious and the symbolic language of dreams (Freud, 1963) provided an important theoretical base for the field.

It was Freud who pointed out the complexity of providing a verbal account of the imagery of dreams. He stated:

We experience (*a dream*) predominantly in visual images; feelings may be present too, and thoughts interwoven in it as well; the other senses may also experience something, but nonetheless it is predominantly a question of images. Part of the difficulty of giving an account of dreams is due to our having to translate these images into words. "I could draw it," a dreamer often says to us, "but I don't know how to say it." (1963)

As early as 1895 Freud, was exploring the intra-psychic function of imagery in *Studies on Hysteria*. (Breuer and Freud, 1895) Hysterical patients experienced vivid memory images that Freud and Breuer believed to be images that corresponded to traumatic childhood experiences that had not been assimilated properly into the intra-psychic system. By the verbal description and exploration of the image, "its vividness would fade, as if the patient were "getting rid of it by turning it into words" (Suler,

1989). For Freud the dissipation of the image indicated alleviation of the symptom.  
(Suler, 1989)

Freud's transition from the hypnotic technique used with hysterics to the method of free association seems to correlate with an "implicit shift in focus from visual to verbal processes." (Suler, 1989) The development of behaviorism in the early part of 1900s regarded the study of images as "unproductive, impractical and unempirical." (Holt, 1964 in Suler, 1989) Words and language came to be viewed as the most important tools in treatment as they were seen as suitable for "objective scientific investigation.... Verbal linguistic processes connoted sensible rationality and thinking, whereas mental images suggested unrealistic, quixotic imaginings." (Suler, 1989)

In Europe after World War II, psychology became very interested in the study of mental imagery and a series of images theories and techniques began to flourish. An example of this is in the work of Swiss psychoanalyst Carl Jung.

Carl Jung (1875-1961) was very interested in the psychological meanings of symbolic imagery, the mandala symbol in particular, as a way to access the nonconscious (Jung, 1973). A mandala is an ancient symbol represented by the circle. In Sanskrit, mandala means circle and center. Jung (1973) stated that mandala drawings appear mostly in connection with chaotic psychic states of disorientation or panic; he believed that the purpose of the mandala drawings was to seek order from the inner confusion and chaos. He drew and painted, and he encouraged his patients to do the same. Earlier on, he said "to paint what we see before us is a different art from painting what we see within." (Jung, 1954, p. 253)

The contribution of visual imagery and the art-making process in art therapy is described as “distinctive” (McNiff, 1988), a therapy that is set apart from other therapeutic modalities because the image and imaging process are the main focus of treatment. Because of this many professionals in the field of psychotherapy view art therapy as a non-verbal therapy. It is true that in this approach words are not always necessary. It may be more useful to think that one way art therapy contributes to the field of psychotherapy is as “a relief to excessive talking.” (McNiff, 1988, p. 20) The art-making process and the final artwork are viewed and used as the patient’s way of communicating and manifesting her inner world. In Kramer’s position (the creative process itself is therapeutic), the art therapist nurtures and supports the creative process. (1971) The drawing process itself is not viewed among art therapists as the sole therapeutic agent. (McNiff, 1988; Dalley, 1984) The final product is verbally discussed with the art therapist, and it is generally during this processing time that “the patient can gain insight both intellectually and emotionally by connecting the meaning of the picture to her/his own internal/external life experience.” (Ledesma, 1996) The use of art as a therapeutic agent encourages symbolic communication between patient and therapist. (Naumburg, 1966)

Winnicott (1971) understood the usefulness of art to engage difficult children in the therapeutic process [see “Squiggle Game,” p. 13]. Similar ideas have been developed and formatted into board games with the purpose of engaging the resistant child. For instance “The Talking, Feeling and Doing Game” by Richard Gardner (1975); or the “Draw-A-Story,” interactive games in which the therapist and patient first draw lines on paper in an alternating fashion, then the patient is directed to develop the lines toward

creating a picture. In an attempt to lower the patient's resistance to treatment, the final drawing is the focus of further discussion through questions introduced by the therapist. (Gabel, 1984)

Because art-making has been mainly known to be a tool in the treatment of children, it is possible to believe that this modality can't be utilized with the adult population. There are numerous examples exemplifying the merits of art and art-making with adolescents and adults within a therapeutic context such as the Arts Incentive Program in Boston which helps female victims of abuse, the art therapy program at the Kovler Center in Chicago serving victims of war and torture, or the Alternative Behavior Treatment Centers (ABTC) serving adolescent males who have sexually abused others.

In working with an immigrant population, art therapy has proven to be a positive communication bridge to engagement in treatment. The immigrant patients can express their inner conflicts and their perceptions of identity, especially in regard to the new country, through visual images more easily than through words. (Ledesma, 1996) The expression of their feelings and perceptions pictorially promotes integration of negative and positive experiences from their country of origin and in the United States. (Ciornai, 1983 in Ledesma, 1996)

The use of imagery in clinical treatment touches upon the recently "revitalized" idea of how the human brain interacts during mental processes and on the "synergistic purpose" of the two hemispheres of the human brain. (Siegel, 2001) The left side of the human brain is the one connected to language in contrast to the right side which, according to Siegel (1999), "is considered to work as a pattern recognition center, assessing the gestalt and context" through a "holistic framework." Schore (1994)

indicates that developmentally, visual “antecedes and is superordinate to verbal.”

Levenson (2003) further points to current neuroscience thinking “that therapy is a right-brain to right-brain process, having to do with the transmission of images.”

Imagery appears to provide clinicians with a “special language” to access the unconscious of their patients. “By working with images therapists claimed they could skirt defenses and gain more direct access to unconscious affective and ideational processes than by working strictly with verbal communications.” (Suter, 1989)

This qualitative research study focuses on the use of art within the context of traditional verbal psychotherapy treatment in an attempt to learn:

1. Why traditionally trained psychotherapists choose to make use of this alternative modality of art-making in addition to the verbal modality of treatment
2. When (in the treatment process) clinicians decided to make use of a non-verbal intervention such as art-making in their treatment, and
3. How the use of art-making within the context of verbal treatment impacted the clinicians’ understanding of their adult patients.

The results of this qualitative research study will be discussed within the theoretical framework of object relations, and in particular the work of Winnicott. (1955, 1967, 1971) An outline of relevant concepts from the theory such as internal objects, transitional object, and transitional space will be presented in conjunction with concepts related to art therapy.

## CHAPTER III

### RESEARCH STRATEGY

#### Hypotheses to Be Tested or Questions to Be Explored

This was an exploratory study which focused on the experience of psychodynamic clinicians in private practice who have used an intervention of art-making within their verbal treatment of their patients.

This study explores why psychotherapists decide to make use of art-making in their work with some patients; when they determine that an art-making intervention would facilitate the therapeutic process; and how the use of art-making increase the clinicians' empathic understanding of their adult patients.

The study assumes that verbal modes of communication provide limited access to some type of psychodynamic material and that a complementary mode of communication, such as art-making can assist the patient in revealing those dynamics to the clinician and oneself.

The focal group of the study was psychodynamic clinicians who utilize complementary modalities of treatment such as art-making along with talk therapy in the treatment of adults. These clinicians have each worked at least for the past five to ten years in a private practice that primarily serves high functioning adults. The method of inquiry was exploratory. The researcher searched for generalizations leading to detailed

understanding of the group under study within the data collected during face to face interviews with these psychodynamic psychotherapists in their offices.

The main question of this study was why psychodynamic psychotherapists choose to make use of art-making in addition to the primarily verbal modality. Additionally there were two guiding goals for this study. The study aimed to understand (a) when in the treatment process clinicians decided to make use of a non-verbal intervention such as art-making in their treatment, and (b) how the use of art-making within the context of verbal treatment impacted the clinicians' understanding of their adult patients.

#### Theoretical and Operational Definitions of Major Concepts

This qualitative research study explored why psychotherapists decide to make use of art-making in their treatment with some patients; when they determined that an art-making intervention would facilitate the therapeutic process; and how the use of art-making increases the clinicians' empathic understanding of their adult patients.

The study assumed that verbal modes of communication provide limited access to some types of psychodynamic material and that complementary modes of communication, such as art-making, can assist the patient in revealing those dynamics to the clinician.

The study relied primarily on object relations theory. Object relations theory focuses on the internal representation that people form of others, themselves, and the interaction between both. These representations provide information about the patient's internal world and their unresolved conflicts. Since all patients tend to externalize their

inner worlds, the activity of art-making will reflect that world and any associated unresolved conflicts.

This study explored how art is used by the patient as a transitional object to access material that otherwise would be difficult to bring forward verbally, when this intervention is incorporated and why such an intervention of art-making is undertaken. As a therapeutic team the patient and clinician can access unprocessed memories- the patient participating in the creative process and the clinician by empathic observation and understanding of the patient's intra-psychic object world.

The concepts explored were: art therapy and its contributions to the verbal psychotherapy treatment of adult patients; transitional objects and transitional phenomena.

#### Statement of Assumptions

Art-making allows the patient to tap into that illusory place that Winnicott conceptualizes as the space where the boundaries between reality and fantasy are not completely established (1971). This intermediate area is an important one because it launches the patient into a relationship with the world outside of the self. (Winnicott, 1971)

Art-making gives the patient permission to express that illusory world by representing through imagery what is most personally important. In this way, the art product (drawing, painting, sculpture, photography, collage) functions as a transitional object as explained by Winnicott. (1971) It is also assumed that art-making will allow the clinician to increase empathic understanding of her patient.

Additionally it is assumed that:

- Most psychotherapists depend on a verbal modality to obtain data from adult patients
- Those psychotherapists who have chosen to make use of art-making may have done so to improve communication with their adult patients and/or increase understanding of the patient's inner process
- Art-making becomes a useful modality to propel psychotherapy forward when a stalemate, rupture or impasse occurs in the treatment
- Art-making allows for increased understanding of the therapeutic relationship

#### Type of Study and Design

The purpose of this research study was to learn why psychodynamically trained psychotherapists choose to make use of art-making in addition to the verbal modality of treatment with their adult patients; when do they determine that an art-making intervention would facilitate the therapeutic process; and how the use of art-making increases the clinicians' empathic understanding of the patient. The answers were learned through data collection and its interpretation. This research was an exploratory qualitative study.

The definition of qualitative approach was provided by Cresswell (2003, 2<sup>nd</sup> Ed.):

Qualitative approach is one in which the inquirer often makes knowledge claims based primarily on constructivist perspectives (i.e., the multiple meaning of individual experiences, meanings socially and historically constructed, with an intent of developing a theory or pattern) or advocacy/participatory perspectives (i.e., political, issue oriented, collaborative, or change oriented) or both. It also uses strategies of inquiry such as narratives, phenomenologies, ethnographies, ground theory studies, or case studies. The researcher collects open-ended emerging data with the primary intent of developing themes from the data. (pp.18)

According to the American Heritage Dictionary of the English Language (1990), *to explore* is to study, to examine, to analyze and/or to investigate something

According to Stebbins (2001), exploration in the social sciences “is a broad-ranging, purposive, systematic, prearranged undertaking designed to maximize the discovery of generalizations leading to description and understanding of an area of social or psychological life.”(p.3) Sometimes exploration is needed because the world has changed and the old ways of doing things no longer fit sufficiently, or the phenomenon under consideration is poorly understood.

This study focuses on recent change in clinical practice as clinicians seek to better understand their adult patients. I believe that the contribution of art-making to clinical practice with adult patients is poorly understood.

Exploratory research is beneficial for finding patterns and exploring new concepts that have not been looked at before or have received no systematic empirical scrutiny. (Stebbins, 2001) The descriptive element of this research was essentially describing what have been seen or heard from clinicians and makes some attempt to explain what has been found in the interviews conducted.

Sixteen participants were selected using a purposive sampling. Cresswell states, “The idea behind qualitative research is to purposefully select participants or sites that will best help the researcher understand the problem and the research question.” (2003, p.185) Selected participants were psychodynamically trained licensed clinical social workers, licensed clinical professional counselors, and psychologists in private practice working with adolescents and/or adults for at least 5 years in practice and having used art-making as a non-verbal intervention at least once within a traditional psychodynamic modality of treatment.

The participants' ages ranged from 35 to 63 with an average age of 45, with the majority being females (only five of the participants selected were males). The study was conducted in English.

Gathering of data was done through semi-structured tape recorded interviews. The length of each interview was 60 to 90 minutes. The interview was conducted in the clinicians' offices or by phone. Four out-of-state participants responded. I requested the dissertation committee chair, Dr. DiLeonardi, permission to interview these participants via phone as there were not funds available to sustain long distance traveling.

Semi-structured interviews were chosen because they are more focused on obtaining information, and they allow me to be guided by an interview protocol constructed by the contents of published documents written on the topic of study. It also provided the participant clinicians the freedom to express themselves while allowing me the means to prevent the interview from losing sight of its goals. (Stebbins, 2001)

In the first section of the interview participants were asked to provide a verbal journey of their professional development and their experience with art and art-making. In the second section of the interview participants were asked to detail how they decided to incorporate art-making into the verbal treatment of their adult patients. They were encouraged to provide case samples to support their statements. In cases where art materials were provided, such as drawings and/or paintings, participants had obtained previously signed consent from the patients to make use of their art work in ways that the clinician felt appropriate.

This study aimed to understand why psychotherapists in private practice, practicing traditional verbal psychotherapy with adult patients, choose to make use of the

alternative modality of art- making as an addition to the traditional verbal modality of treatment. The additional goals of this study were to explore (a) when psychodynamic psychotherapists decide to make use of non-verbal interventions, such as art-making, in the treatment of their adult patients, and (b) how the use of art-making within the context of verbal treatment impacts their understanding of the patient.

### Scope of Study

The focal group of this study consisted of psychodynamic-oriented licensed clinical social workers, licensed clinical professional counselors, and psychologists with at least five years of private practice experience working primarily with adolescents and adults. The study was conducted in English. The clinicians chosen for this study have made an intervention of art-making in their treatment at least once with one or more of their patients. Gathering of data was accomplished through semi-structured tape recorded interviews.

The interview focused on four areas:

1. Personal participant information such as demographics, degree, years of practice;
2. Theoretical orientation;
3. The participant's relationship to art and art-making;
4. The participant's use of art-making in treatment

An interview protocol for recording information during the interview was used.

### Data Collection Methods and Instruments

Selected participants were psychodynamically oriented clinicians in private practice working with adolescents and adults for at least 5 years in practice and having used art-making as a non-verbal intervention at least once within a traditional psychodynamic modality of treatment.

The purposive sample was gathered through direct postings of fliers (see Appendix D) and via direct mailing of the flyer to social work, psychology, and counseling programs of local universities such as University of Illinois at Chicago, University of Chicago, Loyola University; Northwestern University, DePaul University; School of Professional Psychology, Roosevelt University, Institute for Psychoanalysis, and to local psychologists and counselors.

Recruitment also was made via organizations' listserv sites such as: American Association for Psychoanalysis in Clinical Social Work (AAPCSW), Art Therapy Dialogue Group, Community Social Work Research, Illinois Counseling Association, National Association of Social Workers (Ohio, New York and California chapters), National Association of Social Workers in Private Practice, New York private practice Networking Group, Professional Social Workers in USA, Private Practice of Social Work List, Chicago Therapists Networking, National Institute for Mental Health, National Organization of Social Workers, Clinical Social Work Federation; the Illinois Mental Health Association, The Illinois Counseling Association, the American Counseling Association, and referrals by word of mouth.

Ads were posted in relevant journals such as *Psychotherapy Networker*, *Social Work Today*, and *Social Work Practice*. There was no response from any of the journals used for the purpose of advertisement.

Universities were addressed in writing by introducing the study and its requirements for participation. The letter (see appendix B) was written on ICSW's letterhead. It was expected that the universities would allow the researcher to submit written information to potential subjects and/or post fliers of research study requests on their campuses. Most of the universities allowed the posting of the flier in their general posting bulletin board.

Two interested candidates responded, one seeing the posting at the university and the other one from a general mailing, neither of these potential candidates had the requirements required for this research.

Once participants were identified, a letter of introduction was sent explaining the research study, requesting their participation, and indicating that they would be contacted at a later date to set up an interview appointment. (See Appendix C) At the time of the interview, the researcher provided each subject with a consent form to sign. (See Appendix A)

A minimum of 20 participants was originally expected for this study. However, by the 16th participant the data was saturated. The committee chair and I agreed to stop the gathering of participants.

Because the study was open to participants nationally, some participants that were out of state were interviewed by phone. In those instances participation was confirmed via phone and/or email, a letter explaining the study in conjunction with a consent form

was mailed to participants with a self stamped envelope for the participants to return the consent. Once the signed consent was received, a date and time for the interview was set. Each interview was recorder with an Olympus WS-300M phone recorder device.

The interviews conducted in the participants' offices were structured as follows:

- Explain the purpose and procedure of the study
- Explain the meaning of informed consent and confidentiality
- Explain the right to terminate participation at any time
- Conduct one 60 to 90 minute semi-structured interview

Data collection consisted of one in person semi-structured interview which was tape recorded. The interview focused on four areas: (a) subject's personal information such as demographics, degree, years of practice; (b) clinical orientation; (c) the subject's relationship to art and art-making; (d) the subject's use of art-making in treatment. An interview protocol for recording information during the interview was use. (See Appendix F)

Twelve interviews were conducted in the psychotherapist's office and four were done by phone. The interviews on site added to further observation which, in some instances, increased understanding of how the clinician worked. In those cases where the participants were interviewed by phone, a detailed verbal description of their office and its accommodation to the process of art-making was requested.

A difference between the interviews conducted on site from those done by phone was noted. The face to face interviews provided visual material to expand the discussion as the interview was unfolding.

With those interviews conducted by phone, discussion was rich but limited to what the participant was verbally reporting and describing without the enrichment of being in the clinician's environment. This implied to craft questions related to the participant's environment that could stimulate detailed description of their offices to help me to form a mental image of their therapy space.

For instance, one of the participants, an analyst based in Canada, explained that she had her office wall space divided in two sections—one general section for the hanging of personal adornments and one section for the display of her patients' artwork. She described her office as having a partition wall which divides her office into a space for treatment and another one "closed to the window and more reclusive" for the hanging of her patients' artwork. This decision making on the part of the clinician opened further exploration regarding her rationale to have her office arranged in such a way.

In another instance, a participant who also was a trained art therapist and ceramicist decided to move her rented office to her home because she did not have easy access to a sink and water in her rented one, and this limited what art materials she could use.

The study showed that most of the participants utilized markers, colored pencils, oil pastels and paper (8" x 11" or 24" x 30"). There were two participants who worked with photographs brought in by the patient. Two participants were professional ceramicists and utilized clay in conjunction with two dimensional materials. They did make special arrangements to accommodate their patients when working with clay. For instance, when the patients worked with clay, the clinicians covered the floor and the table where the patient worked with plastic.

The in-depth interviews were directed toward learning about the actual process of choosing art-making interventions within ongoing treatment of an adult patient.

I was interested in learning about the decision making process that took place by the psychotherapist, whether the art-making intervention was planned, how the session was organized when an art-making intervention took place, and if the patient was consulted in advance. I also wanted to know the psychotherapist's background, his/her connection to art and art-making, a description of the practice, the practitioner's theoretical orientation, and to obtain information about the participants' views, life experiences, and how those views and experiences were integrated into the overall treatment.

Ethnicity, sexual orientation, gender, and religion were not considered for this research. The interview data collection was advantageous in that it provided with historical information about the participant while allowing "to have some control on the line of questioning." (Creswell, 2003, p.186)

The information gathered was based on observation without interpretation. The direct observation provided the researcher with a firsthand experience of the subject and her/his environment. While I made every effort to note and record each detail of all relevant components within the interviews, that is, the details of the interviews, the surrounding environment, subject's behavior, non verbal cues, etc., it was possible that my observational skills were too limited to attend to every relevant component (Creswell, 2003, p. 187)

A protocol for recording observational data was used (See Appendix E), as recommended by Creswell:

An observational protocol structure...single page with a dividing line down the middle to separate descriptive notes (portraits of the participants, reconstruction

of the dialogue, a description of the physical setting, accounts of particular events or activities) from reflective notes (researcher's personal thoughts, such as speculations, feelings, problems, ideas, hunches, impressions, and prejudices) (Boydan & Biklen, 1992 in Creswell, 2003, p. 189)

Even though it was possible for participants to share samples of their patient's artwork, only one participant made use of this opportunity. Because the artwork was not going to be published and he was sharing within the boundaries of clinical research, he felt that the consent previously signed by the patient covered the sharing the artwork with me. This information was valuable as it provided with a deeper way of observing how the participant clinician addressed his patient's artwork and in what way the image increased his understanding of the patient's internal dynamics.

Field notes on first impressions were recorded shortly after the face to face or phone interviews and kept on file for future reference. Taylor & Bogdan (1984) stress the importance of keeping detailed field notes after each meeting with participants, "everything that occurs in the field is a potentially important source of data." (p. 53)

### Plan of Data Analysis

Data analysis involves "making sense out of text and image data. It involves preparing the data for analysis, conducting different analyses, moving deeper and deeper into understanding the data, representing the data and making an interpretation of the larger meaning of the data." (Creswell, 2003, p. 190)

Data analysis was organized in the following manner:

1. Organizing and preparing for data analysis by transcribing interviews, optically scanning material, and sorting and arranging the data.

2. Reading all data collected with the purpose of obtaining a general sense of the collected information and its meaning.
3. Preliminary description and discussion of the themes by conveying findings through a narrative that will discuss these different emerging themes and their interconnections.

In analyzing the data, the following themes unfolded.

1. There is a dichotomy between verbal and non-verbal approach in psychotherapy treatment. Participant clinicians felt that art-making expanded their adult patients' communication in a way that words did not in that it provided them with a more direct and accessible way to experience and express their feelings.
2. The use of art as catharsis/transitional object. Participant clinicians looked at their adult patients' artwork, whether a drawing, a scrap book, a clay piece or a painting, as a transitional object and as the avenue by which their patients expressed internal emotional and psychological tension.
3. The use of art to increase self-esteem/self-validation. Participant clinicians stated being able to assess the level of self-esteem in their patients through the art-making activity as well as through the final product more easily than if the treatment was relying only on the spoken word. They believed that art-making increased their adult patients' ability to tap into new areas of psychic functioning to find new solutions to old problems.

4. The use of art to increase insight. Participant clinicians observed that art-making helped some of their adult patients to change their level of awareness and to have a better grasp of their own mental dynamics.
5. The use of art to integrate unconscious/conscious material. Participant clinicians reported art-making to be a useful tool for accessing what was behind their patients' words, inhibitions, denial, avoidance, or rejection especially in working with trauma survivors.
6. The use of art to increase understanding of the patient. Participant clinicians set time aside to process the art-making experience with the patient. It was during these times that most of them reported having a feeling of increased recognition about the patient. They felt that their understanding of the patient through the artwork led to a natural increase of empathy.
7. The use of art as record keeper and/or marker of the therapeutic process. Participant clinicians found that the visual record of the treatment enhanced the therapeutic process from the beginning to the end as well as being a "visual, direct, concrete" document that directly shows the progress the patient has made during treatment and they treated the visual document (artwork) as any other clinical record.

The themes were discussed within a theoretical framework using object relations theory toward further understanding of the findings. Cresswell states:

The meaning will be derived from a comparison of the findings with information gleaned from the literature .... In this way the researcher suggests that the findings confirm past information or diverge from it. It can also suggest new

questions that need to be asked—questions raised by the data and analysis that the researcher had not foreseen earlier in the study. (p.195)

The field notes and data gathered were coded both digitally into a computer file and in hard copy format. Audiotapes of each in-depth interview were transcribed verbatim. Transcripts were formatted with a Word program using margins wide enough for note taking. Pages were numbered. Demographic data was also coded digitally in both a computer file and on a hard copy.

In proposing the study to the committee I thought of making use of ATLAS.ti software, which is known for its utility in qualitative analysis, particularly of larger bodies of textual, graphical, audio, and video data. This software is useful as a research tool because of its capability to use graphic and audio files in primary documents. This feature was going to be a valuable instrument if graphic material was part of the data collected. With the exception of one participant, none of the participant clinicians shared their patients' artwork, therefore ATLAS was not used.

EndNote 6.0 (published by ISI Research Soft) is a reference and image database, an online search tool and a bibliography, and manuscript maker. It was used to provide easy access to online bibliographic databases. It helped to search for, store, and manage bibliographic references in the researcher's private reference library and it helped to format citations.

#### Limitations of the Research Plan

The purposive sample was compiled exclusively of psychologists, licensed clinical social workers, and licensed clinical professional counselors who use a traditional

verbal psychodynamic modality of treatment, were working primarily with an adult population in private practice, and who have incorporated art-making in the treatment of their adult patients at least once.

The exclusive focus of this research study was on the contribution of art-making to a traditional verbal psychodynamic modality of treatment. I am aware of other complementary modalities such as music, dance, and drama therapies, which are utilized in psychotherapeutic treatments. A comparative analysis across these complementary modalities certainly would add to this research study. However, the scope of such an undertaking extends beyond the purpose of this study at this time.

## CHAPTER IV

### FINDINGS

This chapter provides a description of the participants, their motivation for participating in this study and the results of data analysis.

#### Description of the Participants and Methods Used in Art-Making

There were 16 participants in this study. The number of participants was determined when a saturation point was achieved, when new data was repetitive or redundant. The participants ranged in age from 35 to 63, five of whom were males and 11 were females. All participants were Caucasian. They each took part in one semi structured interview of 60 minutes in length. All participants were in private practice and had a wide range of experiences in the field in inpatient as well as outpatient treatments.

Participants were recruited utilizing flyers and direct mail, through e-groups such as Chicago Therapists and the American Association for Psychoanalysis in Clinical Social Work (AAPCSW). Letters were also sent to Chicago large universities such as Loyola University, Northwestern University, University of Illinois at Chicago, and the University of Chicago. One direct contact was made with the director of the art therapy certificate program at Northwestern University, Dr. Harriet Wadeson.

The 16 participants included five licensed clinical social workers, three psychologists, five licensed clinical professional counselor, one licensed mental health counselor, and two psychoanalysts. The group was further divided into categories:

1. Seven clinicians reported not having any experience in the arts and from this group one clinician was taking art therapy courses on a continuous basis.
2. Five clinicians had experience in the field of drama, dance, photography, and ceramics; three of them reported taking art therapy courses to enhance their knowledge of the use of art-making in treatment.
3. Four clinicians had acquired an art therapy degree in addition to their counseling and/or doctoral degrees.

The clinicians that did not have experience with art became interested in incorporating art-making into their practices as they were searching for new ways to access the patients' inner worlds. Those clinicians that had experience with art-making had a direct and personal experience with the creative process of art-making and in this way, they could account for the soothing qualities of art-making. Within this group were those who wanted to have more understanding of how to utilize art and art-making therapeutically so they enrolled in a certificate or masters program to complete courses in art therapy.

A subcategory of 13 clinicians was identified who introduced art-making into treatment and the 3 who were introduced to art-making by their patients.

Participants who began utilizing art-making in their treatment reported being ambivalent about how to present the modality to their patients. Some reported being concerned that their patients might stop treatment and others reported some anxiety about not knowing how to work with adult resistances, such as "I'm not an artist," "I can't draw." In spite of this they found ways to prove to their patients that the introduction of art-making was not about making a beautiful picture but about the process and the

emotions accessed through the creative process that was important and therapeutic in the treatment. One clinician put it:

I try to talk with the adult about the process, that this is not about the product, that this is not about creating a masterpiece, this is about learning from the process of the art-making and what we can learn about where we are emotionally, in our feelings and all of that through the creation of the art.

Those clinicians that were introduced to art-making by their patients reported not understanding at first how to read their patients' behavior of sharing the artwork with them; they felt inadequate and even anxious. One clinician reported working along with her patient out of not knowing what to do with herself while the patient was working on her plasticine piece.

In general there was a clear understanding in those participants who were not art therapists that they made use of art-making to help their patients in the therapeutic process but "they did not make interpretations about drawings or analyze them" as they thought that to be the task of an art therapist. This view was also true among the five clinicians that also identified themselves as artists.

All the participants were in private practice and had a wide variety of adults, adolescents, and children as patients. The disorders ranged from mood and anxiety disorders, schizophrenia, personality disorders, eating disorders, sex offenders and trauma survivors (sexual abuse and survivors of torture). All of the participants worked individually, seeing couples and conducting groups, and many of them also worked in not-for-profit mental health organizations or a practice groups.

This group of clinicians has chosen to go beyond their traditional background in psychotherapy by including complementary modalities of treatment; their main focus was on their patients and how to serve their patients better.

Complementary modalities used by these clinicians ranged from art, music, poetry, journal writing, photography, psychodrama, dance, to EMDR (Eye Movement Desensitization and Reprocessing) and DNMS (Developmental Needs Meeting Strategies).

The art materials they reported using included crayons, watercolors, oil pastels, and chalk on paper. The majority relied on an 8" x 10" sheet of paper as it fit into the patient's chart. Occasionally a larger piece of paper was used. In those instances, the patient took their artwork with them and sometimes the clinician took a picture of it for the charting record. Two participants reported utilizing clay—one was a clinician intervention and the other one was solicited by the patient. Two participants made use of photography, journaling, and writing, creating scrap books or collage work, and one participant encouraged patients to make 3D work to work through issues of grieving the death of a loved one.

All the clinicians supported the value of art-making as a record keeper or marker of the treatment. They agreed that art-making provided the vehicle for the expression of internal images, feelings, thoughts, and sensations in a concrete form; therefore creating "a tangible, permanent record of the images that does not undergo changes and/or distractions through later recall from memory." (Lusebrink, 1990) Only one participant who works with victims of torture mentioned making use of the art produced in session as a record to be used in court.

Although images have the capacity to contribute to the meaning of words by providing detailed information of past occurrences and preverbal memories (Lusebrink,

1990), most of the participants did not use the art as a diagnostic tool and they seldom reported making an interpretation from it. One clinician stated:

I know that there is a lot of symbolism like if people do this it means that but...I think what Freud said “sometimes a cigar is just a cigar” with a client I like to think about what issues they are working through, if I see it represented in the artwork, then I’ll say something about it. But usually I say, “what do you think this means? What do you see in this? What was going on with you when you were doing this? You know, something like that.

### Motivation to Participate in this Study

Participation in this study was voluntary. The participants who volunteered to participate in this research study said that they were doing so because they were eager to communicate their discoveries in utilizing art-making in their treatment with others. This research study gave them the avenue to express their ideas, share their experiences and treatment issues. Upon signing the consent form all of them indicated a wish to have a copy of the findings sent to them. They saw this study as part of a process that could help support new trends in clinical treatment. One participant clinician stated:

After doing this work for over 30 years . . . one of the things that I think I learned is not to think so rigidly about how therapy works. . . . If I want to be able to have a number of different kinds of people coming to see me, maybe I need to have a number of different kinds of approaches that I use.

### Data Collection

This was exploratory research project. Only in the recent years have studies been conducted related to the impact of creativity in different areas of human functioning. The Dana Foundation ([www.dana.org](http://www.dana.org)) is a leading source for studies related to the topic of creativity, the arts and their impact on human development and brain functioning. Art-

making and its usefulness in psychotherapeutic treatment is becoming a topic of interest in the last few years within the traditionally talk treatment. Because of this interest, exploratory methodology was most suitable for the research of this dissertation. Stebbins states,

Researchers explore when they have little or no scientific knowledge about the group, process, activity, or situation they want to examine but nevertheless have reason to believe it contains elements worth discovering. (2001, p. 6)

The interviews were conducted face to face at the clinicians' offices or, when the participant was out of the state, the interview was conducted by telephone. All interviews were tape recorded.

When the interview was conducted at the participant's office, it allowed me to have firsthand experience of the space where art-making took place. For instance, it was noticed the decoration on the walls and noticed that in a few cases the walls had a few framed drawings done by patients. When clinicians were questioned about the process of choosing what art work went on the wall, they indicated that the patient has terminated treatment and has given them a piece of art work as a present. This was interpreted by the clinician as the patient's desire to always be present in the consulting room.

Most of the office spaces were suitable for talk psychotherapy with no sink in the office to clean brushes, with carpeted floors, with no drafting table to draw on. I noted how participants became creative when utilizing art-making in the session.

For example, the majority of the participants reported using small size paper, usually 8" x 10", as it was more suitable for storing the artwork in the patient's file.

Another participant transformed their coffee table into a working space or brought from

home wooden TV dinner tables from home that were easy to store when the art activity was completed.

When no tables were available one participant reported taking down the decorative photos from the wall in order to tape large pieces of paper on it so that the patient could work standing up. Another clinician reported using a large clipboard so that the patients could do their artwork on their lap. Another participant, who frequently used collage, reported laying the materials on the floor by clearing an area of her office and sitting besides the patients to observe their creative process.

One clinician with a home office reported using large pieces of paper which were stored beneath the office rug when the session was over as she did not have any other place to keep large drawings. Only one participant reported utilizing a laptop to work with photo montage

When the participants were interviewed by phone, it was requested a brief description of the office space and if there was something special that they wanted me to know. One of the analysts described his office walls as “plastered” by the artwork done during the session, especially if the artwork was done by children. With adult patients he had a whiteboard where the patient could draw with a marker. After the drawing was made and processed, a Polaroid photo was taken for record keeping. Another analyst reported having a designated wall to hang his patients’ paintings, changing the paintings often.

The use of interviews made the exploration more focused as opposed to exploration by observation only. This was because an interview protocol was used to keep the interview on track.

The disadvantage of the interview process was that clinicians were not equally articulate when explaining their reasoning behind the introduction of art-making into their verbal treatment with their patients. General statements such as “art is a healing force” or “the art process is how you approach life” or “artwork is our reality” or “through artwork we heal ourselves and the world,” forced to further question such statements in order to obtain clarity. It seemed that these statements were made with the unspoken assumption that I fully understood the meaning of the statement and that I agreed with their views of art-making. Because of the need for more clarity, in some instances participants appeared to become defensive.

All interviews began with a request that participants give a general description of their professional lives and of themselves including educational background (degrees), clinical background, personal interests, and their connection to art, art-making, and the creative process. Only one clinician presented herself as having two careers: that of a social worker and a photographer.

Broad and open-ended questions brought flexibility to the interviews and allowed for a friendly and pleasant flow of the interview.

There were more focused questions around the topic of the use of art and art-making in treatment such as, “what motivated you to introduce art-making in the treatment?;” “do the patients know that you work with art-making in treatment?;” “how do you introduce art-making into the treatment?” These questions helped the researcher to increase understanding of the data received. The main goal of the data collection process was to get as accurate and in-depth range of information as possible.

Participants were not encouraged to share their patients' art work but when they did, it came out of their own volition and need to further explain the therapeutic process by looking at their patients' artwork. It was the participant's opportunity to directly share their "reality" (Cresswell, 2003) with me. There was no collection of such visual data by this researcher. There were only two participants that offered to share art-work of their patients during the interview. They did so to support what they were reporting in relation to the therapeutic treatment.

Two of the 16 participants, who are also art therapists, reported making what is called response art. Response art is artwork done by the clinician as a response/reflection of the experience of working with a particular patient. These two participants had different approaches to response art. One has used her art primarily with the patient that does not make artwork:

I will make art work when thinking about that person. I will take something about that experience, the most significant aspect of that experience . . . and give it back to him. It was a portrait. I show him the art work the next time he returned. He was quite pleased. First of all someone thought about him and second that I captured what was going on with him. He felt seen, you know, like somebody noticed him.

The other clinician emphasized how meaningful response art has been with her patients and how she has used it to foster the therapeutic relationship "I've given them... something tangible ... concrete... that they can look at it, they can think about it, they can experience it, and brings the therapy into their week."

## Analysis of the Data

As the world around us changes rapidly, those in the helping professions are forced to reevaluate their methods, goals and objectives, in order to interact with more diverse patient populations. New conceptualizations, paradigms, definitions, strategies, and techniques are challenging our views and ways of being in the world. And for psychotherapists these changes challenge us to expand our knowledge of therapeutic approaches. (Coleman-Farris-Dufrene, 1996)

The common denominator in the group of clinicians that participated in this research was their willingness and desire to go beyond their traditional understanding of psychotherapy as a way to reach their patients. Their focus was on their patients and how to serve them better. One participant stated, “I’ve seen with the use of art how certain things in her life had had such a severe emotional impact.” Another said, “Without the incorporation of art in the session I won’t be able to have a good understanding of the patient.”

By observing their patients’ creative process the clinicians were able to reflect on their patient’s internal world representation.

In analyzing the data the following themes unfolded:

1. Dichotomy between verbal and non-verbal approaches in psychotherapy treatment
2. Art as catharsis and as a transitional object
3. Art to increase self-esteem/self-validation
4. Art to increase insight
5. Art to integrate unconscious and conscious material

6. Art for empathic understanding of the patient
7. Art as record keeper and/or marker of the therapeutic process

The data shows that participants considered art-making as an important contribution to their verbal treatment because:

1. It allowed patients, who demonstrated difficulties in verbally expressing their feelings and verbally describing their emotions a safe way to do so without words. The participant clinicians agreed that the art-making process offered them a window into the inner world of their patients. Through their imagery and its discussion with the patients, clinicians were able to discover their patients' deepest dreams and fears. This process of discussion validated the more subjective side of the treatment instead of the intellectual side and helped their patients to verbally account for their inner experience.

As a byproduct of such discussion process, participant clinicians reported increase understanding of their patients' inner struggles with their lives and coping with issues of daily living. This in turn brought with it an improvement in the therapeutic relationship, especially in those instances where the treatment was at an impasse.

The participant clinicians also observed that the art-making process allowed their patients to have access to a more intuitive mode of knowing (Gardner, 1993), thinking, communicating, and problem solving.

2. As the patient embarked in the art-making process, clinicians saw their patients entering into what seemed a much calmer and meditative space than before they began to work, with a much higher level of concentration and focus. It was their

observation that the act of art-making became the means by which the patient could express from a place free from self-criticism and self-judgment. It was this quality of feeling within the creative process that all the clinician participants could relate to, especially those participant clinicians who worked with survivors of physical and sexual abuse. The nature of the creative process invited their patients to play, to compose, and to create order out of chaos. For participant clinicians it was this process of sorting out, from playing to composition and order which brought patients in touch with issues of self-esteem and self-validation that were easier to identify and to talk about.

3. The participant clinicians made an intervention of art-making when observing their patients struggling to bring out their inner experience with words; when the treatment seemed stagnant or when they were in need of gathering more information about the suitability of the therapeutic team of clinician-patient or to further information obtained via the intake process.

#### *Verbal/ Non-Verbal*

“We are just a thinking society.”

Western psychotherapy is based on the premise that emotional conflicts can be resolved through rational analysis. (Coleman-Farris-Dufrene, 1996) The intellectual discourse that takes place in the consulting room has placed the art-making process in a subordinate position as if words are the only way for psychic healing and change. In the therapeutic process we aim to help our patients to recover the non-recognized feelings and abilities; we want them to achieve the creation and integration of new attitudes and

relationships as the result of increased insight. In the consulting room we make use of our ability “to be with another” by paying attention to verbal and nonverbal ways of communicating with and by the patient. In this way we attempt to enter into the patient’s world through language and to develop an empathic understanding of the patient.

(Palombo, 2006)

However, as we tend to think in images prior to conceptualizing the world with words, by allowing patients to draw their “problems, feelings, or worlds,” we are expanding their capacity to communicate and further understand their own experiences.

(Oster-Montgomery, 1996)

One participant clinician has found that utilizing art-making with her adult patients with eating disorders allowed them to get in touch with “unconscious parts” of the self that are filled with unprocessed feelings and emotions in relation to their disorders. As she put it:

We think our way out of listening to our gut wisdom but when you don’t think, you got access the other part of you who aren’t as verbal. I believe that every one of us has a voice of wisdom deep inside and it is easily out shut it by those thinking parts, those very verbal parts.

“Art opens communication in a way that words don’t...”

It is not unusual in the clinical practice to have one, two or more patients that have difficulties using words to describe to the clinician their internal world with words. The patient can supplement art-making with thoughts, emotions, and free associations giving the clinician a window for tapping into the internal world of the patient in a multifaceted manner. The patients who found words to be a barrier to expressing their internal life finds in art-making a way to visually communicate their inner reality.

The majority of the clinicians involved in this research worked with adult survivors of abuse, sexual, physical, and/or emotional, dissociative disorders, and they found that the act of drawing could be the only way for these patients to convey their painful emotions, unspoken family secrets, and repressed memories. (Oster-Montgomery, 1996)

They try to be sensitive to the needs of these patients. One of them stated “I try to be open to the kind of process that best will work for my clients... Whatever process is best for our clients is what we need to be open to do...” This stand requires the therapist to be opened to self-reflection and growth, constructive criticism, new forms of knowledge, and supervision when needed. (McNiff, 1989)

The question for these clinicians has been when to introduce an alternative modality such as art-making into their verbal treatment to deepen the therapeutic work. One participant who works with victims of torture has found that art gives words to what can't be spoken due to traumatic events. He states,

Some of these clients come wanting to talk. . . . Other times they do art while they are talking and other times I say “make a representation of yourself.” Whether I use art as a therapeutic technique, or when the client talks about an experience or when the client decides to depict something that happened to him through art, the primary focus still is in talk therapy.

#### *Catharsis/Transitional Object*

“The artwork brings the therapy into their week”

It can be said that the general population is aware of an infant's use of a Teddy bear and/or a blanket in the absence of the mother; these transitional objects then become the link between the child and the mother in her absence and represent a path to independency from the baby-mother unit.

As adults we continue negotiating between our inner and outer worlds. Winnicott believed that adults were in need of transitional objects out of the need to balance inner and outer world's demands and that, in that context, art provided a temporary relief. (Amber & Burke, 2000)

Statements such as “she uses art as an outlet for expression and connection with the outside world,” as a “catharsis,” a “servant to transmit information between inner and outer self,” suggest that participant clinicians look at the artwork, whether it is a drawing, a scrap book, a clay piece, or a painting, as a transitional object. The idea that the artwork is a constant reminder of the therapeutic process, something “very concrete and very visceral” to hold to while the patient navigates his therapeutic treatment. A one clinician stated: “the artwork becomes something concrete to look at it.” The artwork then becomes the transitional object that allows the patient to be reminded of the “wonderful insights in the session that they somehow may lose because the therapeutic process is such an emotional floating experience.”

“Art helps the patient to organize their sensory input.”

Participants talked about art-making as “relaxing and calming”; as a way “to deal with a lot of emotions”; as a helping “the patient to organize their sensory input.” The process of art-making serves as a self-regulator of the patient's experience. The art object whether painting, drawing, sculpting, collage, or photograph, can be understood as a kind of transitional object, “a link between inner and outer worlds, belonging wholly to neither, yet clearly pertaining to both.” (Storr, 1972, p. 244)

One participant whose main practice focus was on grieving and mourning, commented on the impact of art-making for families following the loss of a family member as "...sort of documenting the life and process of the grieving family...". It seems then that "...as the transitional object soothes the child in the absence of the mother, so the creation of a symbolic image enable the patient both to grieve the loss and to remain connected to the deceased..."(Brody, 2001, p. 385)

According to Adler (2000) self-expression is an attempt by the creator to repair that what was damaged or lost. She bases her understanding of creativity as Melanie Klein viewed it "as an urge to repair the internal parental object." (p. 52) therefore indirectly attempting to repair the self.

#### *Self-Esteem/Self-Validation*

"Art is a way to being valued"

Self-esteem is pride in oneself or how one feels about oneself. People with high levels of self-esteem feel a sense of value and worth, they have confidence in themselves and they act accordingly. Generally in the consulting room we are used to treating people who are doubtful about themselves, doubtful about their own worth; they often feel anxious and/or depressed with little or no faith in themselves or the world around them. This state of being has left them feeling outcast, experiencing adjustment difficulties, and not being able to contribute to the world in an effective manner.

“Artwork helps me to have a picture of what about that experience was most important to her”

The data suggests that research participants were able to assess the level of self-esteem in their patients through the art-making activity as well as through the final product.

For example, the use of drawings can generate diagnostic impressions allowing the clinician a unique avenue into the inner life experience of the patient as well as offering clues for treatment planning. (Oster & Montgomery, 1996)

One clinician who holds a doctorate in psychology and is also a registered art therapist, explained her choice of doing a drawing with the patient in order to assess where the patient was emotionally, if they will be able to work together, what kind of relationship pattern the patient holds, and levels of self-esteem and self-confidence.

Another clinician who works with victims of torture reflected on how art-making increased one patient’s sense of worth and being valued by experiencing the clinician’s acceptance of his (patient) final artwork which became internalized as acceptance of him; furthermore, the patient’s sense of being valued was manifested by his desire to keep the drawing to show it to his children and grandchildren “one day.”

Through the creative process that art-making provides the patient can tap into new areas of psychic functioning and find new solutions to old problems. (Bozzuto, 1990 in Lijtmaer, 2002) Marion Milner (1900-1998), London born author and psychoanalyst, (she is better known by her pseudonym, Joanna Field), and who was a pioneer of introspective journaling, made use of doodling and painting in therapy.

She describes the lengthy treatment of a psychotic patient and the insights she gained by making considerable use of painting and doodling in the treatment (1988), and wrote extensively about her observations on the benefits of painting. (1957)

### *Increases Insight*

“Art is a path to their internal life”

Insight is defined as the power to see into a situation, the capacity to discern the true nature of a situation. (American Heritage Dictionary of the English Language) In the consulting room we may refer to insight as introspection or the knowledge acquired about oneself. It includes both “to looking within and to what is learned by that search.” (Poland, 1988)

A patient may struggle with finding insightful meaning to his/her speech and this process into his/her inner world were done verbally may be lengthy. Art-making can provide a more direct approach to insightful self knowledge.

One participant reported introducing art-making to one his patients as a way to access the wounded part of her self. He described this patient as “guarded and defensive” with difficulties in accepting the trauma she has experienced and in talking about this life experience. It was through the process of art-making that this patient was able to recognize her difficulties in accepting the trauma in her life and it was through the discussion on her artwork that the patient began to talk about the traumatic event.

This participant clinician also shared one incident where the patient began the session by saying: “I’m going to draw, to do something happy today. I feel so happy.”

This clinician stated that his patient began to draw a happy sun but then she drew trees and grass and the trees were black. Upon completing her drawing, this clinician encouraged his patient to look at the picture she created, to give it a title and then tell a story about the picture with the title and then tell the story again but including herself in it. It was at this point that she got stuck and became self-conscious about how her words were differing from the experience of her internal world. “She looked as if she was saying “ah! I can’t fool the world!” This seemed to have been a breakthrough point for this patient who had experienced tremendous losses and neglect in her life. The participant clinician recalled:

As she began to tell the story she became more and more emotional, she kind of realized that was about loss and she herself began to embrace, identify, and integrate the traumatic emotional memory that was buried.

Art-making helped this patient to “change her level of awareness.” It allowed the patient to grasp a defensively ignored and misrepresented aspect of her own mental dynamics, begin the work toward accepting the damaged parts of her self as well as being open to experience intense emotions and feelings in response to her “stored” trauma.

The experience toward insight could be described in two steps. The first involved a feeling of sudden discovery, a kind of “Eureka!” moment. The second step in the process toward insight is slower, more gradual where the patient, and generally the clinician too, experience a sensation of the obvious “Yes, that it is!” It all becomes clear for the patient and the clinician. (Wilson, 1998; Poland, 1988)

It seems that the simple question “What do you see?” becomes an invitation to self-awareness:

It is not me just sitting there observing the patient at work ... it is like a psychodynamic model where you sit and listen and may be do few comments and that’s is basically what all clinicians do, I think

*Integrator of Unconscious-Conscious Material*

“The artwork is the unconscious wanting to manifest in the world”

The term “unconscious” was popularized by Freud’s theory of the mind. (Freud, 1915) He used the concept to refer to two different kinds of psychic experiences: those thought processes that have easy access to consciousness and those that demonstrate difficulties entering into consciousness. (De Masi, 2000)

The unconscious includes our instincts, “un-confessable wishes,” and fantasies that are difficult to acknowledge or to own, such as traumatic memories and emotions associated with trauma.

One of the most important skills for a psychodynamic clinician is the ability to listen to what is behind the various themes the patient talks about during the session and being able to offer them back to the patient in the form of associations and interpretations.

Participant clinicians had numerous stories to attest to the usefulness of art-making to increase insight in their patients. One clinician who works mostly with survivors of torture related the following story about his Guatemalan patient:

I said “make a representation of yourself.” He made a picture of a tree. The tree was dying but it had a little bit of growth that if it is tended to it would be able to grow. And he began to make associations with himself, that he was the tree that was damaged.

And then, this same clinician reflected on the importance of the image drawn as a manifestation of his patient’s deepest thoughts about himself, and the use he made of the image to assess this patient’s internal process and progress in treatment:

I don’t know if it was more powerful or very different than for me to talk about it, he just saw it there. He saw the tree as himself. At another time I brought the tree

again. “This is such a powerful image and maybe we can go back and look at it and what comes to you now or what other images come now by looking at the tree.”

“Art aims the therapy process as a movement toward wholeness”

The participant clinicians reported art-making to be a useful modality for them to access what was behind their patients’ words, inhibitions, denial, avoidance, or rejection especially in working with trauma survivors. “I feel like art is a good way to work with trauma as a way for catharsis, to express things, get them out as an intervention for the recovery of unwanted memories,” one participant stated.

The clinicians know that it is common for the self to dissociate during trauma, “bearing an intolerable memory to the unconscious ... To attach words to feelings does not come easy for trauma victims as the linking affect to cognition may lead to re-experience the traumatic event through flashbacks, dreams or nightmares.” (Howard, 1990)

In a safe environment, the process of art-making can offer much needed soothing energy as one clinician stated: “the paper page creates a boundary and therefore a container for the image and, symbolically, the experience.” As trauma is stored as imagery, art-making provides a way for the patient to process, to resolve, and to create new responses to the pain caused by the traumatic event. (Appleton, 2001)

All the participants agreed that art-making allows their patients to become in contact with unwanted or undesirable parts of themselves. The clinicians stated not interpreting their patients’ artwork but they agreed that the imagery in the artwork was used to illuminate their therapeutic conversation over memories of trauma.

Lijtmaer (2002) explores the process of creativity via art-making to help a female patient who used art-making to work on issues related to her trauma. In her final discussion of this patient Lijmaer concludes: “By entering into her inner world of imagination and a symbolic universe, by remembering the past and working through it, she encountered the pathway to reality, to express the unspeakable and to soothe herself through her art.” (2000)

One clinician discussed the use of photographs with survivors of childhood sexual abuse (males and females) to elicit forgotten memories and further encourage them work on journaling and/or scrap books to tell their stories. She reported that introducing art-making into their verbal treatment allowed for the disclosure of the traumatic experience of sexual abuse in a less confrontational manner, facilitating the expression of issues of fear, sadness, shame, of loss of control, the loss of innocence, the loss of happiness and their carefree spirit:

I find it really helpful to have them bring pictures in; pictures of themselves as they were at that age. Photographs are amazing because there is so much none verbal that it seems many of them would say to me, “Oh look how I look before the abuse happened, look how I look during the time it happened, look how I look after

Art-making allowed her patients to regain control over their anxieties around the issues of sexual abuse, in this way the art-making was contributing to increased feelings of dignity, empowerment, and emotional independence. The clinician stated:

It helped them to get in touch . . . to get them out of their adult heads and into themselves as a child so they can really be able to see where the responsibility lies, where the shame lies, where is the innocence that they had at that time.

“Art is the unconscious struggling for consciousness”

Clinicians reported on the struggles they saw their patients to go through when trying to express themselves verbally and how that struggle could potentially create a stalemate in the process of the treatment. One clinician offered art-making to mobilize the therapeutic process and in turn she enabled difficulties to be expressed with the art materials:

I encourage them to draw what is going on in their minds without thinking. ...I do it when the client or therapy has gotten stuck. I am looking for a different channel from where to work... I do it because I feel like the client is at the verge of a breakthrough and I believe that the art-making process will help to facilitate the bridge between the unconscious and consciousness...

“Artwork is the same as a dream”

In working with a group of adult survivors of cancer one participant utilized art-making to recall images from the patients’ dreams and described how the artwork became the avenue of permission to express stored anger about their illness.

His experience with this population echoes the findings that the medical field has been making on the use of art-making with cancer patients. In 2006 Northwestern Memorial Hospital conducted a study showing that cancer patients engaged in art therapy demonstrated a significant reduction of anxiety and physical pain. (NMH, 2006) Similar results of improved depressive mood and reduced fatigue were reported from a study conducted at Rambam Medical Center in Israel. (2007)

One participant, a painter, musician, and clinician as well, who has battled Parkinson’s disease and cancer for years, reported on the impact that drawing had upon recovering of her fine motor skills.

She stated discovering “the power of the mind and the focus of attention and what that can achieved” and focused herself to use the newfound knowledge with her patients. She recalled keeping art materials in her office as well as having her own artwork on the walls and her electric keyboard in the waiting room and had her patients draw a dream or scene of the dream because she believed that they needed to find some other pathways to get in touch with their unconscious material.

### *Art as Empathic Understanding of the Patient*

“The artwork did provide me with a lot of information about the patient”

A clinician whose work was mainly in the area of loss and grief described art as “an integrator of memories.” Besides working with individuals she worked with families who had lost a family member. With this group she primarily worked in a two hour session on an art-making project.

She shared her experience of a few projects. One of them was called “the empty chair,” where each participants was given a wooden chair, symbolizing the empty chair that is left by the deceased, which they had to decorate and paint in memory of the lost one; or “the cracked pot” where the family was asked to break a terracotta pot into pieces with a hammer and glue it together symbolizing what happened to their family when experiencing the death of a loved one. In this way, patients were allowed space and time to mourn the loss of their loved ones, to come to terms with it and to reflect on new approaches to their lives without the deceased member. The participant clinician observed: “I think that in a visual way they think about the deceased member as part of the family still. The artwork did provide me with a lot of information about the patient.”

The participant clinicians set time aside to process the art-making experience with the patient. It is during these times that most of them reported recognizing their feelings about the patient. They felt that their understanding of the patient through the artwork allowed for a natural increase of empathy. The artwork seems to be “the bridge which assists the clinician in reaching an empathic understanding of the patient.” (Pereira, 1991)

Empathy is the capacity to recognise or understand another person’s state of mind or emotion. It is the ability to “put oneself into another's shoes” and “to become aware of what the other is feeling.” (Pereira, 1991) According to Kohut empathy is “vicarious introspection,” an active process of search and enterprise to deeply expand our knowledge. (Kohut, 1958)

One clinician talked about how she utilized the artwork that her patients, who were artists, brought into the consulting room to build the therapeutic relationship and, “to make the relationship as strong as it can be ... I am aiming at a sense of acceptance and a sense of hearing at all levels no matter what way they bring out about themselves.”

Another clinician liked to do artwork with her patients at the point of intake; it gave her “a visual base line.” She reported telling her patients “right up front, let’s draw a picture together and see how we work together.” Drawing together gave her the necessary information regarding how they were going to interact;

Is this going to work? ... are they trying to continue my lines? ... are they trying to obliterate what I put down? ... do they honor the other?... are they willing to meet? ... do they huddle in the corner? ... do they stay far away? ... do I want to work with this person?... and does this person really want to work with me?

The process of “tuning into” the patient can be enhanced by observing and engaging in the art-making process with the patient. One clinician reported having a 40 year old female patient with a very long and disturbing history of childhood sexual abuse. The woman was obese and always in a state of medical crisis, unable to relax even during sessions. One day the patient informed the clinician that she needed some clay to manipulate while in session:

So I did bring plasticine ... I said to her “I’m going to work too” because it felt like she might have felt that I was watching what she was doing ... it was relaxing and calming to her ... I certainly felt I was being more accepting of her because I was working with it too

The art-making process allowed the clinician to recognize her patient’s vulnerability “and how fragile she was.”

Another clinician explained how her knowledge of her anxious and depressed patient increased when looking at the art work made during session, “It gave me a better sense of the patient. It helped me to have a picture of what about that experience was most significant to her in why she chooses a symbol to represent it “

It was a common thread among the participant clinicians interviewed that art increases their empathic understanding of the patient,

You can ask 50 questions and get the information you need and then you can ask them to draw a picture “tell me about where you live”... “tell me who you live with”... “draw a picture about that”... and you can get so much information in the drawing that the patient may not have given you with words

Or,

Sometimes they write poems... or write music ... or sing a song ... My sense is that whatever process works best for the patient is what we need to be open to do... if that is the way to tap into what is going on inside them ... to learn about them ... without having them start with the words which sometimes are so difficult for them to say, I am happy to do that

The data also suggested that sometimes is the therapist's anxiety to move the treatment forward that can interfere with empathic understanding of the patient. One participant clinician, who is also a photographer, explained how her eagerness to work on issues of loss and grieving with a teenager after the suicide of her best friend brought the treatment to a very premature termination. The clinician felt so strongly about working those issues through the art-making process that she forgot where her patient was emotionally; "I really learned from that experience is that is so important to let them to lead you."

#### *Record Keeper—Marker of the Therapeutic Process*

In our field we are required to document the treatment progress of our patients. Clinicians are familiar with writing progress notes and treatment plans; clinicians have their own system for compliance. The participant clinicians in this research brought a fresh perspective to the process of treatment documentation. They found that the visual record of the treatment enhanced the therapeutic process from the beginning to the end as well as being a "visual, direct, concrete" document that directly can show the progress the patient has made during treatment. These clinicians treated the visual document (artwork) like any other clinical record as "confidential material, locked and put away and kept for 7 years."

“Powerful way for the patient to gauge their own progress”

The artwork provides a visual record of the patients’ treatment; it becomes an aid for reflection on how the treatment is developing and where they are going as well as a reflection of the process during the termination phase.

It gives a visual record of what the patient has achieved in therapy ...when I’m going through the termination with the patient I always pull out the art that they have made and I found it to be such a powerful way for the patient to gauge their own progress.

In some instances the patients have asked the clinician to keep their artwork while working therapeutically because “they were afraid that someone is going to see them at home... some ask me to keep the artwork while we’re working together.”

Clinicians reported innovative ways to keep their patients’ visual records. One participant, who had her office at home, told the story of one patient who happened to be painter, let her keep the artwork during the entire treatment. Because the clinician did not have a place for the large drawings, she kept his visual file under the office rug “so whatever he wanted to draw, he went under the rug.”

Another clinician who treated some professional painters, reported establishing a section of a wall in her office to display the artwork “I have a piece of wall that is over my desk where all the material that isn’t immediately psychological goes.”

“Concrete documentation to write an affidavit to present in court”

Some patients choose to take the artwork with them while others decide to leave it with the clinician. For one clinician who works with survivors of torture, the artwork is a vital part of the treatment, in particular when he needs to write an affidavit supporting his patients’ political status in this country. He requested that all his patients leave their

artwork with him so that he would have direct access to the visual document when called to present the case in court.

Other clinicians like to keep photographic records of the artwork if the patients decide to take the artwork with them. The photo then is placed in the patient's folder with a short note documenting the art-making session.

## CHAPTER V

### DISCUSSION AND IMPLICATIONS

This exploratory qualitative research study examined the use of art-making and its contribution to traditional verbal psychodynamic psychotherapy treatment. I decided to focus the study on the experience of clinicians incorporating art-making into the verbal treatment with their patients. This decision to focus exclusively on the experience of clinicians utilizing art-making in their practices was informed by my belief that much has been already written about the patients and their experience within the therapeutic process but very often our field falls short of focusing on the clinician's experience. Sixteen clinicians in private practice who had utilized art-making at least once in their treatment with a patient were identified and interviewed.

The salient themes that emerged from the participants reinforced the idea that verbal communication is limited when trying to access the patient's unwanted traumatic memories.

The participants concluded that in order to work with issues of trauma, art-making provided a much more direct path than words to repressed memories as the visual images tend to escape the mind's censor more readily than words (Wright, 1996); the artwork allowed the patient to have a concrete and direct path toward understanding of their inner experience, and since trauma destroys the inner sense of self, art-making can reestablish that sense of connection. (Laub & Podell, 1995) It seemed to these clinicians that encouraging and allowing their patients to just talk freely during the session as a way to

reveal their line of thought (Bollas, 2002) and unveil repressed material was enhanced by the production of artwork. These clinicians decided to make use of an intervention of art-making when they noticed their patient struggling to express their feelings and thoughts in words. The art-making process can provide a vehicle for working with and integrating traumatic memories. (Schnetz, 2005) By discussing the art-making process and the final product, the patient can put words to the traumatic event and become more open to experience the overwhelming emotions attached to it. (Bloom, 1997 in Schnetz, 2005)

Art-making allows for distance and control in manipulating the media, and thus provides a sense of containment for the patient. (Lusebrink, 2005) By asking the patient to think in images instead of words, through two dimensional or three dimensional artwork, the patient and the clinician become “attentive, dispassionate observers” (Bollas, 2002) of that part of the patient’s inner reality for which the patient may not easily find words. Kuchler & Melion (1991) argue that images are an important part of the memory process and that images carry an important role in our understanding of the world. (Schnetz, 2005) By verbally processing the art-making experience, the art product and its imagery, clinicians reported an increased understanding of their patients’ inner reality.

The participant clinicians realized that the art-making process was cathartic in that it provided the patient with a “purgative” movement for the discharge of emotional tension and anxiety. They believe that the art-making process allowed their patients to evoke, and in some instances, to relive, the traumatic events. The artwork was seen as a reminder of the therapeutic process, functioning as a transitional object, a term introduced by Winnicott (1955), an in between subjective (internal fantasy) and objective (external

reality) where the artwork blends elements of both experiential worlds. (Lapanche & Pontalis, 1973)

Ambers and Burke (2000) state that an extensive focus on the objective qualities of experience can result in an impoverished inner life but too much involvement in private fantasy can result in an autistic view of one's self and the world. The nonverbal part of the art-making process and the verbal processing of the final artwork with the clinician provide avenues for balancing inner and outer world experiences.

Even though the transitional object and the work of art serve as a bridge between inner and outer worlds, one can agree with Kramer (1992) who argues that there is no direct development from the transitional object to the artwork; for her there are two essential elements missing: the element of form and the element of symbolization. The transitional object is a found thing, with no attempt from the infant to alter the appearance of the object to better evoke her mother. Furthermore, the transitional object does not carry the multiple meanings that characterize symbols; "it remains exclusively linked to one important person, though innumerable moods may be unloaded onto it." (p.130)

The study also has shown that the participant clinicians utilized the art-making process and the final product to assess their patients' self-esteem and self-confidence. They observed that the discussion of the artwork increased their patients' capacity for introspection and allowed for disclosure of unbearable or unwanted fantasies, memories, and emotions associated with trauma.

The patient's self-esteem and self-confidence seemed to become enhanced by creating artwork in the presence of an audience (the clinician), who supported and admired the art-making process while being attentive to the patient by observing,

analyzing, and discussing the artwork. In this interaction the patient regains a sense of being liked and approved of. Clinicians acquired new knowledge about their patients through the art-making process and the discussion of the final product and in turn, the patients became more attuned to their emotional needs and longings.

Long gone are the days where Freud's recommendation to maintain "the same evenly suspended attention ... in the face of all that one hears" (1913) aiming to help the clinician to rely on memory. This technique allows for the recollection of the interaction with the patient which then "exists in the minds of clinicians and patients and can be retrieved as needed, therefore a written history is not required for good psychotherapeutic care... (APA, 1997) Documenting the content of the session through progress notes has become a standard practice. Visual documentation of the patients' treatment process and progress allows for a more direct understanding of the treatment.

The purpose of today's documentation is two fold. One, clinicians document a case (progress notes) to ensure that another clinician can learn of the status of the treatment and continue with it in the event that the treating clinician is absent or dies; and then two, where the clinician documents every encounter in detail so to support the cost of care. (APA, 1997)

The clinicians participating in this study had to find ways to record and store the artwork produced during treatment. The artwork (visual document) proved to be a concrete way to record the therapeutic process for the purpose of discussing the therapeutic progress with the patient or when presented in court as a complement to a written affidavit as well as for the clinicians in need of reviewing the treatment progress.

### Clinical and Theoretical Implications

All the participant clinicians reflected positively on the contributions of art-making during the interview. This position can easily foster what Kavalier-Adler (2000) calls “the creative mystique”—a belief that the pursuit of creative self-expression is endowed with all kind of healing powers. (p. 5)

Kubie (1958) views the culturally promoted idealization of the creative process as a product of neurosis. He argues that such idealization which can easily permeate the therapeutic room “can cause the patient to hide from their own pathology, and thus perpetuate destructive patterns of living and working.” (in Kavalier-Adler, 2000, p. 5) It can also blur the therapist’s conceptualization of the treatment by the perception that the patient could gain insight exclusively through creative self-expression.

Some reflections from a few participants that indicated that art-making could actually be over-stimulating for the patient in ways that could impinge on the therapeutic healing process, resonates with the ideas of Kubie (1958) and Kavalier-Adler. (2000) Some comments from participant clinicians were “I found out that too much sensory stimulation would have the opposite effect (from a healing effect);” “art could over-stimulate the patient and they could lose some of their abilities to control themselves and get a little wild.”

The art-making process involves the use of the imagination. This process can aid on repairing parts of the self and inner world of the patient. The comments above seem to indicate that the process of art-making can in itself bring about psychic unbalance in some patients and may not necessarily be an avenue of psychic restoration. According to Kavalier-Adler (2000) the act of creativity via art-making can be dominated by a

pathological compulsion, allowing for cathartic relief and symbolic form of emotional expression instead of be governed by a healthy movement toward individuation, self-development, and insight.

The questions to be answered are: if some patients benefit from art-making, why in others does the art-making process not seem to bring about a release from anxiety and anguish, a sense of well-being and inner balance? These questions could be the springboard for future exploration and expansion on the focus of this study.

There are also further considerations that this study did not address related to the form and symbolic meaning of the final product, such as art materials and colors used in the art-making process, as well as a more in-depth examination of the component elements such as organization of the picture, perception vs. reality, proportion and perspective, and the role of the clinician during the creative process.

The majority of the participants in this study did not speak as much about these elements of the art-making process, in distinctive contrast with those participant clinicians who were practicing artists, who had taken art therapy courses, or had become art therapists themselves. As art psychotherapists, these clinicians faced the challenge of “effectively assessing their patients’ visual communications so that they may develop an empathic alliance as well as a directive course of therapy.” (Gerber & Lyons, 1980)

Followers of Rudolph Steiner (antrophosophists) believe that our spiritual body (soul) becomes manifested in the world through color and that color can be read as a map that gives us understanding and direction about the human psyche. (Howard, 1998; Steiner, 1992) Furthermore, they see each color of the spectrum as having a defined vibratory energy that can be used for health and healing. (Mayer, 1960)

In the consulting room art therapists told us that colors chosen by the patient can be used diagnostically. Colors carry within them the psychic emotion that moves the patient at a particular time. For instance, saturation and intensity of color, its muddiness, the meaning attached to it (conventional/collective; Western/Eastern world; individual/personal) can provide the clinician with immediate information about the nature and strength of the emotions the patient is experiencing.

In current practice we need to increase our sensitivity, awareness, and understanding of issues of race and culture as well as the socio-economic-political status of our patients. For instance the use of color in relation to race, identity, emotion, social-economic-political stand, and experience as revealed in the imagery created by the patient and can provide a constructive and stimulating therapeutic dialogue which could shed light on the patient's present difficulties. The participant clinicians did not incorporate thoughts related to this topic in their presentation of the art-making process. This study did not address the relationship between the colors, depicted images, and language of the patient and their racial and socio-political-cultural histories. It can only echo the themes that Campbell, et al (1999) asks about:

1. How does race and culture of both clinician and patient impact on the art-making process, artwork and therapeutic relationship?
2. How can we harness the therapeutic possibilities generated by images, color and language, which reflect people's racial and cultural histories?
3. What are the content and meaning of the dynamics that arise in inter-cultural psychotherapy and the process of art-making?(p.15)

4. The materials used, chosen by the patient or by the clinician as a response to patient's symptomatology, are also to consider when weaving art-making into a verbal treatment.

Art therapists use art materials in the art-making process with a purpose to indicate states of mind, feelings, thoughts, and ideas. (Case & Dalley, 1992) They would also tell us that the choice of materials, when left to the patient, is guided unconsciously.

For instance, a patient who is cut off from her emotional life and in need of control may tend to avoid color and choose graphite pencil, pen, or drawing ink. The choice of these materials post a question: is the patient addressing this issue from a rational view or is she willing to immerse totally himself in further exploration and discussion of the theme depicted visually?

With color pencil drawings the expression of feelings can be somewhat detached and hard but cannot be erased as with graphite pencil. Because of this lack of fluidity, may not be suitable for the expression of strong emotions or feelings. Water based materials such as watercolors, colored ink, acrylics, or finger paints allow for less controlled expression of psychic states.

Finger paints are most commonly used with children. However, they are excellent materials to use with adults allowing for repressed and aggressive needs to be easily expressed. By painting with the fingers, the patient is forced to press, squeeze, scratch, and smear the paints onto a surface. The adult can easily regress to the time where the trauma occurred, the clinician can get a direct view of the process and get immediate access to the patient's undisclosed areas that the patient may have never disclosed by using other materials or verbally.

The majority of the participants did not have offices suitable for providing a range of art materials from which the patient could choose. They offered their patients non-fluid materials such as graphite pencil, markers, and colored pencils that are much easier to store. In doing so, they maintained the patient's emotions and feelings contained and controlled.

It may also be observed that the patient will make use of different materials according to where they are in the therapeutic process and/or where they are emotionally in one given session.

For instant clay allows for the creation of three dimensional pieces where figures can be moved, new parts can be added or taken away, color can be added, it can be hollowed out, or can sustain an internal structure, it can be kept wet from one session to another or can be easily destroyed and reused. (Case & Dalley, 1992)

The use of this material may allow the patient to experience a sense of anxiety relief while the use of watercolors on wet paper may tend to increase anxiety with those patients in need of increasing control of themselves and/or the world around them.

For the most part the participant clinicians used non-fluid materials i.e., colored pencils, charcoal, markers, graphite, magazines for collage, and photographs. These choices were made because the artwork could be easily stored and did not need drying time that watercolor, acrylics, and/or clay need. It is not surprising that only those participants that took art therapy courses and/or became art therapists themselves were able to talk about materials in relation to the patient's diagnosis and presenting symptomatology.

The majority of the participant clinicians did not address how the artwork contributed to their understanding and knowledge of their patients' developmental process. Generally, the main focus was on how the image triggered the recollection of a repressed traumatic image and focused on the intensity of the emotion through verbal processing of the drawing. The artwork can be useful into gaining insight about a patient's perception of reality, the maturity of their intellect, and limitations in their growth. (Lowenfeld & Brittain, 1987)

Understanding the level of development portrayed in the patient's drawings can help the clinician to be more effective in assisting the patient in reconstitution and/or resolution of the conflict. (Gerber & Lyons, 1980) Psychological tests such as the Draw-a-Man test (Harris, 1963), the House-Tree-Person test (Buck, 1948), and the Psychological Evaluation of Children's Human Figure Drawings (Koppitz, 1968) use a developmental approach as the basis for the interpretation and understanding of the data. "When applied to an adult patient, this type of approach adds validity to the assessment procedure." (Gerber & Lyons, 1980, p.106)

One of the clinician participants who is also an art therapist, talked at length about her use of simple line drawings during the assessment sessions. This practice allowed her to assess the developmental level of the patient and the issues the patient brought to treatment. During one of these sessions, she proposed to the patient to draw together, this allowed the clinician to assess the potential of their work together.

The developmental approach to the patient's drawing helps the clinician to increase empathic understanding of the patient and also adds validity and clarity to the treatment process and progress when communicating with other mental health professionals.

One topic that I did not see reflected in the participants' report of their experience in the use of art-making was that of potential space defined by Winnicott (1971) as the space of playing, the space between reality and the imagination.

It seems that the participants felt more comfortable with the final product and viewing it as a transitional object rather than with a direct observation of the art-making process as a potential space.

They seemed to miss observing the behavior displayed by the patient when interacting with the art materials, body posture, facial, and verbal expression, the sense of freedom by breaking barriers and/or inhibitions, their ability to fantasize. This kind of observation could add very useful information about the patient and the development of treatment.

It was unclear to me how much of this absence of observation and/or exploration of the potential space concept by the participants was due to a lack of clinical knowledge about it or the absence of art therapy training.

### Implications for Social Work

The central value of this study for social work is the contribution of art-making to expand and to deepen primarily talk psychotherapy treatment as well as the possibility that clinicians, well trained in talk treatment, can utilize and incorporate the visual as another modality to deepen the clinical work.

The participant clinicians attested to the fact that involving their patients in an art-making activity soothed them by the simple act of manipulating different art materials and focusing their energies through the process of being creators.

Ultimately the artwork allows for an undeniable reflection of the patient's past and present, and its impact on the present; this in turn leads to further therapeutic discovery and understanding of the patient's present psychic structure and conflicts. In our multi-ethnic society art-making also can provide the clinician with an entry into the nuances of the immigrant patient as the internal map of the patient becomes revealed through the creative process.

Social work programs would add a valuable resource to their curriculum by offering introductory courses in art therapy, geared to introduce their students as well as seasoned mental health practitioners to the field of art therapy. Recently a psychiatrist tried to discourage my patient for continuing treatment with me believing that this patient's treatment was "crafts and arts." In his understanding, art therapy was the making of crafts. The comment of this fairly recent graduate made me reflect on the importance of training of complementary therapies in mental health related programs.

Education in the field of art therapy will increase awareness and understanding for students and seasoned mental health practitioners to distinguish the differences between psychodynamic art therapy from studio art and psychodynamic art psychotherapy and arts & crafts.

Literature related to art therapy indicates that psychodynamic art psychotherapy can provide a "bridge for symbolic communication which offers an opportunity for patients to understand themselves and feel understood by others." (Michaels, 2007)

The therapist's internal experience of and attunement to the patient is fundamental to recovery and emotional growth in treatment. The participant clinicians in this study have shown an extraordinary ability to be open to integrating into their practice new

modalities of treatment beyond the verbal in order to serve their patients better. This capacity for flexibility within the boundaries of therapeutic treatment will increase the success of the clinical work.

In spite of such flexibility and willingness to incorporate other forms of communication to understand the patient, it became clear that those clinicians with a background in art therapy were able to plan the art-making activities within the context of the goals and objectives of the therapeutic treatment more effectively than those clinicians with no art therapy background and they had the necessary understanding to study the artwork from different perspectives, that is, emotional, symbolic, and developmental.

In an art therapy session, the art-making process is divided in two stages. The first involved a period of creative activity where the patient was engaged in the art activity; this was followed by a period of discussion which focused on the production of the artwork, how it made the patient feel, how the artwork reflected their feelings, how the process of creating an image related to the patient's situation. (Dalley, 1984) Those clinicians with art therapy background were able to plan the art-making session in these two stages; they were able to assess how to use themselves in the process, particularly during the first phase, with a sense of confidence in being a silent observant of the patient's creative process. Because they utilized art-making often, the artwork was viewed as part of the treatment process instead of an isolated intervention to target a particular issue in the patient's life.

The skill and effectiveness of an art therapist seems not to lie only in the ability to intervene or aid in the interpretation of the artwork. It involves conscious and careful

planning of sessions, choice of materials, the surrounding environment, the stage reached in therapy, and the main presenting problem. Most importantly, the relationship between the therapist and the patient is of central importance as through the artwork the clinician is able to access deeper understanding of the patients' inner reality.

The images from the artwork may evoke strong feelings in the patient and also in the clinician. The exploration of these images by a dialogue between the clinician and the patient can be ground for the development of clinician- patient dyad, and in that the artwork provides with an avenue through which the therapeutic relationship can develop and deepen.

The distinctions in the use of art-making and its process in treatment between those few participant clinicians with art therapy background and those without it, indicated the importance of further training in the use of art-making as therapy in the consulting room. For instance, understanding composition (where the objects are place in the paper), or better knowledge regarding the meaning and use of color cross-culturally, can increase clinicians' empathic understanding of the patient as well as deepen the process discussion after art-making to increase the patients' insight concerning their intra-psychic issues.

Training in art therapy within mental health programs will enlarge the awareness of treatment modalities and possibilities and provide clinicians with an in-depth understanding regarding the use of the creative process within a psychotherapy treatment, as a treatment modality, and/or treatment intervention.

It will give clinicians an in-depth understanding of art materials, their use according to symptomatology present in the patient, and how to prepare the session for the intervention of art-making.

#### Limitations of the Study and Implications for Further Research

This research was limited to the contributions of art-making to talk therapy. Modalities such as music, dance, sand play, and poetry therapy were omitted in this study. A crossed examination of the contributions of each of these modalities could enrich theoretical and practical knowledge of the clinical practice; it will broaden the way clinical treatment is understood, and it will expand the focus of the treatment beyond the verbal communication providing with different ways to access the inner reality of the patients.

A sample of art therapists who exclusively use art-making as the modality of treatment as well as therapists that are also artists could enhance the scope of findings in similar research. It could further the understanding of the underlying characteristics of an art therapist (or psychodynamically art therapist) vs. a psychodynamically trained clinician.

Also in order to assess the usefulness of art-making from the perspective of the patient, a sample of patients in long term outpatient treatment could expand and ground the study.

The art therapy field has become increasingly interested in research based studies as a way to validate their field. *The Journal of the American Art Therapy Association* is the voice of the field with a quarterly publication featuring articles about art therapy

based treatments in inpatient, outpatient, and community based settings. The articles published in this journal are useful contributions to the mental health field as clinical material for clinicians to articulate theory and case studies around treatments that incorporate art-making.

Further discussion and research concerning how art-making differs among patients with different diagnoses, differences in cognitive styles, and modes of representation between anxious, depressed, and psychotic patients could enhance and expand this study.

The study was limited as it mainly focused on the healing aspect of art-making and questions regarding any negative impact on treatment were not addressed by the clinician participants. Generally participants felt comfortable with describing the positive impact of art-making in their verbal treatment with almost no thoughts about its overpowering qualities and also limitations.

It seemed very obvious for the participant clinicians to view the final product as a transitional object but there were no comments regarding observations about the process of playing, breaking down of inhibitions, and regression that may or may not have occurred.

The study also does not address the different environments in which art therapy is practiced or can be practiced. Besides the setting of private practice, inpatient and outpatient settings, vocational and educational environments, there is the neuropsychological environment, although art therapy programs in neuropsychological settings make up only a small part of the field. (McGraw, 1989) Neuropsychological

assessment evaluates the motor, visual and spatial skills through the use of drawing and construction tasks of those with some form of brain injury. (Lezak, 1983 in Garner, 1996)

According to Garner (1996), once these art-based tests have been used to establish the location and nature of brain injury, they are generally not used again. He argues that if art-based activities are used to diagnose brain damage, “it should follow that they also can be important in rehabilitation.” In this case, art therapy can be useful for retraining or maintaining skills in individuals with a traumatic brain injury. (McGraw, 1989; Hendrixson, 1986; Poldinger & Krambeck, 1987) It also provides these patients with a medium for the integration of distressing emotional experiences. (Michaels, 2007)

## CHAPTER VI

### CONCLUSION

In the era of globalization and a fast changing world those of us in the helping professions, such as psychodynamic psychotherapists, are challenged to constantly reevaluate our treatment goals and objectives in order to better serve a very fluid, dynamic, and diverse population. It becomes imperative to clinicians in mental health to have access to different modalities to weave into the treatment when the traditional verbal modality falls short in providing a deeper and more rapid understanding of the intrapsychic world of our patients.

Complementary therapies, also called alternative therapies, such as music, dance, poetry, sand-play, and art, offer an exciting pathway into our patients' inner worlds that can expand the understanding found in more traditional verbal psychotherapy. Patients may be able to both experience and express feelings through music, dance, and art that are less accessible verbally.

This study focused exclusively on the impact and contribution of art-making on a primarily verbal approach to treatment of an adult population. It aimed to understand:

1. Why traditionally trained clinicians made an intervention of art-making in their verbal treatment with their patients;
2. At what point in the treatment process clinicians decided to make use of a non-verbal intervention such as art-making in their treatments, and

3. How the use of art-making within the context of verbal treatment impacted the clinicians' understanding of their adult patients.

As a trained registered art therapist, the challenge of this research study was to maintain an objective stance as well as an open mind throughout the interview process. The freshness of language and vision of the participant clinicians while sharing their experiences with art and art-making resonated well with me and I had to make a conscious effort not to give myself over to the excitement of their discoveries so to avoid influencing the interview process.

I also needed to exercise discretion while listening to interventions that, from the perspective of a trained art therapist, were inadequate or not totally appropriate.

Another challenge came while analyzing the data as I could not help but noticing the subtle differences between those clinicians with and/or without some art therapy training.

Although it is true that clinicians without art therapy training can also gain access to their patients' inner world through their artwork, to be trained in the field of art therapy will give them a in-depth understanding on how to utilize art-making to expand their psychological knowledge of their patients and assumptions on the treatment, it will train their eye to view the entire creative process from art-making to artwork to gain greater understanding of the patient's issues including the physical, the emotional, and spiritual. Our experience of the visible world is not only a matter of registering impressions or responding to external stimuli, it involves the feelings, memories, imaginative constructions of many kinds, and many of them may not enter into our conscious awareness effortlessly. (Maclagan, 2001)

This study seems to show that incorporating art-making into talk psychotherapy with adults provided the clinician and the patient with a more direct and clear path to objectively observe the patient's internal dynamics by observation of how the patient related to the artwork, the imagery display and the verbal dialogue that the artwork elicits.

By processing the artwork produced the therapeutic relationship was enhanced and in turn participant clinicians observed that it contributed to increasing the patient's self-esteem; the art-making and artwork becomes a path to the expression of feelings and emotions in ways that words could not easily access.

The participant clinicians observe the internal psychological map of their patients revealed through the art-making process; their patients' artwork gave them the necessary incentive to make use of art-making in treatment often and in those instances when the patient was unable to describe verbally what they were experiencing internally.

The participant clinicians reported that because the art-making process allows patients to have an internal experience of calmness, their capability to express their internal experience through words, while discussing their artwork, became enhanced.

A competent psychotherapist must remain curious and flexible enough to draw on a broad repertoire of strategies to engage the diverse clientele who come for help. One of the main results of this study was the demonstrated capacity of the interviewed clinicians to think "outside the box," within therapeutic boundaries, to help their patients to heal their wounded selves with the understanding that there is always something to what they are unaware. It was that stand that leads them to introduce art-making into their verbal treatments. They demonstrated a sense of pride and satisfaction in being able to

adapt to the needs and demands of their patients and to help them gain access to part of their inner life through non-verbal means.

It seems that these participant clinicians understood that art is not a mere entertainment but a way to disclose about one's internal life, and to increase a connection between the internal and external realities.

The act of living and carving a meaningful, coherent life is a creative act. We as humans have an innate drive to create as well as a drive to communicate and symbolize. These drives are at the core of what psychotherapy is about. A work of art can “touch the depth of soul, evoke imagination, and engage emotions and serene thought” (Knill, 1995) enhancing and enriching the verbal approach to treatment.

APPENDIX A  
PARTICIPANT'S INFORMED CONSENT

INSTITUTE FOR CLINICAL SOCIAL WORK  
**Individual Consent for Participation in Research**

I, \_\_\_\_\_, acting for myself, agree to take part in the research entitled: The Contributions of Art Making to a Traditional Psychodynamic Modality of Treatment.

This work will be carried out by Beatriz E Ledesma under the supervision of of Dr. Joan DiLeonardi, PhD., faculty for the Institute for Clinical Social Work. The work is sponsored by the Institute for Clinical Social Work, 200 N Michigan Ave; Suite #407, Chicago, IL 60601-7202, 312/ 726-8480.

**PURPOSE**

The purpose of the study is to understand why psychodynamic psychotherapists in private practice choose to make use of the alternative modality of art-making in addition to traditional verbal modality of treatment. Each of the steps that comprise the completed study will be subject to scrutiny of the Institutional Review Board. The results of this study will be submitted and defended as a dissertation for the completion of the PhD program.

**PROCEDURES USED IN THE STUDY AND THE DURATION**

Participation in this study is strictly voluntary. Names of the participants are confidential. They will participate in one face to face semi-structured interview that will last 60 to 90 minutes. The interview will be tape-recorded. The interview will take place in participants' offices. The participants or researcher are free to stop the interview at any time with no negative consequences. There will be no payment for participation in this study.

**BENEFITS**

It is possible that participants will benefit from participation in this study and from the opportunity to share their experiences with the researcher.

**COSTS**

There are no costs associated with participation in this study research.

**POSSIBLE RISKS/SIDE BENEFITS**

There are no risks, inconveniences or negative emotional responses as a result of participation in this research study.

**PRIVACY / CONFIDENTIALITY**

Identifiable information will not be revealed. Data obtained for this study will be kept in a locked cabinet in the researcher's home office. Content of all interviews will be treated as confidential material

**SUBJECT ASSURANCES**

By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Beatriz E Ledesma LCPC at 773/ 561-0825 or Dr. DeLeonardi at 312/ 726-8480. If I have any questions about my rights as a research subject, I may call Daniel Rosenfeld, M. A.,



APPENDIX B  
COVER LETTER TO UNIVERSITIES

Beatriz E. Ledesma LCPC  
[phone number]  
[e-mail address]

Dear .....

I am Beatriz Ledesma ATR, LCPC, a candidate for a doctoral degree at the Institute for Clinical Social Work. I am writing to you in the hope that you will allow the posting of fliers in your school to assist me in gathering participants for my research study.

My study focuses on the contribution that art making offers to a traditional psychodynamic modality of treatment. I am interested in interviewing psychodynamic oriented psychotherapists in private practice, whose primary population is adolescents and/or adults and who are using or have used an intervention of art making within the context of a verbal psychodynamic treatment.

I'll be happy to meet with you, if desired, to give you further details of my study.

I'll be calling you in few days to confirm your receipt of this letter and to obtain your verbal response to my request.

I am grateful for the time you took in reading this request and look forward to your assistance with my research study.

Sincerely,

Beatriz E Ledesma, LCPC

APPENDIX C  
COVER LETTER TO PARTICIPANTS

Beatriz E. Ledesma LCPC  
[phone number]  
[e-mail address]

Date .....

Dear .....

I am Beatriz Ledesma LCPC, a candidate for a doctoral degree at the Institute for Clinical Social Work. I am writing to you in the hope that you will consider participation in my research study “Art making and traditional psychodynamic treatment of adults.”

The purpose of this study is to better understand the contribution of art making to a traditional verbal psychodynamic psychotherapy treatment of adult patients in a private practice setting. This study will be conducted by the researcher, Beatriz E. Ledesma LCPC (phone number) under the supervision of Dr. Joan DiLeonardi (phone number). Both researcher and supervisor can be reached via U.S.mail at the following address: 200 N Michigan Ave. #407, Chicago IL 60605 .

If you agree to participate in the study you will be interviewed by the researcher Beatriz E. Ledesma LCPC, for between one hour and ninety minutes concerning your experience in choosing art-making as a suitable intervention in the treatment of your adult patients.

This interview will be tape recorded. You will be encouraged to share photographic documentation or actual artwork done by your patients assuming provision of proper consent from the patients.

I will be contacting you by phone in the next couple of weeks to learn if you would be interested in participating in this study

Thank you for your time

Beatriz E Ledesma, LCPC

APPENDIX D

FLYER

*DOCTORAL STUDENT AT THE INSTITUTE FOR CLINICAL SOCIAL WORK  
IS SEEKING PSYCHODYNAMIC LICENSED CLINICAL SOCIAL WORKERS,  
PSYCHOLOGISTS, AND LICENSED CLINICAL PROFESSIONAL COUNSELORS  
IN PRIVATE PRACTICE WHO ARE USING OR HAVE USED ART- MAKING AS  
AN ALTERNATIVE TO TRADITIONAL PSYCHOTHERAPY TO BE  
PARTICIPANTS IN A RESEARCH STUDY.*

*IF INTERESTED OR FOR MORE INFORMATION PLEASE CALL:*

*BEATRIZ LEDESMA*

*[phone number] OR*

*[secondary phone number]*

APPENDIX E  
OBSERVATIONAL PROTOCOL

## Observational Protocol

## Descriptive Notes:

Office location

Office Layout: Art section

Location of art materials

Sink

Natural or artificial light

Location of windows

Colors

## Reflective Notes:

Researcher's Immediate Emotional Response to the Office Environment

Researcher's Thoughts about the Subject's Presentation

Researcher's Ideas & Conjectures

Researcher's Prejudices

Unexpected Problems

## Demographics:

Date

Time

Place of Observation

Location

APPENDIX F  
INTERVIEW PROTOCOL

## Interview Protocol

- Professional history: education, experience in the field, personal motivations and goals
- Theoretical orientation, population served, prominent diagnosis
- Personal and professional relation to art and art-making process
- Decision making process to include art-making in the treatment
- Use of artwork and patient's creativity as a transitional object and transitional phenomena
- Understanding of the patient through the art-making process

### Clinician—Personal History

- Degree
- Years in practice
- Years in private practice
- Population served
- Demographic of population served
- How referrals are made
- Theoretical orientation

Clinician—Personal History with Art and Art Making:

What was the attraction toward art?

When was the first time art-making was used in treatment?

- Brief explanation of treatment
- Diagnosis
- How the decision was made
- Why the decision was made

APPENDIX G

STATEMENT ON PROTECTING THE RIGHTS OF HUMAN SUBJECTS

### Statement on Protecting the Rights of Human Subjects

The researcher protected the participants from any physical and mental discomfort, harm, and danger that could have arisen from research procedures. If risks of such consequence existed, the researcher was prepared to inform the participants of that fact. Any of the research procedures caused any serious or lasting harm to the participants of this study. Fully informed and voluntary consent was obtained from each participant. The participants were informed of the procedures for contacting this researcher within a reasonable time period following participation should stress, potential harm, or related questions or concerns arise after the interview.

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