Using Drawings in Assessment and Therapy

Second Edition

A Guide for Mental Health Professionals

Gerald D. Oster
Patricia Gould Crone

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Dedication

In memory of
Willie Oster, a beloved father
Louis Michaels, lost but not forgotten
G.D.O.

This edition is dedicated to my children, Austin Gould and Rhea Crone, who both love to draw, appreciate their mother for who she is, and put up with me while I wrote this book. If they had not been so independent, it would have never gotten written. It is also dedicated to my mother, Jimmie Stringfield, who during the time it took to write this book was diagnosed with Alzheimer's disease and has reached its advanced stages.
P.G.C.

Contents

Foreword

In many ways and for many years there has been an historic tension between the clinical approaches of the counseling psychologist and the artistic commitments of the art psychotherapist. In this wonderful and important book, this conflict of perceptions has been transcended. Gerald Oster and Patricia Gould Crone explore and demonstrate with comprehensive clinical examples, the complementary dimensions of these two fields.

Even in its first edition (1987), *Using Drawings in Assessment and Therapy* broke ground in its attempt to offer mental health clinicians the opportunity to synthesize the common ground between two disparate approaches to psychotherapy and to find in the overlap, innovative and responsible assessments and interventions. In this second edition of the text, updated, expanded, and rich with current clinical examples, Oster and Crone take their ambitious synthesis even further.

Art therapists have struggled to maintain their commitment to the visual arts and the centrality of the image in their work. Often this has put them at odds with the empirical efforts of the field of

psychology as it has endeavored to demonstrate the efficacy of assessments and interventions. Psychologists, on the other hand, have often attempted to incorporate the techniques and approaches documented in the art therapy literature to augment their interactions with clients who may be noncompliant or nonverbal. This text moves past these limited parameters and succeeds at a deeper level of integration. Gerald Oster, the psychologist, is able to appreciate the power of the imagery and avoid the reductive oversimplification of the techniques that verbal therapists have sometimes applied to art therapy assessments and interventions. Patricia Gould Crone, the art psychotherapist, is able to support the text's intention to review the field of art therapy and make its approaches comprehensible and accessible. In effect, the two together have accomplished a rare task: the integration of complementary approaches born out of mutual respect.

Using Drawings in Assessment and Therapy is neither simply an art therapy book nor fundamentally a counseling book that has attempted to incorporate art therapy techniques. Its unique place in mental health literature is based on its emergent voice woven from two disciplines. Its inclusion of the ideas and findings of the most current art therapy scholarship (including new research in assessment and projective tests) and its framework of contemporary clinical approaches (including crisis intervention and practical solutions) suggest its relevancy for today's mental health practitioners.

It is wonderful to read a text that offers practical resources for the difficult work we do and more importantly, models a process of innovative dialogue in its theoretical approach. Crone and Oster understand each other and each other's fields the way therapists understand their clients. Just as the practice of psychotherapy, in art or verbal modalities, constructs new understandings, *Using Drawings in Assessment and Therapy* provides the reader with new approaches, new techniques, and new hope.

Debra Linesch, Ph.D., MFT, ATR-BC

Preface

After the success of this book's first edition in 1987, we continued our pursuit of gathering newer information on the uses of drawings. We were also encouraged by the positive responses from clinicians in a wide range of settings. Their use of the book and its resources expanded their treatment repertoire by introducing drawings during the therapeutic hour. After this exciting initial feedback, we began speaking to many audiences through the years in conferences and seminars, which broadened our knowledge base on using drawings to enhance emotional expression and communication. And in adding this new information to our everyday practices as a psychologist and art therapist, we continued to realize the difficulties that language alone presents in relaying and understanding complex emotions. We have seen over time that alternative techniques, such as drawing, have substantially broadened the clinician–client interchange and have allowed many different paths for more meaningful experiences and insights. By combining both verbal and nonverbal input, the therapeutic relationship becomes consistently richer through materials that add depth and breadth to the encounter.

Since the time of our collaboration during the early 1980s, we have had the fortunate opportunity to observe the continued growth of research and the sharing of personal experiences on the clinical use of drawings. Through this dissemination of literature and case studies, it has become evident of the value that client-created drawings possess during intake interviews and diagnostic evaluations, as well as during individual, group, and family therapies. We discovered the impetus for using drawings to open many pathways of self-expression that made revealing painful thoughts and feelings much less threatening. We were constantly amazed that it took only simple directives to produce outstanding results that enriched the many sessions. Often through these sessions, drawings proved to be the only safe way to externalize painful emotions, especially in situations of abuse.

Providing clients alternative ways to "speak" should be a crucial aspect of every clinician's toolbox. Because drawings add flexibility and creativity to the therapeutic encounter, they enhance the understanding of interpersonal dynamics, as well as build cohesion and trust. The use of drawings also establishes a framework for rapport building and promotes communication, which is so important during the early stages of group and family therapy. For the individual in treatment, drawings can become concrete markers for important events, methods for remembering dreams, techniques to reveal unconscious material, and points of review during the termination process. These uses of graphic images offer a fresh view of problems and conflicts that enhance the development of treatment goals and impact the direction of treatment. The addition of drawings within psychotherapeutic treatment often produces many salient moments and reveals pertinent issues that can be seen then discussed. For these numerous reasons, drawings have been accepted as valuable clinical techniques for all mental health professionals to learn and incorporate during assessment and therapy.

This revised edition of *Using Drawings in Assessment and Therapy*, like the original, is organized into six chapters with appendices and references. By offering a practical compendium

that describes a broad spectrum of clinical applications of drawings, we have attempted to synthesize a variety of drawing methods that are commonly used during both the assessment and therapeutic phases of treatment. The original text was viewed as a "seminal work" in the field by Eliana Gil and was fortunate to have had broad exposure in book clubs and translated into many languages. For this updated version, we have continued our journey by reviewing updated literature, offering many new case illustrations, and providing common and not so common directives that have been used by other clinicians in their pursuit of broadening client communication.

Each chapter establishes foundations in clinical diagnosis, developmental theory, psychological assessment, and new research and applications of art therapy assessment. Additionally, we have attempted to review theoretical and applied discussions of individual, family, and group therapies accompanied by corresponding case examples. This revised book can be valued as a basic resource for drawing protocols, directives, and procedures, as well as a reference for ways to effectively intervene with a broad array of difficult problems that are facing clients today. The book offers numerous guidelines that enhance the understanding of the visual language and that can be introduced during everyday treatment. By reviewing numerous techniques and approaches to arrive at developmental, cognitive, and emotional indicators in client drawings, this book adds clinical breadth to the study and treatment of emotional disorders in both children and adults.

The initial chapters review the historical connection of artistic expression and how it found a niche within traditional mental health treatment through its rich symbolic interpretation, and how the ensuing research developed into further assessment techniques and therapeutic direction with the advent of the art therapy discipline. Also presented during this portion of the book are overviews that demonstrate how simple drawing directives can assist and enhance therapeutic situations. Reviews of drawing directives are described to emphasize indicators of emotional development and cognitive maturity. Discussions on the value of using drawings are then

enhanced with case examples and illustrations. The sections emphasize how drawings can be used during intake screening and psychological testing to establish brief therapeutic goals are emphasized. These chapters will be especially relevant to those clinicians who find themselves in frontline positions of intake, assessment, diagnosis, and referral.

The remaining chapters discuss the therapeutic process in individual, family, and group structure as it relates to the introduction of how drawings can be used to facilitate client expressiveness. Numerous examples of techniques and client images focus on important clinical issues and therapeutic milestones. Issues in establishing rapport, using drawings in dreamwork, portraying family dynamics, and group selection and process are all presented to highlight important stages in psychotherapy. By focusing on the spontaneity that drawings can provide during the treatment hour, we hope to encourage readers to think creatively about ways to use these techniques in their unique approaches to work.

Finally, the appendix includes an annotated list of suggested readings. The authors of these books provide a state-of-the-art view on how drawings can be introduced and used in broad-based clinical treatment. Through the years, the richness of graphic images within client drawings has highlighted its value as a welcome technique that has continued to grow and be shared with other health and mental health practitioners. We offer this revised edition with this ongoing cooperation in mind — that drawings can bring about creative, exciting moments to everyday treatment and do add richness, revelations, and insights that otherwise would not be expressed, exchanged, and shared, thus, greatly enriching the therapeutic experience.

Gerald D. Oster, Ph.D.
Patricia Gould Crone, M.A., A.T.R.

Acknowledgments

In the 20 years since we planned the first edition of this book, much of our lives has unfolded. Many people have entered our space and many have passed and are sorely missed. To everyone that we have been associated with over the years, we certainly remember their value and contributions.

Of course, our respective families have been a source of strength and have kept us humbled. Raising our children has produced many memorable moments, as well as provided many insights into our own shortcomings. At the time of the publication of the first edition, Aaron Oster's imcminent birth pushed forward the completion of the volume. Now nearing 18, Aaron will be leaving home for college soon and his 15-year-old sister, Corri, will be departing shortly thereafter. Needless to say, they have offered a lifetime full of surprises. Austin Gould was a toddler when the first edition was completed and is now 20 years old and in college. Rhea Crone, now almost 14, was not even born during the publication of the last edition.

Much recognition also must go to Shannon Vargo and George Zimmar at Brunner-Routledge for convincing us that this revision was important and needed to be completed, as well as to Gerry Jaffe for timely editing comments. Their encouragement and structure allowed us to finish the task and to overcome the many distractions in our lives. Before this volume is published, they will have read its contents numerous times and offered sound modifications. Their commitment to its conclusion and vital feedback has been invaluable.

Since we are much older now and have worked in a myriad of settings, we need to acknowledge these places of learning and training. These include the Thomas Finan Center in Cumberland, Maryland, where we originally worked together; the Regional Institute for Children and Adolescents in Rockville, Maryland; Montgomery General Hospital in Olney, Maryland; and the University of Maryland Medical School in Baltimore where Gerald Oster worked since that time. In addition, Patricia Gould Crone's later experience included working in private practice in Cumberland, Maryland and consulting with the Oakland public schools in Oakland, Maryland. Then later with the move to Kentucky, Patricia's extensive work continued with Kentucky River Community Care's Children and Family Services, the Kentucky Designated Child Sexual Abuse Coordinator Program, The Child Advocacy Center (C.A.R.E. Cottage), and the Kentucky Art Therapy State Board of Certification for which Patricia Gould Crone is the chair.

Of course, this revised edition could not have been completed without the many people with whom we work on a daily basis in our clinical settings. Their willingness to use drawings to express their life's stressors, family origins, dreams, and fantasies offered unique glimpses into their entire psyches. To all who have assisted in these collaborations and efforts toward shaping this book, we will forever be grateful.

And finally, we would like to acknowledge family, friends, and colleagues without whom the book would never have been completed. To Jo Warwick (Dr. Oster's wife) who has been an inspiration to the idea that we never stop learning, as she is receiving

her master's in special education after many years of other involvements. And Patricia wants to thank Artie Ann Bates, Helen Brunty, Shelagh Cassidy, Jeanetta Clemons, Kari Collins, Shana Craft, Bob Crone, Irene Davis, John Gould, JoAnn Hurt, Gina Ison, Greg and Becky Neace, Mickey Stringfield, Brenda Taucher, Scott and Bridget Turner, Missy Guillen, and Gerald Oster (for his kindness, support, and patience during some difficult times).

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Clinical Uses of Drawings

EXPRESSION THROUGH DRAWINGS

With the ending of a dynamic century in mental health and the beginning of the 21st century, clinicians continuously need to reenergize themselves with new techniques and standards for examining diagnostic questions and promoting therapeutic change. In this quest, therapists and diagnosticians remain fascinated and appreciative of the myriad use of procedures, such as the use of drawings, in their everyday clinical work. This enthusiasm for introducing alternative methods to engage and communicate with clients has produced renewed attention among practitioners and researchers for finding simple and direct applications that can answer specific questions and document progress (Edwards, 2002; Hammer, 1997; Linesch, 2000; Malchiodi, 1998; Oster & Montgomery, 1996; Riley, 2001; Rubin, 2001; Safran, 2002; Wadeson, 2000).

Throughout this rapidly changing time period, the uses of drawings in assessment and psychotherapy remain alluring with their ability to illustrate concrete markers of the inner psyche. Through their many variations, drawings have provided a basic format for

the sharing of personal feelings and experiences, as well as furnishing direction in promoting change and realizing treatment goals. These graphic images endure in their use by demonstrating their primary value as clinical tools for generating hypotheses about intellectual, developmental, and emotional functioning.

Whether those involved in the unfolding diagnostic and therapeutic process are children, adolescents, or adults, the act of creating drawings provides an expanded and insightful view of the self and serves as a tangible focus for discussion, interpretation, evaluation, change, and review of progress in therapy. Both the activity of drawing and the drawing products themselves make it easier for individuals in therapy to actively and clearly communicate their present levels of functioning, as well as their underlying conflicts and concerns that otherwise might not be communicated in a clear manner (Killick, 1997). Through their many uses in assessment and therapy, drawings give clients the opportunity to relate their thoughts and feelings in a broader and richer fashion than words alone could express. And they demonstrate once again that a picture is worth more than a thousand words.

Drawings Are Less Threatening

Often, drawings are less threatening and provide a sense of safety and comfort that is sometimes not available during the evaluative or therapy sessions. For example, using drawings with traumatized clients provides one of the few ways to externalize emotions and events that may otherwise be too painful to disclose verbally during initial diagnostic or psychotherapy sessions. For the abused child or adult; the resistant, angry, or oppositional child or adolescent; or the family in chaos, drawings allow an alternative action to express suppressed emotional pain or unspoken family secrets (Malchiodi, 1990, 1997, 1998). When these vulnerable individuals refuse to verbally reveal themselves and their secrets due to fear of receiving retaliation or rejection, therapeutic vehicles like drawing become a highly valued avenue for "telling without really telling" (Peterson & Hardin, 1997). Adding drawing directives as part of

a diagnostic process, intake interview, or treatment program enables many children, adolescents, and adults to view themselves more objectively within a safe and expanded framework by reviewing their own artwork, as opposed to direct examination that may produce initial defensiveness and guardedness. The act of drawing and the subsequent products that are created allow a novel curative approach through which individuals who have come for therapeutic assistance can graphically portray and see their emotions and ideas that otherwise they could not easily describe.

Drawings Provide Focused Discussion

Drawings help bring to the surface more relevant issues that are needed for diagnosis and treatment planning, including therapeutic opportunities for creative interventions. Drawings can quickly reveal additional and important information on current developmental, intellectual, and emotional functioning. They can also portray presenting problems that may not have been assessed through conventional means of psychological testing. In today's mental health environment, where quick turnaround is needed to describe relevant problem areas and limited sessions are the norm, drawings become even more strategic as a means of expediting assessment and treatment. For these reasons, drawings maintain the attention of researchers and clinicians involved in the evaluation and diagnostic process, as well as in areas where additional techniques are needed to enrich the therapeutic healing process (Kaplan, 1999; Malchiodi & McNiff, 1998).

Drawings Supply Creative Solutions

One of the primary goals of therapeutic intervention is to encourage resourceful solutions to everyday living. By asking clients to graphically construct their problems, feelings, or worlds, they can begin to enlarge their framework for communication and supply alternative symbolic meanings to their experiences (Oster & Gould, 1987; Oster & Montgomery, 1995). Through self-expression,

clients are given a greater chance to lessen their inner pain, tension, and confusion and reduce their sense of isolation, as well as communicate tangible illustrative ideas for coping with their everyday problems. The following case example portrays some of these salient issues.

Marlena

Marlena was 14 years old when admitted to an inpatient unit after she revealed suicidal thoughts to a friend and displayed cuts on her forearm. Through interviews with her school counselor and during her emergency room examination, it was discovered that Marlena had been depressed for a long period of time with symptoms of disturbed sleep and diminished eating. Reportedly, she had lost 20 pounds over two months, mainly through purging after eating. Although she had been in outpatient treatment for many years and on antidepressant medication, this was her first psychiatric hospitalization. According to Marlena, she had witnessed her mother being abused by her stepfather and had suffered the loss of her grandparents, to whom she felt especially close. Apparently, she had recently been preoccupied with their deaths and had been in a state of intense sorrow, even though they had died many years ago. At the time of admission, she clearly articulated that she wanted to die.

During her psychological evaluation many days later, Marlena emphatically stated that she was not afraid of dying and wanted to end her life. When asked to draw her feelings before entering the hospital, she immediately sketched the following symbols of her inner pain, displaying her preoccupation with death-related themes and fears (Figure 1-1). Through this intense drawing, she graphically portrayed her pain, sadness, thoughts of death, and her wish to join her grandparents. Using this drawing as a concrete platform to verbally discuss her recent distress, she related that she had been cutting herself for several

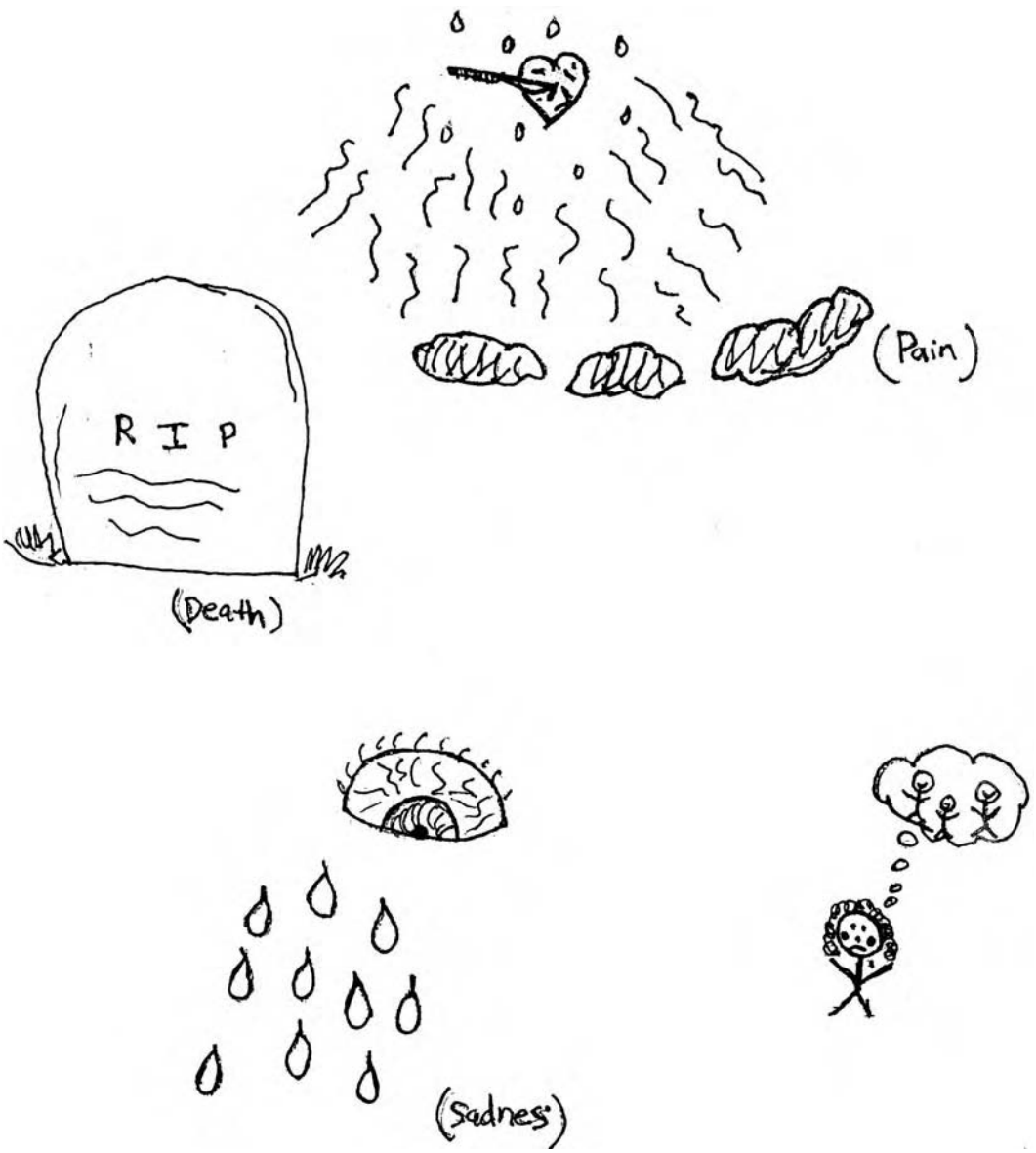

Figure 1-1

months and also revealed that she had even overdosed previously, but had never told anyone about this suicidal action.

On further self-report scales that focused on her feelings of depression and suicide, she noted that nearly every day she thought that it would be better if she were not alive and thought often of killing herself or of having a deadly accident. Her profile was considered a loud cry for help. She said that she did not feel safe from herself and wanted to remain in the hospital or go to another longer-term facility.

Because she was viewed as a very high risk for continued emotional conflict, suicide ideation, and possible suicide attempts, Marlena was recommended for a residential treatment center that would address her safety issues. This type of more restricted placement would provide an atmosphere where she could express her many conflicts and concerns through longer-term therapy. It was also suggested that expressive therapies, such as art, could be a highly beneficial modality for her during her treatment to continue in the evaluation of her suicidal tendencies and to examine and resolve her many conflicting issues.

Drawings Provide Visual Representations of Problem Areas

The above example (in addition to many others that will be shown in this book) demonstrates the varied uses of drawings during assessment and treatment and how they expand opportunities for discussion through the created images and characters in the pictures. When drawings are used in this manner, they provide an indirect platform for discussion rather than addressing emotional problems in a straightforward fashion (Moon, 1994). By expanding therapeutic approaches through the use of drawings, opportunities are created to visually represent feelings and thoughts that come alive, instead of remaining hidden and elusive. For example, graphically portrayed images of loneliness, self-loathing, or personal inadequacies can be externalized onto the drawing products and

for the first time have a chance of being seen rather than being verbally processed or remaining veiled through defensive posturing (Brooke, 1996). Viewed in this fashion, drawings underscore two important aspects of the therapeutic process — the client's inner dialogue while creating and the outside dialogue between client and clinician (Dalley, Rifkind, & Terry, 1993).

During clinical work, drawings can be used in a variety of ways to expedite assessment and the diagnostic process. For instance, drawings can be used as a facilitating technique to help overcome feelings of apathy or helplessness. Children and adolescents, as well as some adults, often experience a deep sense of disempowerment. They frequently perceive themselves as victims of a chaotic, unfair, or uncaring world (Moon, 1994). Upon initially presenting for treatment, it is not unusual to find these clients overly protected and guarded as their emotional walls have surfaced and everyone around them may be perceived as excessively distant. Even more threatening to them are the strangers in their newly constructed world, as all newcomers may be perceived as hostile. To counteract this defeated and helpless stance, clinicians must be willing and able to provide positive therapeutic experiences within a supportive environment that expands their clients' perception of their daily experiences.

Drawings Expand Therapeutic Engagement

Clients, especially those who have been traumatized or victimized, must be transformed into actively engaged participants of the therapeutic partnership (Malchiodi, 1997). Few therapeutic goals can be accomplished without a trusting relationship in which feelings can be ventilated and new behaviors learned. Fresh meanings must be discovered and novel actions rehearsed, which reinforces the new interpretations of their heretofore threatening world.

Treatment from a purely verbal approach is often not enough to uncover past trauma or to reveal different possible reasons for maladaptive behaviors. By introducing drawing directives, individuals in treatment can expand their frame of reference, gain new

understandings by seeing their problems, and discover possible alternative solutions to their problems. In this way, they have attained a new level of awareness through their nonverbal products and can appreciate themselves more fully. The act of drawing itself enables the client to feel less helpless and provides a tool for active engagement in therapy. Drawings used throughout treatment can also stimulate creativity and support an innovative approach to the problem-solving process and emphasize specific treatment issues. When added to the clinicians' treatment techniques, drawings can expand the possibilities of prescriptive remedies and hasten recoveries.

ALTERNATIVE PROBLEM SOLVING

The mere act of drawing can stimulate creativity and provide relevant, personal statements that represent both conscious and unconscious meaning (Oster & Gould, 1987; Oster & Montgomery, 1996). The drawings allow the child, adolescent, or adult who is being assessed or beginning treatment to offer significant information through spontaneous imagery that may have been otherwise censored through their verbal defenses. These graphic products support opportunities for individuals to gain insight and fresh, meaningful perspectives that are not available to them through the usual modalities of verbal treatment. When introduced into the treatment process, drawings can highlight the important relationship that is constructed between therapist and client or what is termed the "therapeutic alliance" (Wadeson, 1987). By using various drawing directives, expressive products are created to be exchanged, discovered, and commented upon. Drawings help establish this working relationship which, in turn, stimulates interactions and spontaneity and expedites deeper levels of sharing insight in the therapeutic relationship (Rubin, 1997).

Drawings provide a platform for the diagnostic process and expand treatment possibilities. Through these visual markers, new ways of self-expression are channeled into productive dialogue. From a simple picture or a series of drawings that graphically

portray problems or solutions, imagery can be used to enhance communication. The drawings can become personal imprints or statements that define a point in time and a feeling that has been aroused. For example, Cathy was an 8-year-old girl placed in her aunt's home due to her mother's unstable lifestyle. Her drawing (Figure 1-2) illustrates the salient and painful things that had happened to her and the feelings that she was trying to keep inside. Through her use of drawing she was able to overcome her initial fears of treatment and share parts of her terrible ordeal.

By observing the process of drawing and what is shown upon completion, therapists can more clearly see vivid portraits of their

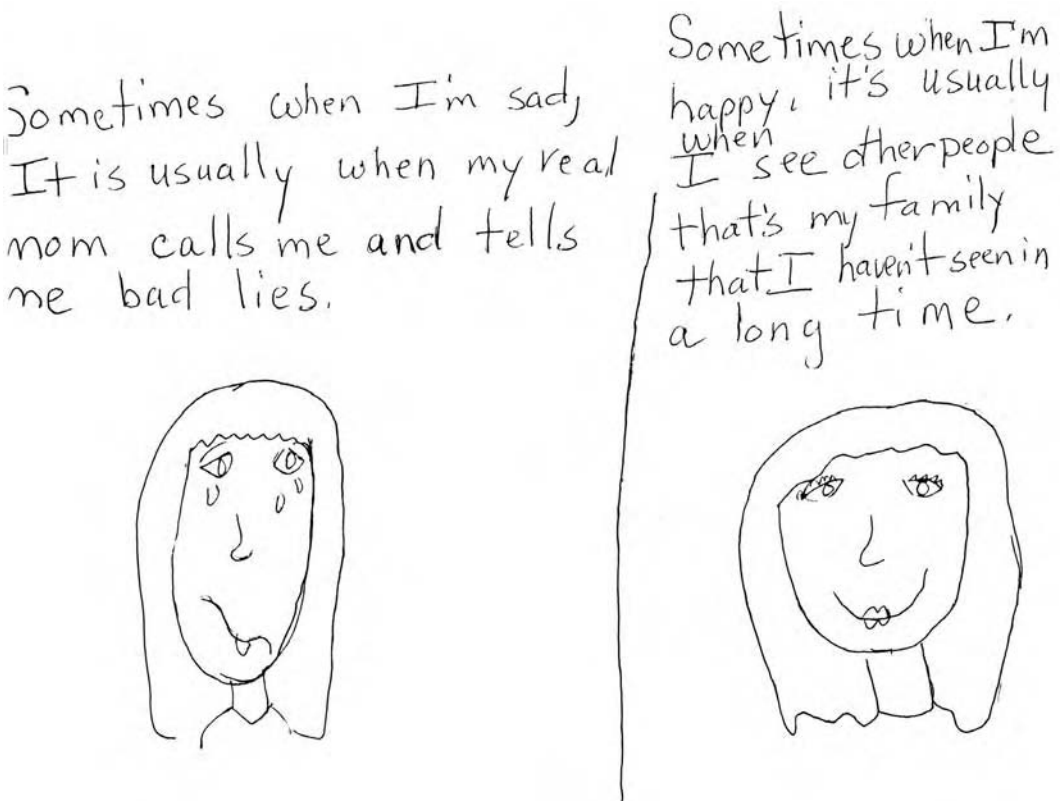

Figure 1-2

clients' outer world or masks that they present to the world (Oster & Caro, 1990). This is especially poignant for latency age children and teenagers who might otherwise hide behind their interpersonal facade. For instance, Denise was a 10-year-old girl referred to therapy for being sexually abused by her adopted father. She was adopted at the age of 8 and prior to that event had a long history of neglect, abuse, and multiple foster placements. In Figure 1-3, she presents her mask or what she presents to her outside world. She draws her masks and identifies them as happy and shy. In Figure 1-4, she draws what she feels behind her mask — "hurt, sad, fear, anger, and guilt."

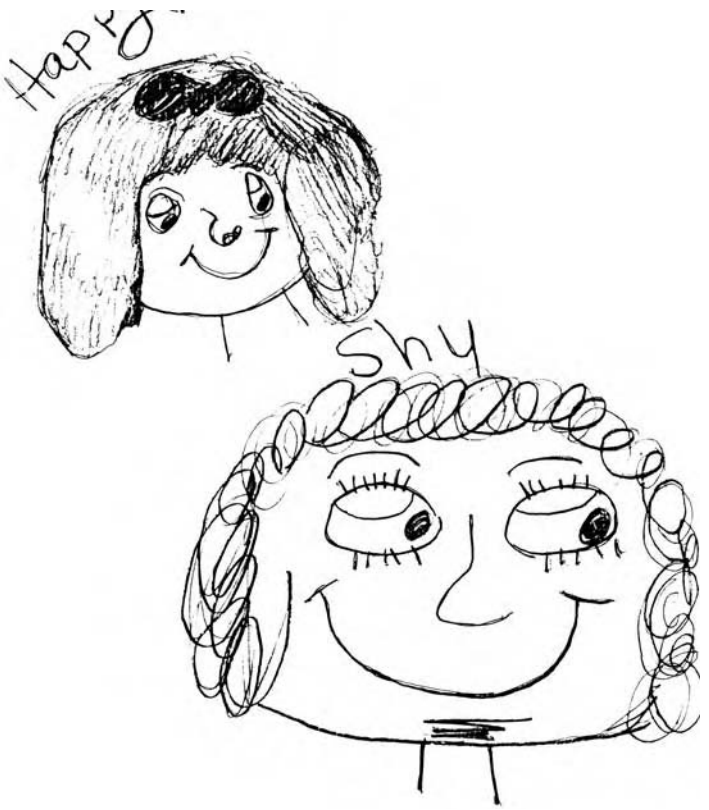

Figure 1-3

Figure 1-4

By encouraging clients to express their personal meanings onto the drawings, therapists enhance verbal interchanges and create a better overall therapeutic effect. Through this creative process, therapists have the opportunity to assist their clients to make more

accurate self-judgments and broaden their objective selves. The following case exemplifies this approach further.

Meung

Meung was a 12-year-old, first generation, Asian male who was being seen in outpatient treatment due to failing grades at school and being argumentative at home. Because his parents had been divorced for many years, Meung was primarily being raised by his single mother. Over time, however, his mother became busier in her professional career and became increasingly frustrated by Meung's passive-aggressive demeanor and lack of motivation.

When initially seen in the therapist's office, he was quite sullen and reticent to disclose his personal turmoil. In fact, his self-protective stance seemed overly done and his defensiveness seemed unusual for someone his age. His ill-groomed appearance and general discomfort signaled that he may have been exposed to much family discord.

As a therapeutic gesture of sharing and an attempt to relate on a possibly different level, Meung was asked to draw one of his problems and how he might resolve it. Remarkably, he attacked this directive with vigor and produced drawings that were quite direct. As these two drawings reveal quite vividly, Meung was feeling overwhelmed by his mother's anger (Figure 1-5), but could view a solution to this problem (Figure 1-6); that is, he wanted his mother to spend more time with him and to be less serious and more playful. As Meung was willing to share these drawings with his mother in future sessions and use them as a springboard to assert his needs, the mother was able to make use of this information and change her schedule for more "play" time to happen.

In summary, drawings in therapy can facilitate spontaneity among young children, help troubled adolescents move beyond

Figure 1-5

Figure 1-6

personal developmental hurdles, and uncover underlying conflicts in adults that can lessen psychological pain. As our examples illustrate, drawings also project one's inner life into graphic form that can later be used as a springboard for stated goals. And they do not inhibit discussion. Rather, drawings establish alternative avenues of communication that become vehicles for expression of fears, wish fulfillments, and fantasies. Drawings represent a symbolic speech that is not a substitute for talking, but instead stimulate increased discussion in reviewing the products that are constructed either during the intake interview, diagnostic session, or the therapy hour.

HISTORICAL VIEWS OF DRAWING

Drawings, as well as other artistic creations, have always been an extension of personal and interpersonal communication. In primitive times, evidence indicates men and women etched and carved on stone and cave walls to depict their feelings and actions. They entered dark caves to paint and sculpt on the rock walls images, mostly of animals, that were possibly produced as part of some kind of ritual. The earliest known works of art were about 20,000 years ago during the last stage of the Paleolithic period and are mostly in Spain and southern France (Janson, 1991). What little is known throughout early history has been enhanced through these art creations and pictographs. These drawings and other artwork have been cataloged in archeological investigations as examples of how early men and women attempted to produce their ideas and emotions. These basic, but expressive, notations must be viewed as the essence of beginning communication and have been studied and analyzed by archeologists and art historians.

Health and mental health professionals have also made attempts at understanding the aesthetic experience, explaining the process involved in producing art, analyzing the genius of certain artists, and exploring the meaning of particular artwork. During the past century, there has been a burgeoning interest in the interpretation and use of drawings to describe the emotional and psychological aspects of the art expression of individuals in treatment (Betensky,

1995; Leibowitz, 1999; Malchiodi, 1998). These drawings are thought to reflect the inner worlds of clients, depicting their feelings and relating information concerning their psychological health, as well as their conflicts and concerns. The format of the drawing method has provided the opportunity to explore nonverbal thoughts and feelings, to see alternative problem-solving possibilities, and to make uniquely personal statements that represent many conscious and unconscious wishes (Riley, 1997).

Throughout Europe in the late 1800s and early 1900s, interest grew in the art productions of the mentally ill. Their drawings soon became a framework for discussion among mental health providers pursuing diagnostic criteria for various forms of psychopathology (MacGregor, 1989). Many writers of that time believed that art expressions could confirm a diagnosis, especially more severe forms of mental illness, such as schizophrenia. For instance, Tardieu's (1872) *Etude Medico-Legale sur la Folie* included patient art productions as legal criteria for the diagnosis of emotional disturbance. Also, Lombroso (1895) attempted to demonstrate that drawings and paintings of the mentally ill offered insights into their inner state (Malchiodi, 1998).

During the 1920s, Hans Prinzhorn, an art historian and psychiatrist, was able to collect 5000 pieces of artwork created by patients being treated for mental illness throughout Europe. His 1972 publication, *Artistry of the Mentally Ill*, gathered much attention to the possibilities that art expression held for diagnostic value and rehabilitation. Also, during this time period, children's drawings were the subject of much speculation in describing intellectual and emotional development (Goodenough, 1926).

Sigmund Freud (1933) also focused an abundance of attention on masterpieces and their creators. He assumed that universal human conflicts and neuroses could motivate artists to create their inner experiences on canvas. For both the artist and the patient, the end product was perceived as a unique way of reflecting inner, personal struggles and in making sense of life.

Freud (1900/1958) also hypothesized that symbols represented forgotten memories and were likely to emerge through dreams or

art expressions due to intrapsychic distress. The symbol, according to Freud, became a disguise for anxiety-laden content and protected individuals in treatment from feeling overwhelmed by their underlying tension. In his writings, he explained how images presented in dreams could be drawn and how for some patients they were more easily expressed in this manner than by trying to describe them in words. With the advent and appreciation of Freud's writings and the ongoing psychoanalytic movement, trained professionals began to grasp the symbolism of art products completed by their emotionally disturbed patients and were more accepting and able to use them more readily in their everyday work (Kris, 1952).

For his part, Carl Jung (1971) also asserted that symbols represented parts of personal experiences that could be enhanced through analysis. His emphasis on creativity as a primary component of the treatment process placed special importance on personal images in the form of archetypes with universal meanings. Although Freud was never particularly fond of asking his patients to draw in sessions, Jung often encouraged his clients to draw and he thought that this use of fantasy through symbol production was a way to evolve and heal (Jung, 1956). With both of these major psychoanalytic figures explicating their views on symbols and artistic expression, drawings quickly became a popular issue for discussion within the mental health community.

Through these early works, drawings and other art activities within sessions became appreciated in terms of spontaneous expression that gave access to unconscious material (Case & Dalley, 1992). Due to Freud's and Jung's explorations of the mind's unconscious process, art therapists and others, who valued the interpretive possibilities of creative expression, established a groundwork for diagnostic questioning and therapy that paralleled and incorporated the work in psychoanalysis. These psychotherapists realized that verbal language alone was not adequate for revealing the unconscious experience and that drawings could provide an added dimension of unique images that could not otherwise be described with words. With the aid of drawings, these therapists used graphic images as bridges to the unconscious,

rather than merely relying on possibly defended verbalizations of thoughts and feelings. Also, many therapy patients soon found it much easier to construct images of disturbing dreams, or conflictual feelings, than attempt to verbally describe them through spoken language alone, with its many limitations.

Art therapy (as a field) was first developed by Margaret Naumberg (1966), who came to the United States from Europe. She was psychoanalytically trained and emphasized the use of free association and interpretation with spontaneous artwork. Then in the 1950s, Edith Kramer developed the idea that the process of creating artwork in itself is a healing one and did not require verbalization. The therapist was seen more as an educator or artist. By the 1960s, art therapy was established as a field. Another major influence in the 1970s was Hanna Kwiatowska, who introduced the idea of art therapy used in family evaluations and therapy. Then Janie Rhyne (1973) developed art therapy as part of the humanistic movement and emphasized the use of art activities to simply allow for self-expression and the enhancement of group interactions.

Today art therapists work in a wide variety of clinical settings using drawings and other media with individual, group, and family treatment, as well as aiding in assessment. Art therapists, after meeting qualifications, can be registered through the American Art Therapy Association (AATA) or can be certified through the Art Therapy Credentials Board after successfully passing an exam. The standards of practice have been established by AATA, and ethical considerations regarding the therapeutic use of art by disciplines outside the field of art therapy are outlined in a brochure published by AATA.

DEVELOPMENT AS SEEN THROUGH DRAWINGS

Through the explorations of using drawings in clinical work, and especially in developmental psychology, it was shown that simple construction of shapes and figures and how they change follows an orderly sequence in a child's maturation (Oster & Gould, 1987;

Oster & Montgomery, 1996). In a process that is similar to their prehistoric ancestors, young children discover that they have the capacity to produce images as a means of self-expression. Although they first find joy in creating meaningless scribbles, this activity soon gives way to orderly shapes, even by age 3, as children begin to gain a greater satisfaction in recreating images of what they perceive around them.

The earliest defined shapes are circles. They become the main form for representing heads, eyes, or mouths (DiLeo, 1973). Circles or ovals are the simplest patterns and are depicted in most cultures. These elementary shapes, which are the easiest to draw, tend to be a function of basic eye–hand coordination that result from the growth and development of the nervous system.

These early exploratory attempts at art seem to be representations of ideas rather than a direct image of an object itself. Through experimentation, children begin to draw what they think exists, rather than what they actually see. Across nationalities, whether with pencil or crayon on paper or sticks in the sand, children continue the process of drawing (Peterson & Hardin, 1997). In trying to add meaning to these drawings, they usually produce images of important concepts; for example, they initially attempt to construct human figures, then often construct animals, houses, and trees. Over a century ago, writers described their observations of children's drawings, which revealed in their artistic expression their stages and developmental levels (Cooke, 1885; Ricci, 1887).

Stages of Development

One of the early descriptions of children's drawings was completed by Cyril Burt (1921). Based on personal observations and a systematic study, Burt classified sequences in children's drawings by distinct stages. He indicated that children between ages 2 and 3 begin to construct scribbles. He viewed these activities as purposeless expressions that became more refined and differentiated over time. At age 4, children start using single lines to replace their unorganized scribbles. During the next couple of years, children

begin to draw crude basic shapes that are structured to represent people and animals.

During the latency years from ages 6 to 10, Burt classified children's attempts at drawing as "concrete and detailed" to parallel Piaget's (1959) concept of "concrete operations." Burt observed that children at age 11 preferred to copy and trace the works of others as opposed to creating original art work. Burt believed that drawings by 11- to 14-year-olds show a deterioration in quality due to advances in their cognitive functioning, enhanced use of language, and emotional development. The inclination for this age group is to draw geometrical forms and decorations, rather than human forms. Burt noticed that an artistic revival occurred again during the middle adolescent years when they show more interest in color and form.

Later investigators, most prominently Elizabeth Koppitz (1984), who constructed developmental scoring systems for children's drawings, also came to a similar conclusion that early teenagers' drawings are inferior to latency-age children. However, she hypothesized that youngsters who reach puberty become excessively self-conscious and critical of their drawings. They start drawing rapidly and carelessly, making sketches with little effort or producing stereotyped figures or cartoons.

Although there have been criticisms of all developmental stage theories, most investigators of child development have acknowledged discernible differences in drawings during maturation. Mainly, the majority of researchers and theorists over the years merely refined each of the phases of development that were espoused by earlier workers in the field. For example, DiLeo (1973), in his review of earlier works in the 1800s, spoke of the discovery of stages or sequences in graphic expression of children that have been confirmed throughout present-day research.

These earlier investigators suggested six sequential stages to artistic development. First is scribbling, which seemed similarly related to an infant's babbling speech. Next is the emergence of a tadpole stage, in which drawings resemble a circular head with appendages. A transitional phase follows, whereby a trunk appears

(usually an elongated tear drop beneath the head) with some details of a human figure. Occurring next tends to be a full-face drawing of a person with added body parts. Another transitional step may be observed, in which attempts at profiles are made. Finally, an accurate profile orientation is completed, which is considered an introduction to movement.

Rhoda Kellogg (1969), who attempted to integrate the fields of child development and anthropology, collected and examined nearly a million drawings from children, looking for common images and structures. She demonstrated that drawings develop in an orderly fashion from certain basic scribbles toward a consistency of shapes. She emphasized that meaningless scribbling by infants turns into specific forms and symbols. She noted that by age 2, children's drawings can be differentiated into 20 different types of markings and appear to be the foundation of graphic expression. These dots, lines, and circles apparently display various muscular movements without perceptual guidance. Every child, Kellogg believed, can make these markings and those who cannot are somehow disabled. Others shared the thoughts that there are actual neurobiological reasons for art making, and these connections seem to have an influence on the drawings of children (Dissanayake, 1989; Morris, 1962).

For example, Katy was the 2-year-old child of parents who were explaining to the therapist the behavior problems of their 6-year-old child (Katy's brother) for whom they were seeking treatment. During this initial stage of gathering information, both parents were needed so they brought the 2-year-old into the office and the therapist gave the 2-year-old some markers and paper to entertain herself with. The example in Figure 1-7 is what she drew and a good example of the dots, circles, and lines mentioned above. Notice how the lines go off the edge of the paper, indicating Katy had yet to develop an awareness of boundaries (the edge of the paper).

Research from these early investigators has provided both health and mental health professionals with an abundant and varied understanding of the developmental and the psychological aspects of

Figure 1-7

children's drawings. It is especially important for the clinician using drawings as therapeutic tools for interpretation and diagnosis to recognize that for specific age groups, what appears to be

abnormal features drawn may be quite the norm. It has been these descriptive studies of children's drawings that have provided a framework for detailing artistic development and have laid the foundation for using drawings in current ways to assess intelligence and personality.

DRAWINGS IN THE ASSESSMENT PROCESS

In the past decade or more, there has been a renewed interest regarding drawings and drawing directives used as adjuncts in the assessment process (Hammer, 1997; McNeilly & Gilroy, 2000; Safran, 2002; Silver, 1996). Within the psychological battery, drawings serve a special function by offering a minimally threatening, yet maximally absorbing introduction. Drawings serve as an easy bridge between the examiner and client and provide an added degree of communication — a nonverbal connection. These products are seen as a language in themselves and can be analyzed, like language, in terms of structure, quality, and content (Koppitz, 1968).

In everyday practice, psychological examiners and therapists need a thorough understanding of the subtle, yet complex problems that they confront with their clients (Gabel, Oster, & Butnik, 1986; Oster, Caro, Eagen, & Lillo, 1988). For example, drawing tasks permit uncomfortable or language-challenged examinees a way to feel more comfortable with the perceived pressures of the examiner. Likewise, clients with emotional difficulties can be led from drawing to verbal expression in an easier manner. Drawings can serve as a modality to make it easier to articulate emotional and interpersonal problems and needs.

Clients can then begin to use this graphic representation to express their inner feelings toward their families, a particular parent, or persons with whom they may have conflicts. Clinicians who can effectively use drawings to generate diagnostic impressions and therapeutic direction are at a stronger advantage in having an extra window that has been opened into their client's unique, inner world. Understanding how to use drawings within the context of

diagnostic evaluations offers numerous opportunities for clinicians to address problem areas that may not otherwise be discussed during routine verbal examination and can be invaluable for future treatment planning.

The study of drawings and their clinical use in assessing cognitive development, personality, and emotional characteristics have been substantially documented over the past century (Hammer, 1967, 1997; Harris, 1963; Klepsch & Logie, 1982; Leibowitz, 1999). Drawings can be a primary source for measuring current level of functioning and for expressing present problems, concerns, and conflicts during an evaluation. Hammer (1967) stated that drawings serve as an "illustrative glimpse" of a patient's inner world that constitutes traits, attitudes, behavioral characteristics, and personality strengths and weaknesses, including the ability to mobilize one's inner resources to cope with interpersonal and intrapsychic conflict.

Important concepts, such as intellectual status, can be estimated by counting the number of details in a drawing, and emotionality can be observed through the expansiveness, constriction, or shading of a drawn figure (Koppitz, 1984). For example, Barbara was a 14-year-old female who was in the initial stages of her treatment for alleged sexual abuse by her adopted father. She had a history of severe neglect, abuse, and multiple placements prior to her adoption. She drew this picture (Figure 1-8) to express that she was sad. The way in which she drew her figure was developmentally inappropriate and indicative of a much younger child, alerted the therapist to the possibility of some problems with her intellectual functioning. More history was obtained and revealed she had fallen out of a two-story window when in the care of her parents when she was 2. A referral was made to a neurologist and for a psychological assessment, which revealed she was functioning at a borderline intellectual level. Also, her drawing seemed empty and the line quality anxious and impulsive, indicating a higher level of depression and lower level of coping skills than originally thought.

Additionally, one can observe highly defended individuals manifest their lack of spontaneity in drawings by creating monotonous

Figure 1-8

reproductions or by wanting to trace rather than draw a requested figure (Gumaer, 1984). Characteristics of depressive symptoms in drawings might include lessened color, greater constrictiveness, incompleteness, and execution with minimal effort (Oster & Gould, 1987). Drawings by schizophrenics are noteworthy for themes with religious content, and experiences of paranoia are often portrayed by inclusion of eyes, windows, and televisions (Wadeson, 1980). When drawings are interpreted in this manner, they are seen as capable of tapping early, unconscious layers of personality. Clients who use drawings have the opportunity to express many aspects of their personality through their graphic expressions, so that many and varied clues of their intellectual status and personal perceptions of the world can be seen.

For example, John was a 17-year-old male being treated for ADHD (attention deficit/hyperactivity disorder). John drew Figure 1-9 when directed to do a free drawing. His portrayal of a blood-shot eye incorporating the entire page caused the therapist to consider the possibility of the beginnings of paranoid traits or problems with substance abuse. These initial hypotheses were later clarified in subsequent evaluations and therapy sessions.

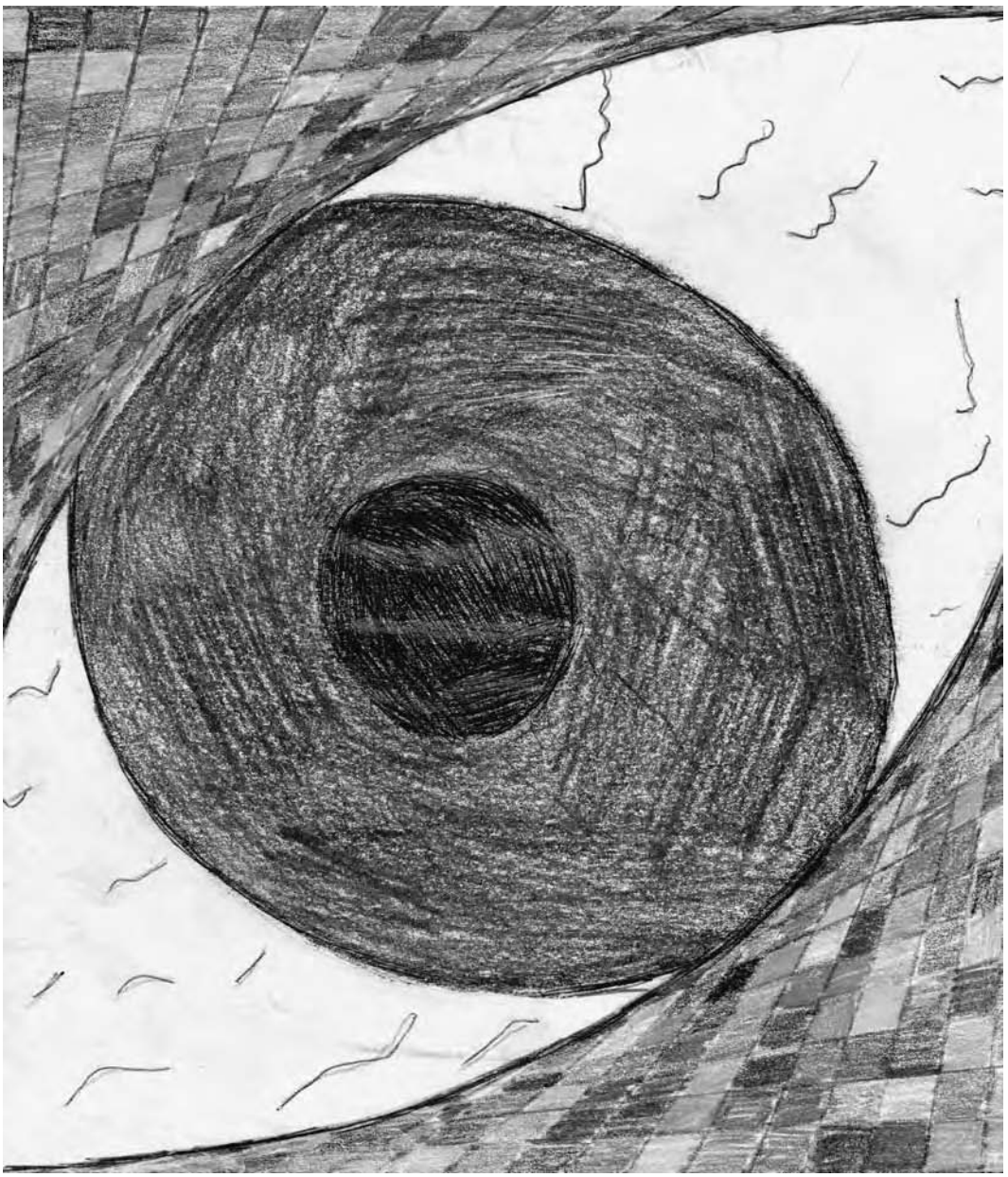

Figure 1-9

SYMBOLS OF PERSONAL MEANING IN ASSESSMENT

It is important that the clinical techniques chosen for assessment and therapy support interpersonal sharing and elicit expression of personal symbolic meaning for the client. This selection process is crucial because not all clinical tools can maintain or increase rapport with individuals in distress, especially those who have been confronted by trauma. There is growing literature documenting an unconscious need to reenact the experienced trauma (Terr, 1981, 1990), and the expression of these traumatic scenes through drawing allows for healthy and positive experiences. With the introduction of drawings into the diagnostic or therapeutic situation, clinicians can feel assured that most people will respond positively to the opportunity to express their emotional pain in this less threatening and novel method.

It is also vital when using drawings to inquire about the clients' own interpretation of their drawings instead of imposing the views of the clinician. Avoiding interpretation is especially important because most clinicians are not trained in the intricacies of art therapy. Even those who are trained art therapists often prefer to not overinterpret the drawings or attempt to provide unique, theoretical-based meanings to the images before them (Naumburg, 1987). In most everyday practice, it seems best to allow people in treatment the freedom to confirm or disconfirm the symbolism in their own drawings and to speak of their own personal meanings contained in their pictures.

There may be times, however, when comments from the examiner or therapist are needed to encourage client-centered interpretations. Questions and comments about feelings associated with the work may induce considerable feedback and provide important information that was, heretofore, unknown to the client or therapist. For example, when 8-year-old Michael was asked to draw his worst memory on paper it was not the recent abuse that he pictured, but a car accident several years prior that was still troubling him. With this picture, the therapist was able to delve into

those troubling memories and feelings and help Michael to resolve them and use this newly freed energy to attack other conflicts surrounding the more recent abuse. When clients are able to create their own images on paper and recognize their own personal meanings, an increased awareness occurs, allowing once hidden emotional conflicts to be discussed openly.

The main purpose in providing drawing experiences as an adjunct to diagnosis and treatment is not to teach art, but to encourage the release of suppressed or repressed conflicts through a different medium of expression. This emphasizes the supportive value of adding drawings to diagnostic batteries or to treatment. But one needs to remember that a picture or series of drawings is never isolated from the dynamics of the total therapeutic process. The entire view that drawings provide from initial intake sessions to leaving therapy is an enriching experience that carries many secrets of the client's path toward growth.

PSYCHOTHERAPEUTIC ADVANTAGES OF DRAWING

The process of psychotherapy varies tremendously due to different presenting problems and personality styles of both clinician and client. There are general features in practice, however, that are consistent. One of the essential goals of the psychotherapeutic process is to expand the clients' abilities to express themselves more effectively and to relate more comfortably on an interpersonal level. This kind of maturational growth permits individuals in therapy to overcome destructive and maladaptive habits or behaviors that are creating personal discord and potential conflict with others. When direct verbal dialogue is constricted and insight into problems and their causes is limited, clinicians need alternative therapeutic techniques that will enhance their understanding of the client's underlying dynamics.

A single approach used to help clients overcome problem areas is ineffective due to the complex nature of the human condition. Various therapeutic approaches and theoretical systems of treatment have ultimately been created due to this problem and have

allowed clients (and clinicians) to discover various workable niches. These therapeutic strategies (e.g., storytelling, play, psychodrama, movement, and dance) have all been attempted within the structure of individual, group, and family therapeutic sessions within distinct approaches (e.g., analytical, gestalt, cognitive-behavioral, family systems) (Chodorow, 1991; Edwards, 2002; Gil, 1994). Of all the techniques used in hastening the goals of psychotherapy, drawings and their numerous uses appear to accomplish the objectives of developing individual expression and enhancing interpersonal skills in the easiest and most profound manner (Oster & Gould, 1987; Oster & Montgomery, 1996).

For most individuals in therapy, drawings are a less common approach for expression than the spoken word. Varying aspects of the drawing are less likely to be consciously controlled, allowing for additional pre- and unconscious material to be revealed. Because drawings provide a concrete method for individuals to expand their emotional expression, unexpected discoveries often result, providing a springboard for further discussion and interpretation.

Drawings also offer an added path for obtaining insight into underlying conflicts, ego strength, and character traits. This extra dimension allows clients to understand themselves at a different and possibly deeper level and enhances their appreciation of themselves as unique individuals, as subsets of their family, and in job or school settings. Drawings allow clients to externalize their feelings by creating a concrete object (i.e., the drawings). This objectification (symbolic representation) of distressing and frightening feelings can, over time, be used as symbols for self-expression (Wadeson, 1980).

The drawing products also become a permanent record for reviewing the therapeutic process. These concrete markers are especially important in deciding what goals have been met and when to begin an appropriate termination (Cangelosi, 1997). Drawings should be kept in separate folders and dated so that they can be reviewed as continuous unfolding symbolic representations of the therapeutic experience. This brief summary of events during

therapy is particularly important when repeated themes within the drawings are noticed. This concrete record of progress and identified areas of concern can be used for research purposes and can be shared with other professional team members for treatment purposes or teaching if permission is granted.

CRISIS-ORIENTED INTERVENTIONS

Therapists who focus on brief psychotherapy and crisis intervention also need alternative clinical techniques to address critical situations (Malchiodi, 1990, 1997; Oster & Gould, 1987). They need a variety of tools to rapidly obtain relevant information that is both sensitive and revealing, surrounding the precipitating events that led to the presenting problems. Issues such as suicide attempts, acute drug reactions, unexpected medical illness, personal and familial stress surrounding loss of income or job, broken relationships, disclosures of abuse, or death of a significant other are all possible crisis events that may be confronted by therapists in their offices. These situations will likely be exacerbated if the traumatized individual cannot access support from family, friends, or trained professionals.

By introducing drawings into crisis-oriented sessions and short-term treatment, a different language is used to identify the clients' problems and increase the likelihood that they can be addressed and resolved. Clinical tools, such as drawings, assist therapists in understanding how realistically their clients are confronting their problems and whether or not they are able to organize their thoughts to discover ways to overcome stuck points. Drawings also become excellent marking points to assess whether longer-term treatment is indicated. Landgarten (1981) explained that "art tasks serve as a simple means to assist individuals in ventilating stressful affects of anger, guilt, and loss."

During crisis intervention and brief therapy, treatment goals can be graphically portrayed through drawings, as realistic and concrete or as symbolic metaphors that are representational. In starting this process with people in distress, it is oftentimes helpful to request

drawings of past, present, and future events. This simple direction of a drawing task gives clients the opportunity to visually demonstrate their feelings and the events that they have been through, as well as provide a platform for developing possible solutions in the near future.

The idea of future drawings is especially important when working with suicidal individuals who have otherwise lost all hope to continue. These drawings enhance awareness of personal responsibility and empower individuals within their particular situation to creatively seek problem solutions. Additionally, the act of drawing itself enables clients to feel less helpless. The before and present drawings tend to make clear the recent distress and provide a concrete outline for discussing the events leading to the present situation. This once-removed step of drawing the problems and events makes it easier to talk about emotionally laden issues.

Tracey

Tracey presented as a tall, well-nourished youngster with visible cuts on her arms. She acknowledged being depressed for the past two years and admitted to much animosity toward her stepfather. She perceived him as controlling, verbally abusive, and critical of her. She also acknowledged much inner pain and emotional distress. She felt weighed down by depressive and suicidal thoughts and appeared very angry and frustrated.

In a series of drawings, Tracey attempted to portray her current distress. First, when asked to draw a picture of her feelings she poignantly portrayed her anguish by sketching her arm after cutting it, stating "cutting myself relieves my anger" (Figure 1-10). Next, when asked to construct a picture of her world, she portrayed her surroundings as being "sliced apart and spinning out of control" (Figure 1-11). She also depicted her thoughts before her admission as "like a cloud, hanging over me and weighing me down."

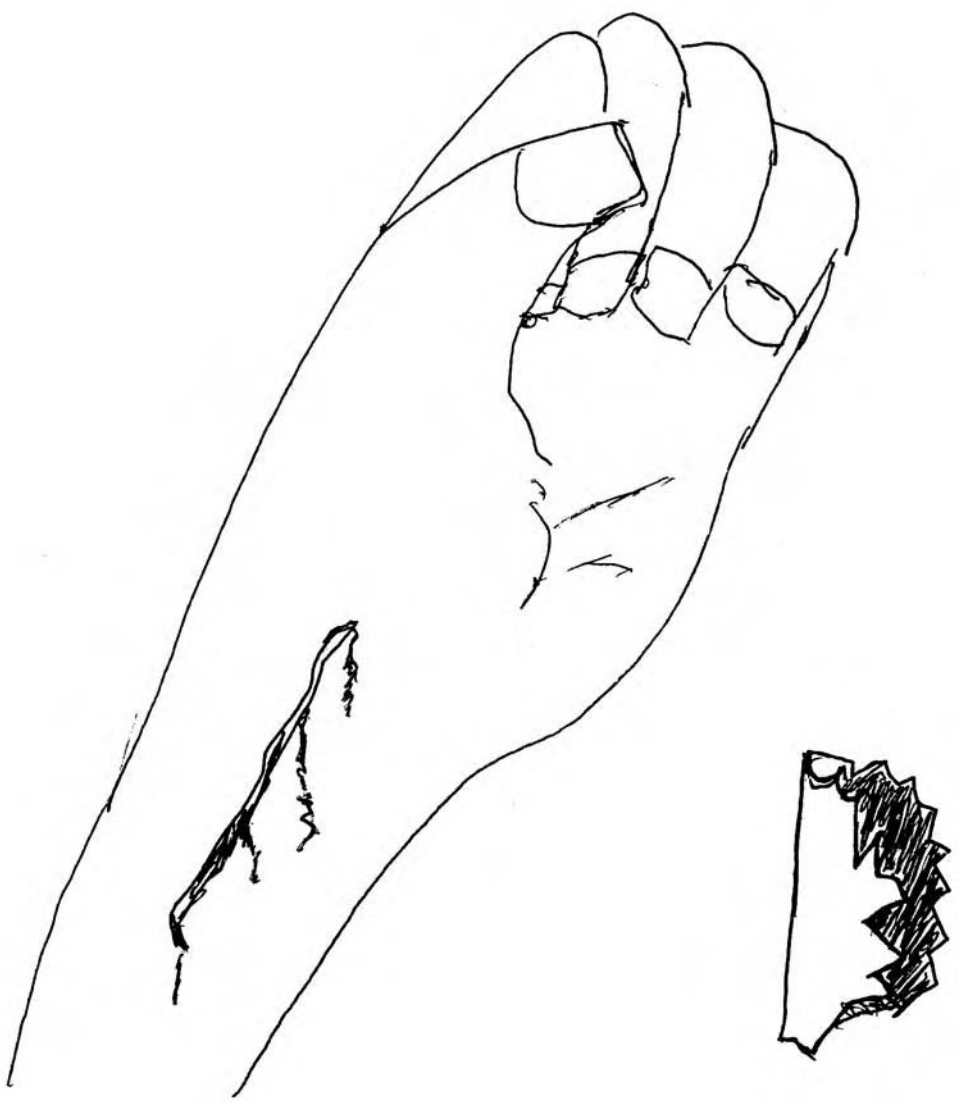

Figure 1-10

Other portions of a psychological evaluation underscored her intrapsychic distress and added consistency to what she revealed through her drawings. Her scores on a depression scale and suicidal ideation index were well above the cutoffs for clinical concern. She acknowledged that most of the time she

felt sad, lonely, and uncared for. She often viewed life as unfair and had frequent feelings of wanting to either run away or hurt herself. During the month prior to admission, she experienced thoughts of wanting to kill herself nearly every day. She also thought that others would be better off if she were dead and thought about what to write in a suicide note. She no longer

Figure 1-11

viewed life as worthwhile and thought her life was too rotten to continue.

Projective data from test sources like the Rorschach Inkblots and Thematic Apperception Test (TAT) also expressed much emotional turmoil within her life. She expressed many self-doubts and disclosed much personal rage. Her responses indicated much disappointment in life and feelings of inferiority. The information also suggested that she had a difficult time disengaging herself from affectively-laden environments and would find it difficult to back away from conflict. With her emotional resources being easily compromised, feelings of helplessness and hopelessness interfered significantly with her effective growth and development and created constant turmoil in her life.

Based on the results of her evaluation, Tracey seemed highly vulnerable to further self-harm. She appeared desperate to share her distress, both verbally and nonverbally, in the hope that others would listen. She was found to need much therapeutic feedback from various sources that would provide her with accurate information and enhance her problem-solving skills. Individual and expressive group therapies, especially art therapy, were recommended.

Drawings Increase Clarification and Coping Skills

In general, when drawings are used within a crisis intervention framework or in brief psychotherapy, they become most helpful when providing clarification and assisting with developing increased coping skills rather than attempting to explore deeper issues. As Malchiodi (1990, 1997) mentions in her best-selling *Breaking the Silence: Art Therapy with Children from Violent Homes*, all drawing directives should be used with caution and for certain populations the goals may differ. Although interpretation may benefit mature individuals seeking greater self-understanding, drawing directives used with children exposed to trauma should be

focused more on supporting coping skills, stabilizing the child, and understanding the child's self-concept and experience. The resolution of trauma, especially for the abused child who has been reported to protective service agencies, passes through many stages of crisis. These steps may include initial disclosure, being interviewed and physically examined, as well as possible court proceedings and testimony.

In her original book and revised book editions, Malchiodi (1990, 1997) also explores how drawings are particularly useful in settings that help overcome domestic violence. These oftentime intense and particularly stressful situations may cause direct questioning to be unproductive and frustrating to both client and clinician. The use of drawings in these instances provides tools and establishes a connection for building rapport. The drawings make it easier to break the ice, which then allows the client to feel safe enough to reveal important feelings that would otherwise not have been spoken.

Drawings Can Portray Past Events

Other uses of drawing directives during short-term therapy are to identify past problems, memories, or anniversary dates that may coincide with recent events. A request to draw a past problem that is similar to the present one may underscore the current crisis and become useful in conceptualizing the presenting symptoms for treatment. Another angle in introducing drawing directives is to focus on the client's available resources. Asking clients to draw their personal strengths, social supports, and current and past style of successfully coping with stress can be quite productive when examining short-term strategies for relief.

These drawing directives follow a crisis information model that has actually been in existence for many years (Caplan, 1964; Lindemann, 1944). The focus on these sessions is also directed toward problem solving, rather than curing emotional disturbance. These drawing exercises enhance the crisis session by offering the

client a "psychologically prophylactic" experience (Malchiodi, 1990, 1997). Drawing directives offer clients explorative visual modalities that bring their own images of resourcefulness into working consciousness and give them concrete visual evidence that allow them to control at least some of their experiences.

To summarize, because crisis intervention is usually time-limited and focused on specific issues, it is most helpful when the drawing directives simply assist clients to identify and clarify the problem areas or crises that led them into treatment. This diagnostic information is crucial for clients needing swift intervention and for intake personnel and examiners who need clarification of the extent of the problems and the clients' ability to deal effectively and realistically with their problems. Visual signs that alert the examiner or therapist to the existence of emotional upheaval assist in providing active feedback to prevent further trauma and help cope with current crises, as well as developing future goals.

THE IMPORTANCE OF OTHER ART MEDIA

This book primarily considers the value that drawings and drawing directives can have on the diagnostic and therapeutic process. Drawings offer easy implementation and a structured approach to the assessment and therapeutic encounter. They also decrease the possibility of regression for the patient or client that other art materials may produce. Additionally, more research and clinical theory have been demonstrated in support of using drawings for diagnosis and therapy than for any of the other methods that are usually used by creative specialists. Although there are added benefits to using other art supplies, more training and experience are required before introducing these materials into the treatment session. Clinicians who are trained specifically in art therapy have had extensive instruction in using a wide variety of media to create art products and use them as symbolic language to achieve multiple therapeutic goals (Edwards, 2002; Hogan, 2000; Waller & Gilroy, 1992).

For health and mental health professionals not formally trained in the uses of creative media, drawings (mainly pencil or markers and paper) are generally a safer form of expression. For example, finger painting is sometimes too stimulating and because it is a less sophisticated form of expression, may lead to unwanted regressive behaviors by the client. These actions could possibly complicate the diagnostic or therapeutic process in a way that may overwhelm the untrained clinician. Similarly, the use of clay can often lead to regressed and often angry expressions (e.g., beating and pounding), which may appear purposeless to the untrained observer or may in fact be without any meaning other than a lack of control (Betensky, 1973). Thus, its use may be largely ineffective within sessions.

The materials required for drawings as suggested in this book include pencils, markers, and crayons. These instruments usually lend themselves to tighter control of impulses, whereas other material such as pastels and chalk offer less mastery due to their tendency to smear (Oster & Gould, 1987). The various clinical populations with whom clinicians are working also dictate the choice of media used. For instance, very young or handicapped individuals may need material that is easier to manipulate (Wadeson, 1980). In that case, the clinician would more likely choose media such as colored markers, which move across the paper easily and do not smear. Older individuals, by contrast, would find the offering of crayons an infantile gesture and would prefer media associated with more mature levels of functioning.

IMPLICATIONS OF COLOR

The implications of color in drawings is beyond the scope of this book. Its use, however, is periodically mentioned in several of the case examples and illustrations. Rorschach, in 1942, was one of the first clinicians to emphasize the relationship between color and emotion. Through the responses to his inkblots, he hypothesized how one's attention to color was central to one's emotional life. For instance, he demonstrated how an absence of color in respond-

ing to the inkblots was associated with emotional constriction, whereas many perceptions based on color implied a person who tended to be emotionally volatile.

Qualitative interpretations of the color used in drawings have also been made by several investigators, such as Furth (1988) and Luscher (1969). Although these researchers did not always agree on the interpretation of specific colors, they suggested that color did symbolize certain meanings: the feeling, mood, and tone of a particular picture. Furth produced data reflecting qualitative meanings for color interpretation. He suggested that the choice of red may represent surging emotions or danger, blue is representative of energy, and white is indicative of repressed feelings.

Other works on the use of color in drawings were completed by the developers and early users of the House-Tree-Person (H-T-P) (Buck, 1948; Hammer, 1969). Their initial findings suggested that (a) red was many times associated with anger, (b) yellow was seen as being related to dependency and infantile behaviors, (c) brown and black when seen together indicated anxiety and depression, and (d) blue and green often were viewed as controlled behavior and self-restraint. Additionally, clients who repeatedly used light, barely visible colors, were actually attempting to shield their true experiences. These interpretations were mainly viewed as only educated hypotheses gained through limited research and clinical experience. Therefore, no definitive conclusions should be made that particular colors in a drawing provide the basis for a clear-cut understanding of any client.

Furthermore, an individual's "color experience" remains circumstantial (Betensky, 1973). Color is highly subjective in its meaning. An example is when a child chooses a certain color, like black, because it is the only color available or because it portrays a particular condition, such as nighttime (instead of choosing it because of being depressed). Color also has various meanings in different cultures. Thus, cultural backgrounds in relationships to use of color should be noted by therapists as well. It becomes incumbent on clinicians to pay close attention to their clients'

specific reasons for choosing a particular color and to discuss these issues.

CONCLUDING IMAGES

Effective treatment occurs when examiners and therapists begin to understand the inner world of their clients. For this to happen, a shared language must be created through verbal and nonverbal means to promote movement and growth (Linesch, 1988). Drawings can help in this challenge of uncovering joint meanings of intrapsychic conflicts and of their resolution. Through drawings, clinicians can gain glimpses of their clients' struggles, as well as estimate their cognitive and emotional resources. The act of drawing and the drawings themselves offer a powerful nonverbal method of relating information that can be explored during the further phases of assessment and treatment. These completed art products offer a visual communication with richness, uniqueness, complexity, and spontaneity that is not usually available through talk therapy alone.

Expressions through pictures are more symbolic and less specific than words. These metaphors of inner distress can elicit memories and fantasies that are beyond ordinary awareness. Individuals engaged in the drawing process can then communicate in this symbolic language without having to acknowledge that their drawings are part of their real self. This protection from emotionally laden material makes the relating of these thoughts and feelings less anxiety provoking and less likely to produce defensive posturing.

Most examiners and therapists will likely use drawings in addition to other materials, including behavioral observations, feedback from outside referrals, and self-reports. The use of drawings provides important supplemental hypotheses that may readily support this information. Drawings also provide an alternative way for the client to participate in the therapeutic process through creative and growth-oriented tasks.

Throughout this book, visual means of expressing affect and psychological discomfort are shared through case illustrations to clearly document the value of using drawings within the diagnostic and therapeutic format. The creations that are produced and the interpretations and discussions surrounding them provide enormously rich potential for discovery and psychological growth. The reader will discover that the clinical uses of drawings can enhance the evaluation process, as well as add greatly to subsequent therapy sessions while providing additional meaning to termination. The settings and the structure may vary, but pictures are truly worth a thousand words. When images are combined with words, the best of both worlds are brought together and problems can be effectively solved.

2

Beginning Assessment and Treatment

RESPONDING TO REFERRAL QUESTIONS

Carni

Carni, a 9 1/2-year-old girl, was referred by a community mental health center where she had been seen for therapy and provided with medications (an antidepressant and a mood stabilizer). Presenting symptoms included lability of moodiness and overly demanding behaviors, as well as intense sibling rivalry characterized by physical fights. Her parents were divorced and both later remarried. During these transitions, Carni had remained confused over parental loyalties. This uncertainty created much turmoil within her reconstituted families.

After relocating to yet another locale with her mother, Carni continued to experience adjustment problems and was brought for additional treatment at a new clinic. At that point, she was

no longer taking medication and the child psychiatrist at the new clinic requested current information before renewing her prescription. An updated psychological evaluation was ordered to glean her current stressors and symptoms, to assess her cognitive and emotional strengths and weaknesses, and to develop therapeutic goals and recommendations.

Identifying Presenting Problems

To establish effective treatment, a client's presenting problems must be clearly identified and interventions delineated that offer deeper understanding and practical solutions. For example, it becomes imperative for clinicians to plainly state the reasons why someone in emotional turmoil may require emergency services or hospitalization, or why a physician or another mental health professional may be referring a patient to an outpatient clinic or a private practitioner for further evaluation. Without a comprehensive assessment of the contributing past history and a clear view of the presenting problem areas, any path toward treatment recommendations or alternative living situations would undoubtedly be misdirected.

Even within a managed care environment, it is imperative to take a sufficient amount of time for an accurate and thorough evaluation. Referring clinicians need relevant client portraits that can be succinctly communicated to all clinicians who are involved in case management or treatment. To access this knowledge and document it accordingly, information needs to be gathered by (a) clarifying questions from the referral source, (b) conducting mental status evaluations, (c) providing self-report questionnaires, and (d) determining intellectual capabilities and personality traits by administering objective and projective tests.

As part of any rigorous assessment, psychological testing plays a crucial role in generating hypotheses and establishing a baseline of cognitive and emotional strengths and weaknesses for treatment direction. This assessment must be more inclusive than merely providing IQ testing and clinicians use other tools such as drawings

to obtain relevant data. This process includes gaining access to background history (including developmental, medical, and school information) and recording careful observations during interviews, in addition to administering the various tests, questionnaires, and experiential directives.

The final objective in this comprehensive evaluation consists of integrating all responses into an organized and clearly written report. This document profiles the client's strengths and weaknesses, indicates how these characteristics interact in everyday functioning, and culminates with short- and long-term goals and objectives. With this working knowledge, direction for gathering accurate diagnosis and treatment planning can then be communicated to all treating professionals. The resulting written portrait of the patient allows the primary therapist or referral source to pinpoint the problems, explain the findings, and target specific symptoms for intervention relief.

Main Referral Sources

In everyday practice, referral sources may have many unanswered questions about the behavior of their troubled clients. Generally, they must seek additional information from those mental health professionals who are in positions of providing standardized evaluations (Gabel et al., 1986; Oster et al., 1988). These health and mental health clinicians who initiate referrals, whether they be pediatricians, primary care physicians, social service workers, school counselors, or other health and mental health personnel, have specific concerns that necessitate further inquiry. At the point of referral, they need to determine whether additional, often costly, interventions are necessary and viable.

This judgment in determining whether additional testing is required is most salient within a managed care environment that oftentimes limits the number of tests or days in treatment. This process of decision making relies on many considerations and sources, but mainly on clinicians who routinely conduct intake interviews (e.g., social workers) and initial diagnostic evaluations (e.g., psychiatrists

and psychologists). Other clinicians, such as art therapists and substance abuse counselors, are often included in this process when they are part of a multidiscipline team to add their perspectives to this information-gathering phase of diagnostic clarification.

These mental health professionals bring their unique expertise into this decision-making process after attempts have been made to determine an individual's degree of intrapsychic distress, but remaining questions persist and more certainty is needed for diagnostic clarity or treatment direction. Upon accumulation of this added documentation from the testing process, the referral source can then make informed recommendations toward treatment options. Through this comprehensive evaluative process, effective treatment planning evolves into suitable action, whether through medication or therapeutic interventions. The methods and procedures chosen during this process become more important than mere diagnostic tools — they guide practitioners and their clients on a path toward healthy problem solutions.

The following cases provide clarity to this process and illustrate how referrals can be initiated and shaped into testable questions.

Carl

Carl was a 43-year-old cemetery groundskeeper admitted to an inpatient unit due to possible psychosis, paranoid and delusional thinking, and unpredictable behaviors. Initial diagnoses by a psychiatrist ruled out bipolar and psychotic disorders. Carl's presenting problems included him thinking that Secret Service agents were watching his movements, because an important person was buried at the cemetery where he worked. He also expressed chronic fixation that he was going to have contact with then First Lady, Hillary Clinton. Behavioral symptoms included decreased appetite, poor sleeping habits over a several month period, excitability, and pressured speech. Carl had never been hospitalized previously for his emotional difficulties and there was no known history of prior treatment and

no evidence of substance abuse. Extensive testing was requested to document relevant information to his cognitive and emotional functioning to assist in accurate diagnoses and treatment planning.

Janelle

Janelle was a 6-year-old referred for evaluation after exhibiting sexually explicit behavior in school and being out of her parents' control. She had not disclosed or identified an alleged perpetrator, but it was thought she may have been abused. The school counselor made a referral to child protective services who in turn referred Janelle for a thorough assessment to identify indicators of possible sexual abuse or signs of emotional difficulty.

Marty

Marty, aged 17, was referred for psychological testing by a director of an after-school program for adolescents following increased delinquent behaviors, including extensive drug and alcohol usage, several episodes of running away from home, and disrupting his school. Marty had previously spent time in a detention center program due to criminal charges, but no thorough assessment of his problems had ever been conducted. Although already being treated with antidepressant medication and involved in group therapy, his psychiatrist ordered additional testing to fully determine Marty's intellectual and interpersonal capacities and to provide additional treatment direction as residential treatment was being considered.

ANSWERING REFERRAL QUESTIONS

Puzzles that Need Solutions

In the above examples, the primary referral sources (that is, a staff psychiatrist and an after-school program director) had questions regarding diagnostic indicators and alternative directions for treatment. To accurately gauge the degree of disturbance, additional information was needed to help the examiner determine the extent of the presenting problems. The need for a multiple-measures approach to this assessment became necessary to explore the various diagnostic criteria.

The answers to referral questions lie within an elaborate puzzle, and numerous bits of data are collected to clarify an overall picture or portrait. A carefully designed evaluation provides the framework for the pieces to fit. The process of testing, including multiple cognitive and behavioral avenues of assessment, establishes a broad baseline of information that allows direction for desired changes.

The gathering and documentation of observations and test results also supplies the referral source with an active treatment plan where change can be effectively seen and measured. These assessment sessions with the client are themselves a form of therapeutic intervention, and the decision to interview or administer a particular test must consider the possible influence it will have on the client. The beginning interviews and initial tests that are used have the potential to initiate an individual's self-examination and self-reflection, producing alternative views of his or her life and possible resolutions of problems.

Multiple-Measures Approaches to Assessment

The psychiatrist, psychologist, and other mental health professionals who perform diagnostic evaluations and psychological testing attempt to explain the patient's range of presenting problems, then combine this deeper understanding into applicable conclusions.

Once the referral questions have been clarified, procedures and materials are selected that produce a broad sampling of the client's intellectual and emotional resources. Through structured interviewing, self-report questionnaires, and the administration of various psychological and neuropsychological tests, working hypotheses are created from client responses that directly relate to the original questions of referral.

To adequately assess an individual's symptoms, personality style, intelligence, and perceptions of his or her world, a multiple-measures approach must be implored (Anastasi & Urbina, 1996; Klepsch & Logie, 1982). A referral question should never be answered by simply introducing and interpreting one technique without considering other relevant details. Only through a consensus-building perspective of varied information and test results can the examiner be sure of his or her impression.

To assist in the process, extensive techniques have been created to (a) measure intelligence (e.g., the Wechsler Intelligence Scale for Children (4th version) [Wechsler, 2003]; Kaufman Adolescent and Adult Intelligence Test [Kaufman & Kaufman, 1993]; (b) screen for brain impairment (e.g., the Bender Visual–Motor Gestalt Test [Bender, 1938]); (c) gauge educational attainment (e.g., the Wide Range Achievement Test (3rd edition) [Jastak & Jastak, 1993]); (d) evaluate severe emotional disturbance (e.g., the Rorschach Test [Rorschach, 1942]); and (e) address descriptions of personality (e.g., the revised Minnesota Multiphasic Personality Inventory {MMP-2} [Butcher, Dahlstrom, & Graham et al., 1989] and the Personality Assessment Inventory {PAI} [Morey, 1991]).

With the abundance of information derived from these tests, a more complete portrait of the person's intrapsychic and interpersonal dynamics that have contributed to his or her distress and the issues leading to the original referral questions can be identified and provided. Also, as the field of art therapy matured, many art therapists began serious scientific research to establish different forms of art therapy assessments (Feder & Feder, 1998). As a historical reference, the following clinicians were considered pioneers in developing different types of art therapy approaches (Feder & Feder, 1998):

1. Elinor Ulman and Gladys Agell, "Ulman Personality Assessment" (series of four drawings) modified by Agell. Studies detailed the diagnosis of emotionally disturbed populations with case study correlations.
2. Elinor Ulman and B. Levy's experiential approach judged psychopathology in drawings. Their work replicated Myra Levick and faculty research art therapy program at Hahneman Medical University's art therapy program.
3. Hanna Kwiatowska's "Family Therapy and Evaluation through Art," extended art therapy research into the field of family therapy.
4. Barry Cohen's "Diagnostic Drawing Series" was one of the best system's to demonstrate solid research reliability in the diagnosis of psychosis.
5. Linda Gantt and Carmello Tabone's "Draw a Person Picking an Apple From a Tree" based on the "Formal Elements of Art Therapy Scale" measured specific global variables considered to be the graphic equivalents of psychiatric symptoms.
6. Rawley Silver's "Drawing Series" was first used for assessing cognitive strengths with deaf populations and then examined depression in adolescents.
7. Myra Levick et al., "The Levick Emotional and Cognitive Art Therapy Assessment" (LECATA) field testing and standardization started in April 1999. This has been an integral part of evaluation for high risk children in the Miami-Dade County School system in Florida. A series of five drawing tasks are scored according to specific concrete criteria for intellectual (Paiget) and developmental defense mechanisms (Freud). It is based of Levick's text *They Could Not Talk and So They Drew* (1982). Seminars are offered by The South Florida Art Psychotherapy Institute.

DRAWINGS IN THE TEST BATTERY

As part of the diagnostic and treatment process, drawings have become key elements in generating working hypotheses concerning organic dysfunction, learning difficulties, and emotional distress (Oster & Gould, 1987; Oster & Montgomery, 1996). Observing drawings and the act of drawing provides the examiner with an abundant and rich source of data to gain added information about an individual's style of relating to the world. Drawings reveal a realm that is beyond most observations, objective measurements, or personality questionnaires: the dimension of fantasy and imagination (Klepsch & Logie, 1982).

These visual symbols also offer an entry point into the subjective world of clients that may differ appreciably from their verbal presentation (Leibowitz, 1999). And later, they can be used as retest measures to assess progress or deterioration. Their special value remains, though, as clinical tools and as adjunctive interviewing devices that stimulate therapeutic direction surrounding cognitive functioning and personality traits (Anastasi & Urbina, 1996). With the use of drawings providing this supplemental knowledge, examiners acquire greater insights into the conceptual and emotional responses that have been gathered through a regular test battery.

DRAWINGS AND COGNITIVE DEVELOPMENT

Human figure drawings have been considered the most clinically fascinating of all assessment techniques used with children and adults and have been used to estimate personality or intellectual functioning since the 1920s. With the rapid rise of intellectual testing during the early 20th century, drawings were soon discovered to be useful by-products of clinical assessment that uncovered developmental disorders and were often included in full assessment batteries. The scoring systems devised at that time through drawing directives were primarily based on the assumption that as children grew older, their drawings reflected accurate changes in their level of cognitive maturity (Klepsch & Logie, 1982). The following sections discuss the various uses of drawings within psychological test batteries.

Quick Estimates of Intelligence

Human figure drawings were initially used as rapid estimates of intellectual maturity in children (Goodenough, 1926). The drawing of a man was thought to be associated with key developmental milestones in the evolving child and was associated with an implicit rule system. For instance, 3-year-olds usually draw people with only a head with one-dimensional arms and legs; 4-year-old children typically make tadpole-like drawings, with appendages representing arms and legs attached to a circled head; and at 5 years of age, most children draw a head containing details of eyes, a nose, and a mouth and a body with arms and legs. With each passing year, fine motor coordination develops through better control over the media and more mature line quality as well as added details and complexity. The following drawings reflect this progression as the child ages (Figure 2-1, Figure 2-2, and Figure 2-3).

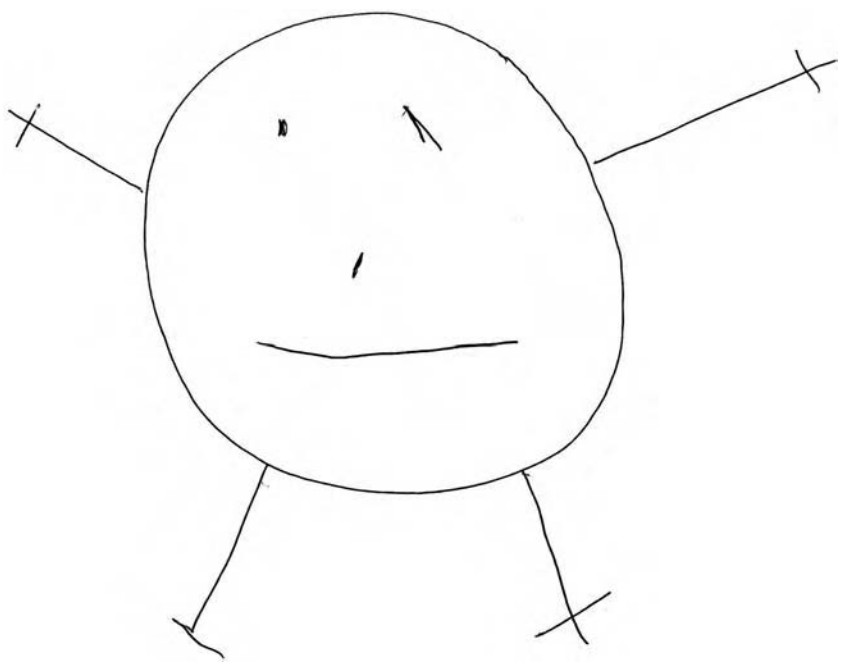

Figure 2-1

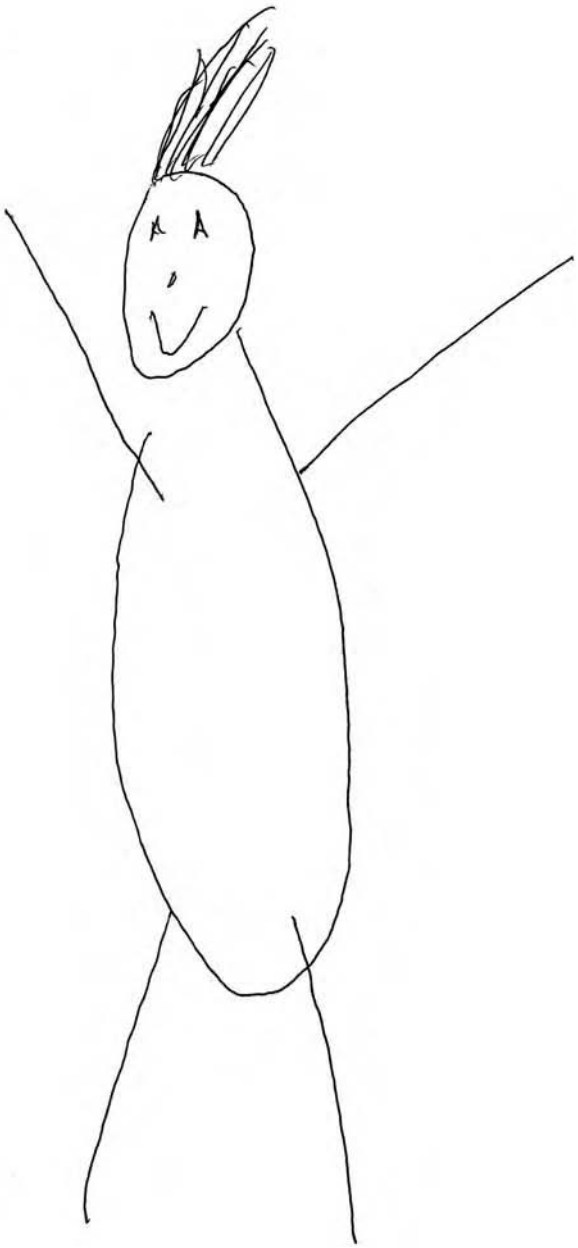

Figure 2-2

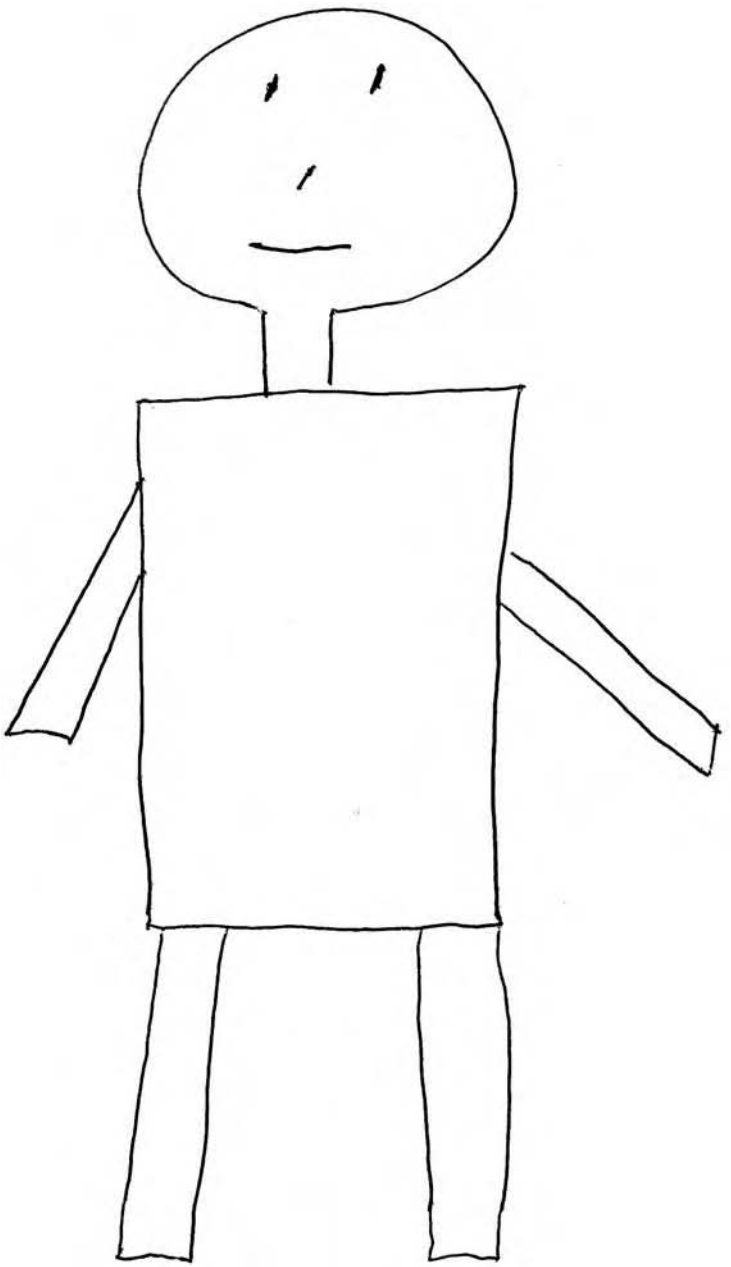

Figure 2-3

From Enjoyment to Structure

Dale Harris (1963) described age progression through children's drawings that included three general stages of development:

1. In the first stage, the child is basically focused upon the delight and enjoyment experienced merely in producing marks. Over time, these productions begin to form character and structure.
2. The next stage includes imitative drawings; during this phase, the child is able to increase differentiation and organization of detail within human figures.
3. The final stage is not merely a process of children's individual development, but is generally learned. For instance, they learn to use consistent rules of design and balance in their drawings. This last stage demonstrates aesthetically pleasing results to the child, in addition to communicating to others in an organized manner.

Observing how children normally express themselves at various stages through their drawings is key to understanding part of their basic development. All children seem to follow similar and progressive changes in their drawings, shifts that are usually characteristic of each age group. While researchers in the late 1800s and early 20th century described these early childhood stages by merely observing children's drawings over time, comprehensive studies by Lowenfeld (1947), Gardner (1980), and Golomb (1990) provided more thoroughly researched concepts for understanding children's drawings through various perspectives of developmental psychology, art, and anthropology (Malchiodi, 1998). These educators and researchers demonstrated that young children from cultures in various parts of the world go through similar stages of artistic expression that include scribbling, basic forms, human figures, schematic representations, realisms, preadolescent caricatures, and adolescent artistic abilities.

Developmental Progressions

Scribbles were viewed as children's initial attempts at expressing themselves in gesture. These squiggly marks depicted their awakenings to the concepts of lines and shapes on paper. The simple shapes and later more complex patterns were believed to be the foundations for later drawings and experimentations toward grapho-motor maturity. Later, at ages 3 to 4, basic forms seem to emerge during a time when children are eager to talk about their drawings, which often have little resemblance to what they are saying. It is at this stage that storytelling can be introduced in the therapeutic work with children (Gardner, 1980). In addition to these basic forms, more advanced designs emerge (such as triangles, circles, and squares), as well as a beginning focus on size and color (Kellogg, 1969).

During the 4- to 7-year-old sequence, a most important development is the emergence of primitive figures of the human body. These rudimentary figures, often called tadpoles because they resemble the initial stages of frog development (Lowenfeld & Brittain, 1982), often consist of an elongated head with basic facial features and two legs (often just two lines from the circle) and sometimes arms. Even though tadpole human figures are common in this stage, Golomb (1990) pointed out that children understand more than they actually include in these basic designs. She discovered that if young children were asked to name various body parts they would often mention them even if they were not in their drawings. If they were asked to draw a person doing an activity that required the inclusion of arms, like throwing a ball, they usually included them.

During the ages of 7 to 9, children rapidly progress in the complexity of what they can draw. They often experiment with visual symbols that not only represent human figures, but also create added details for animals, houses, trees, and other objects that they observe in their surroundings. Their refined depictions often include humans with heads and trunks and with additional detail (Figure 2-4 and Figure 2-5). There is also an increasing ability to create time sequences (such as someone hitting a ball or going on a journey) that suggest a series of events happening (Malchiodi, 1998).

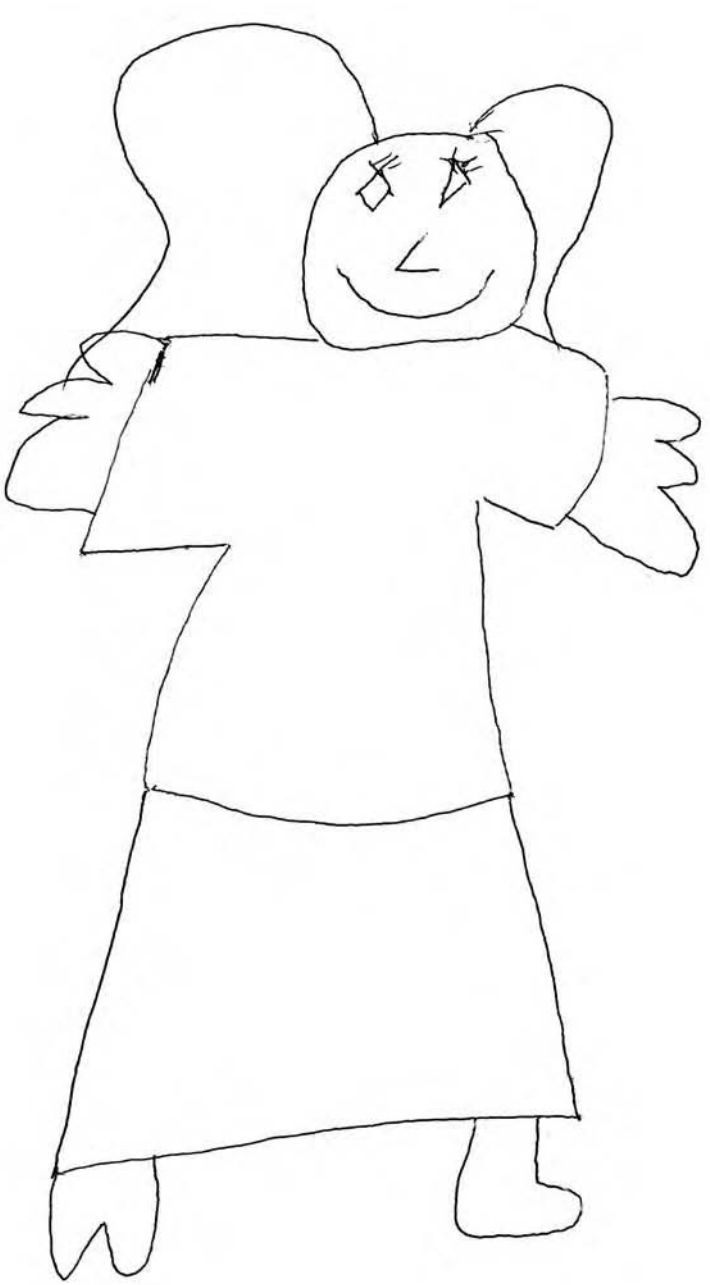

Figure 2-4

Figure 2-5

By age 10, children usually become quite interested in depicting realism. Their attempts move away from schematic representation toward detail and differentiation of what they see around them. They begin to add perspective, more color, and gender differences to their drawings. Children at this stage also focus on the thoughts, opinions, and feelings of others, and their understanding of cause and effect and interrelationships is beginning to develop.

With this ability to portray a more accurate depiction of their immediate environment, children ages 10 to 12 become more conventional and literal in their art expression. In this stage, children are more interested in how things look and may shy away from complex drawing activities, like hands, because they are too difficult to draw in a realistically satisfying way (Malchiodi, 1998). Also, some children may simply conclude that they can no longer capture their perceptions or feelings on paper because they cannot make it look real enough.

Gardner (1980) points out that during this time for preteen children there are alternative methods of communication, such as a greater sophistication of language skills, that are more encouraged in their environment. By age 13 and beyond, children who continue to use artistic expression have the capacity to produce drawings that are more accurate and generally more effective. They include greater detail, exhibit an increased critical perception of their surroundings, have an enhanced mastery of the materials, are more attentive to color and design, can create abstractions, and have the developmental ability to have insight (Figure 2-6).

Thus, knowing what is expected or normal in drawings at certain developmental ages becomes exceedingly crucial for examiners who are undertaking assessments of children. This fundamental knowledge of comparative normal growth provides important baseline information that is required when attempting to explain anomalies or abnormal perceptions or behavior. Further, understanding developmental differences provides a basis for establishing viable interventions. This is particularly meaningful when working with children who may have learning delays. For example, examiners who understand that 7- and 8-year-olds who remain engaged in

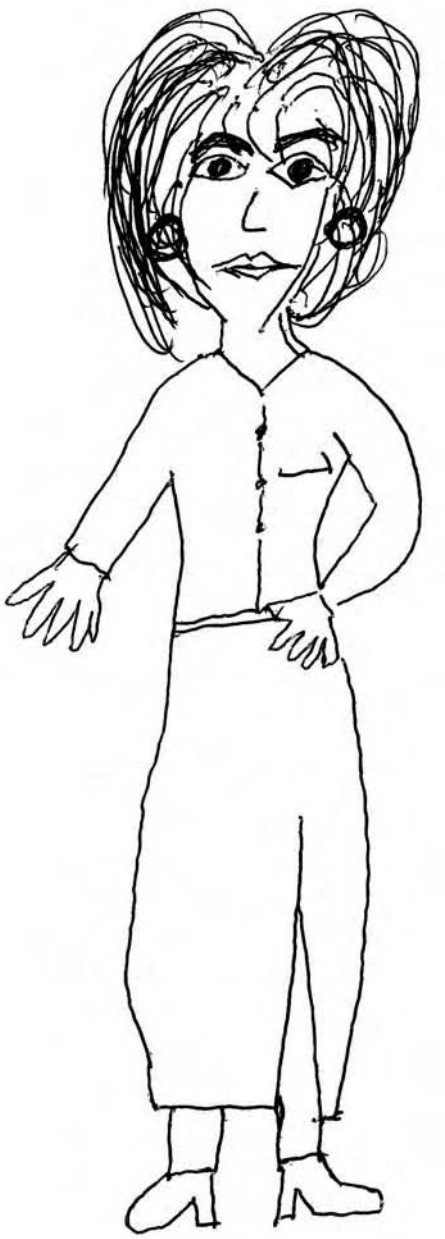

Figure 2-6

scribbling or making tadpole drawings are exhibiting delays in development. Their reported observations can substantiate the need of specialized educational interventions.

Developmental Scoring Systems

It was Elizabeth Koppitz (1968) who first constructed a comprehensive system of analyzing human figure drawings based on the statistical averages of their developmental appearance in the maturing child. She researched and displayed normative data tables of age sequences for both boys and girls from 5 to 10 years old. These tables described in detail the number of items expected, common, not unusual, or exceptional for children at these various age levels.

As demonstrated in these tables, the item frequency increased as the child got older. Once past a certain threshold, these items became a typical feature within the human figure drawing at a certain age. Koppitz's system was the first to provide clinicians the opportunity to assess whether a child's drawing had common features at certain ages. This age comparison became an important qualifier to screen for normal cognitive development and was used as a key determinant for educational decision making.

Years later, Koppitz (1984) was able expand her original research on the development of salient features in human figure drawings to incorporate middle school students, aged 11 to 14. One vital finding of her research on these older children showed that the natural act of drawing was no longer a favored pursuit of these early teenagers. Through her careful investigations, she verified how the details in human figure drawings did not increase systematically after age 11. This elaboration of her collected data once again emphasized the need for researchers to carefully differentiate their sample populations into age groupings when discussing any childhood phenomena.

In explaining her work, Koppitz (1984) described six steps to consider when interpreting completed drawings in children and young adolescents. These steps included (a) observing behavior and

attitudes during a drawing, (b) gaining a global impression of the drawings, (c) examining the drawings through a developmental perspective, (d) judging the quality of the drawing, (e) analyzing the content within the drawing, and (f) assessing signs of neurological impairment. Her use of this systematic approach suggested to psychological examiners that they could access considerable information from a child or teenager constructing drawings, as well as from the drawings themselves, regardless of the artistic level of skill. When this multiple-step approach was used, substantial data were yielded that assisted the examiner to gain an extensive picture of the student or client.

USING DRAWINGS AS PROJECTIVE DEVICES

Personality Dimensions of Human Figure Drawings (HFDs)

By changing the instructions to a drawing during evaluations, examiners can emphasize the potential for personality interpretation. Used in this manner, human figure drawings can be analyzed for the appearance of emotional indicators. Through observing key ingredients of a drawing, examiners gain reflections of emotional attitudes or possible conflicts, such as those surrounding issues of separation and individuation. When the drawing directions, or directives, are used in this fashion, examiners confront people with situations that are a bit more ambiguous and unstructured. The minimal direction that is provided allows individuals in assessment or treatment to construct their drawings in numerous variations as to size, placement, and other dimensions. Through these drawing instructions, individuals interject (or project) personal meanings onto the task based on their unique histories and perceptions of their world.

Three strong advocates of drawing interpretation — John Buck (1948), Emanuel Hammer (1967, 1997), and Karen Machover (1952) — have been considered the main proponents of using human figure drawings as projective tests. They each developed

interpretive systems that focused on the appearance of unusual characteristics in drawings or elements associated with indicators of emotional problems. Their methods, based on projective-analytic theory, assumed that deep and often unconscious feelings and motives could be accessed through careful examination of their clients' drawings.

The drawing page, in a sense, became a canvas upon which individuals could project glimpses of their inner world traits and attitudes, personality strengths, and weaknesses. In everyday practice, individuals who are being assessed sometimes find it easier to communicate through drawings rather than through verbal projective techniques. When used this way, the drawing task is one step removed from direct examination. Uncomfortable examinees are given the opportunity to project their inner concerns and conflicts on a sheet of paper, as opposed to verbally relating to the examiner. This opportunity of expressing through an "emotional palette" allows an alternative and sometimes safer avenue to express deeper feelings (Hammer, 1997).

Emotional Signs and Indicators

Through their personal experiences, clinical undertakings, and research, the proponents of projective drawing interpretation identified a series of indicators within drawings, relating them to specific personality traits and explaining the symbolic significance to emotional conflict. The signs reflected in their clients' drawings provided clues to underlying personality makeup and offered tendencies toward characterological interpersonal styles. The vital signs within the drawings also demonstrated possible problem areas that could be identified to resolve during future treatment sessions.

These characteristics within human figure drawings have been interpreted through focusing on size, placement on the page, aesthetic appearance, and gender issues, to name just a few of the components. Other indicators of emotional conflicts can be grouped into three interpretive categories:

1. First is the overall line quality of the human figure. This ingredient relates to whether (a) the lines are heavy, sketchy, or broken; (b) the proportions are accurate; and (c) there is proper integration of body parts. For example, heavy lines may elicit a sense of tension, while faint line evoke feelings of uncertainty (Leibowitz, 1999).
2. Shading of the figure is another aspect of the drawing considered by the examiner. An excessive amount of shading is often associated with a high degree of anxiety.
3. Another grouping of signs that can be examined within portraits are specific features that are not usually seen in human figure drawings. These uncommon indicators include such items as a large or small head, large teeth, clinging arms, crossed eyes, and cutoff hands or arms. When seen in drawings, certain hypotheses can be generated relating to personality characteristics. Conversely, features such as as eyes, nose, feet, and neck are always anticipated in drawings completed by latency age children and older. Omissions of these parts as details are generally considered important conflict areas in the final analysis of potential emotional problems.

Criticisms and Controversies

Like all projective clinical instruments used in the interpretation of personality traits, such as the Rorschach and TAT, using drawings to elicit conclusions about emotional conflicts has raised serious questions about their questionable reliability and validity (Neale & Rosal, 1993). This controversy has even led several investigators to promote a ban on using figure drawings as projective instruments. They view drawings purely as a technique to establish initial rapport and should only be used as part of the interviewing process (Gresham, 1993; Joiner & Schmidt, 1997).

Contrary to these findings, however, positive research discoveries do persist. For example, Riethmiller and Handler (1997) demonstrated the usefulness of projective drawings when

individual signs are not used out of context and artistic ability and amount of detail are controlled. They point to studies such as (a) by Kot, Handler, Toman, and Hilsenroth (1994) that showed drawings to differentiate among homeless men, hospitalized psychotic men, and normals; (b) the research of Marsh, Linber, and Smeltzer (1991) on drawings that distinguished adjudicated from nonadjudicated adolescents; and (c) the study by Waldman, Silber, Homstrom, and Karp (1994) that discriminated incest survivors from normals as proof of the usefulness of using specific clues in drawings as emotional indicators of distress.

Regardless of the criticisms and controversy, tremendous use has been made by clinicians who have been thoroughly trained to provide comprehensive interpretations of drawings, though mostly through anecdotal single case studies and their own clinical experience (Leibowitz, 1999). These astute insights to drawings have allowed practitioners over the years the opportunity to gain important information concerning their clients' conflicts, wish fulfillments, and fantasies that can later be discussed during treatment planning or therapy. For examiners, the use of figure drawings for rapport building and as transitional tasks between clinical interviews and test batteries can create a broad picture of an individual's strengths and weaknesses that can then be disseminated to the referral source. When linked with other interviews and assessment tools, drawings can reveal an individual's concerns in a truly unique way. They can also portray troubling demands of the person's environment that may be impinging on his or her everyday functioning and may be too difficult to discuss through mere words alone.

Variations in Drawing Directives

Because drawings have become such a popular tool among clinicians, numerous modifications to common drawing directives have been devised to reflect varying circumstances and settings. Alternatives to the human figure drawing technique include asking individuals being tested or in treatment to construct houses, trees,

families, a dream, or their world, to name a few of these adaptations. There is an assumption in these newer techniques that each directive taps a unique segment of personality makeup. For instance, when the directive is to draw a house, the examiner is attempting to stimulate internal connections related to the warmth or troubles within family life or emotional distance felt among family members. This addition of a drawing sequence to include a house becomes especially relevant for children when the emphasis of the referral and possible presenting problems is focused on their possible perceptions of the underlying tension within the household.

This emotional relevance also overlaps another alternative to human figure drawings, which is the family drawing. This directive is often used when attempting to understand an individual's perceived status within the family hierarchy. For example, individuals who view themselves with a greater degree of significance in the family, compared to siblings, will often place themselves in closer proximity to the parents. Conversely, family members who feel isolated from their siblings or parents generally draw themselves off to one side, which may be their way of reflecting a sense of estrangement. A child may also draw themselves closer to the parent who makes them feel safer and is better at meeting their needs. Also, a child may draw themselves further away from a possible abusive parent that is still in the home before any disclosure has been made by the child. Viewed from a different theoretical framework, such as an object relations perspective, individuals who draw themselves closely connected to a parent may be demonstrating a wish fulfillment of exiling a more favored sibling off to a side, when in reality this is not the case (Gillespie, 1994).

When another directive, such as a tree drawing, is requested, an assumption is made that the tree reflects deeper and more unconscious feelings about the self (Bolander, 1977). It seems easier for a client to ascribe less desirable personal traits to an inanimate object, such as a tree, because it is one step removed from self-description.

By contrast, the drawing of a person is certain to signify a more direct expression of real-life feelings, though the resulting product

may also contain considerable unconscious projections (Gillespie, 1994). In the final analysis, the majority of completed drawings express a combination of perceptions and projections, making it important to consider both views during interpretation. Through the opportunity provided by varying drawing directives, clients can either reflect their perceived world of social relationships, or portray unconscious intrapsychic feelings.

THE IMPORTANCE OF BEHAVIORAL OBSERVATIONS

Observations of behavior during intake interviews, diagnostic evaluations, or psychological testing provide another avenue for gaining salient clues in determining answers to emotional conflict. During clinical assessments, the knowledge gathered through these observations and the inferred characteristics derived from the observations are often as important as any obtained scores. The behaviors seen through careful surveillance are also equally valuable for making meaningful recommendations.

During the administration of an assessment battery that includes drawings, clinicians have the chance to scan a client's attention span, distractibility, frustration tolerance, anxiety level, motor coordination, problem-solving approach, ability to sustain effort, and reflectivity (Kaufman & Lichtenberger, 2001; Sattler, 1997, 2001). Through these careful behavioral observations, clinicians can then reach tentative conclusions about personal characteristics such as self-concept, work habits, or response to encouragement. For instance, the degree of effort exerted during a drawing task may reflect a general attitude toward new learning experiences: in this case, enjoyment or challenge versus uncertainty and anxiety.

Questions of impulsivity, perfectionism, or compulsive traits can also be ascertained through diligent viewing of a patient's approach to a drawing directive. Low frustration tolerance, for example, is hypothesized when an individual becomes easily annoyed over minor mistakes and begins to erase or scribble over the details. Certain portions of the person's emotional expression, such as an angry voice, a sad face, or a nervous hand tremor, can also be

regarded as possible indicators of acute inner turmoil or more permanent traits of personality.

A clinician's ability to make astute observations also enhances the value of the interactive process of assessment and treatment. Even the time spent establishing rapport with a client is a potential asset in the creation of working hypotheses that detail areas of concern. The clinician needs to be careful in attempting to make too many interpretations based on gesture or expression, as it is easy to hide one's feelings during an evaluation. Observations, just like any individual test, are solitary bits of information and need to be integrated with other data before an accurate assessment of the client can truly be documented.

Psychological testing itself is only a time-limited sampling of behavior. Other factors may intervene that obscure more accurate descriptions of performance on any one interview or test. Therefore, a priority arises to provide variety of more objective and subjective assessment procedures that will discern the complexities of personality into a holistic impression (Oster & Gould, 1987). The next chapter details the history of these techniques and introduces many directives and scoring systems, as well as examples that assist the clinician in making clearer diagnoses and treatment decisions.

SUMMARY

The assessment process is a critical segment of the overall treatment. Examiners are often asked many relevant questions to differentiate symptom patterns into workable diagnoses. These clinicians may also be needed to assist referral sources in taking immediate steps to help a person in crisis. The active use of drawings facilitates this process by providing a larger range of potential responses, both verbally and nonverbally. The varying drawings provided by examiners become a springboard for gaining additional insight into problem areas. They also supply a different method for expressing and reducing acutely intense feelings and

emotions that cannot otherwise be expressed through conventional interviews and testing.

Essential objectives during the initial intake or testing process are to provide timely and accurate diagnostic formulations and to pave the way for treatment interventions. The introduction of drawings into these sessions offers a unique experience that does not rely on words alone and allows the clinician an alternative technique that is time sensitive, easy to use, and actively engaging. As the next chapter will describe in fuller detail, visual symbols derived from drawings provide vital information that tap into underlying feelings and emotions that are beyond conscious awareness.

For guarded or withdrawn individuals who may be contemplating suicide and who are struggling for words to describe their personal feelings, the opportunity to portray their intense feelings through drawings may be easier and less threatening and offers a structured framework on which to focus. And for the person who is most comfortable with words, drawings allow an alternative and creative experience that breaks through usual defenses. Clinical techniques, such as drawings, contribute a great deal to the understanding of emotional conflicts and give clearer direction to treatment. In the following case study, the young woman approaching psychological testing was cooperative but sullen and did not indicate the seriousness of her thoughts and feelings until she was asked to construct a drawing.

Marcie

Marcie was a 14 year old when admitted into a psychiatric unit of a community hospital due to out of control behaviors. She had been running away from home (around six times over the previous month), refusing to attend school, and had become oppositional toward authority figures. Apparently, she and her mother had been involved in many arguments and confrontations and Marcie had been avoiding going home or attending school and stayed with friends. Although this was Marcie's first

hospitalization for her emotional and conduct problems, she had been in previous outpatient counseling and had also participated in an "Operation Runaway" program. However, both attempts at intervention were brief and uneventful.

Psychological testing was requested to assess Marcie's cognitive and emotional functioning to assist in diagnosis and treatment planning. She was also being interviewed for alternative educational placements and her appropriateness for this setting, as well as for accommodations that needed to be addressed.

Results from the evaluation showed Marcie to be of average intelligence with stronger areas in hands-on learning and weaker areas demonstrated by inconsistent attention and mental inflexibility. On self-report questionnaires, she denied acute distress and symptoms of more severe chronic problems, including suicide ideation. However, other emotional indices derived from the evaluation suggested signs of affective lability and possible problems in interpersonal boundaries. The testing data also suggested that she had a tendency toward oppositionality and negativity. She seemed to be harboring much anger that she appeared not able express in an effective and adaptive manner. There were also suggestions that she had suffered some damage to her self-esteem and felt helpless to overcome her problems without assistance from others. However, her defensiveness and avoidance of potentially growth-producing situations limited her chances of obtaining the help she apparently desired.

Since Marcie was guarded and unable to comfortably share her inner thoughts and feelings on standard measures, she was asked to draw her most pressing problems. Despite her previous denials of depression and suicide, she was much less hesitant to construct the following drawing indicating her underlying distress (Figure 2-7). With this added information, she was able to disclose her obvious pain and discuss more forthrightly what she would be willing to accept regarding intervention planning. It was deemed important that within Marcie's future individual

and group therapies that expressive therapies that focused on action, such as art, would be most helpful in her pursuit toward self-understanding, as well as increasing her problem-solving skills.

Figure 2-7

3

Drawings in the Diagnostic Process

DIAGNOSTIC INDICATORS

Clinicians continually need to search for diagnostic procedures that effectively assess the developmental, cognitive, and emotional status of their clients. While many instruments depend heavily on expressed verbal responses, many clients in distress may not be sophisticated enough, alert enough, or oriented enough to communicate their inner experiences. When confronted with these issues of emotional trauma or cognitive impairment, alternative methods must be used to encourage accurate disclosures. Since mental turmoil is not easy to always express, many avenues are needed to portray the experiences of everyday problems (Malchiodi, 2002; Peterson & Hardin, 1997).

The value of drawings to help understand what is happening to clients presenting in crisis derives from their clinical richness and numerous interpretive scoring systems that have been developed over the last 70 years (Cohen, 1990; Hammer, 1997; Leibowitz,

1999). Methods that use drawing techniques to produce spontaneous imagery of inner tension and life transitions are more likely to gain unconscious material that elicits hidden signals of cognitive and emotional distortion or limitations (Hanes, 1997). Despite some criticism of their use, art expression has been valued as an important source of information about personality and emotions.

By understanding the process and the underlying dynamics produced by graphic images, clinicians have the opportunity to witness emotions, events, and ideas that are not easily or accurately accessed through words alone. Since drawing interpretations consist of varied approaches that depend primarily on the knowledge and experience of the examiner, it becomes essential that clinicians gain substantial knowledge of the common drawing directives and scoring systems. This chapter emphasizes this need to gain a solid foothold in this process and reviews their contributions to the understanding of individual development and personality.

Art as Personal Expression

The creation of art products involves an expression of a person's style and approach toward everyday problem solving. To deny that clients do not represent parts of themselves through their drawings ignores significant aspects of their identity, self-perceptions, and views of their world. A variety of conflicts can be portrayed on paper in numerous ways based on the person's manner. For example, drawing with bold strokes versus using tiny, constricted figures can suggest an assertive or passive individual. Hammer (1958) proposed that children's drawings tap early, primitive layers of personality that were established before their intellectual control has taken over. In his original work, he states:

> The drawing page … serves as a canvas upon which the subject may sketch a glimpse of his inner world, his traits and attitudes, his behavioral characteristics, his personality strengths and weaknesses including the degree to which he can mobilize his inner resources to handle his psychodynamic conflicts, both interpersonal and intrapsychic (p. 6).

By using alternative, nonverbal techniques such as drawings, clinicians can assist traumatized clients to reveal their inner thoughts or secrets during evaluations that they would otherwise have difficulty revealing. These visual records become personal and unique statements that verbal descriptions could not otherwise identify. These creative expressions and unspoken images become a bridge from within to help close the gap between clients and the clinicians who are attempting to discover their clients' emotional and cognitive resources and vulnerabilities.

The following sections of this chapter discuss the main drawing directives typically used during intake interviews, as well as diagnostic and psychological evaluations of children, adolescents, and adults. These procedures provide clinicians with an entry point for exploring the subjective world of their clients that may not be as readily available through verbal presentations or standard techniques. Some of these procedures are explained with clinical case studies to guide the clinician through the overall landscape of potential assessment tools. Interpretative analyses are provided to expand the breadth of diagnostic hypotheses that drawing directives offer the assessment process. These clinical impressions offer assistance in understanding the complexity involved in comprehending a client's presenting symptoms and identified problem areas.

GOODENOUGH-HARRIS DRAWING PROCEDURE

The Goodenough-Harris Drawing Test (Harris, 1963) is primarily used as a screening device by health and mental health professionals to quickly assess and estimate the cognitive ability of a school-age child. Of all intellectual screening measures, it is probably the briefest and most convenient to use. Scoring systems were based on developmental and intellectual abilities exhibited in large samples of children's drawings. Besides its general use in estimating intelligence, this drawing test was extended to evaluate children with auditory handicaps, suspected neurological weaknesses, adjustment problems, and character defects.

This drawing technique was based on Florence Goodenough's original conjectures suggesting that fairly accurate judgments of intellectual development could be specified from observing a school-age child's attempts at drawing a man (Goodenough, 1926). Her scoring system became popular with child and school psychologists, as well as pediatricians and was used without modification from its original standardization until Dale Harris's revision in 1963. At that time, drawings of a woman and a self-portrait were added to the instructions.

Their research and scoring methods established a solid foundation for many of the subsequent procedures for drawing methodology and interpretation. Cognitive functioning, such as intellectual quotients (IQ scores), was determined by inclusion of such features on the human figure as individual body parts, clothing details, proportion, and perspective. The test manual included 73 scoreable items based on age differentiation, relation to total score on the test, and relation to group intelligence scores (Harris, 1963).

Once established, this scoring method corresponded relatively well with the original standardized tests of intelligence that were being created at that time, such as the Stanford-Binet Tests, and even more closely with the Wechsler Scales for children. However, over the years, research studies discovered that the estimated IQs derived from the drawings were generally lower than overall IQs from these more comprehensive batteries of intelligence (Palmer, 1983). Consequently, the Draw-A-Person (D-A-P) Test should never be used as a substitute for more complete scales of intelligence, neither should it be the sole basis for determining academic or social placement. Results of this screening measure should only be used to select those children who may need more comprehensive evaluations.

The directions for administering the D-A-P are relatively simple. In Harris's revision, the child is requested to construct three figures — a man, a woman, and a self-portrait. For each drawing, the individual is instructed to construct each human figure in complete form; that is, not as a stick figure and more than just the head and shoulders. Unlike other directions concerned with determining

personality aspects of the drawing, the Goodenough-Harris scoring system strives for determining cognitive awareness and perceptual-motor maturation. Time constraints are unnecessary, because the examiner is evaluating the client's total perception concerning human body parts.

Drawings completed by younger children are usually very basic, consisting of a head with few facial characteristics with arms and legs protruding from the head. Often, the young child constructs the head and body together as one circular shape. If a child's figure is purposeless or seems like uncontrolled scribbles, the resulting score is given a zero credit, which is equivalent to 3 years, 0 months in this scoring system. Any drawing that appears to have direction is scored as one credit and is equivalent to 3 years, 3 months. Each subsequent credit adds a 3-month interval. With ongoing development, the normal child produces drawings that are increasingly heterogeneous and more accurate.

The overall picture of this scoring method gives credits regarding whether (a) such body segments as the head, trunk, arms, and legs are included; (b) the arms and legs are attached properly; (c) there are eyes, a nose, a mouth, and hair; (d) there are details of fingers; and (e) proportions of the features are accurate. Tables are provided in the test manual that convert raw scores to standard scores (IQ equivalents) and percentile ranks (Harris, 1963).

MACHOVER'S DRAW-A-PERSON TEST

Goodenough, along with other clinicians, realized that the Draw-A-Man test also provided possible indicators of personality dynamics, in addition to intellectual aptitude. With this in mind, the D-A-P Test was adapted for personality description and interpretation by Karen Machover (1952). She hypothesized that certain graphic expressions within the drawings reflected specific personality characteristics. These traits derived from a D-A-P were believed to reflect the person's self-concept, portraying unconscious projections of conflicts and concerns. For example, she viewed the construction of body parts (such as the head) as

containing suggestions of social balance and control of bodily impulses, while the arms and legs were perceived as symbols of social adaptation.

Future research of the human figure asserted that intense emotions (e.g., hostility) appeared to be commonly projected onto drawings through the creation of glaring eyes, bared teeth, sneering lips, or even placing weapons in the hand of the human figure (Hammer, 1967, 1997). Poor reality testing could also be assessed in drawings by (a) manifestations of bizarre facial features (for instance, animal faces on human figures); (b) nonhuman, robot-like characters; (c) religious or mysterious symbols on the drawings; or (d) depersonalized, empty facial expressions. Other personality aspects commonly seen in human figure drawings included (a) aggressiveness, as seen in the use of claw-like hands; (b) concerns regarding sexual identification; (c) portrayals of dominant and inferior persons; and (d) impulses toward rebelliousness and seductiveness.

Instructions

The D-A-P technique, when used for personality interpretation, is introduced to examinees by providing paper and pencil and instructing them to just "Draw a person." This brief direction is sometimes met with quizzical looks and questions such as, "Do I make a stick figure or a whole person or what kind of person?" (Koppitz, 1968). These inquiries are best answered with general terms (e.g., "Make the drawing in any way that you would like"). If people feel insecure about their artistic ability, a reassuring statement such as, "Just do your best," or "I am not interested in how well you draw, rather I am just interested in you drawing a person," or "Whatever you do is all right" is usually sufficient to encourage their effort.

After the initial drawing, the examinee is asked to construct a person of the opposite gender. This directive is salient to delineate sexual identification. According to Machover (1952), the overwhelming majority of individuals first draw a person of the same

sex. During the drawings, clinicians should observe the sequence in which different body parts are drawn, and other important procedural details, in order to start generating clinical hypotheses about the examinee's personality dimensions. At times, it is helpful for the clinician to instruct the client to make up a story about each drawn figure to elicit specific characteristics, such as age or personal feelings.

Interpretations and Cautions

Proponents of the human figure drawing test mostly agree that there is no one-to-one relationship between a specific sign or emotional indicator and a definite personality or trait (Hammer, 1967, 1997; Koppitz, 1968; Machover, 1952). Research studies of these variables have shown that anxieties, conflicts, or attitudes are often communicated in the drawings by unique signs and symbols and vary according to client and time frame. At best, there may be several characteristics that consistently indicate emotional problems (Malchiodi, 1998). Therefore, meaningful diagnoses cannot and should not be made from a single sign; rather, the total drawing, as well as combinations of indicators, must always be included when analyzing the drawing.

Additionally, drawings must be interpreted on the basis of chronological age, developmental maturation, emotional status, social and cultural background, and other relevant history of the individual. For instance, sketchiness in the line quality has heretofore been viewed as an emotional indicator of anxiety. Yet, this sketchiness appears to increase with age and is normal for most adolescents, who tend to demonstrate some degree of anxiety when producing artwork (Koppitz, 1968).

However, there has been renewed exploration of using drawings for diagnostic value and numerous studies of the D-A-P Test have indicated clinically rich and informative signs within the drawn human figure that consistently differentiate populations (Leibowitz, 1999). The following list of these emotional indicators offers a guideline for observing specific indicators within the graphic image.

Mainly, theorists and researchers in the field of drawing analysis have concurred on the interpretation for each particular sign (adapted from Jolles, 1971; Mitchell, Trent, & McArthur, 1994).

1. Poor integration of body parts — impulsivity/low frustration tolerance
2. Shading — anxiety (more shading, greater the degree of anxiety)
   a. Shaded face — seriously disturbed, damaged self-concept
   b. Shaded arms — aggressive impulses
3. Line quality
   a. Sketched — insecure, uncertainty
   b. Light — low self-esteem
   c. Reinforced — anger, vulnerable emotional defenses
4. Figure slanting more than 15 degrees — instability, mental imbalance
5. Small size — insecure, withdrawn, depressed, feelings of inadequacy
6. Large size — expansiveness, positive mood
7. Transparencies (seeing through the clothing) — immaturity
8. Exaggerated teeth — orally aggressive, sarcastic
9. Short arms — tendency toward withdrawal, turning inward, inhibiting impulses
10. Long arms — ambitious; reaching out toward others
11. Large hands — indicator of acting out behaviors
12. Hand cut off — troubled, feelings of inadequacy
13. Profile of person — evasive, possibly paranoid, excessively withdrawn
14. Disheveled hair — possible sexual concerns, underlying confusion
15. Opposite sex drawn first — sexual identity confusion, strong emotional attachment to opposite sex
16. Elaborate belt, emphasis around waist area — sexual conflicts, covert tension

Brenda

Brenda was 14 years of age when admitted onto an inpatient unit after superficially cutting both of her wrists. She reportedly wanted to show her family how much she was hurting inside, but did not want to really kill herself. Hospitalized previously due to emotional conflicts and similar suicidal gestures, Brenda felt helpless and avoided many social and educational experiences. She mainly perceived the world around her as unkind and overly demanding. Additionally, her limited stress tolerance caused her behavior to be erratic and unpredictable, motivating others to view her as extremely fragile.

During the initial portions of a diagnostic evaluation, Brenda was instructed to D-A-P. Although at first she was opposed to revealing much of herself, she became at least grudgingly more cooperative to this request. And as a result, her illustration (Figure 3-1) was quite revealing. In the drawing, her helplessness and despair seemed quite visible and apparent. Her cut-off hands seemed to indicate her feelings of inadequacy. Also, her facial features tended to suggest a sense of frustration and failure. The rigidness of the figure was also consistent with her other test data that portrayed her as constricted in her perceptions and easily overwhelmed by emotion in her immediate environment. Using this picture and other drawings as a visible record, Brenda became much more willing to express a side of herself that she had not shared with others in her past.

Lester

Lester was a 12-year-old boy who was referred for therapy for having behavior problems at school that he seemed unable to correct with the usual prescribed consequences. He had been stealing, talking back to his teachers, and disrupting class. This D-A-P drawing was done during one of his initial sessions for evaluation purposes (Figure 3-2). In the drawing we see a

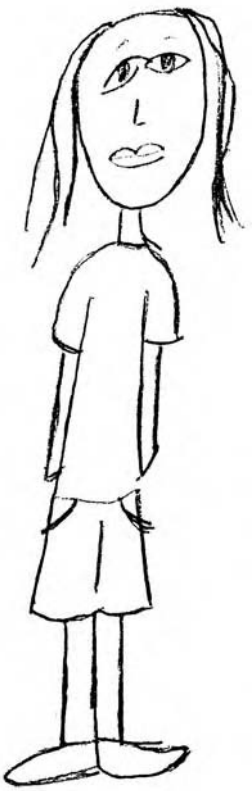

Figure 3-1

somewhat sketchy, small figure in the upper left-hand corner of the page. The figure has large hands and he has graphically emphasized the belt area on the person. The above characteristics of Lester's drawing made the therapist aware that Lester could possibly have feelings of insecurity, some depression, as well as sexual conflicts and tension; all of which he could be acting out through his behaviors. This drawing helped the therapist to see that the above issues might be areas to explore in his therapy.

Figure 3-2

Carolyn

Carolyn, a 13-year-old female, was referred by her school and social services after a teacher caught her in the bathroom masturbating. She had also been having some problems with leaving school without permission. Her mother had recently started seeing a new boyfriend who was considerably younger with a history of substance abuse problems. Carolyn's own father was mostly absent from her life. She had no siblings and not many friends. Carolyn did this drawing of a person (Figure 3-3) during the initial evaluation sessions. Here we see a large figure that appears younger than her age without any noticeable gender identification.This drawing also has emphasis placed on the belt and the line quality is bold. Carolyn is experiencing stress in her life with adjusting to her mother having a new boyfriend. The large figure indicates an expansive mood and the emphasis of the belt indicates some sexual conflicts and tension, as well as possible conflicts regarding her sexual identity. Due to the expansive, bold quality of the drawing and her recent erratic

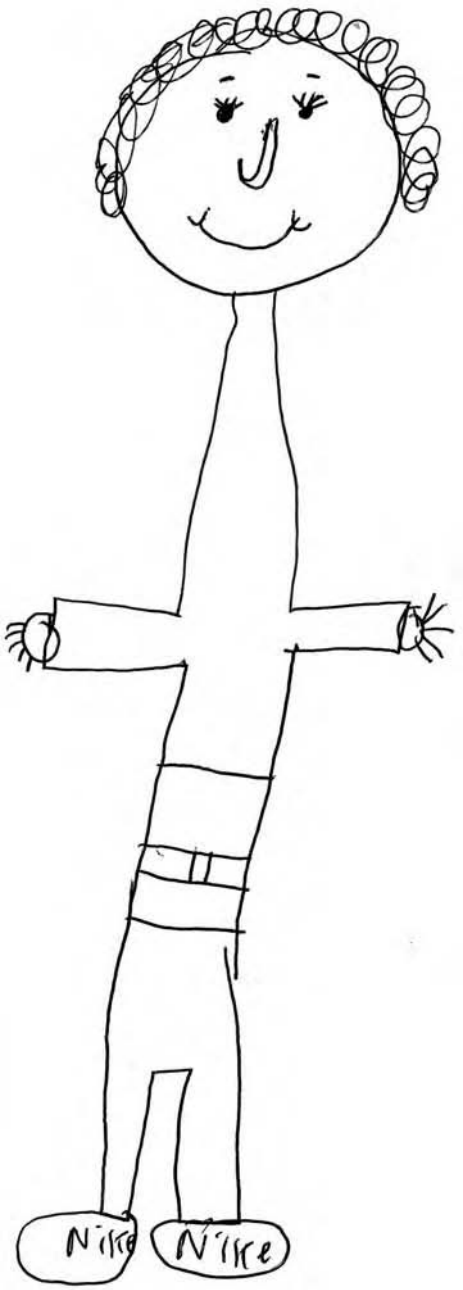

Figure 3-3

behaviors, the therapist might consider the possibility of a developing bipolar disorder.

DRAW-A-PERSON-IN-THE-RAIN TECHNIQUE

Through the years, other clinicians and researchers have developed numerous other directives to detect emotional traits. One particularly intriguing modification of D-A-P is the Draw-A-Person-In-The-Rain (D-A-P-R). The creators of this variation (Verinis, Lichtenberg, & Henrich, 1974) designed a procedure that supposedly elicited an impression of emotional vulnerability from clients when placed within a symbol of an environmental stressor (e.g., rain). Additionally, the amount and intensity of rain in the drawing seemed to represent the perceived external stress being experienced by the individual. For example, a neurotic individual purportedly would construct a drawing with much rain, but still be wearing some type of outer protection. This novel directive has displayed extremely impressive results in our own practices over the years (Oster & Gould, 1987; Oster & Montgomery, 1996).

Clinicians would use this technique to assess the degree to which people are experiencing internal tension and how well their coping capacities are being sustained when added pressures are confronted. The individual's emotional defenses are symbolized by the drawn objects of protection against the rain (e.g., umbrella, coat, boots). Without displaying these outer garments in the drawings, clients appear to be suggesting their inability to manage even minor stress and their subsequent feelings of helplessness and inner regression. Thus, a psychotic individual would tend to construct a figure that seemed defenseless.

This drawing technique offers useful information to the diagnostician when the referral source has expressed concerns about the person's vulnerability to external pressure. Such referral questions as (a) How will this person respond to stressful circumstances? (b) What kind of personal resources does this individual possess to deal with anxiety-provoking environments? (c) Is this person able to plan effectively in situations that might be considered

anxiety-provoking? and (d) What kinds of defenses (e.g., denial, withdrawal) does this person employ when confronted with unpleasant situations? can all be answered when this procedure is used in conjunction with other available cognitive and personality test information measuring similar constructs.

Emotionally immature individuals given this directive during evaluations will often project their own perceived helplessness of being dumped upon in their drawing by illustrating a disheveled person without protective covering or holding a broken umbrella. These portrayals appear to represent low self-esteem, an inability to cope with daily stressors, and unresolved dependency issues. It has been shown that individuals who construct these types of drawings have neither the motivation to leave their undesirable circumstances, nor are they prepared to face the challenges of removing themselves from even minor stress when left to their own initiative.

Persons who are not easily overwhelmed when confronted with stress will generally add protective clothing or devices and have contented faces in their drawings. Others, such as character disordered individuals, for example, would also tend to portray themselves with little evidence of stress and wearing some kind of rain gear. These individuals are at least demonstrating that their basic defenses are intact, even if they use denial as their primary mechanism to avoid unpleasant thoughts and feelings. People who react unfavorably to the slightest degree of tension will likely picture themselves as panic-stricken without a means of escape.

It is best for the clinician to make comparisons between this isolated drawing directive and other human figure drawings completed during a comprehensive evaluation, as well as results from other assessment instruments within the test battery. For example, suggestions from a D-A-P-R drawing reflecting withdrawal tendencies may coincide with similar personality responses to the Rorschach or TAT and may further substantiate a passive style of interpersonal functioning. Additionally, other drawings in the D-A-P series may all seem fairly normal. Only when a novel introduction of a stressing symbol is required does a more accurate

drawing occur that is directly related to underlying conflicts. In this case, only when faced with potentially stressful external circumstances does the person's compensatory ability falter, revealing weak emotional resources and vulnerabilities.

By providing this variation of the D-A-P along with other drawing directives, clinicians obtain a glimpse of the examinee in both nonstressful and stressful conditions. Many times, a person's disposition toward abnormal reactions is not visible through standard drawing directions. Only when an unusual request is made during a series of drawings is the existence of pathological signs discovered, which is the key purpose for administering projective instruments.

Karl

Karl was seen for psychological testing due to declining grades and social withdrawal. A nice, but exceedingly shy 13-year-old youngster, Karl was quiet but seemed to be harboring much inner turmoil that he was unable to express. He had few friends and his interests were related to solitary activities, mostly computer-related games. Because of his lack of social skills, he also appeared very frustrated in his everyday dealings with his parents and usually found himself withdrawing to his room instead of creating conflict.

Karl was asked to construct a D-A-P-R after other test data indicated that he tended to be an avoidant personality. His responses to other questionnaires and projectives suggested a high degree of rigidity in problem solving and an inability to cope with even minor pressures. His picture seemed to mirror these other results (Figure 3-4). He not only added a raincoat for protection from the light rain, but hid under a shelter. His graphic portrayal was very unusual in signifying his need to hide from any perceived threat in his surroundings. Also, his lack of hands and cut-off feet appeared to reflect his helplessness. Through this picture, the examiner could really see how Karl viewed his world as threatening.

Figure 3-4

Evan

Evan was 17 years old when he was admitted to the hospital following a suicide attempt. He was initially brought to the emergency room by an ambulance presenting in a fetal position, trembling and tightly clutching a stuffed animal. Shortly into the ER evaluation, his affect reportedly changed dramatically, as he ceased shaking, relaxed, and easily spoke with the staff. During the examination, he displayed self-inflicted superficial wounds up and down his right leg and arm, and admitted to having attempted to overdose the previous night by taking aspirin and sleeping pills. He also had apparently expressed homicidal thoughts toward his father and stepmother, who lived out of town, who he accused of having physically and sexually abused him many years ago. Three weeks prior to his admission, in fact, he hit his head coming out of the shower and began experiencing memories of this abuse. He mentioned that he had been feeling scared, depressed, and confused since that time.

Test results found Evan to be functioning in the high average (110 to 119) range of intelligence, and alert and oriented during his early days on the hospital unit with no signs of hallucinations or delusions. On mood questionnaires, he denied chronic depressed symptoms, but during the past month had frequent thoughts about killing himself. Projective aspects of the testing did not provide evidence for a formal thought disorder; however he stated that during this time, all his feelings were mixed up and trying to come out all at once, leaving him feeling confused and overwhelmed.

As part of this evaluation, Evan was requested to complete a D-A-P-R. His drawing (Figure 3-5) was certainly a reflection of his apparent distress and inner bewilderment. He seemed helpless and perplexed without protection. His portrait illustrated that the slightest of stressors would break down his defenses. The position of his broken umbrella also appeared to allude to his sexual concerns and possible conflicts. Combined with other test information, it was determined that Evan's

Figure 3-5

emotional vulnerabilities and inability to cope with his recent stressors required a longer stay within a highly structured environment.

MOTHER-AND-CHILD DRAWINGS

Another variation to the basic D-A-P instruction is to construct a dyadic illustration of a mother and child. This drawing directive is based on Object Relations Theory and has the notion that mother-and-child drawings yield a special portrait of the interpersonal self, not revealed in static human drawing pictures. The drawing encourages clients to indicate how they perceive relationships, especially a primary one such as the one between mother and child. However, the developer, Jacqueline Gillespie (1994, 1997), perceived this adaptational drawing as more than just an indicator of the social self. She believed that the picture represented an inner emotional bond between a mother and child in the earliest days and months of their combined lives. Object Relations Theory defines these early interactions as the source of self-perceptions within interpersonal relations that become primary segments of the maturing and adult personality.

Gillespie (1994, 1997) suggested that drawings are completely individualized. Her impression is that each construction is similar to a unique fingerprint, as well as personal, much like a dream. To her, drawings like a mother and child portrait offer personifications of the self, carrying both conscious manifest content and other nonverbal images not immediately accessible to everyday understanding. Although this method does not produce reliable indicators of pathology, it does assist clinicians in gaining a greater awareness of how their clients relate to their parents or other primary caretakers (Malchiodi, 1998).

The direction to this drawing method is simply to "Draw a mother and child." Although the task does not specifically request that clients draw their own mother, it is usually implied in order to understand developmental issues, such as symbiosis, separation, and individuation. From this instruction, individuals can identify

with either the mother or child, since both figures may become the subject or object, depending on internal or external circumstances. This modification to D-A-P was designed to encourage projections of the inner life and to identify personality characteristics of the self that produce unusually strong components of unconscious perceptions and struggles.

Sherry

Sherry was 18 years, 8 months old when admitted into the hospital unit due to out of control behaviors within her home. She was involved in severe verbal and physical arguments with her older sister who had returned home from college. Upon admission, she was viewed as depressed and irritable with a sullen affect. This was not Sherry's first inpatient experience. She had been hospitalized several times for her emotional problems and had spent time in residential drug treatment programs. In the past, she had been diagnosed and treated for attention deficit disorder (ADD), oppositional defiant disorder, and panic disorder with various therapies and medications. Despite these efforts, she remained fragile and naive.

During her initial interviews and evaluations, Sherry spoke readily of her past drug usage. She acknowledged still using alcohol and marijuana on occasion, but stated that she had been clean of the heavier drugs that she had been using previously. She denied past or current suicidal thinking, but admitted to a past accidental overdose. She mentioned that her current predicament had more to do with her dislike of her older sister and her own need to be in control.

Results from the evaluation portrayed Sherry as guarded and defensive, reflecting a naivete to her problems. Projectives indicated that her emotional resources were rigid and that she could become easily overwhelmed when confronted with external tension, acting out her distress in an oppositional or aggressive manner. She perceived others as critical of her and often felt

left out and unimportant. Also, she appeared to view her world in idiosyncratic ways, which created misunderstandings and contributed significantly to her arguments and conflicts.

During the drawing phase of the evaluation, Sherry was asked to construct a mother-and-child drawing to reflect her need for security and her perceived ambivalence regarding issues of separation and individuation. From this request, Sherry composed the following illustration (Figure 3-6). In her creation,

Figure 3-6

she displayed the hand of an overbearing and dominant mother figure. The child figure appeared much smaller and somewhat inadequate. It also seemed to suggest that the comfort and safety she experienced in being protected was not going to last much longer. In discussing the drawing, Sherry alluded to her fragile self-esteem and the inner anxiety that she could not express effectively. It was determined that she was still in need of active intervention, but remained at high risk for continued struggles through her young adult years.

HOUSE-TREE-PERSON TECHNIQUE

The H-T-P drawing technique is usually seen as the standard in drawing directives during psychological testing and was originally developed as an ancillary to intelligence tests that were being constructed during the early 20th century (Buck, 1948). Today, the H-T-P is one of the most used methods to gather data regarding an individual's degree of personality integration, cognitive maturity, and interpersonal connectedness.

These three objects — a house, a tree, and a person — were chosen due to their common familiarity to very young children, their acceptance by people of all ages, and their ability to stimulate an enhanced fund of free associations. Besides their use in psychological assessment, drawings of these objects have been shown to be useful as (a) a screening device for detecting maladjustment, (b) an evaluative aid for children entering school, (c) an appraisal device in screening applicants for employment, and (d) a research instrument to locate common factors in an identified group of people (Oster & Gould, 1987; Oster & Montgomery, 1996).

Instructions for this drawing test specify that the examinee draw a house, a tree, and then a person on separate sheets of paper, without any additional comments as to type, size, or condition. Clients are expected to draw these three objects in any manner from among the many they have personally experienced. The ordering of asking to construct the H-T-P always remains the same. This sequence is viewed as gradually more psychologically difficult,

with the tree drawing and the human figure appearing the most likely to produce personal responses (Hammer, 1958, 1967).

House Drawings

The drawing of a house is thought to elicit connections regarding a person's home life and the interpersonal dynamics that are experienced within the family setting. The house, it has been theorized, symbolizes the main place wherein affection and security are sought. Drawings of a house seem to represent sources of nurturance and support. House drawings may also encompass significant figures associated with the home, most likely family members, in terms of their accessibility, approachability, and stability. They are also a type of environmental drawing, in that there is an opportunity to explore what is going on outside the house (Malchiodi, 1998). This view invites stories about the neighborhood and its location, in addition to friends who live nearby and other social support outside the family home.

According to DiLeo (1983), one emotional indicator that may appear in a house drawing is a chimney emitting a moderate degree of smoke, which is often associated with feelings of warmth and affection. Conversely, an emphasis on the smoke could allude to a greater degree of household tension. Most often, when a request is made to draw a house, observed results usually produce a house-like structure that illustrates only the exterior. Even with this type of drawing, much can be surmised concerning emotional accessibility, need for external structure, and personal defensiveness, to name only a few signs of personality makeup. To obtain a more complete drawing that encompasses the interior, a direct request from the examiner has to be made.

Developmental differences may also be expressed through house drawings. Although a child may display personal attitudes toward parents and siblings in the construction of the house, married adults tend to focus on the spousal relationship. Further, children under the age of 8 most often draw a chimney perpendicular to the slant of the roof, whereas an upright chimney

demonstrates that they have surmounted an important cognitive hurdle in their development (DiLeo, 1983). Some interpretations of house drawings have also implicated certain details as related to sexual conflicts. For instance, when the chimney is overemphasized, there may be conflicts surrounding phallic issues of power or dominance. Also, certain elaborations of the window fixtures suggest concerns with oral issues of dependence (Hammer, 1958, 1967, 1997).

The following emotional indicators or signs within house drawings provide a limited interpretive guideline for the numerous variations that may be observed from the request to draw a house (adapted from Burns, 1987; Jolles, 1971). Specific interpretations should only be offered in the context of all factors within the combined H-T-P, in addition to confirmation gained from the clinical history, presenting problems, and other assessment information.

1. Details
   a. Essential (usual drawing) — At least one door, one window, one wall, roof, chimney
   b. Irrelevant (e.g., shrubs, flowers, walkway) — Needing to structure environment more completely (associated with feelings of insecurity or needing to exercise control in interpersonal contact)
2. Chimney — symbol of warm, intimate relations, associated with phallic symbol of significance
   a. Absence of chimney — lacking psychological warmth, conflicts with significant male figures, passivity
   b. Overly large — overemphasis on sexual concerns, possible exhibitionistic tendencies
   c. Smoke in much profusion — inner tension, anger
3. Door
   a. Above baseline, without steps — interpersonal inaccessibility
   b. Absence of door — extreme difficulty in allowing accessibility to others

   c. Very small — shyness or reluctant accessibility
   d. Open — strong need to receive warmth from external world
   e. Very large — overly dependent on others
   f. With lock or hinges — defensiveness
4. Fence around house — need for emotional protection
5. Gutters — suspiciousness
6. Perspective
   a. From below — feelings of an unattainable desirable home life
   b. From above — Rejection of home situation, feelings of alienation
7. Roof
   a. Unidimensional (single line connecting two walls) — unimaginative or emotionally constricted
   b. Overly large — seeks satisfaction in fantasy
   c. Significant crosshatching — strong conscience and guilt feelings
8. Shutters
   a. Closed — extreme defensiveness and withdrawal
   b. Open — ability to make sensitive interpersonal adjustment
9. Walkway
   a. Very long — lessened accessibility
   b. Narrow at house, broad at end — superficially friendly
10. Wall (adequacy of) — directly associated to degree of ego strength
   a. Strong walls — sturdy self-concept
   b. Thin walls — weak or vulnerable sense of self
11. Window(s)
   a. Absence of window(s) — hostile or withdrawing
   b. Many — openness, desire for outside contact
   c. Present on ground, absent from upper story — gap between reality and fantasy

d. With curtains — reserved, controlled
e. Bare — behavior is mostly blunt and direct

Cecilia

Cecilia, who was 17 years old, had been depressed for several weeks following the disclosure to her family that she preferred a gay and lesbian lifestyle. Her family had reacted negatively to this news and sent her to a Christian counseling center. During her first session, Cecilia revealed the depths of her sadness and her plans for cutting her wrist. The counselor immediately requested the family to hospitalize her and they complied.

During her intake interview, Cecilia spoke of the tension of living with her mother and two sisters. Her father had left the family years ago and was remarried with two other children living in California. Although she was angry at her father for abandoning the family, she also felt jealous of his freedom.

Cecilia also discussed the precipitants of her conflicts. She recently had to transfer schools as a result of sexual advances she had made toward a female friend. This person apparently became extremely angered and threatened her. Apparently, her sexual behaviors and impulsivity had gotten her into much trouble at this particular school.

Her psychological profile during testing suggested that she was of average intelligence (90 to 109 IQ) with much inner turmoil that she could not express effectively. She felt lonely, uncared for, and hopeless that things would ever improve in her life. Her responses underscored her depth of depression and suicide ideation. Projective data revealed a low tolerance for stress.

As part of the evaluation, she was requested to construct a house drawing to reflect her perceptions of home life and environment. The largeness of the house seemed to express her tendency toward acting out (Figure 3-7). Also, the bare windows

and shutters around the door appeared to underscore her blunt and direct approach to her interpersonal problems. Finally, the emphasis on the chimney may have been associated with her conflicts over male figures (possibly her father) and her sexual concerns regarding dominance.

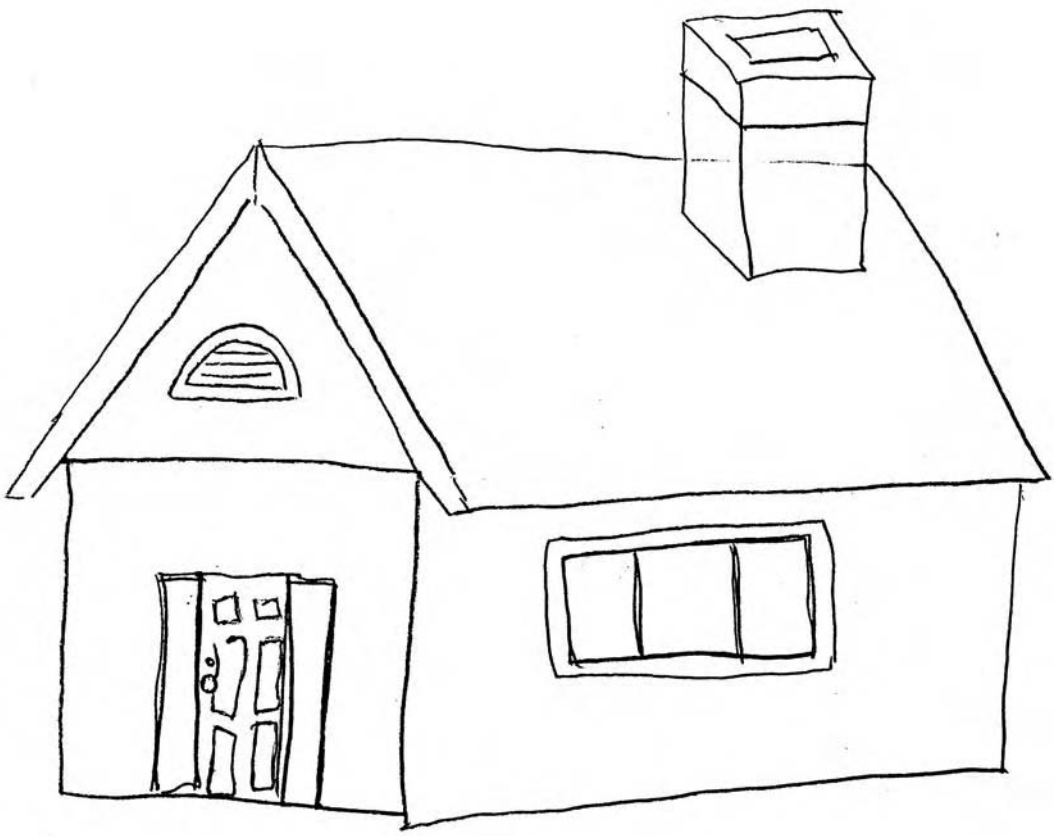

Figure 3-7

Taylor

Taylor was also 17 years old and in the hospital. However, his story was very different. He had consumed LSD on several consecutive days and began exhibiting bizarre and inappropriate behaviors, such as altered perceptions and loosened associations. He was in honors classes in 11th grade, an artist and musician who worked weekends at a music store, and had never been in previous treatment, but there was an extensive history of mental illness in the family. Several members of his extended family suffered from emotional disturbance, with two being schizophrenic.

While Taylor's objective testing results (that is, intelligence tests and self-report inventories) were unremarkable, his responses to projectives and drawings revealed a different snapshot of his emotional life. His answers to the Rorschach and TAT suggested that he was acutely sensitive to his surroundings, causing him to become unclear and unfocused when confronted with ambiguity. Also, his tolerance for stress at the time was quite limited, creating heightened tension and overreactions. He also seemed susceptible to being overwhelmed by his feelings and did not trust his control over them.

Taylor's portrait of a house also demonstrated some of these characteristics. His overworked house (with drawn bricks and tiles) seemed to reflect his inner tension and his attempt to contain his thoughts and emotions (Figure 3-8). The embellished environment with trees and a mailbox also appeared associated with his underlying anxiety and his need to control things around him. Although the walkway may have indicated at least superficial accessibility to him, the shades on the window seemed to suggest his ambivalence about disclosing aspects of his home life or possibly his caution in revealing continued paranoid thoughts.

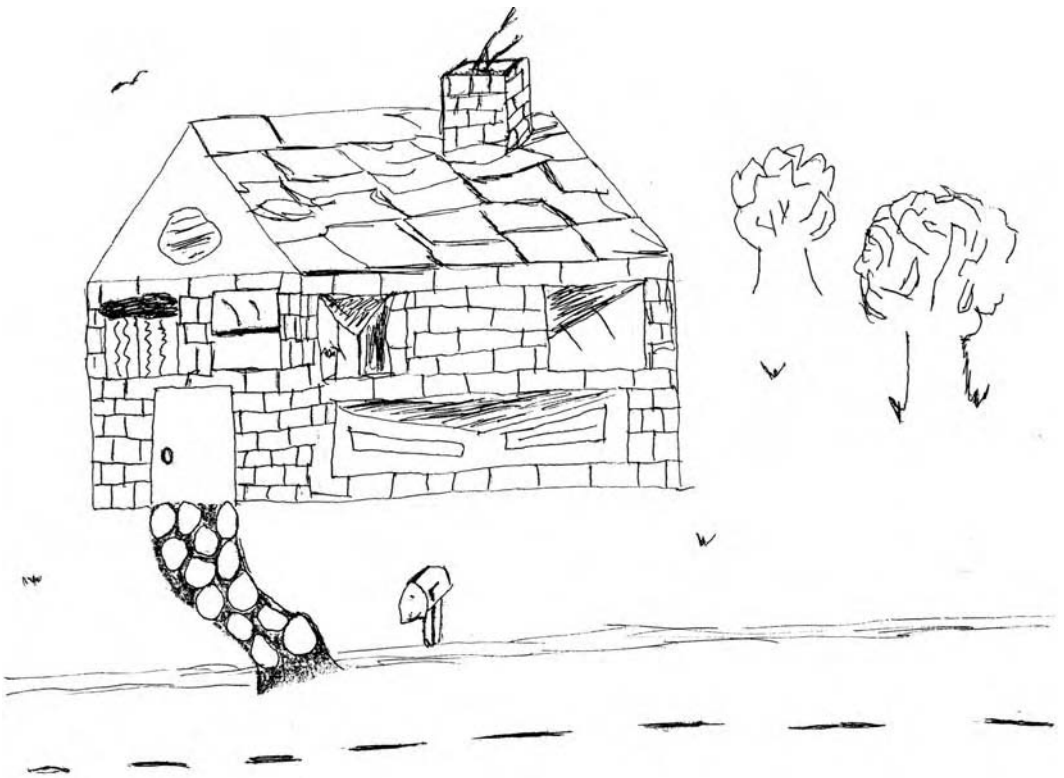

Figure 3-8

Dan

Dan was 15 years old when he was admitted to an inpatient unit due to depressive and suicide ideation. He was brought to the emergency room by his father because of a suicide note he had written in school and he had seemed very depressed, confused, and agitated when it was discovered. Joseph already had been in outpatient counseling for two years and was on medications for depression and anger control. He also had a history of ADHD since 3rd grade and had been treated by his pediatrician.

Dan presented as a tall, slender, and muscular young man with blonde hair, which was dyed green and orange. Although he was alert and oriented, he seemed reticent to engage in conversation. His affect was constricted and his attitude was oppositional. He denied serious depressive ideation and even denied that he had written the suicide note. Responses from projective tests indicated a high degree of negativity, a low tolerance for stress, and limited problem-solving skills.

When asked to draw a house, Dan approached the task hurriedly and in a highly defended style. His illustration showed bare windows, reflecting his blunt approach to people, and a door above the baseline without steps or a handle, indicating interpersonal inaccessibility (Figure 3-9). Besides the constricted house, he did not include a chimney, which seemed to suggest a lack of psychological warmth.

Dan's responses to testing resembled his provocative stance. He seemed emotionally vulnerable and kept relationships at a

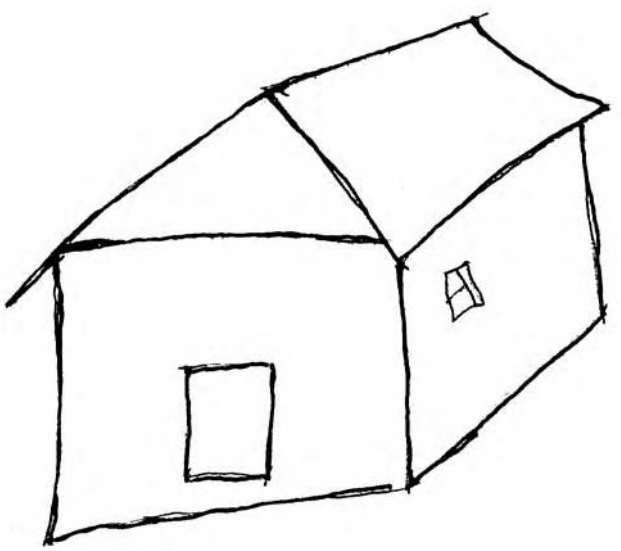

Figure 3-9

superficial level. He also appeared hesitant to engage with others in a meaningful manner, which seemed to limit his potential. The world was threatening to him and even in his drawings he did not want anyone to get inside.

Tree Drawings

Tree drawings are thought to be related to one's life role and one's capacity to obtain perceived reinforcement from the environment. Generally, the drawing of a tree has been considered especially rich in providing insights to life content. Interpretations from these drawings describe accurate biographical situations, as well as offer personal characteristics of the client.

The tree appears to reflect longstanding, unconscious feelings toward the self. These emotions tend to reside at a more basic, primitive level of functioning. Of the three drawings, the tree seems easier to project negative self-feelings because it is less connected to the home life or to directly viewing one's person. Besides Buck's (1948) early descriptions and interpretations of tree drawings in his H-T-P manual, two other systems have been developed that focus solely on the tree as an independent diagnostic entity. These abundantly illustrated books offer lengthy descriptions and details regarding its interpretive value (Bolander, 1977; Koch, 1952). Clinicians should refer to these two elaborate books for a more comprehensive understanding of using tree drawings as projective instruments.

The following signs or marks that may appear on a tree drawing are just a small fraction of possible interpretations. However, they do give therapists and diagnosticians a beginning guide for exploring personality characteristics related to their clients. Identification of these personality markers in the drawing assists the clinician in exploring issues that may be overlooked during initial interviews or later in more traditional testing.

1. Extremely large tree — aggressive tendencies
2. Tiny tree — feelings of inferiority and insignificance
3. Faint lines — feelings of inadequacy, indecisiveness

4. Two lines for trunk and looped crown — impulsive, variable
5. Exaggerated emphasis on trunk — emotional immaturity
6. Exaggerated crown — inhibited emotionally, analytical
7. Emphasis on roots — emotionally shallow, reasoning limited
8. Scar, knothole, broken branch — associated with trauma, e.g., accident, illness, rape (time determination in relation to length of tree)
9. No ground line — vulnerable to stress
10. Ground line present, no roots — repressed emotions
11. Shading (dark or reinforced) — hostile defenses, aggressive
12. Fine, broken lines — overt anxiety
13. Knotholes — sexual symbolism
    a. Small and simple — sexual assault, initial sexual experience
    b. Outline reinforced — shock impact greater
    c. Circles inside — experience in past and healing
    d. Blackened — shame associated with experience
    e. Large — preoccupation with procreation
    f. Small animal inside — ambivalence over childbearing

Jarred

Prior to his hospitalization, 16-year-old Jarred had become increasingly depressed and wrote a suicide note to a friend who, in turn, reported it to the school counselor. Initial symptoms included excessive sadness, irritability, sleep problems, and weight loss. Psychological testing results showed him to be extremely bright with IQ scores in the very superior range (135 to 140), but also very oppositional when confronted with difficult situations. Although depression and suicide screening forms did not indicate

significant and chronic distress, he did acknowledge occasional suicidal thoughts when upset. Standard projective testing suggested that he used denial as his main defense and attempted to place himself in a positive light. However, he did seem to experience little security in his life and tried to hide many of his painful inner feelings and conflicts from others. These personality descriptions were also reflected in his tree drawing (Figure 3-10).

His drawing was remarkable for several reasons. First, it looked quite regressed, especially considering his high intellectual level. Also, in a similar manner to his responses from other projective tests, his tree suggested a highly defended and guarded stand

Figure 3-10

(notice the protruding, spike-like branches and reinforced lines). His lack of a ground line seemed to represent his vulnerability to stress and the looped crown his tendency toward impulsive actions. Further, the scribbles inside the crown seemed to allude to an emphasis on mental activity and inhibited emotionality.

With this extra information and graphic record of his characteristics, diagnostic impressions were confirmed and treatment planning initiated. The use of a visual image to support the other instruments assisted the clinician in clarifying and communicating the diagnosis to the clinical team. These findings were also shared with Jarred, who concurred that his lack of communication and inability to express his anger appropriately was at the core of his frustrations and interpersonal problems.

Thomas

Thomas was a 13-year-old youngster who was initially seen in outpatient treatment due to increasingly aggressive and out-of-control behaviors. He had recently attacked his mother, had been suspended from his special education school for frequent fighting, and had been hospitalized previously due to his ongoing oppositionality. Additionally, conflicts at home necessitated a planning meeting for possible alternative placement. Although he had been placed on medication with positive behavioral and emotional results, this intervention was stopped due to unpleasant side effects.

When first seen for testing, Thomas was very resistant. He objected at first, then only reluctantly came to the room, but soon left when he did not get his way. Upon returning with much encouragement, he only agreed to work for a short, specified length of time. During the various tasks given to him, his learning weaknesses in reading and fine motor coordination were apparent. Also, projective testing displayed limited and inflexible perceptual processes suggesting that he would be

easily overwhelmed when confronted by perceived stress, no matter how minor, and likely feel very threatened and overreact. He seemed to pay little attention to details in his environment, causing weaknesses in his reality testing. His incapacity for organization seemed to make him prone to poor judgment and impulsive actions.

When asked to draw a tree, Thomas drew the following illustration (Figure 3-11). In his drawing, one can see his limitations. His creation was blunt and rigid, much like his then presentation. Also, the crown was simple and looped, alluding to his impulsive actions. The branches seemed cut off and broken, possibly suggesting his fragile self-concept, while the inner circle on the trunk and branches may have conveyed his past traumas (it was later discovered that his natural father, with whom he no longer had contact, had physically abused him).

This simple drawing reflected Thomas' limitations, as well as his emotional vulnerabilities. The visibility of his impairment was quite apparent. Sometimes, just a brief picture can reflect many possibilities for intervention planning when attempting to judge someone's capabilities and resources.

Bertha

Bertha was 14 years old when she was admitted into an inpatient psychiatric ward of a community hospital after a suicide note that she had written in the form of poetry had been discovered by her mother. In the note, she had been discussing the formation of a suicide pact with another girl, who had already cut herself once and had been hospitalized elsewhere. Bertha's early history was replete with sexual abuse by a family friend. She was currently living with her mother and had no contact with her heroin-addicted father.

Psychological testing was ordered to determine Bertha's degree of depression, her personality characteristics, and her emotional vulnerabilities. Her intellectual abilities were found to

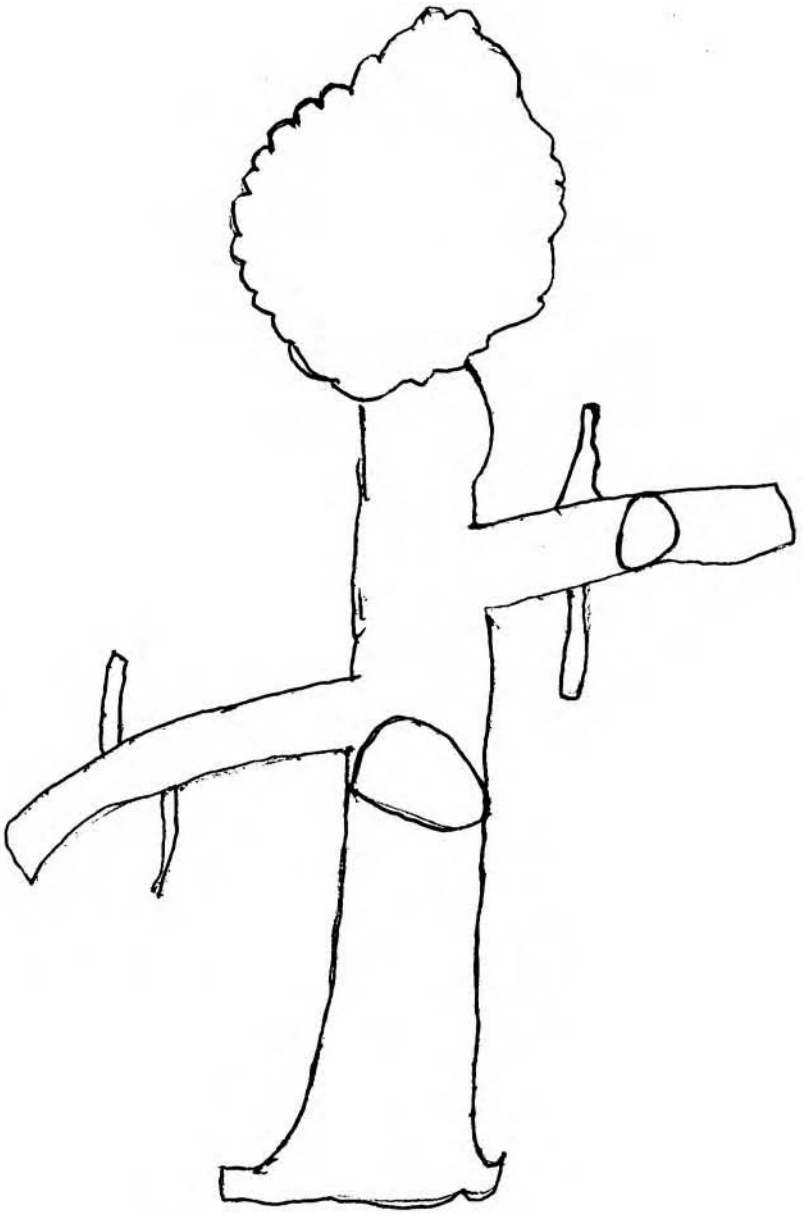

Figure 3-11

be intact. She scored within the high average range (110 to 119), but her disparity between verbal reasoning and expression (103) and her nonverbal skills (123) suggested she was more likely to act out her thoughts and feelings. Mood questionnaires showed her to feel worried and helpless. She viewed life as unfair, thought others did not approve of her, and wanted to hide from people. At the time, she was also preoccupied with thoughts of death and dying and wanted a quick end to her inner pain. Projective aspects of the testing suggested that she was overly critical and easily disappointed in herself, as well as self-degrading.

The image that she displayed through her tree drawing was quite revealing (Figure 3-12). Her bent-over palm tree seemed constricted and pained (not sturdy enough to hold onto its fruit). In comparison to the paper size and to her other drawings, it

Figure 3-12

was quite constricted and seemed to express her own feelings of inferiority and insignificance. Her emphasis on the crown also reflected her contained anxiety and the falling fruit her own fall from grace when sexually abused.

Person Drawings

Wide agreement exists that human figure drawings are primarily a manifestation of clients' perceptions of themselves or who they wish to be (Wenck, 1986). The drawing of a person apparently stimulates conscious awareness of bodily image and self-concept, both physically and psychologically. For instance, feelings of inadequacy may be represented by tiny drawings or dangling arms on the person. The drawing of a person may also arouse emotions regarding an ideal self. Of the three H-T-P drawings, the person is the most difficult to construct and the one drawing most likely to be refused by individuals who are sensitive to their shortcomings or who fear failure. Therefore, a request to complete the drawing (more than a stick figure) often needs the most encouragement from the examiner.

More research has been conducted on person drawings than on house or tree drawings, and several variations of scoring methods have resulted (see preceding sections on the Goodenough-Harris Drawing Test and Machover Draw-A-Person Test). The following emotional indicators can be used in conjunction with those provided in the earlier sections to gain a fuller appreciation of personality characteristics derived from interpreting a person drawing (adapted from Jolles, 1971; Mitchell et al., 1994).

1. Arms — used to change or control surrounding environment
   a. Folded over chest — hostile or suspicious
   b. Held behind back — wanting to control anger, interpersonal reluctance
   c. Omitted — inadequacy, helplessness
2. Feet — degree of interpersonal mobility

a. Long — striving for security or virility
b. Tiny — dependency, blunted feelings
c. Omitted — lack of independence

3. Fingers
   a. Long and spike line — aggressive, hostile
   b. Enclosed by loop (single dimension) — wish to suppress aggressive impulse
4. Head
   a. Large — preoccupation with fantasy life, focus on mental life
   b. Small — obsessive-compulsive, intellectual inadequacy
   c. Back to viewer — paranoid or schizoid tendencies
5. Legs
   a. Absent — constricted, possible castration anxiety
   b. Size difference — mixed feelings regarding independence
   c. Long — striving for autonomy
   d. Short — emotional immobility
6. Mouth
   a. Overly emphasized — immaturity, oral-aggressive
   b. Very large — orally erotic
7. Shoulders
   a. Unequal — emotionally unstable
   b. Large — preoccupied with the perceived need for strength
   c. Squared — overly defended, hostile toward others

Francine

Francine was an 11-year-old girl who was referred for an evaluation by the Child Advocacy Center where she had received a physical examination for allegedly being sexually abused by her maternal uncle who was staying at her grandmother's house

where she lived. Her mother had been unable to take care of her since birth due to her intellectual limitations. The uncle had reportedly been drinking and watching pornographic movies the evening this occurred. The grandmother was asleep. After her examination, which was positive, the uncle was arrested and Francine was allowed to remain at her grandmother's. Then another one of her other uncles moved in, who also had substance abuse problems, and the grandmother was apparently unable to make him leave so Francine had to go live in foster care. Her father was filing for custody but had substantiated physical abuse on Francine when she was 5.

Francine's person drawing (Figure 3-13) reveals long, spike-like fingers representing her hostile, aggressive, angry feelings about what had happened to her. We also see the complete absence of legs, possibly indicating a high level of anxiety regarding her pelvic and genital area resulting from what her uncle allegedly did to her. In addition, we see a large mouth representative of oral erotic issues. The characteristics evident in her person drawing would all indicate that Francine had suffered sexual abuse. These indicators helped the therapist formulate treatment goals, such as providing a safe place to express her feelings regarding the abuse and possibly use artwork to develop her strengths, self-concept, and a more comfortable body image. Another person drawing at the end of treatment may reveal a healthier body image if treatment has been successful.

Roberta

Roberta, age 7, was referred to a therapist for a history of neglect and alleged sexual abuse by her father. Roberta and her sister were removed from their mother's care because she was also being investigated for having knowledge of the abuse and not doing anything about it. Roberta and her sister were in foster care when the therapist first met them. Roberta's younger sister

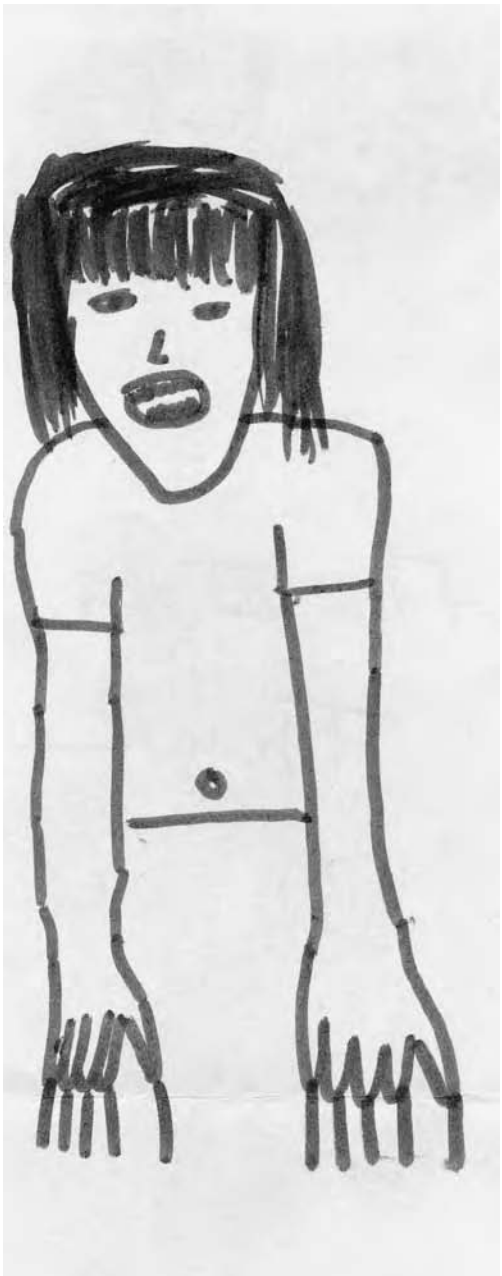

Figure 3-13

was mostly out of control, biting, and destroying things. However, Roberta presented herself as very withdrawn, fearful, and nonverbal. In these examples, we have house, tree, and person drawings all from Roberta.

Roberta's house (Figure 3-14) has no chimney, indicating the lack of warmth in her life and possible conflicts with significant male figures in her life, in this case probably her father. The

Figure 3-14

door to her house has no baseline, representing Roberta's inaccessibility and it is very large, a sign of being overly dependent or, in Roberta's case, possibly having a significant amount of unmet dependency needs. The excessive amount of windows indicates a desire or need for contact.

In her person drawing (Figure 3-15), we see reinforced lines (anger and vulnerability) and the lower part of the body drawn appears confusing. The legs are unclear, possibly indicating a great deal of anxiety and confusion regarding that area of her body. The feet are omitted, a sign of lack of independence.

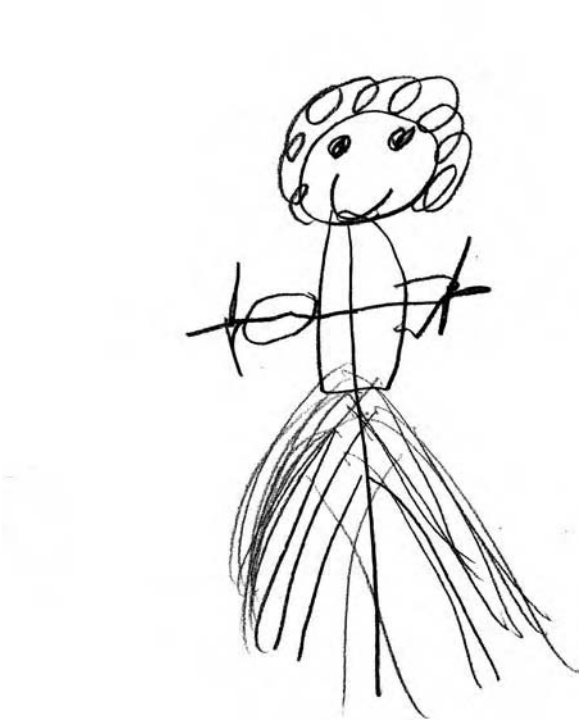

Figure 3-15

Roberta's tree drawing (Figure 3-16) also has no ground, again indicating feelings of vulnerability. The blackened knothole is characteristic of trauma and shame. The two-lined trunk

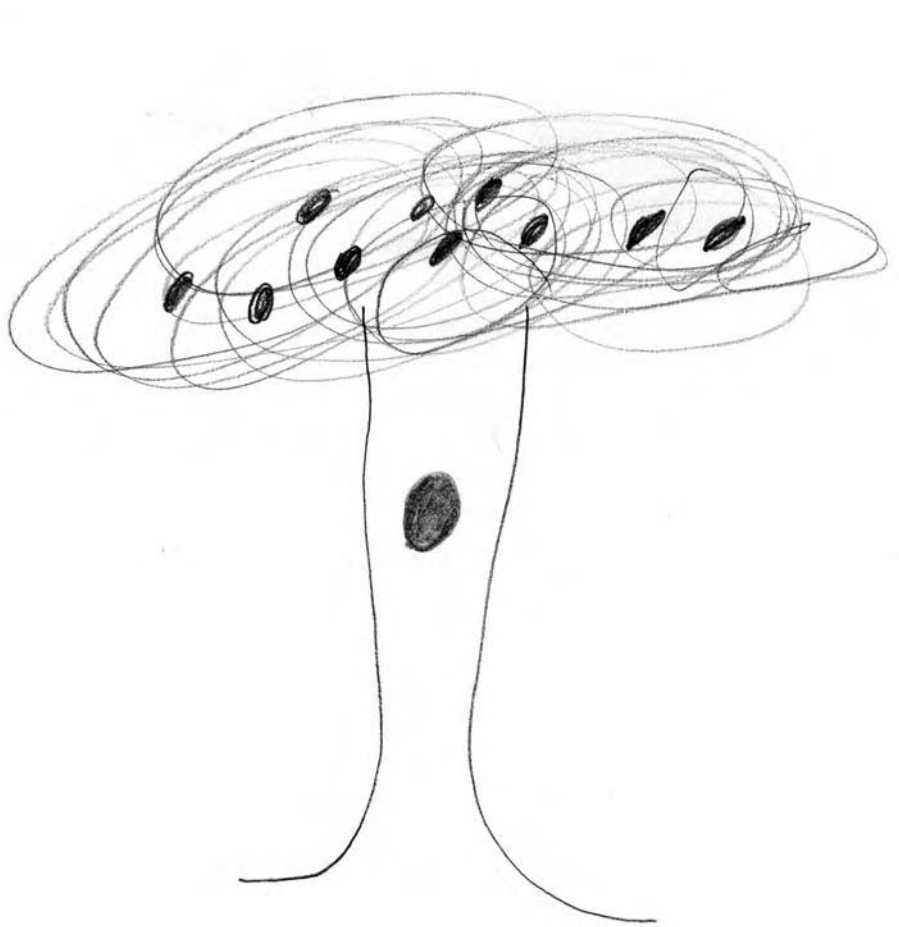

Figure 3-16

and looped crown could show a tendency toward being impulsive.

In the above three drawings, we see a child who is experiencing a great deal of emotional stress and conflict with an intense need for contact, but no skills for obtaining it (accessibility or independence) and getting these needs met. There are also strong indicators that the alleged abuse occurred. Her vulnerability, anger, and tendency toward impulsivity all promote the development of acting out behaviors. Ideally, Roberta could develop a trusting and therapeutic relationship through which she could resolve some of these conflicts and learn how to get her needs met appropriately.

KINETIC-HOUSE-TREE-PERSON TECHNIQUE

Robert Burns (1987) developed the Kinetic-House-Tree-Person (K-H-T-P) technique based on his assumption that drawings with action reflect a client's underlying well-being more profoundly than static drawings. His collection of intriguing results from the instruction "Draw a house, a tree, and a person on this paper with some kind of action" provided new insights not previously realized from individual drawings. The actions, styles, and symbols derived from this novel instruction seemed different from standard drawing directives and, for Burns, this meant a new experience between examiner and examinee.

In his research, Burns (1987) discovered that the personality dynamics revealed through integrating the basic instructions of the H-T-P to incorporate all three figures on one sheet of paper increased the interpretive value of this well-established technique. He also showed that after a client has constructed this more action-oriented drawing, the clinician can generate salient hypotheses associated with (a) the feelings or impression surrounding the entire picture, (b) the perceived warmth or hostility of the house, (c) the activity level of the drawn person, (d) the strength of the tree, and (e) the relationship between tree and house (e.g., how

close are the two objects, or how sheltering or protective is the tree?).

Burns (1987) viewed the advantages of action drawings as providing supplemental significance to personality dimensions in many difficult clinical situations. He also suggested that this novel drawing directive initiated a beginning to the therapeutic healing process. Through numerous illustrations, combined with his substantial clinical insight gained through many years collecting and analyzing drawings, his book on this kinetic addition to the H-T-P offered an enriched understanding to his newer, unified approach that was not always apparent in separate drawings.

FAMILY DRAWING PROCEDURES

Another enhancement on using person drawings as projective indicators of personality is the Draw-A-Family or family drawing technique. This informative technique was originally suggested by Appel (1931) and later expanded by Wolff (1942). Its tremendous popularity among drawing procedures most likely paralleled the therapeutic emphasis on understanding family structure and implementing family interventions during the 1970s and 1980s. The wealth of information gathered when broadening the focus to the family constellation is enormous and advances the drawings arsenal of clinical tools used by both health and mental health professionals.

The instructions for this drawing procedure are minimal. The examiner provides clients with pencil and paper and asks them to merely "Draw a picture of your whole family" (Harris, 1963). If they do not spontaneously offer the names of their family members, they are asked to identify them afterward to elicit additional associations. When completed, the family drawing tends to reveal attitudes toward family members and perceptions of family roles. These interpersonal relationships are often expressed by the relative size and placement of the figures and by substitutions or exaggerations of distinct family members. For example, clients may omit themselves from the family drawings, suggesting feelings of rejection, especially during separation or divorce. This underlying

reaction toward disapproval is, occasionally seen in family drawings by adopted children, especially during their adolescent years when identity concerns are brought to the forefront (DiLeo, 1983).

Barbara

Barbara, age 12, with borderline intellectual functioning, was referred for evaluation following allegations that her adopted father had sexually abused her. She lived with her adopted mother and biological sister. Barbara was having a difficult time managing her aggressive behaviors and was repeatedly placed in crisis stabilization. In her family drawing (Figure 3-17), she placed herself next to "Dad," representing her confused ambivalent feelings toward him. However, the reinforced line quality of his hair and the aggressive manner in which it is drawn suggests Barbara's feelings of anger and vulnerability in reference to him. Her own disheveled hair may indicate sexual

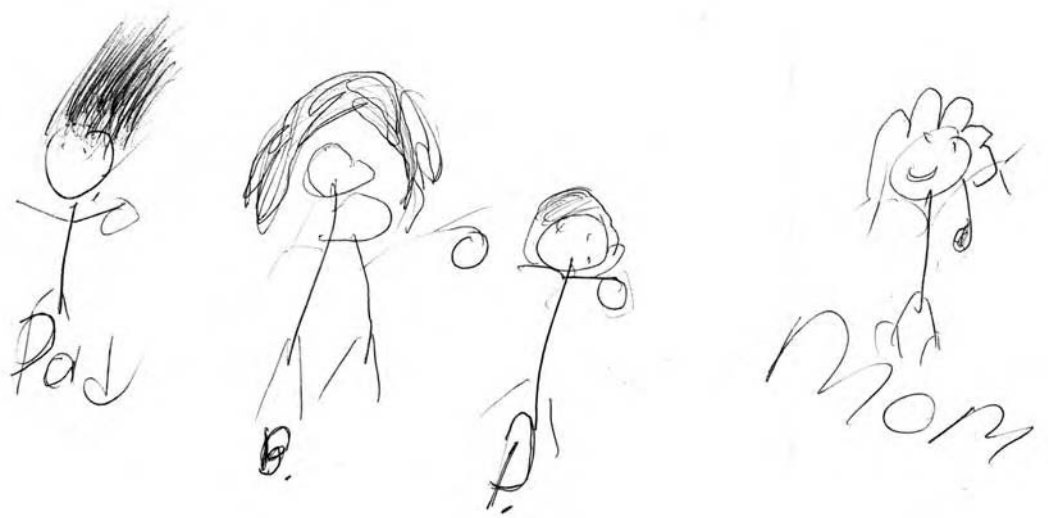

Figure 3-17

concerns and underlying confusion. It is also important to note that she placed the therapist (P) next to her. Her "Mom," who she felt did not protect her and with whom she had role confusion and jealousy as a result, was placed to the far right. Her sister, with whom she experienced intense sibling rivalry, is omitted from the drawing. This drawing is a clear example of Barbara's perception of her family and made clear all the dysfunctional family issues that were detrimental to Barbara's progress. It also showed Barbara's perception of the therapist's role in her life, which introduced the need for accurate feedback in Barbara's therapy.

Kinetic-Family-Drawing

A particularly useful alternative to the standard family drawing is explored through the Kinetic-Family-Drawing (K-F-D) (Burns & Kaufman, 1970), which added the instruction of "doing something (an activity) together." This alteration of the original Draw-A-Family also directly requested individuals to include themselves in the picture. It is usually given after the first family drawing, so as not to contaminate the possibility that clients will omit themselves or other family members.

The K-F-D's special contribution lies in the principle that how clients view themselves in their family system may be different than how they see themselves outside the household. Thus, this modification provides an additional clinical tool for ongoing assessments during individual and family therapy. It can be used for such practical concerns as decision making during custody disputes, determining whether a child should be removed from a parental home, or demonstrating to parents how their turmoil and differences may be impacting their children (Hammer, 1997). Also through this method, clinicians have observed clients attempting to represent boundaries within their drawings as protective coping skills when there are suggestions of inappropriate behaviors (for instance, physical or sexual abuse) occurring in their families (Malchiodi, 1998).

Additionally, this adaptive drawing technique sometimes produces a strong reaction like, "We don't do anything together" (a key revelation to initial hypotheses regarding familial interaction). Although this directive is pertinent when used with children, it stimulates perceptions of previous years as a child when used with adults. It could produce memories of past family experiences and interrelationships, which are fruitful in relating previous occurrences to current history and symptoms.

From this drawing directive of a family in action, it is common to observe clients illustrating their families in a passive posture (e.g., watching television or a movie), which may suggest a possible lack of direct communication or with further probing, an enjoyment of just being together. Another common response when using these kinetic family drawings is a picture reflecting dinner table scenes. In these portrayals, clients may place the parents at opposite ends of a long table (representing their emotional distance from one another) or place themselves at one end (attesting to the perceived competition that they may experience). Whether the dinner table is full with food or bare may address the examinee's worries about living in an environment that is lacking in enriched stimulation or concerns regarding the amount of emotional nurturance that is experienced.

Other features discovered from family drawings include compelling interpersonal dynamics between parents and the client or among siblings. For instance, dramatic results may reflect a child's panic during interactions with an alcoholic father, feelings of isolation in a stepfamily, or withdrawing from perceived threats within a dysfunctional household (Hammer, 1997). Clues to these personality traits may consider whether (a) clients draw themselves in proximity to the parents (as a way to demonstrate increased status over their siblings or to express feelings of acceptance or rejection); (b) they omit siblings as a symbolic gesture toward eliminating competition; (c) they include themselves in the drawing (displaying personal feelings of not belonging); or (d) the family is drawn in accurate proportions (making a child or adult much taller demonstrates perceived dominance or ineffectiveness).

Clinicians may also observe the parents' facial expressions in the drawings for valuable clues to uncover hidden thoughts and feelings. Such features as whether clients perceive one parent to be harsh, one to be gentle, or one to be more supportive are all vital areas to pursue during further interviews and testing that may provide clearer direction to therapeutic planning and intervention.

Family-Centered-Circle-Drawing

Another variation in family drawings developed by Robert Burns (1990) is a procedure known as the Family-Centered-Circle-Drawing (F-C-C-D). This drawing directive supposedly assists individuals to more clearly perceive the relationships between themselves and their parents. He proposed that by making a series of family drawings within a structured circle and centering the figures, clients have easier access to unconscious material and reveal more of their internal versions of their parents.

The directions for this technique are relatively simple. Standard paper is used with a circle already drawn measuring 7 1/2 to 9 inches in diameter (or you can ask the examinee to draw a large circle on the paper). The instructions for obtaining an F-C-C-D are to: "Draw your mother in the center of a circle. Visually free associate with drawn symbols around the periphery of the circle. Try to draw a whole person, not a stick or cartoon figure." With less sophisticated clients, you can say, "Make symbols or pictures that represent your parent, and make pictures that make you think of (or describe) your parent around them." The instructions are then repeated, twice substituting father and the person doing the drawing for the original mother figure. Another drawing is then constructed of the parents with the client in a circle-centered drawing.

Once the drawings have been completed, observations are made pertaining to (a) what types of symbols are used, (b) what possible barriers in communication are constructed, (c) how close the parents and individual are to one another, and (d) whether caring is being expressed among the family members. As in all drawing

directives mentioned throughout this book, it is incumbent upon the clinician to be cognizant of other diagnostic possibilities within the images. Aspects of the completed drawings, such as relative size of the figures, omission or overemphasis on bodily parts, facial expressions, and the types of symbols (whether loving or hateful, expressions of anger, positive or negative), are all essential factors in creating initial hypotheses about diagnostic criteria and for later treatment direction.

In his book, Burns (1990) described several features to examine in the final drawings. These observations included:

1. What symbols are directly above or below each figure and are these positive or negative?
2. Relative sizes of the drawings. Is the client smaller or larger?
3. Who is in the center (possibly the controlling member of the family)?
4. Are there clear alliances within the family structure?

Burns's (1990) work with these techniques is a culmination of his attempts at combining Eastern philosophies (such as use of Mandalas) with Western techniques, such as the Rorschach (Rorschach, 1942). His book on Family-Centered-Circle-Drawings provides many examples with extensive clinical interpretations to describe his methods and to supply a foundation for future research and clinical usage. By having clients place the family and separate members at the center of a circle surrounded by visual and freely associated symbols, Burns truly demonstrated a stimulating model for obtaining expressive material to promote clinical insights and discussions.

Natalie

Natalie was a 16-year-old, 10th-grade boarding school student who was admitted into a psychiatric unit of a general hospital after having overdosed on stimulant over-the-counter medication

to supposedly stay awake for exams. Besides this incident, Natalie had been in constant turmoil during the year and was being treated with antidepressant medication and supportive counseling. Although she denied that her actions were a suicide attempt, she did acknowledge increased sadness over her poor school performance and a recent breaking off of a relationship. Her symptoms had included decreased concentration, unrealistically high expectations of herself with subsequent self-criticism and disappointment when confronted with failure, and a general loss of motivation.

Natalie's evaluation was requested to assess her cognitive and emotional functioning to assist in diagnosis and treatment planning. Results derived from beginning protocols suggested a high degree of emotionality. She seemed susceptible to being overwhelmed easily and directed by her feelings. Her responses indicated a low self-regard and fragility with a low tolerance for stress. She appeared to need much structure and direction in her life and without it she felt confused.

Along with standard testing, Natalie was asked to complete a set of drawings. One in particular focused on her discontent. When requested to draw an F-C-C-D, Natalie composed the following illustration (Figure 3-18). While many of these requests usually reflect interests of one or the other parent, such as images of athletic pursuits or reading, Natalie's was much more focused on her conflicts. In the drawing, she suggested that her father was "controlling, fake, a neat freak, verbally abusive, and scarry (scary)." Using this portrait as a visible platform to express her anger and conflicts, she shared many stories of her everyday conflicts with her father whom she rarely visited. She indicated that her father's absence and separation from the family when she was younger had made a large and negative impact on her life. The drawing seemed to break the ice between Natalie and the examiner and allowed her more freedom to express her frustrations.

Figure 3-18

Kinetic School Drawing

A further outgrowth to the kinetic family drawing series, the Kinetic School Drawing (K-S-D) is an adaptation for the school-age child or teenager. Originated by Prout and Phillips (1974) and later revised by Sarbaugh (1983), this directive generates numerous responses that students can represent such as teachers, friends, or themselves during daily activities. The following instructions were offered by the initial creator: "I'd like you to draw a school picture. Put yourself, your teacher, and a friend or two in the the picture. Make everyone doing something." A post-drawing interrogation was later added to elicit associations. The clinician can ask the

student to identify the people and actions within the drawings, along with any unidentifiable objects.

Sarbaugh (1983) was more interested in having students project personal attitudes and opinions onto their drawings and suggested a more open-ended directive with the instruction, "Draw a picture of people at school doing something." If students are uneasy about making this drawing or are perplexed over the direction, examiners can encourage the use of client ideas. The developer of this method also suggested a chromatic phase for the drawings where crayons could be added to enhance interpretive possibilities.

Impressions of the drawings paralleled the guidelines offered for the kinetic family drawing procedures (Prout & Phillips, 1974). The people within the drawings are analyzed according to Machover's (1952) guidelines. The images are then examined further in terms of action, style, and symbols.

By comparison, Sarbaugh (1983) used interpretations based on a symbolic perspective. Her view characterized students through their uniqueness placed onto the symbols. This method was in sharp contrast to using a formal psychological scoring system. In this manner, she believed, students already possessed existing inner symbols and their designs could be misunderstood. Sarbaugh's more subjective bias to this drawing directive was based on her numerous years of clinical experience.

Still later, Knoff and Prout (1985) integrated the K-F-D and the K-S-D techniques into a system they called the Kinetic Drawing System. They emphasized the need to administer both directives to increase their clinical utility and interpretive depth. The integrated results could then (a) determine a student's social–emotional difficulties across home and school settings, (b) identify family issues that are related to school attitudes or behaviors, and (c) isolate the setting where relationship problems are occurring that are contributing to other interpersonal complications (Cummings, 1986). Their manual thoroughly summarizes the research and literature from the K-F-D and K-S-D and introduces their own integrated system.

Larry

Larry was a 16-year-old young man referred for an outpatient evaluation by his mother due to concerns of attentional problems and other mood difficulties that seemed to be interfering in his adolescent maturation. Originally from another country, Larry had been in the United States for several years, but had become more oppositional and defiant toward his mother and was beginning to fall behind in many of his school courses. His first attempt at therapy lasted six months, but he was angry and disappointed in the therapist and refused to continue. He had also been involved in tutoring, but had been disruptive during the sessions.

On a behavioral checklist during intake, the mother described Larry as energetic, irritable, defensive, and distractible and as exhibiting poor concentration and lacking in positive self-esteem. During the testing, Larry did not want to be viewed negatively, so he was inhibited to guess unless certain of the answer. He also seemed to tire easier than most others his age and needed much refocusing and encouragement to continue. His answers varied in their accuracy depending on the amount of attention he displayed. He tended to miss easy questions and accurately solve harder ones, as well as become acutely focused for a short time then become unfocused. Despite these inconsistencies, his overall scores on objective measures indicated average to high average functioning without significant learning weaknesses. Also, his strong denial of symptoms mainly seemed naive and defensive. On a physical complaint checklist and an incomplete sentence blank, Larry attempted to portray himself as lazy and tired with frazzled nerves. He suggested that he had failed in school, that his parent were disappointed in him, and that his mind was slow. He also indicated that he rarely displayed any effort and had an extremely poor attitude toward school.

At that point in the evaluation, Larry was asked to construct a K-S-D to gain a visible record of his perceptions of himself

in school. His striking portrait revealed his general attitude in the classroom. As can be viewed in Figure 3-19, Larry revealed his distaste toward structured education and his acting out was in a passive-aggressive manner. His variable interest and motivation to perform reflected his self-description as someone who was "burnt".

Further testing of Larry suggested affective variability, anxiety, and impulsivity. In addition to his defiant stance and oppositional manner, his achievement motivation appeared exceedingly low and he viewed most obstacles as insurmountable. He also seemed emotionally estranged from others and was likely to act out his underlying tension in an avoidant manner. This lack of attachment was bound to keep Larry unsure and suspicious of his surroundings. Also, there appeared to be attention span interference, characterized by a lack of sustained concen-

Figure 3-19

tration, absentmindedness, and impulsivity, and he was highly disorganized in his planning abilities. Further, his perceptual processes and emotional resources were rigid, which additionally undermined his confidence and determination, leaving him frustrated with himself and others. As a result, Larry was recommended to begin anew in therapy and was also referred for a medication evaluation for his apparent attention deficit symptoms and mood disorder.

Silver Drawing Tests

Through her work with deaf children in therapy during the 1960s and later with learning disabled and adult stroke victims, art therapist and educator Rawley Silver developed structured tasks that assessed the cognitive skills and emotional needs of her clients. In her compiled works (Silver, 1990, 1991, 1996), she demonstrated how to use structured methods of stimulus drawings to prompt responses that solved problems or represented concepts and elicited stories related to mood. Her art tasks displayed how drawings could measure cognitive development related to height, width, and depth that were not previously addressed in earlier drawing techniques. She also used modifications of these procedures in more recent studies to investigate childhood depression, and cross-cultural and gender differences (Silver, 2002, 2003).

Silver regarded art as a language that paralleled the spoken or written word and, therefore, could assist in the assessment of cognitive skills and discovering emotional resources. Her goals in providing these techniques were to (a) bypass language in evaluating abilities to solve conceptual problems; (b) provide more accurate evaluations of personal strengths, which are often overlooked by verbal measures; (c) facilitate early identification of emotional problems, such as depression; and (d) provide a pre-post instrument to assess individual progress, or the effectiveness of educational or therapeutic intervention. Her initial hypothesis was that children who have poor language skills are often restricted in traditional

tests of intelligence. She noted that drawing and other art activities could produce a more accurate picture of a child's resources.

The Silver Drawing Tests (SDT) consist of three tasks or subtests that measure a client's ability to solve conceptual problems graphically. These tasks include a predictive or sequential drawing, a drawing from observation, and a drawing from imagination. In constructing these measures, Silver produced activities that were broader than other drawing tests, such as the D-A-P, and involved a series of appealing tasks that allowed clients to adapt various images in their drawing constructions. There is no time limit, though most examinees take between 3 to 5 minutes to complete the first two tasks that are structured protocols and 5 to 10 minutes to finish the last subtest (drawing from imagination by choosing from a series of images and combining them in a drawing that has a title and related story). The tests can be administered individually or to groups.

The first task is to predict changes in appearance by drawing lines on outline drawings. Responses are scored for level of ability to order a series of objects that represent horizontal and vertical concepts. The second subtest assesses perceptions of space by asking the examinee to draw three cylinders and a stone. This subtest is scored by examining the level of accuracy, in addition to relationships in depth. The final directive measures the ability to form concepts by selecting drawings from two arrays, then combining them into a personal narrative. This latter subtest is open-ended in offering 15 subject drawings. It provides information not only about cognitive level and emotional problems, but also facilitates access to fantasies and unconscious thoughts.

Scoring in this organized system is based on ability to select the content of the drawing, ability to combine forms, and originality and creativity. Performance in each subtest is rated on a scale of 0 to 5 and the resulting scores have been found to be correlated with more traditional tests of intelligence. The rating scales are straightforward and offer clear and concise guidelines that support the interpretations. The Silver manuals are highly structured and well illustrated, providing health and mental health practitioners

with clear methods for their uses. Record sheets and booklets are provided for the system.

Silver (1996) also did extensive research on the Draw-A-Story method (D-A-S) in studying children's images associated with depression, as well as investigating cognitive and creative skills. She developed a drawing protocol of the D-A-S to screen for depression by using a set of simple line drawings that stimulated children to develop stories about their drawings. She selected graphic illustrations that appeared to prompt negative fantasies and requested children to choose two of the images to combine in a drawing. Her research viewed depression as a continuum from moderate sadness to suicidal and self-destructive thinking and she suggested that these states of depressed affect would be revealed through the drawings and stories.

The Diagnostic Drawing Series

The Diagnostic Drawing Series (DDS) is a drawing interview developed by art therapists to provide a reliable and valid assessment tool that is linked to diagnostic nomenclature in the revised *Diagnostic and Statistical Manuals* (Johnson, 1988). This drawing task was created because of the clinical imprecision of other art assessment procedures and the need for establishing a foundation of data for research and clinical purposes. The protocol for the three-drawing test incorporates instructions for unstructured, structured, and semistructured tasks (Cohen, 1990).

The examiner presents the client with three pieces of 18- by 24- inch white paper and a 12-color box of square, soft chalk pastels. The first request is to "Make a picture using these materials." For the second piece of paper, the client is asked to "Draw a picture of a tree." The third directive is to "Make a picture of how you are feeling, using lines, shapes, and colors" (Cohen, 1986).

Norms have been developed for control and various diagnostic groupings, such as samples of individuals with major depression, dysthymia, and schizophrenia. Nonpsychiatric groups have also been included in subsequent studies of sexually abused children and

head-injured persons. The main advantage listed for using the DDS over other art techniques is its ease of administration combined with media that foster self-expression (Mills, Cohen, & Meneses, 1993).

In the manual developed for scoring the DDS, 23 categories have been listed with 183 decisions demanded of a rater. Despite the seeming complexity, there appears to be an extremely high interrater reliability. Thus, the drawing series offers both researchers and clinicians something that is missing from many of the before-mentioned directives, that is, the confidence to use a reliable and valid tool for assessment purposes.

SEXUAL ABUSE INDICATORS IN DRAWINGS

Using drawings in the treatment of sexually abused clients is too extensive to cover in this book. However, it would be helpful for clinicians to know what some the possible indicators of sexual abuse are in drawings. The client may be in treatment for a different presenting problem (e.g., depression or anxiety) and never have disclosed sexual abuse. However, if the clinician observes some of these indicators in the clients' drawings, the clinician might want to explore sexual abuse as a possible occurrence in their lives and be cognizant of this in regards to their treatment. It is possible that the root of the clients' presenting problem may be sexual abuse they have never talked about and never would if the therapist did not use drawings and observe these possible indicators and use the drawing as a nonthreatening way to facilitate their communication.

Therefore, it is important to present a list of possible indicators that might be helpful to the practicing evaluator, diagnostician, or therapist. The developmental aspects especially of children's drawings should be considered and possible indicators should be seen repeatedly as part of a pattern rather than assumed by observing only a few drawings. A diagnosis of sexual abuse should not be based on drawings alone. There should always be a clear disclosure by the client before sexual abuse can be diagnosed (Hagood, 2000).

A compilation of some of the commonalities (Malchiodi, 1997) or indicators found in the drawings of sexual abuse victims are:

1. Sexual connotation in the content, such as images of genitalia, graphic emphasis on the pelvic area of figures, seductiveness in subject of content (Faller Coulborn, 1996; Malchiodi,1997).
2. Heads without bodies or bodies without their lower half (Hagood, 2000; Malchiodi, 1997).
3. Encapsulation (Malchiodi, 1997).
4. Phallic shapes, often trees (Hagood, 2000).
5. Color (red or complimentary) (Malchiodi, 1997).
6. Shapes (hearts, circles, and wedges) (Hagood, 2000; Malchiodi, 1997).
7. Self-deprecation (Malchiodi, 1997).
8. Repetitive marks, blending (Hagood, 2000).

Denise

Denise was a 10-year-old female who was referred for therapy with a history of being (allegedly) sexually abused by her adopted father. She was living with her adopted mother and older sister. The drawing in Figure 3-20 illustrates how she would express her feelings to her adopted father if she could. On the figure representing herself, we see emphasis placed on the pelvic area, an indicator of sexual abuse. In addition, it is interesting to note that she and her father have no hands, which could represent her feelings of inadequacy and for the father a way to render him helpless to touch her.

Carolyn

Carolyn was a little girl, age 5, who was referred by her school for evaluation because she was humping on her desk obsessively. Her behavior was distracting and disruptive to her class


This is me say I hate you I hate you
I hate you I hate you you lier then
R don't Know what to say
I hate you
I hate you
I hate you
I hate you

Figure 3-20

and frustrating for the teacher as she could not get Carolyn to stop this behavior. Figure 3-21 is a picture that Carolyn drew at school as part of her daily work. The teacher requested that the mother sign releases and called the therapist regarding her concerns. This was Carolyn's drawing of a ballplayer. The teacher asked Carolyn what the shape was between his legs to which Carolyn responded, "My dad has a peter and it hurts." The therapist suggested the teacher call social services and an investigation began.

Figure 3-21

Pat

Pat was a 15-year-old adolescent female who was referred to therapy by her school for angry, acting out behaviors directed

primarily at her male teachers. She was also always late for school. In the past there had been allegations made against her father for physical abuse and neglect. Her mother had left her to be raised by her father when she was about 8. Pat had also witnessed her mother being beaten by her father before her mother left him. This drawing (Figure 3-22) by Pat was a self-portrait requested by the therapist for evaluation purposes. The head is drawn without a body floating in disorganized lines with the words "Love Hurts" as the title. This was a recurring

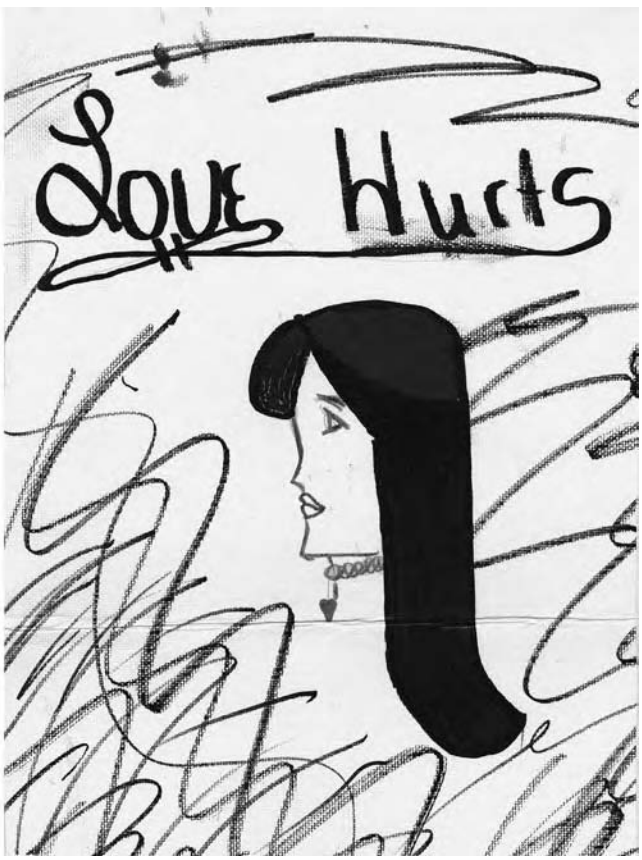

Figure 3-22

theme in Pat's artwork and eventually she disclosed that her father had sexually abused her.

Cathy

Cathy did this drawing (Figure 3-23) in a group therapy session of adolescent girls (who had symptoms of depression) when asked to draw why they thought they were in therapy. Her drawing represents a figure enclosed (an example of encapsulation) and separated from everything, possibly symbolizing her need to isolate herself and simultaneously protect herself. Yet

Figure 3-23

at the same time, this figure who she later identified as herself is calling out for help.

Bill and Pete

Bill and Pete were both in individual therapy. Bill, age 12, had erratic, hyperactive, and destructive behaviors with his peers and teachers at school and at home. Bill, now age 15, had not been to school for over a year following allegations that the principal had been physically and possibly sexually abusive to him. The charges had been dropped and he had attempted, but never successfully returned to school. He was withdrawn and nonverbal. Bill's drawing (Figure 3-24) of a tree is a good example of a phallic shaped tree and also has a possible trauma indicator (the hole in the tree). This tree would alert the therapist to observe his other drawings for any patterns or additional indicators of being abused.

Pete's drawing (Figure 3-25) of two people, a tree, and a bird contain a phallic protruding shape on the tree as well as a hole. The female figure has a phallic shape on her dress, positioned between her legs. The male figure has an emphasis of the pelvic area. These were strong indicators that repeated themselves throughout his therapy. Eventually he was able to become more verbal in therapy and express some fears regarding returning to school and indicated he had to stay with his father. The therapist tried to work with the family to clarify what this meant. It was clear that whenever his father was around Pete never talked.

Pete again attempted to return to school and was successful for a few weeks. Someone reported his sister had disclosed that her father had sexually abused her but it was not substantiated. Around this time, Pete left school one day and never went back. He also quit coming to therapy. The therapist had begun to suspect that possibly the father was sexually abusing Pete, but no disclosure was ever made. The therapist reported her suspicions to social services, but nothing could ever be substantiated.

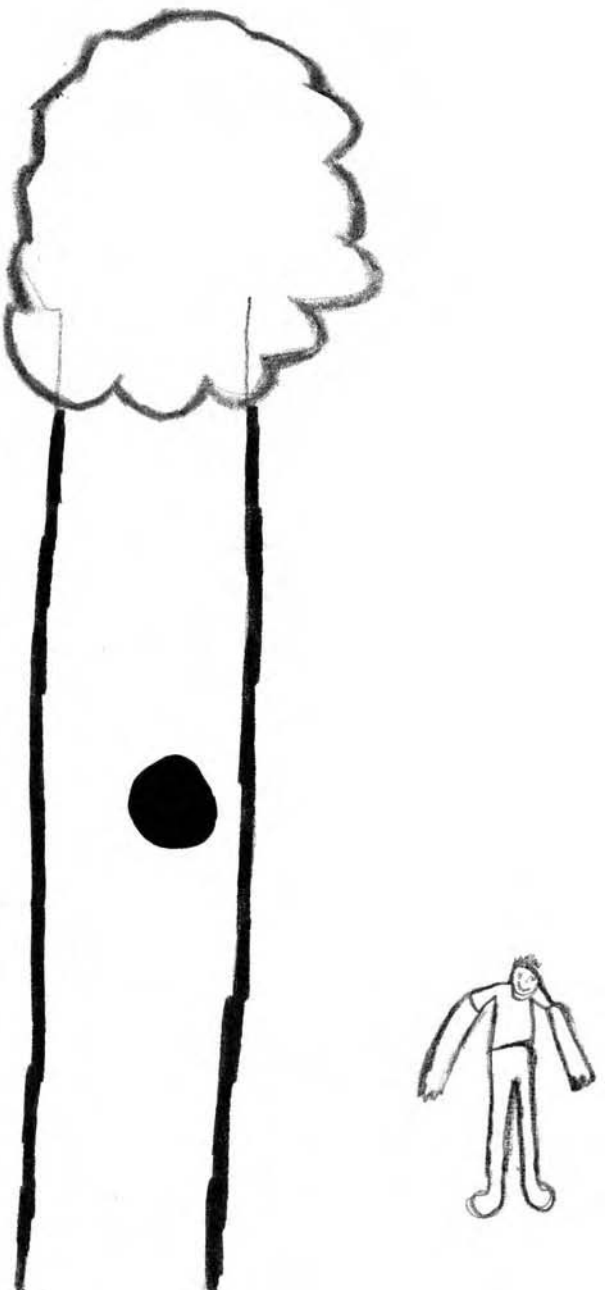

Figure 3-24

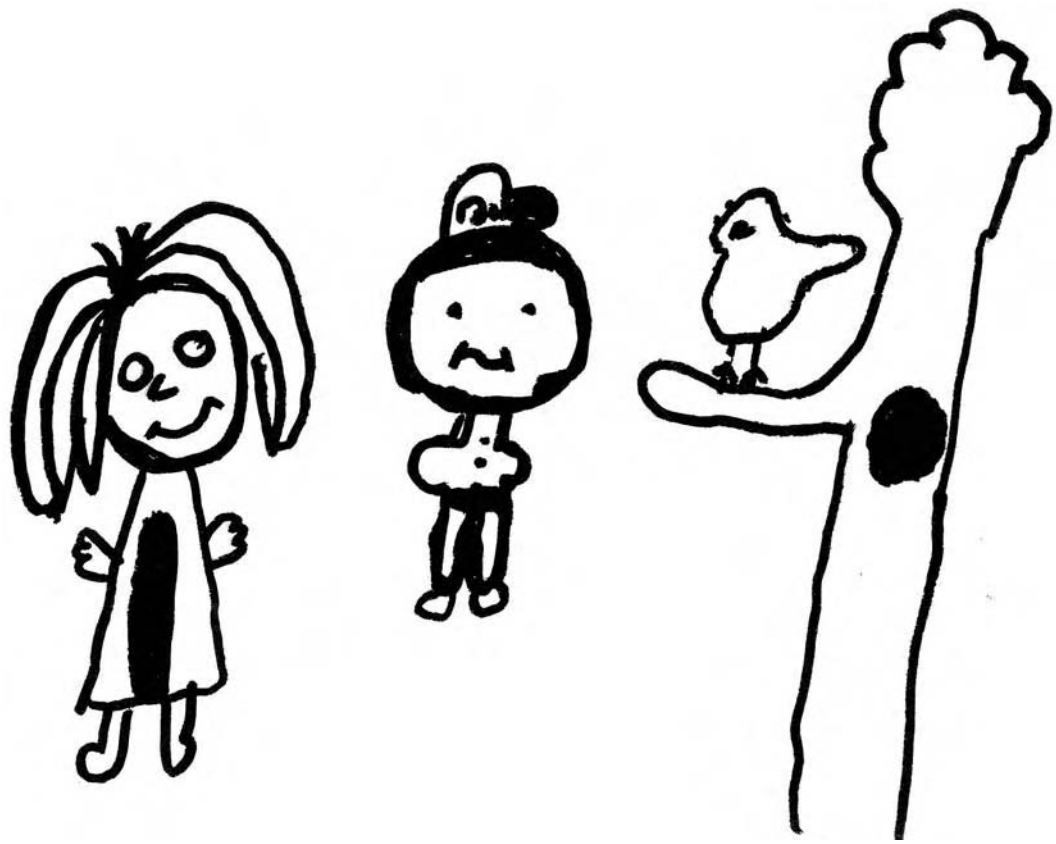

Figure 3-25

Pat

Pat (whose head without a body was observed in Figure 3-22) has drawn an excellent example of complimentary color in Figure 3-26. Here, the lighter section in the middle is red. It contains the floating head and words "confusing, help, fear, hurt, loneliness, and anger." The darker shade on both sides is a complimentary green.

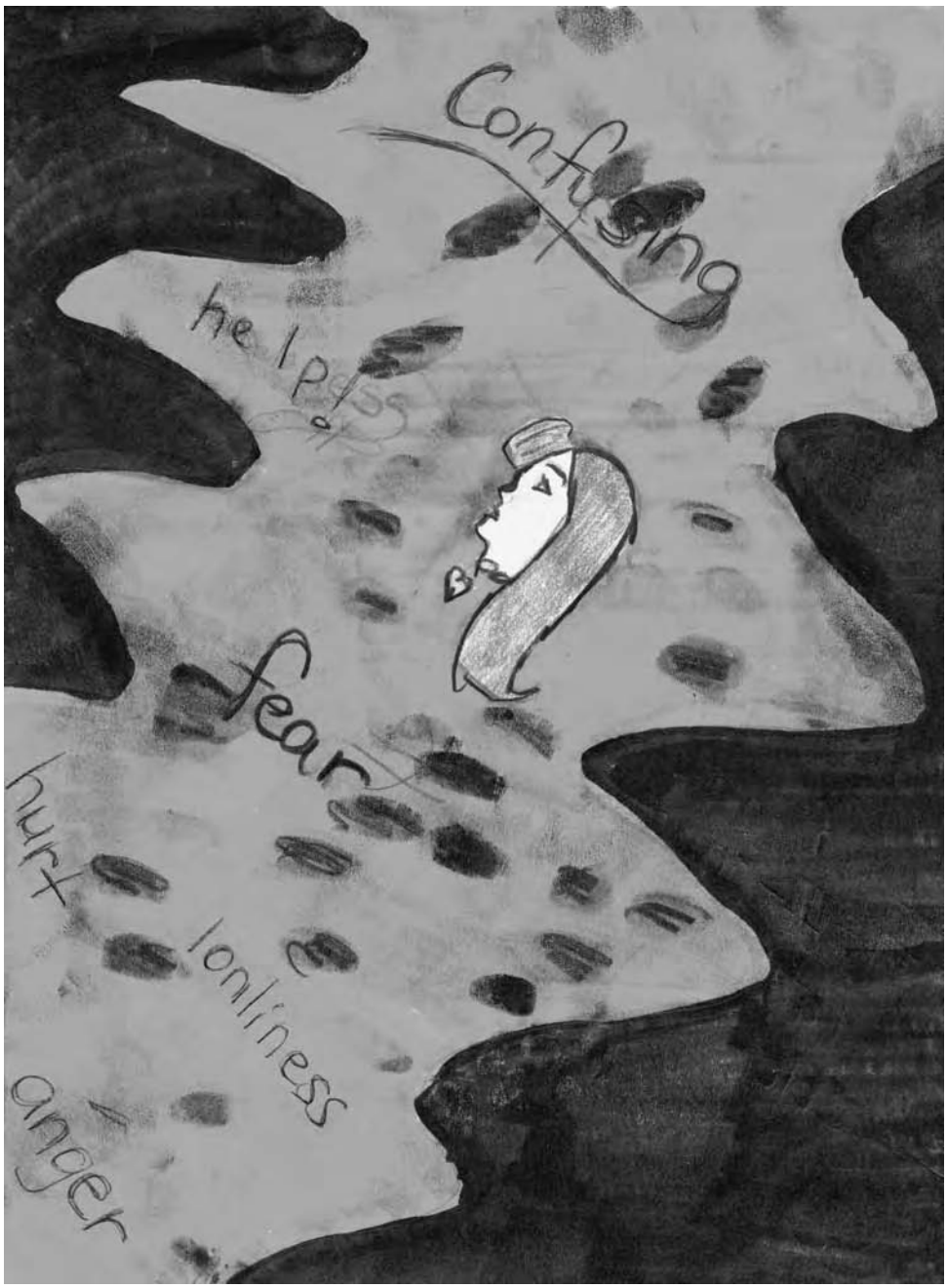

Figure 3-26

Jennifer

Jennifer, age 13, was in therapy for having disclosed sexual abuse by her stepfather. She was in foster care because her mother did not believe her. Her mother was also a victim of sexual abuse. In Figure 3-27, she drew a wedge shape as a symbol of her anger. She stated, "It feels like a big black hole. Sometimes I can keep it in and sometimes I let it out" (portrayed by the relatively small explosion to the right of the wedge). The small house and tree, in comparison, show how large her anger feels to her. Eventually, her stepfather was convicted of abuse and is now in prison. Her mother also dealt with her denial in

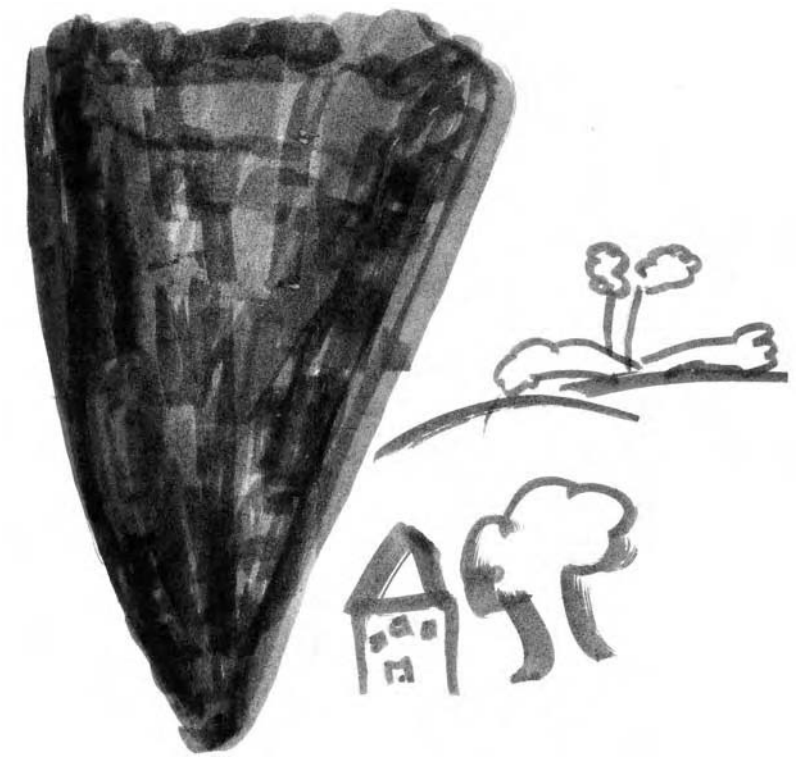

Figure 3-27

therapy and her own past abuse. In the process they discovered that Jennifer's father had been her mother's perpetrator. Jennifer and her mother are now back together as a family.

Katy

Katy, age 6, was in therapy with her sisters. All were in foster care for severe abuse, neglect, and alleged sexual abuse by her father and uncle who were both in jail awaiting trial. Katy had been eating obsessively and gaining a lot of weight. The foster mother thought it was because she had not had food when she lived with her parents. In an attempt to understand more about the eating problem, the therapist asked her to draw a picture about why she liked to eat so much, thinking Katy might not be old enough to have the words to describe these feelings, but could draw about them.

While drawing a house (Figure 3-28), Katy made self-deprecatory statements about herself being too fat, then looked at her drawing and said, "My house is too fat too, it won't fit," then "Daddy doesn't like fat girls, when I go home I'll be safe." While talking about her house, Katy was able to express her fears regarding going home. These revelations helped the therapist and foster mother realize she was overeating as a way of protecting herself. Assuring her she would not have to go home and would be safe with her foster mother helped considerably with Katy's eating problem.

Pat

Another drawing by Pat is seen in Figure 3-29. In this free drawing, she drew her hand cut with blood splurting out while she was saying, "I hate myself." That therapy session began with this self-deprecatory drawing and remarks. The therapist explored with her the reasons why she would feel that way about herself

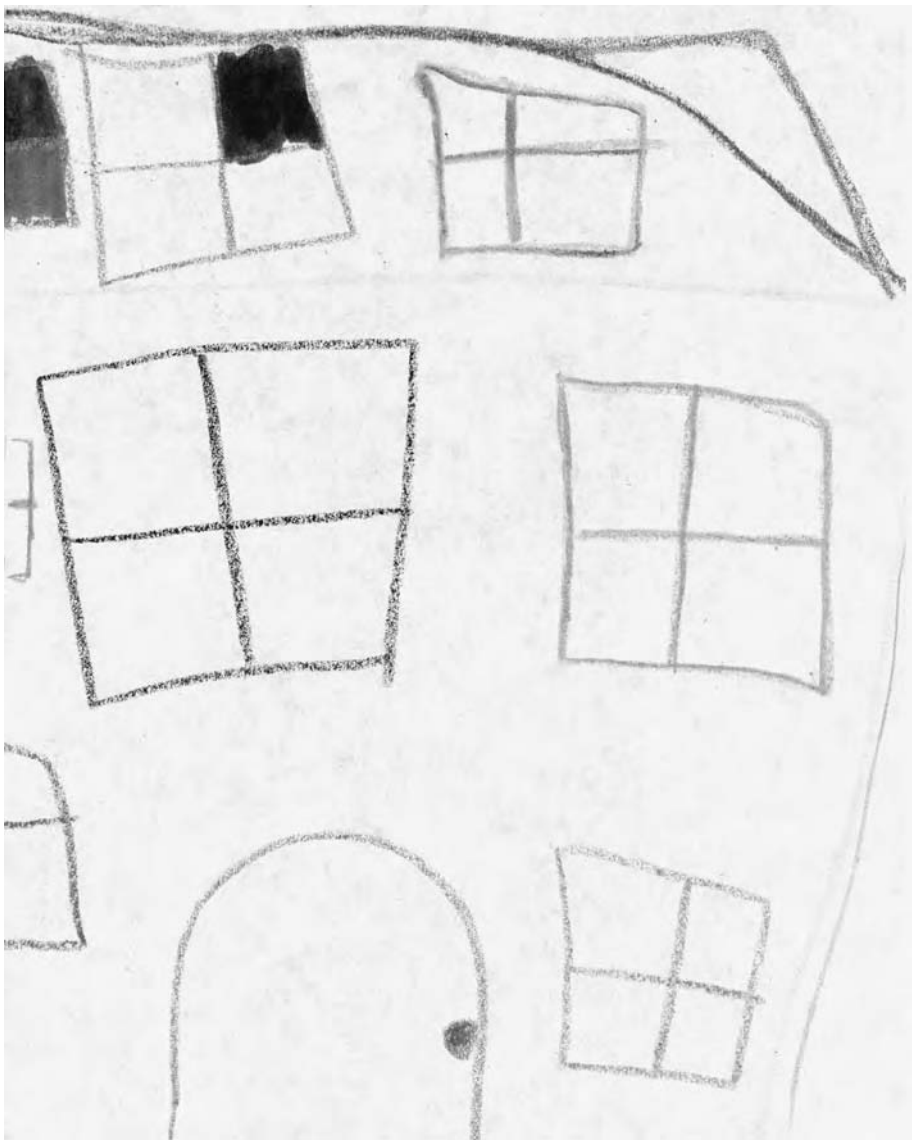

Figure 3-28

and evaluating the possibility of suicidal ideation. Within the extended therapeutic process, Pat began to realize that these were messages she had internalized from her abusive father and were not necessarily who she really was.

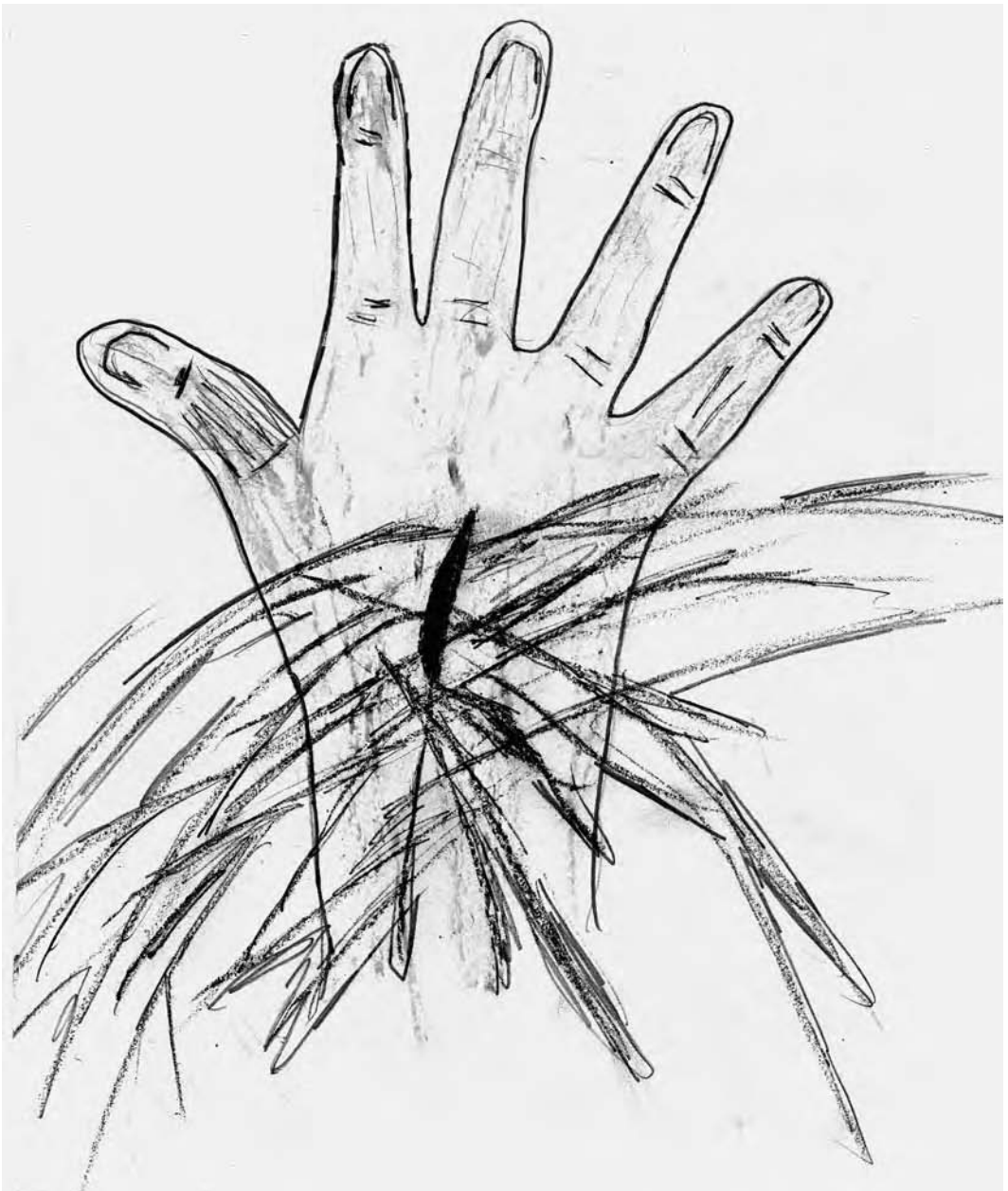

Figure 3-29

Throughout therapy, the therapist also used drawings to identify her strengths. Eventually she was able to join the school band and experience success academically.

In Figure 3-30, repetitive half circles are seen with attempts at blending dark colors. This is a section of a much larger drawing. Pat was in therapy for four years before she graduated from high school and left foster care. She was still in touch with her foster mother and therapist sometimes. Her father was convicted and was still in prison. She chose to not have any contact with her mother. She used drawings to a profound degree to express and process all of her therapeutic issues, which contained many examples of abuse.

CONCLUSION

Creative drawing procedures have been devised over many years and have offered clinicians brief, structured formats that enlarge the interpretive feedback derived during evaluative and beginning therapy sessions. These clinical tools have assisted the diagnostician in discovering different aspects of cognitive and emotional functioning, in addition to aiding the therapist in overcoming resistance and opening new avenues for increased dialogue. The graphic images yielded during these interchanges offer clinicians novel opportunities to pursue the inner and outer world of the clients in a unique and nonthreatening manner.

While numerous drawing directives have been reviewed in this chapter, many more exist and modifications of these procedures only take a bit of creativity to elicit varying responses. Additional directives may include: Draw an unpleasant experience; Draw your favorite animal; Draw your worst memory; Draw a dream, wish, or feeling; Draw a group; and Draw your earliest memory. All can produce much food for thought during intake and subsequent clinical interviews.

Diagnostic evaluations comprise a large segment of developing a workable treatment plan. During a relatively short time, clinicians must rely on various procedures and experiences to assess various

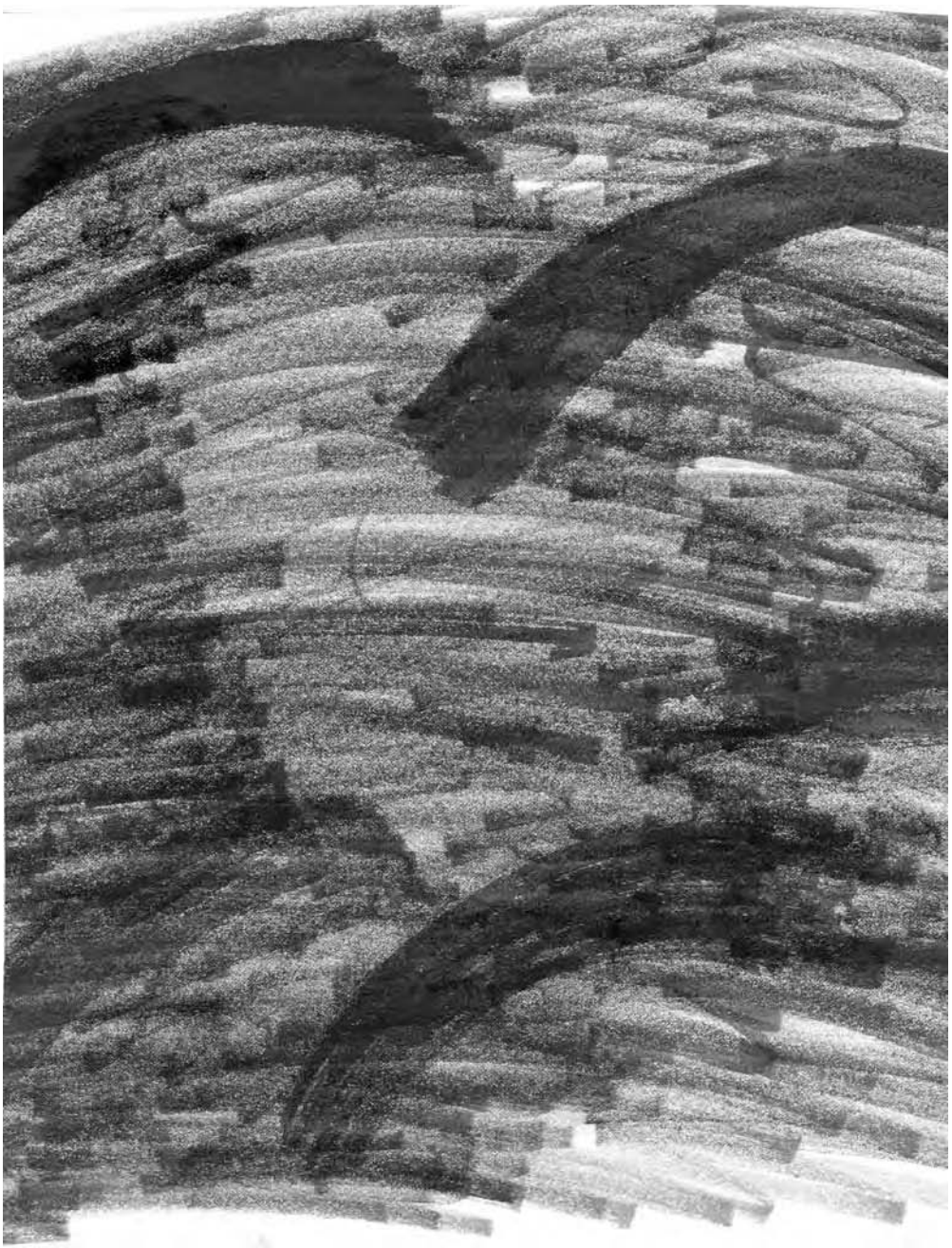

Figure 3-30

aspects of client functioning. No single instrument can provide all this needed information. Thus, it becomes imperative for the clinician to gain knowledge about the strengths and weaknesses of many procedures before choosing a particular test battery.

Throughout this chapter, drawing directives have been shown to be a valuable supplement to psychological testing and for usage during intake interviews. They can provide rich and informative disclosures that are not usually obtained from standard assessment tools. When they are used for diagnostic impressions within the context of other supporting clinical history, drawings become invaluable in providing a rich source for insightful information to referral sources. This knowledge must be obtained and disseminated so that thoughtful interventions and treatment planning can occur, and drawings have been shown to gain a special place in this information gathering process.

4

Using Drawings during Individual Psychotherapy

IMAGES OF PSYCHOTHERAPY

Verbal communication in and of itself cannot express the overwhelming feelings that are disclosed and discussed during the therapeutic encounter. Language oftentimes inhibits the possibilities of client–therapist communication that emerges during the therapeutic exchanges of complex, multilayered, and sometimes intimate thoughts and feelings. By introducing alternative means of expression (such as drawings) into therapy sessions, techniques are offered that have the capacity to more clearly reveal to clients their inner view of themselves.

With the addition of these creative activities within the therapeutic encounter, both children and adults have the opportunity to speak through another voice. The expression of visual symbols provides yet another path for the sharing of personal conflicts and frustrations. These added methods of self-expression convey supplemental avenues for talking about painful issues that may otherwise remain hidden.

Clinicians who use graphic images in their work provide a unique outlet for releasing blockages of intrapsychic distress and supply a vehicle for reflection and insight that provides the groundwork for mature growth. Adding the structure of drawings to therapeutic sessions brings an extra technique for the clinician to overcome a client's resistance or other subtle defenses that could block honest communication and impede progress. By constructing symbolic representations, clients can readily express their concerns and conflicts in a safe and contained environment, then confront them after learning new strategies for problem solving. When treatment goals have been accomplished with the assistance of a broad array of clinical techniques, clients can begin to experience emotional satisfaction, enhance their renewed sense of identity, and more easily accept themselves as competent individuals (Case & Dalley, 1992; Dalley et al., 1993; Landgarten, 1981; Malchiodi, 1998; Riley, 1999).

Mack

Mack, aged 16, reluctantly entered therapy at a community mental health clinic. Brought by his mother, who herself was being treated for a schizo-affective disorder, Mack had been arrested after assaulting his girlfriend. At intake, his affect was flat and he was reticent to reveal his problems and mistrustful of his surroundings. Even with encouragement, the statements he made focused on not wanting to come back for treatment. However, since he was court-ordered for treatment, he was limited regarding his choices and had to attend future sessions, or possibly be incarcerated.

Since the first session was nonproductive in attempts toward reviewing Mack's concerns, the second session introduced drawings to represent his thoughts and feelings. Although limited in his ability to verbally articulate his inner distress, Mack immediately took to expressing himself on paper. With few

prompts, he drew the following illustration to communicate his anger and frustrations (Figure 4-1).

Initially, when therapists see this kind of content in a drawing, they should check with the clients to see if they have had any suicidal ideation. In this case, the therapist was able to see that through his beginning drawing, Mack was able to let down some of his defenses and engage more comfortably in later sessions. Drawing allowed him the opportunity to express himself in a format that felt safer for him and gave the therapist a platform to discuss his intense feelings. Through these expressive experiences, Mack was able to gain new ways to channel his aggression and cope more effectively with his overwhelming and uncomfortable thoughts and feelings.

Drawings expand the possibilities for therapist–client interactions and increase self-expression for the client. They offer tangible meth-

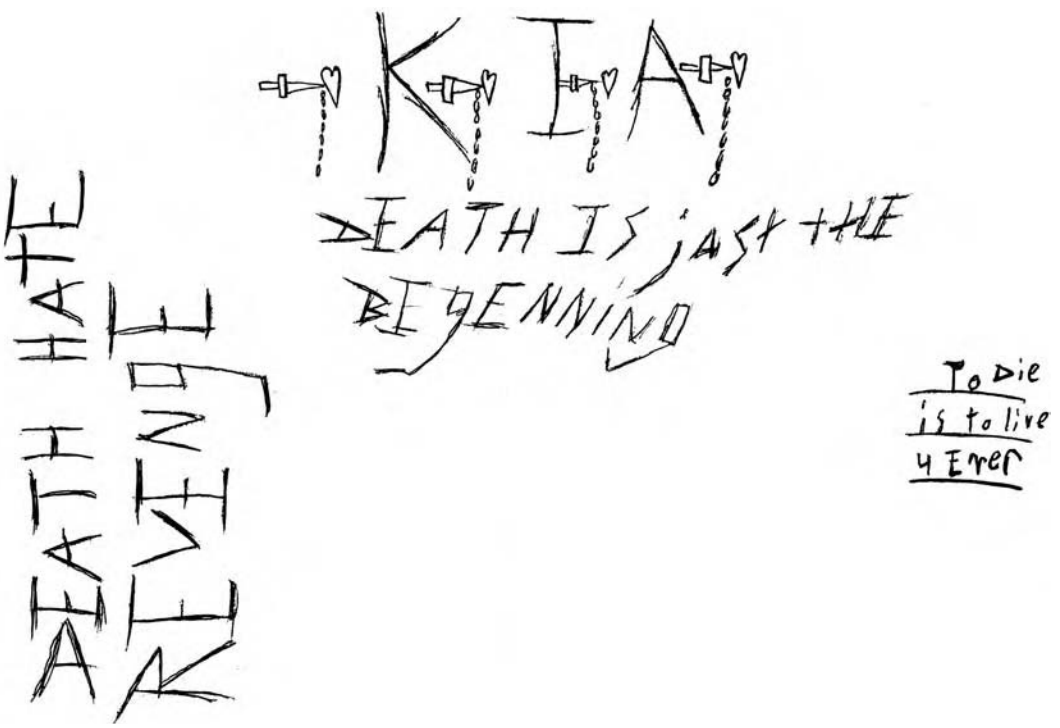

Figure 4-1

ods for breaking the ice and for establishing rapport during the beginning stages of therapy. Drawings are particularly helpful in assisting issues that are associated with (a) identifying goals, (b) gauging reality orientation, and (c) assessing problem-solving skills. They also strengthen the communication of feelings and provide a framework for cathartic-like relief. Their use increases spontaneity and permits access to emotional issues outside the usual norm of everyday awareness that are often difficult to express verbally. The use of art products also furnishes a visual record of feelings and ideas that can be used for therapeutic progress, as well as for review during the termination phase when goals have been accomplished.

Laura

Laura, a 16-year-old adolescent was in therapy for depression and low self-esteem. She was living in a foster home and had not seen her parents in several years. When asked to draw her goals (Figure 4-2), she drew her "door to the future." She filled

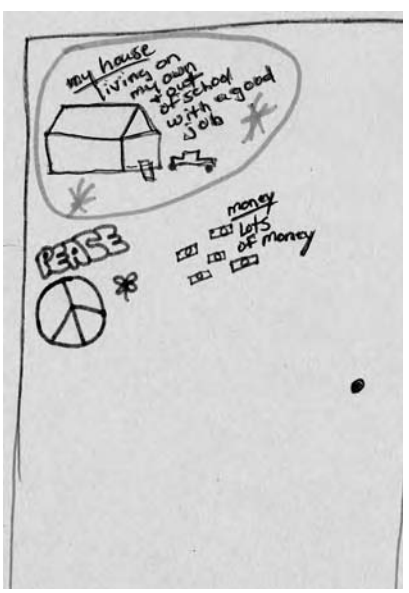

Figure 4-2

only one corner of it with symbols of things she thought would make her happy (i.e., a job, house, money, and peace). This was a start for Laura, and subsequent drawing directives allowed her additional pathways of self-expression.

Especially during therapeutic work with children, clinicians need to create an environment that is safe, pleasurable, and rich in activities that also allow for a release of emotions and frustrations that accumulate during everyday living. According to Moustakas (1959), children look forward to a magical place where they can have an important adult all to themselves, who will actively listen to them and provide the necessary materials that allow for spontaneous communication. Drawings contribute greatly to this therapeutic process where safe outlets of one's self in a free space without fears or constraints is a primary key toward health and maturity.

Children, however, are not the only ones who can benefit from using artwork within the therapeutic hour. Teenagers, as well as adults, also require a nonthreatening and meaningful environment to share their perceptions and conflicts. They too need exposure to a rich variety of methods that can tap into their imagination and bring them outside of their everyday experiences. Using drawings is one way to expand the richness of this interpersonal communication. Through their use, individuals can create graphic images that can later be discussed and reflected upon. It is through this sharing of visual symbols that intimate connections are established and insights gained.

This chapter introduces health and mental health professionals to an array of drawing directives used during individual therapy sessions. A mixture of art directives and drawing formats is offered as suggestions to use during the various stages of the therapeutic process. After considering these novel possibilities, clinicians need to implement these approaches within their own personal situations, theoretical orientations, and interpersonal styles to discover their value. By incorporating numerous art strategies, clinicians'

repertoires for helping their clients become versatile, as well as flexible, and increase the impact of positive therapeutic outcomes.

INCREASING SPONTANEITY AND SELF-DISCOVERY

When used during the therapeutic hour, graphic illustrations have the potential to promote broad outlets of possibilities that culminate in a greater degree of spontaneity and self-discovery. Drawings enhance the client's imagination, especially when the clinician provides a nonjudgmental attitude toward the artwork. The drawn images allow therapists an enhanced understanding of their clients' underlying fantasies and how these hidden dimensions impact on daily functioning, decision making, and goals. By promoting this type of alternate path toward freer emotional expression, therapists are more likely to glean additional insights into problem areas and expanded possibilities for change.

William

Fourteen-year-old William was brought into therapy by his parents due to inattention, impulsivity, and hyperactivity. He was previously diagnosed with ADHD and was started on psychostimulant medication by his pediatrician. Despite this intervention, he was still displaying inconsistent behaviors.

William possessed a very low frustration tolerance, which constantly created problems with peers. He was generally a target of others, primarily due to his overreactions. Subsequently, he was frequently seen in the counselor's or principal's office at school and his parents were often called for meetings about his behavioral outbursts.

As a beginning approach to assessing his everyday problems, William was asked to symbolize his daily functioning on a calendar. Not only was this feedback important for his therapist, but it was of equal importance to the prescribing physician to measure the effectiveness of the medication. The idea of draw-

ing his every day behavior was simple and appealing to William. Each day he portrayed himself in different mood states, with both successes and failures (Figure 4-3). He constructed figures to represent balanced days, as well as exciting times and troublesome ones.

This format allowed William a method for sharing the week with his therapist, as well as for providing him tangible proof that every day would not always end in a horrible dilemma. As can be viewed in each panel of his picture journal, he was able to use this creative approach to improve feedback in an informative and entertaining manner. By introducing this method, William not only enjoyed the creative possibilities of his therapeutic experience but gained a way of self-mastery toward making himself more aware of his progress.

When used in this manner, drawings provide an object of focus during the therapeutic hour and increase, not decrease, the possibilities for verbal exchanges. The sharing of visual images does not interfere in spontaneity or verbal output. In fact, it often assists in overcoming resistance or emotional blockages. Only in particular circumstances (for instance, artistic clients using drawings defensively, or compulsive clients plodding to compose a perfect creation) do drawings hinder spontaneous expression (Oster & Gould, 1987; Oster & Montgomery, 1996).

Esteemed psychoanalyst Ernst Kris (1952) theorized that during the creative process, such as the constructing of drawings, the obstacle between Id and Ego becomes permeable and permits unconscious material to more easily flow into awareness. For Jung (1970), the symbols viewed in drawings provided an exciting passageway to treatment that actually increased dialogue between analyst and patient, both on conscious and unconscious levels. When art activity is perceived in these terms of spontaneous expression that gains access to unconscious material, it becomes obvious that it is indeed a significant vehicle for therapeutic change.

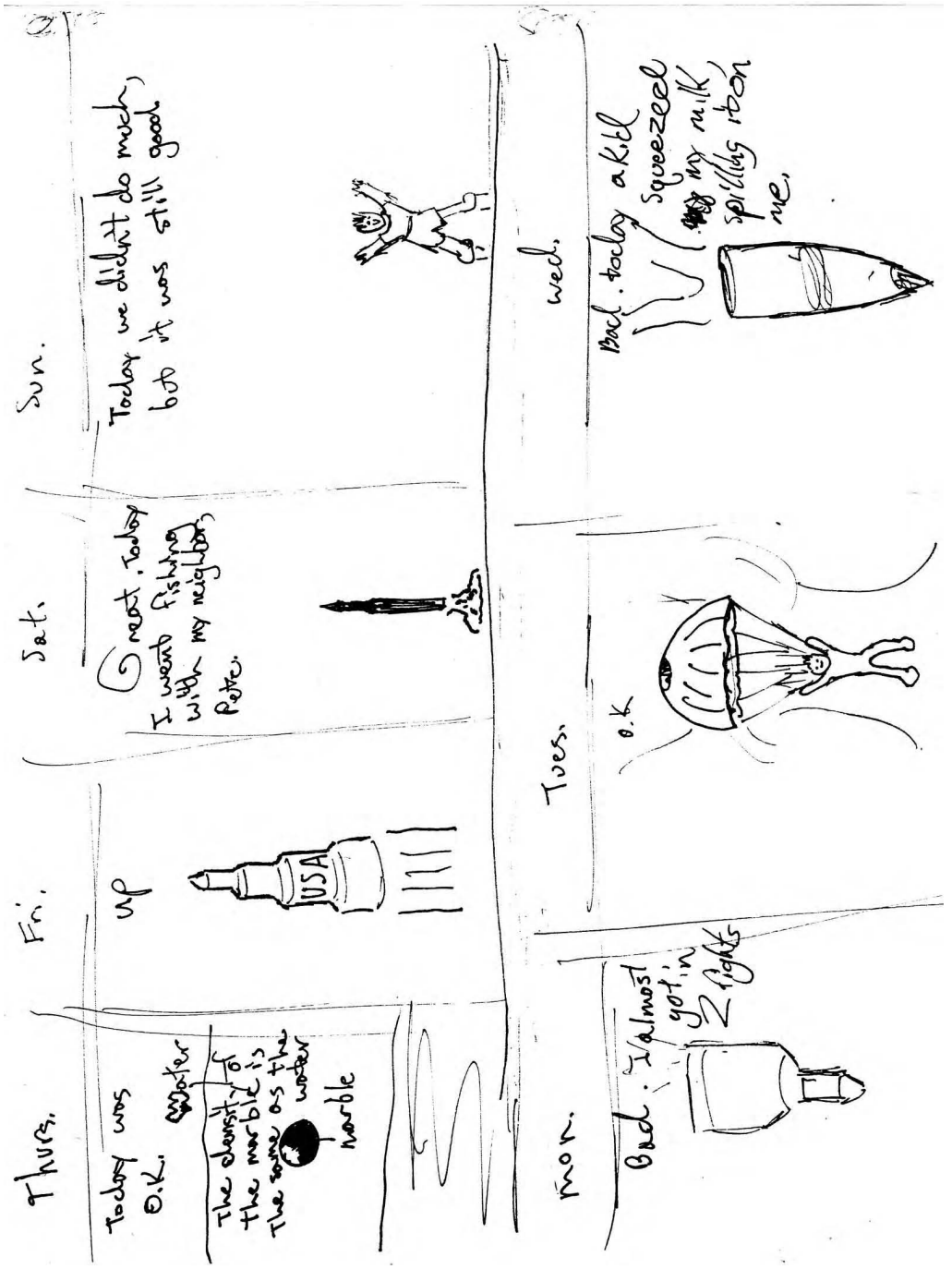
Thurs.
Today was O.K.
The closest I got to the marble is the same as the water
water
marble
Fri.
up
USA
Sat.
Great. Today I went fishing with my neighbor, Pete.
Sun.
Today we didn't do much, but it was still good.
Mon.
Bad. I almost got in 2 fights
Tues.
O.K
wed.
Bad. today a kid squeezed my milk spilling it on me.

Figure 4-3

PROMOTING MATURITY

One of the most important goals of psychotherapy is to increase the client's level of maturity and encourage the practice of improved intra- and interpersonal skills in the everyday life of the client. When drawings are introduced into the therapeutic process, individuals in treatment have the opportunity to experience different viewpoints of their worlds. This clinical technique can expand the personality of the individual by permitting new insights regarding emotional blockages and exploring different attitudes toward change. Drawings become the visual benchmark in this chain of events, leading to improved mental health and development.

A quote by Virginia Axline (1969) can further define this concept of growth:

> When the individual develops sufficient self-confidence to bring his self-concept out of the shadow land and into the sun and consciously and purposefully to direct his behavior by evaluation, selectivity, and application to achieve his ultimate goal in life, i.e., complete self-realization, then he seems to be well organized (p. 13).

Tools of Active Change

The use of drawings in therapy stimulates creativity and frees the individual to become unstuck and to do something. It is an active process implemented during sessions to reinforce action through the activity of drawing and offers a source of satisfaction and accomplishment. By integrating nonverbal techniques, such as drawing, into the therapeutic hour, the resulting graphic expressions become a vital instrument for positive change to occur. The art activities also offer a way to record and reencounter thoughts and feelings several times over to enhance learning (Safran, 2002).

Drawing directives provide novel experiences for individuals in therapy to explore, without the distortions of verbal defenses. They allow for physical forms of reality through art media and the constructed products. It is within this novel engagement that clients' thoughts and ideas become more flexible and, as a result, they

begin to change. This growth and change allows for an increased tolerance of ambiguity and provides the chance for clients to see themselves in new satisfying ways.

Drawings become a primary focus and reason for this shift and offer an ongoing visual record of the experience. Clinicians only need to supply minimal drawing direction to access the necessary images that portray those parts of the person's life that are not being accurately expressed or realized. In our everyday experience as therapists, we see that clients really do have these inner images at their immediate disposal. All it takes is a few prompts and a few minutes to manufacture these symbolic creations onto paper. The outcome of this strategy enables individuals in treatment to lower their emotional defenses and become more accessible to other possible approaches to therapy and ultimately to living more satisfying lives.

One rather easy and direct way to introduce the idea of drawing during sessions as a method for identifying areas of needed change is to suggest that the client "Draw a problem." This basic directive supplies a strong message to clients that healthy turnabouts can occur when the area for needed change is clearly evident and understood by both parties. It has been our experience throughout years of practice that this simple directive opens many doors to new perceptions, as the following examples illustrate.

Craig

Craig, aged 11, was seen in counseling sessions on and off for many years. Initially limited in expressive language skills (when younger he received speech therapy and extra reading classes in school), he was much more adept at communicating through drawing activities. After not having seen him for approximately eight months, the therapist received a call from his parents for a preventative appointment. He was now entering the sixth grade and had always experienced adjustment problems when beginning a new class level. The parents were expecting him to have added problems in making the difficult transition to middle school.

Besides the anticipated difficulties, they reported that Craig had also ended the school year on a downward spiral, displaying many frustrating and aggressive behaviors, including fighting with peers.

Upon reentering the therapy office, Craig immediately took some paper and a pencil to draw and was instructed to portray his problems. Without much deliberation, he created a steam engine (Figure 4-4) to represent the inner tension that he had

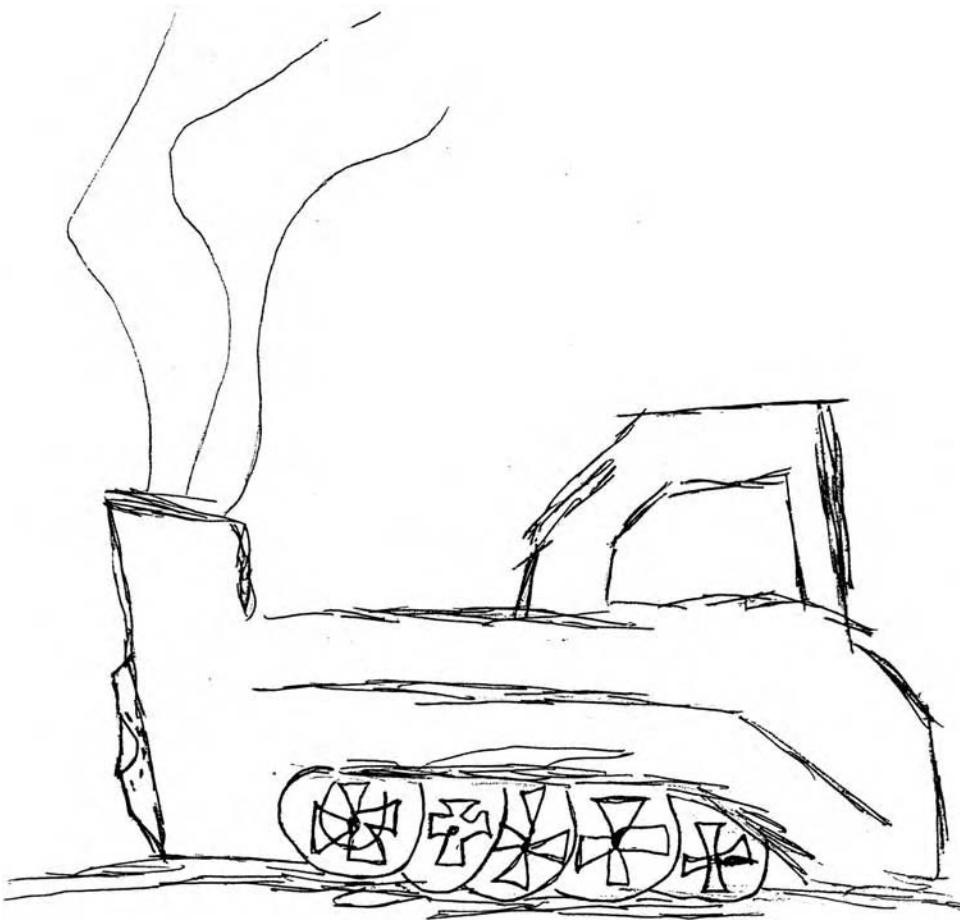

Figure 4-4

been experiencing. He commented that he had been feeling very frustrated and confused over the past several months.

Pointing to the illustration, he stated, "this is like me, blowing off a lot of steam." From this graphic portrayal, he and the therapist sat down to review all the problems he had confronted since his last visit and discussed possible strategies to channel his frustrations in more acceptable ways. Craig was relieved to share some of his inner turmoil and was more than willing to use drawings again to share his conflicts and reduce his stress.

Allison

Allison, aged 13, was brought to therapy by her parents due to escalating disagreements and arguments at home. The oldest of four sisters, Allison viewed herself as needing to be in charge and in control. She complained of being wronged and misunderstood and of experiencing lonely feelings. At the time of intake, her parents were punishing her more often than not. Both she and her parents were beginning to feel helpless about how to resolve their everyday issues. For her part, Allison was viewing everyone as being against her and was rapidly falling into a depressed and negative cycle where her grades were declining and her friendships were waning.

Allison presented for the initial session looking angry and reticent to talk about her problems. Instead of forcing her to respond to questions, she was asked to draw how she viewed the problem. She quickly sketched the following illustration (Figure 4-5) and used it as a springboard to bemoan her punishments and loss of privileges. Her lament of "No one understands me" to her parents' list of reasons for keeping her in her room underscored her feelings of helplessness and loneliness.

The value of handing her a piece of paper to draw her problem was obvious from her willingness to complete the task without opposition or defiance and from her relaxed posture. She was thankful that the therapist did not force her to talk until


6 Months Ago
Jerry's Subs & Pizza
Me
Heather
Lindsay
Stephanie
NOW!
Place: In My Room
No One Understands Me
You can't go out! We don't trust you! You have bad grades
Please!
Me
Dad
Mom

Figure 4-5

she was ready. And she was equally appreciative that the therapist was willing to help in trying to understand her dilemma and to assist her in working through her difficulties.

DOCUMENTING PROGRESS

According to Carl Rogers (1961), the engagement of psychotherapy is a "process of becoming," and as those involved in the therapeutic process soon realize, it is an ongoing challenge. Treatment direction is not static; clients soon realize the fluidity of change as their beliefs are constantly challenged and revised. Drawings are an excellent device for delineating and documenting this ongoing movement toward health. They also provide numerous opportunities for timely interpretations and lively discussions.

A basic principle in therapeutic intervention is to offer a safe and nonthreatening atmosphere that is conducive to assisting clients to reach their potential. In working toward that goal, clients become cognizant of the roles they play or the public masks they wear during their everyday lives. Most people usually develop pretenses or external facades to thwart inner confusion or anxieties, but during this process of deception, they unfortunately become estranged from themselves (Rogers, 1961). This tendency toward hiding from their true selves especially rings true for troubled teenagers who attempt to camouflage their fears or sadness behind outward appearances of anger and belligerence (Oster & Caro, 1990; Oster & Montgomery, 1995). By asking clients to "draw their masks and what is behind them," clinicians get an opportunity to explore this concern in a unique way (Oster & Gould, 1987; Oster & Montgomery, 1996).

Jim

Jim was referred to therapy following the sudden death of his mother in an automobile accident two months before. He had just turned 15. He had not been able to sleep at night and his grades

were dropping. Initially, he had been withdrawn in therapy and unable to verbalize any thoughts or feelings. When asked to draw his mask he drew a happy face (Figure 4-6). When asked to draw what was behind his mask, Jim drew a "sad and scared" face (Figure 4-7). When talking about his drawing with the therapist he

Figure 4-6

Figure 4-7

was able, for the first time, to talk about his underlying feelings and begin to process his grief and fear.

The Benefits of Using Drawing Techniques

From the experiences derived from many years of clinical practice, we have discovered that individuals of all ages can benefit and thrive using creative techniques in psychotherapy. Drawings, like other imaginative outlets, offer novel access to those thoughts and feelings that are outside the everyday norm. By using drawings in sessions, sensitive issues are revealed and expressed that have often been unavailable through words alone. Intense feelings, which may have been suppressed during verbal interactions, can more readily emerge with the use of drawings. Confusing thoughts can be channeled through graphic images and symbols that promote feelings of intimacy and trust and help clarify feelings.

Although everyone can use drawings to enhance communication, certain populations use it more freely and often make excellent use of the chance to draw during their therapeutic pursuits. For instance, creative individuals who already use art materials for self-expression are quite receptive and responsive to the use of drawings in therapy. Children, of course, are usually eager to use markers and crayons because it is a medium that they find more comfortable than talking. Also, children see the benefits of drawing as a means of communication and are rarely resistant to its use.

Other, more specific clinical populations can benefit from using drawings during their therapy hour. For example, in the treatment of eating disorders, pictures can mediate between the inner and outer world and between the client and therapist (Schaverian, 1994). Drawings become an object of transference that can temporarily and unconsciously become a substitute for food. Art productions in these circumstances facilitate a beginning movement toward symbolism and away from food obsession.

Artwork has also been shown to clarify the nuances of working with ADHD children and adults (Safran, 2002). Drawings enhance the expressions of frustration and bewilderment that arise with this

disorder. Their use allows for concrete markers that provide for strong visual learning tools and lend valuable structure to sessions. The graphic record of the experience also is a reminder of the progress that has been made to individuals who would otherwise have difficulty using what they have learned without constant reminders and reinforcers.

Drawings also become valuable tools with resistant clients. For nonverbal, withdrawn, or rageful individuals, the focus on art products can facilitate spontaneous expression of inhibited or prohibited thoughts and feelings without fear of negative consequences. When working with the less expressive client, drawings become an open channel for communications. When confronted by angry clients who may be overwhelmed by their feelings, drawings can become a substitute arena where destructive impulses can be sublimated.

Overcoming Resistance

It is common during initial therapy sessions that individuals are unwilling to construct drawings. Even children may resist the use of drawings on occasion due to insecurities about their drawing ability or their underlying fear of failure. Or they may appear lost and unable to produce anything imaginative. This experience may be especially true for children who have been continually abused or traumatized to where they feel emotionally numbed (Malchiodi, 1998).

Also, adolescents who may be oppositional or adults who perceive drawing as irrelevant or infantalizing may oppose its use during their sessions. This resistance is not unexpected and may merely be defensive posturing to avoid dealing with relevant issues, painful disclosures, or a reluctance to give up the perception of control to an unknown person. When faced with these difficult and frustrating moments, alternative methods must be used. Fortunately, many clinical tools have been created that help therapists to engage these resistant patients and help them down a different path to bridge this impasse (Gabel, Oster, & Pfeffer, 1993).

DRAW-A-STORY GAME

A drawing technique conceived to overcome the resistant client, D-A-S (Gabel, 1984), was adapted from ideas expressed by child psychiatrists Donald Winnicott (1971) and Richard Gardner (1975, 1993), who both worked to bring numerous and imaginative approaches into overcoming barriers of their resistant patients. This game, developed by Stewart Gabel, MD, former chair of psychiatry at Children's Hospital in Denver, provides an alternative and often enjoyable method of engagement for the examiner faced with clients (especially children, adolescents, or lower functioning adults) who hesitate to fully participate in evaluative sessions.

Borrowed from Winnicott's Squiggle Game, where the therapist and client interact through exchanging marks and then attempt to turn them into something that is therapeutically meaningful, the D-A-S technique provides a more structured exercise to reach emotionally charged issues. In developing this method, Gabel (1984) also borrowed from Gardner's "mutual storytelling techniques," which have become standard fare for clinicians working with children.

The D-A-S game emphasizes interactions between therapist and client by alternately drawing lines on the paper. The client is asked to elaborate on the lines to construct a picture. When the product is completed, questions from the examiner are introduced. Inquiries can include "Who is that?" or "What's going on there?" to attempt to break through the resistance to engage in lengthier discussions.

After this initial give-and-take, the therapist requests another mark on a different sheet of paper and then attempts to make this line into another picture. This drawing is a prolongation of the examinee's original picture. The sequence culminates in a series of pictures that ultimately produce a more complete story. This approach maximizes rapport with the client and increases the interactional process to enhance diagnostic material and add awareness for the client (Oster & Gould, 1987).

When a series of drawings with subsequent stories are completed, they can be reviewed to produce alternative outcomes that enhance the patient's problem-solving skills. These alternative stories create additional and possibly more satisfying outcomes to the story dilemmas. This approach can increase the patient's cognitive and emotional repertoire, as well as assist in overcoming specific problem areas. By providing this structured drawing directive or game, more adaptive problem solving is likely to occur. The therapist can expand the themes gained from these stories into future avenues of exploration.

INITIAL STAGES OF PSYCHOTHERAPY

Discovering Pathways to Establish Trust

Clinicians are often confronted by clients whose behaviors and feelings can be described as exceedingly rigid, having little focus, being out of sync, or being fragmented (Axline, 1969). The first job of all therapists is to create an atmosphere that permits individuals to safely explore their weaknesses without criticism. Only after the passage of time in therapy can trust be established that produces enough protection to divulge emotionally charged material. This process then elicits the opportunities for learning strategies that overcome blockages and expand therapeutic direction.

The therapeutic process that includes drawings has multiple frames. The structure (i.e., the therapeutic contract, time frame, and room) and the relationship itself provide boundaries or frames for the therapeutic process and establish a safe environment to explore feelings, fantasies, and attitudes. Additionally, the drawings frame the experiences and contain the emotions, anxieties, and fears; this boundary supplies the inner sanctum of the psychotherapy setting (Schaverian, 1994).

Using drawings at the start of treatment enables alternative outlets for release of conflicts. Many areas of concern can be revealed through pictures. These emotional trappings may seem less constricted through the use of drawings and are more

accurately portrayed. At the same time, there is an enhanced acceptance of mixed feelings that can be expressed.

This integration is often noticed to a greater degree through drawing activities. Throughout the ongoing therapeutic process, increased freedoms from disabling limitations are noticed through the visual records, as clients learn to overcome previously relied upon, but ineffective strategies of interpersonal functioning. Their renewed growth allows clearer direction toward psychological sophistication and inner growth.

Two directives have been particularly helpful throughout our experiences to elicit underlying tension and to better assist in the expression of troubling thoughts and feelings. These instructions in overcoming resistance during intake interviews and beginning therapy sessions include "Draw your ideal self" and "Draw your world." Both requests have produced remarkable results, as indicated by the following two illustrations.

Abigail

This was the third hospitalization for Abigail, an almost 18-year-old female, who was admitted onto an inpatient floor due to depression and a suicide attempt. She overdosed on her mother's medication after leaving her diary and a note on a door indicating she wanted to die. Reportedly, she had been developing this plan for a week. She had also been hospitalized previously for an eating disorder, in addition to chronic bouts with depression and anxiety. Additionally, she had been in weekly outpatient therapy sessions and had been treated with a variety of antidepressant and antianxiety medications.

At the time of the evaluation, Abigail had been living with her professional parents and two younger sisters. She had been in advanced school magnet programs since 4th grade and was considered a good student. She had also been a ballet dancer for many years. However, due to her ongoing emotional

difficulties, plans were being made to send her to a residential treatment program in another state.

Abigail indicated that she had been experiencing depressed periods ever since entering high school and had a difficult time making transitions each year. She stated that she had always been somewhat shy, but her nervousness and self-consciousness had increased. She also mentioned that lately she had become more withdrawn and isolated from her peers. Her only strong reaction to any of the interview questions occurred when she was questioned about the possibility of an eating disorder. She became visibly upset and annoyed and denied the presence of one. She also indicated that going out of state would not help her, as she had already been through a local program without success.

Her scores on the mood questionnaires indicated that Abigail felt extremely worried, upset, sad, lonely, and hopeless that she could change things for herself. She indicated that she often felt like hiding from people, viewed herself as no good, and perceived life as unfair. Somatic complaints of tiredness and restless sleep were also mentioned. She perceived life as "too rotten to continue" and that her life was no longer worthwhile. She thought a lot about hurting herself but not really killing herself, but did think that if things did not get better she would commit suicide. Certainly, her responses indicated a strong "cry for help."

Projective aspects of the testing (Rorschach, TAT, Drawings) suggested severe depressive themes and suicide ideation. Abigail constructed a drawing of herself before entering the hospital as a time bomb that was ticking away. Themes in her stories implied a high degree of sensitivity to her surroundings (viewing much of her world as bleak), feeling unnoticed and guilt-ridden, and being highly reactive to emotionality around her. She also seemed to have many inner conflicts that were appropriate for her age, but was unable to share these on a meaningful level. This inhibition increased her sense of isolation and placed unnecessary barriers between herself and others.

To establish a framework of hopefulness and to begin to establish a bridge to her inner concerns, the examiner requested that Abigail portray her ideal self. It was believed that through this drawing, she would not only share her current worries, but also revel in the thoughts for her future. Instead, Abigail seemed preoccupied with her present needs and her own insecurities.

As her drawing suggested (Figure 4-8), she was focused on her weight and overly sensitive to her appearance. Her present disapproval and somatic complaints were apparent. She wanted

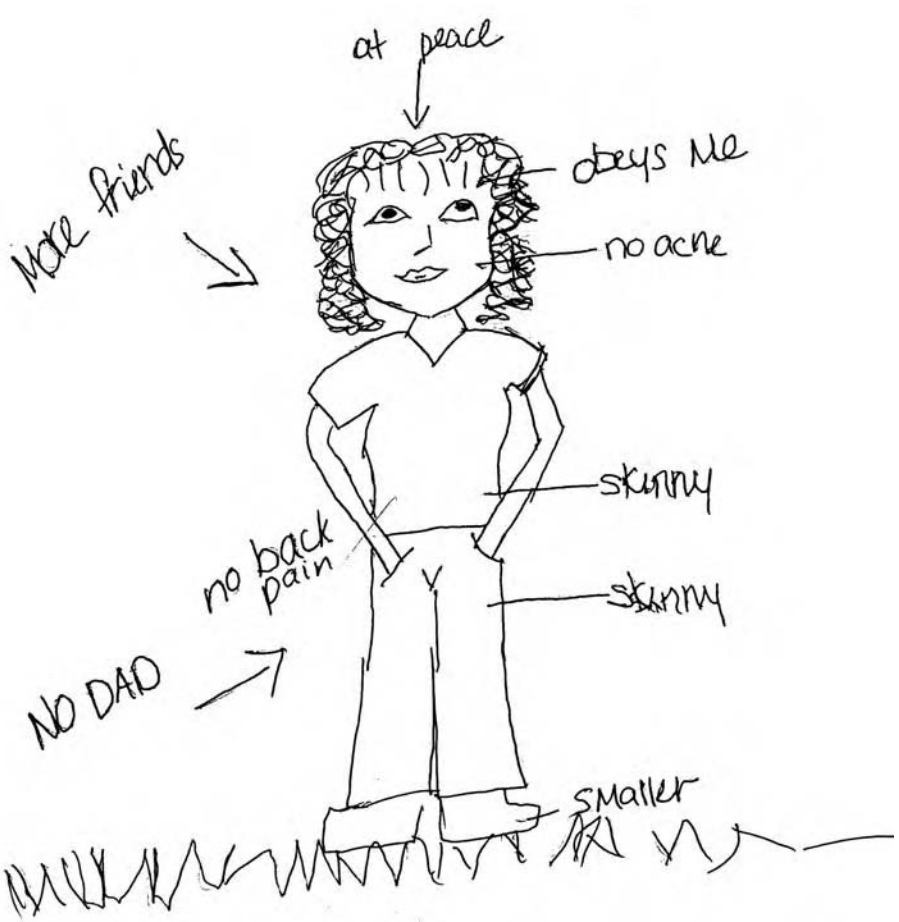

Figure 4-8

to look better in order to make more friends. She also revealed that she wanted to rid herself of her disturbing thoughts and gain greater control of her unpleasant emotions. As an afterthought, she drew the words "NO DAD," and discussed her view of her father as too overbearing. With this picture as a highlight of her needs, she spoke much more freely of her weight concerns and her wish to get better.

Sonya

Sonya was a 15-year-old only child, who had become much more withdrawn and had lost interest in many activities that she had previously enjoyed. According to her parents, the past two years had been exceedingly conflictual between Sonya and them, and had resulted in Sonya becoming involved in many behavioral difficulties. She had been arrested for shoplifting and possession of cigarettes and had skipped many classes by leaving school with peers. Finally, she agreed to be sent to a boarding school, but did not choose to remain after six months. Upon returning home, however, her behavior and emotional difficulties had continued.

As part of a broader evaluation, Sonya was instructed to "Draw your world" as a way to introduce herself to the examiner. While the usual drawing is completed by making a large circle on a paper and illustrating various things that clients possess or their daily activities such as going to school, Sonya's diagram was different and reflected her apparent cry for help. In the construction of her world, Sonya related all the feelings that she had been experiencing (Figure 4-9). She attested to recent depressed feelings over a breakup with her boyfriend and found it difficult to relax.

Also, through talking about the drawing she indicated that she had difficulty falling asleep, had trouble concentrating, felt restless, and was fearful about embarrassment in public. She suggested that she was pained by her tendency to feel so withdrawn and could no longer concentrate on school work. She

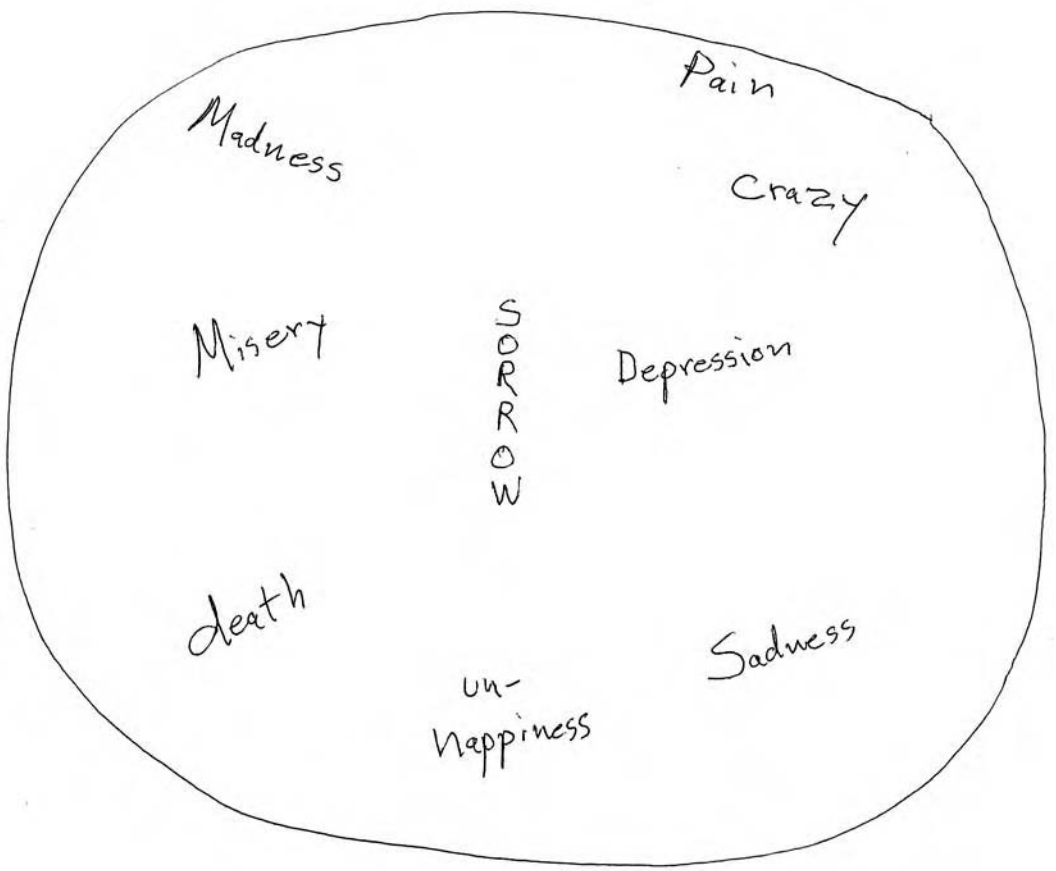

Figure 4-9

also felt much sorrow over the problems that she had created at home and she perceived that she had been instrumental in the arguments between her parents. Because she had a difficult time modulating her underlying tension, she felt fearful and unsure of her surroundings and was thinking that she was crazy. With this drawing, combined with other test data, a course of treatment was outlined for her and her parents, who were all appreciative of gaining therapeutic direction.

Empowering the Client

At the beginning of treatment, many clients seem to perceive their clinicians as "all knowledgeable." They frequently want quick advice and hope for magical answers that take the form of a prescription, or clear solutions to their problems. They may even have formed beliefs that their conflicts will instantly disappear after consulting with "the doctor."

The introduction of drawings from the beginning delivers a strong message that the onus of any therapeutic change will fall upon the clients themselves. This message immediately detracts from the dependency of the relationship and allows freer movement within treatment. The act of drawing and the drawing products become a springboard for active discussion, deeper understanding, and expanding the reference points for lasting change.

Even during the goal-setting stage of the initial meetings, drawings add structure to the sessions and help define and clarify the objectives. Drawings serve as concrete tools that frame each session, as well as provide a vehicle that facilitates desired change. Information that is gathered from various drawing directives is not always available through talking alone. The drawings provide the potential to convey metaphors, tell stories, and present personal views of the world through their images and the reactions produced by the sharing of them (Riley, 1997).

Directives, such as "Draw your world," "Draw a family tree," or "Construct a family shield," make history gathering at intake an enjoyable and highly informative exercise. The instructions to these drawings focus the discussion and add meaningful outlines to the session. These directives establish a creative format that communicates a unique experience is about to take place.

Hank

Hank was 45 years old when entering therapy. Married with several children he was going through many personal and financial crises. As part of the intake process, he was asked to construct a drawing of his family shield to portray his perception of their identity and to solidify the views of his world. Through the process of drawing and sharing his impression, he was able to discuss his family history in a brief and structured manner and was willing to accept that this novel way of sharing as another avenue to pursue his expression of concerns (Figure 4-10).

Using the picture as a springboard, he reviewed his present values identified in the drawing as living within a close community (homes on the left), education (books in the middle), travel (airplane and van on the right), and ideas (both he and his wife were creative individuals). Through this approach, he later contrasted pictures between himself and his parents, his fears, problems, and future dreams. This process allowed much freedom for interpersonal sharing and documented his progress through therapy.

Patient Considerations

While the primary emphasis so far has been on the benefits derived from introducing drawings into therapy sessions, there are exceptions to be considered. For instance, some clients are particularly fearful of how their drawing will be perceived, or some may be too anxious about personal revelation and balk at the idea of artwork. Also, patients who are vulnerable to stress from demands placed on them, no matter how minor, may be overwhelmed at the idea of performing a drawing task. When working with psychotic or defenseless individuals, for example, drawings may be perceived as too threatening to their well-being and, therefore, detrimental to the therapeutic process.

It also becomes crucial during this time for therapists to listen to their clients' personal explanations of the drawings before pro-

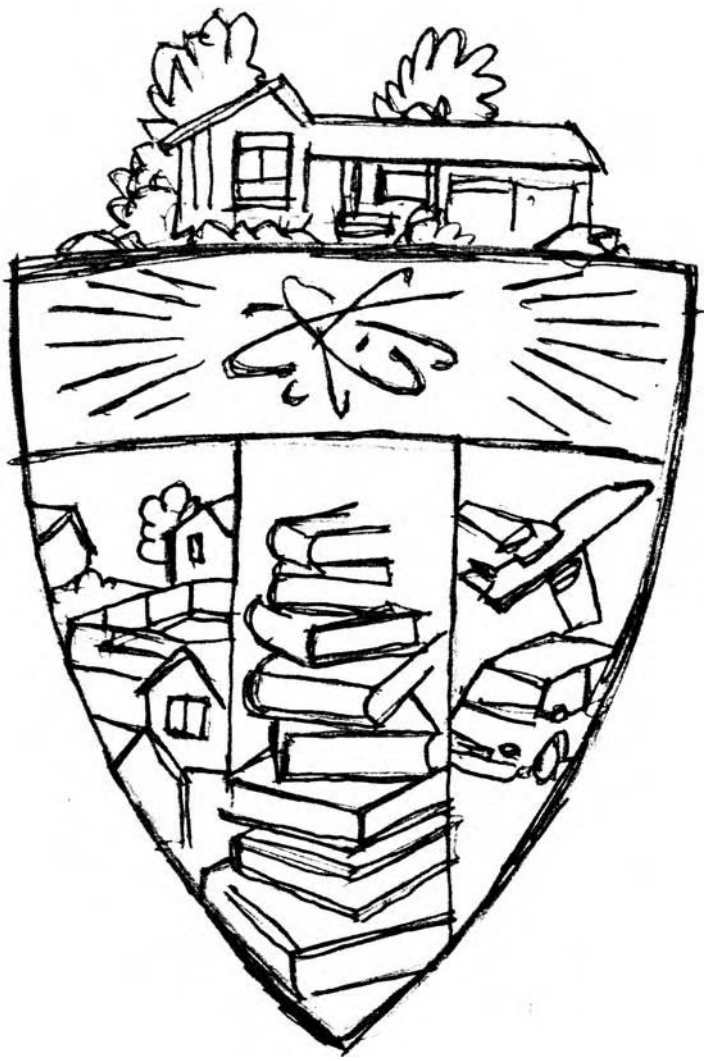

Figure 4-10

viding interpretations or alternative meanings. The artwork produced is more than merely a fixed indicator of pathology. The images can become rich landscapes for ideas, past associations and experiences, meanings, and expressed feelings. This nonjudgmental stance supports the clients' own initiative for positive change and increases their independence.

In all these cases, the therapist using drawings needs to be supportive of the process and art productions and must only interpret relevant information that will not upset a fragile patient. The therapist should emphasize the patient's strengths and use the drawings to enhance participation during the sessions. When confronted with these kinds of obstacles, it would be more prudent to interpret the resistance and offer to draw at a later time, rather than getting into a dispute over the need to draw.

Dealing with Power Struggles

On occasion, therapists find themselves in power struggles with their clients. It is possible that even a simple request for a drawing will exacerbate this situation. Patients may hesitate at the instruction to draw, fearful of revealing too much of themselves. To overcome their objections, it may be prudent to not elaborate on their drawings initially. However, clear expectations are given that the sharing of their drawings is significant to the understanding of their inner selves. Through the formation of the relationship, it may even be helpful to draw without any expectation of talking. This safer approach can create a more relaxed environment that even increases spontaneity.

Some patients, though, may be threatened by merely being observed during drawing activities. If this anxiety produces missed appointments, it becomes preferable to suggest that the constructions can be completed at home and brought to future sessions. It is important that therapists continue asking for drawings in the actual sessions, as observation of the process is a salient part of using art as a clinical tool.

TECHNIQUES THAT ASSIST THERAPEUTIC BEGINNINGS

The Scribble

One way to overcome resistance during beginning therapy sessions is to use techniques that emphasize spontaneity without having to

feel like an artist. A fun and enlightening procedure used to overcome apprehension toward the image-making process is the scribble technique described by Florence Cane (1951). This method is valuable in establishing rapport with adolescents and adults, and to a lesser degree, with preadolescents (Kramer, 1971). Through the years, the scribble technique has been employed as an intervention in various clinical populations to reduce inhibitions and elicit spontaneous imagery from the unconscious (Hanes, 1995). This engaging approach allows clients in therapy to express themselves freely in a nonthreatening and enjoyable manner.

Before the request is made to scribble on paper, therapists can also encourage the use of warm-up exercises, such as copying figures freely in the air with wide, sweeping motions. These bodily movements increase relaxation that helps the clients to transfer these exaggerated strokes onto the paper.

These expansive activities create a freer atmosphere within the therapy room, making it easier to overcome initial inhibitions. The exercises also permit enhanced motor dexterity, which results in less constricted scribbles on the paper. Additionally, this activity produces a more informal connection between therapist and client (or family members when engaged in broader evaluations).

When the scribble is completed, the second step is to request that the client view what has been drawn from assorted angles and offer suggestions for a picture. The final product is completed by removing extra lines and emphasizing what is seen. Some clients will only visualize one picture from the chaos of scribbled lines, others may perceive multiple images or one larger picture, while others may only see various shapes and fill them in much like a coloring book. The entire process stimulates conversation, and often related stories will evolve from associations to the pictures.

Figure 4-11 is an example of a scribble that the client is unable to see anything unlike the clients above who only see shapes. These clients may be less able to form abstractions and be fairly concrete in their interactions. In Figure 4-12, the scribble is very controlled in its execution. The client views this scribble as a monster's face, possibly indicating anger or underlying fears. Both

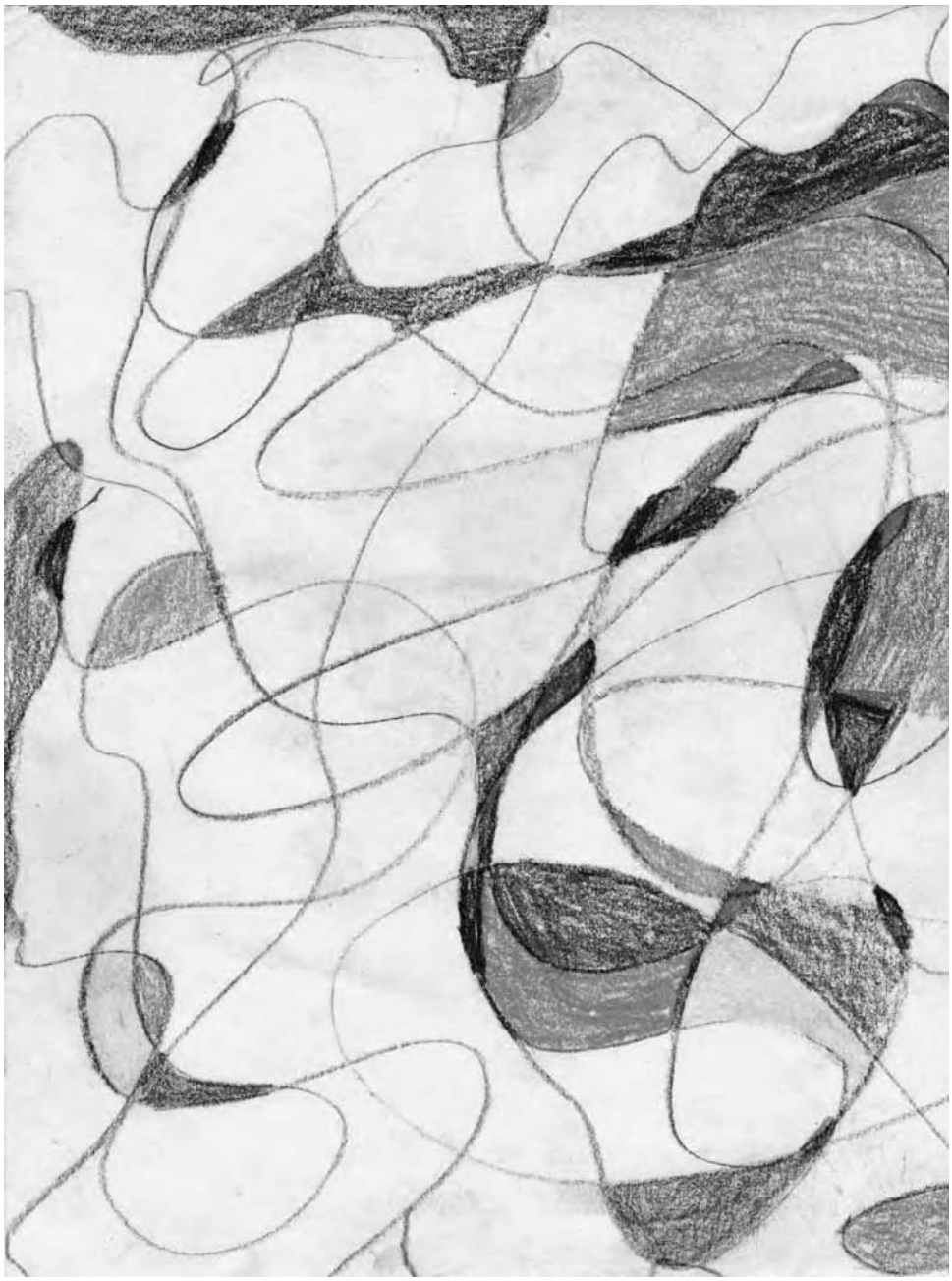

Figure 4-11

Figure 4-12

examples provide valuable information about the clients for the therapist to use in facilitating and fostering their self-expression and developing their communication.

The scribble technique breaks down many inhibitions and assists in many valuable therapeutic functions. Departing from a standardized request (i.e., requesting a regular drawing) to one where entire body experiences are being introduced elicits novelty and furthers the possibility of freer verbal expressions. This enhancement is

especially true for those patients who have only experienced traditional therapies. By offering a looser structure, the therapist is actually urging regressed behaviors within a controlled format. These actions may produce what the client has previously perceived as forbidden movements or expression of moods.

Another advantage to this technique is the possibility of discovering a picture within the scribble that encourages the patient to discuss latent fantasies that are projections of inner thoughts or feelings (Oster & Gould, 1987; Oster & Montgomery, 1996). This discovery of a new image is likely to convey greater personal meanings to the overall experience. The entire scribble process and creation provides a different framework for nonverbal and verbal communication, which substantially contributes to the entire therapeutic process.

Free Drawings

Another way to promote the idea of drawings is to request free drawings (i.e., free association drawings) during the first stages of therapy. Instructions for these drawings are especially relevant when individuals entering therapy are excessively anxious about attempting pictures to express themselves. Most individuals, but mainly children, prefer drawing without restrictions, rather than having someone impose direction. This extra freedom generally enhances increased cooperation for future sessions.

When drawings are created freely, they are more likely to accurately reflect a person's underlying characteristics. Additionally, a resulting product that underscores independent thought and action is a crucial goal for therapeutic work. Through this drawing process, pent-up feelings are released and self-defeating attitudes are exposed and have the opportunity to be changed.

When using this method of free drawings, the direction given to clients is to "Draw anything you wish" and then to "Verbalize whatever thoughts and feelings or associations you may have to the drawing." The flexibility in this directive originates from wanting the client to reduce interpersonal tension and decrease insecurities

about personal performance. The subsequent product enlarges the avenue for communication of inner conflicts and permits the clinician a glimpse of problem-solving styles.

Margaret Naumburg (1966), one of the earlier users of free drawings (and the person who introduced art therapy as a profession in the United States), focused on the spontaneity elicited through the use of this method. She found through her work that children could learn the importance of the unconscious through spontaneous art expression as opposed to more traditional approaches of therapeutic work. By asking for this type of drawing experience, she found an alternative method for listening to her patients freely associate to their visual expressions. Through this symbolic communication, rich insights were gleaned about their conflicts and disorders.

HOW DRAWINGS IMPACT THERAPY SESSIONS

Time Limits

Drawings may alter the usual therapy hour by affecting the duration of each session. The inclusion of drawings may increase the session's length, as extra time may be needed for their completion. It does not, however, increase the usual frequency of meetings. When organizing the sessions, the therapist should consider the time required to finish and discuss the artwork.

Depending on the objectives of the particular session, completing the drawings may be more important than the discussions surrounding the product. Task completion may be more relevant with children who are having a hard time staying focused. At other times, the therapist should be more aware of time constraints in structuring the session for verbal interchange. Being conscious of time is especially pertinent when offering insight or confronting difficult issues. In these instances, although completing all drawings is encouraged, it becomes more important to place closure on the discussion.

Even though time is a consideration, rarely do pencil and paper drawings significantly impede on the session. It always seems

amazing to view a client who is responsive to drawing immediately begin to think in visual images. The symbolic language that is expressed usually comes quite easily and the resulting drawing is completed fairly rapidly. In most sessions, initial drawings usually take only a few minutes of time. From our everyday experiences, it appears that visualizing interpersonal conflicts and inner turmoil is often much easier to draw in pictures than to attempt to describe in words.

Homework

Directives for drawing problems and other concerns are excellent therapeutic tools to use for assignments between appointments, especially when clinicians are unavailable. For instance, when therapists have a planned absence, they can suggest specific drawing directives for clients to complete during the week. This activity emphasizes the connectedness to the relationship and provides the individual with a strong feeling of continuity during the missed appointment.

Also, since information gathering during initial sessions is a prelude to developing treatment plans, one way to hasten this process is to suggest drawing assignments between sessions. This exercise emphasizes the value of thinking through complex issues at greater depth and on various levels of understanding. With acceptance of this type of homework, clients are better prepared for each session.

Drawings constructed at home and brought to the following session make the therapeutic process more viable and richer in elucidating additional historical information. Instead of impinging on the session hour or hurriedly completing drawings during sessions, these assignments allow the necessary time to elaborate on their issues and place extra importance to them. Examples of these exercises might include daily drawings of moods, creating symbols for good and bad days, drawing problem situations and possible solutions, or constructing longer products such as a detailed family tree or family shield.

For someone invested in this type of weekly strategy, it underlines the significance of the meetings and makes for a continuous, more in-depth therapy. There are endless directives that can be elicited during the sessions and all it takes is a creative therapist to hear issues during sessions that can be elaborated upon from one week to the next. For instance, one particular client produced numerous sketches of himself in different family and social situations to define his various everyday selves and ideal selves, in viewing his different inner dimensions, and in describing his goals, fantasies, and hurdles.

Missed Appointments

If possible, interruptions in therapy should be planned and discussed at some length in advance. It is often helpful to clarify at the beginning of therapy that some interruptions will be inevitable, such as holidays and vacations. When there is a planned absence, the therapist may instruct clients to complete drawings that express how they feel about missing a session or about the therapist's absence. The therapist may also request clients to specify what in their past reminds them of the absence.

Another possible directive to request later in the therapeutic relationship is to ask clients to share their anxieties or fears that may be produced by the missed sessions. If the therapist or client will miss several weeks, it may be helpful to assign several drawings or a lengthier project such as a mural or collage. These strategies underscore the significance of the therapeutic relationship in a tangible manner and provide a sense of continuity. They also reduce the uncertainties and anxieties that separations, even temporary ones, can produce. And they let the client know that the therapist understands the delicate issues surrounding separation and changes of routine (Cangelosi, 1997; Gabel et al., 1993).

ENHANCING THE THERAPEUTIC RELATIONSHIP

Discussing Shared Symbols

Drawings are excellent tools for interpretation and for enhancing the therapeutic framework. They are permanent records of progress or deterioration and cannot easily be denied. The artwork itself speaks a metaphorical language. Both the therapist and client have the opportunity to acquire insights from their meanings, as a common language is created and the relationship is enlarged. The graphic images extend the boundaries for dialogue and increase the chance of freer, often symbolic, discussions to emerge because everyday language is no longer useful. When used in this fashion, drawings allow the clients a way to accept alternative explanations of their thoughts and feelings without being defensive and mistrustful.

Desire to be understood on multiple levels is one of the main reasons that brings people into therapy. The images and symbols created through the drawing efforts provide a resourceful device for this undertaking. Art activities bring individuals beyond their everyday notions of their world. Symbols within the drawings often identify the conflicts that brought them into therapy and are viewed as starting points for generating working hypotheses that define treatment goals. These representations then become food for thought and establish the groundwork for deeper understanding and everyday problem solving.

When Interpretations Are Considered

It is preferable to remain a passive and objective observer when drawings are introduced into sessions. This nonjudgmental stance is especially salient for the novice therapist using drawings or other art materials. Although interpretations can be tempting, caution remains the best guide. In general, it becomes more desirable to facilitate expression of the client's own thoughts and feelings from the drawings. Like other forms of therapy, interpretations are prudent only after a working relationship has been established.

Wilkes and Byers (1992) suggest that artwork should not be analyzed, but digested, allowing the personality to emerge through style and content.

It is also important to remember that before interpretations are offered, a consensus of information should be gathered and the timing must be relevant to the discussion. Regarding the use of drawings, therapists must suspend their notions until the client has finished enough artwork to reveal repetitive themes, consistent patterns, and symbols. Early attempts at unraveling interpretations from drawings will most likely cause clients to become more resistant and stereotypical in their art expression. They may hide behind their art, and the advantages that drawings bring to therapy will be diminished.

Outlining Desired Change

Drawings assist the therapeutic process by providing direction for desired change. They allow for a visual record to be constructed so words and actions are directed toward common goals. They also provide yet another valuable technique that broadens the perception of problems and enlarges the possible solutions that can affect permanent change.

Each person in treatment offers numerous challenges to the therapist, who in turn must discover an equivalent number of approaches that result in workable and effective outcomes. The methods used to introduce drawing directives actually extend verbal interactions and augment the collaborative endeavor of the therapeutic process. This continued interchange creates conditions during sessions that allow internal changes to occur.

The active exploration that is a byproduct of drawing broadens the learning path beyond the understanding of intrapsychic dynamics. The addition of drawings provides greater possibilities for change. Through drawings, an avenue is open for repressed wishes, impulses, and fantasies to be unveiled, discussed, acted out safely, and resolved (Oster & Gould, 1987; Oster & Montgomery, 1996).

ESTABLISHING RELATIONSHIPS

A strong therapeutic relationship is accomplished through the clinician's nonjudgmental, supportive, and empathic responses to the clients' sharing of their drawings. Displaying artwork in the office when it is requested, for example, can accentuate an individual's importance. This highlighting of significance is especially exciting for children who like to "own" part of the therapy room.

However, when this need to exhibit is not present, or the room does not allow for display, the emphasis should be placed on keeping the artwork in a safe, private folder. This sacred place underscores the idea of confidentiality and of their permanent value. This folder can then be reviewed in future sessions and progress can be documented over time.

Another point to consider, particularly when faced with withdrawn or resistant clients, is that drawing with patients (dual drawings) can be helpful when establishing a relationship, especially if the therapist minimizes personal contributions. The need to support all accomplishments by patients, no matter how insignificant, is also crucial during the beginning relationship. This process can be emphasized by having clients draw how they feel about personal success or by graphically displaying any successes they have had recently.

Eric

Eric, age 12, was very resistant to coming to therapy and did not want to participate. His mother was making him come because he did not have any friends at school and everyone made fun of him. When the therapist suggested a dual drawing, Eric agreed to participate only if a line was drawn down the middle of the page and the therapist and Eric were to stay on their respective sides. The therapist, recognizing Eric's need for control, allowed him to pick the color marker the therapist would use. This seemed to reduce his anxiety somewhat. The

therapist's color was red (the lighter line) and Eric chose blue (the darker line) for himself. In the drawing's execution, Eric paid great attention to detail and told the therapist what to draw. This was a very productive drawing for Eric's therapy, because he ended up allowing the therapist to draw on his side of the drawing and he on the therapist's side (Figure 4-13). Thus, by allowing Eric to control the drawing and reduce his anxiety, the drawing activity was used to break down barriers and provided the therapist with valuable information regarding Eric's need for control and how this need could impact his relationships with peers.

Figure 4-13

Another helpful strategy to consider during the introductory phase of drawings is to ask clients to either change a drawing or construct another drawing from the same directive to indicate alternative possibilities of thinking about the problems. Providing competing explanations to the drawing enlarges the framework of possible answers for problem solving. This method of expanding the therapeutic frame increases the likelihood that interpretations to the drawings will be accepted, at least under the patients' terms, and enhances the depth of the ensuing discussions. Also, it can be fruitful for the therapist to retrieve old drawings with similar themes to add emphasis to an interpretation, or to demonstrate the effectiveness of change when comparing pre- and post-intervention drawings. It becomes important, therefore, to date and keep all drawings where they can be readily accessible for review.

RESOLVING EMOTIONAL BLOCKS

Individual psychotherapy remains a special time for the exploration of those emotional defense mechanisms that were identified during intake and assessment as potential stumbling blocks to emotional growth. Drawing directives that expand a client's everyday world can be especially beneficial during this investigative phase. For instance, when patients are inhibited or defensive and attempt to avoid and deny problems, this protective stance may be reflected in their drawings or in their approach to the drawings. Their pictures may be constructed rigidly or may not change from one drawing to the next.

For these constricted individuals, it might be worthwhile to direct them toward drawing symbols that exemplify these characteristics. The subsequent drawings can serve as concrete representations of their present difficulties, as well as provide glimpses to previous emotional traumas or hurdles. By intertwining the past and present in this manner, patients have the opportunity to see the effects of their defensive posturing and respond in a proactive manner to overcoming these blockages.

One example of promoting the resolution of a particular conflict is to request clients to draw their feelings. For instance, when management of anger is a central problem, it can be productive to create drawings that symbolize the issues that relate to anger: things that make the person angry or depictions of events or symbols that represent an expression of the anger being acted out. Drawings stemming from these directives provide a safe outlet to channel this anger and are not harmful to anyone when completed within the confines of the therapy room. By allowing this approach to proceed without repercussion, the therapist will often see a dramatic increase of emotions expressed through the drawing exercises. Subsequent drawings that focus on resolution to these angry feelings might also help in the healing process and provide broader skills for the more appropriate expressions of anger or rage that have previously resulted only in negative events.

David

David, an 8 year old boy, was angry with his mother for remarrying a man he did not like. In an early session, David used the following drawing to express this rage at his mother (Figure 4-14). Upon completion, the therapist was able to use the drawing to help David talk about his anger at his mother rather than act it out, as he had been doing at home. In subsequent drawings, David was able to continue to express his anger in these more appropriate ways. Eventually he was able to realize that he was angry at his biological father for not being involved in his life and was able to develop a healthier relationship with his stepfather.

WORKING WITH DREAMS

Dreamwork provides another avenue where drawings can be used to expand understanding and to further resolve underlying conflicts. Freud (1958, 1963) recognized dreams as symbolic experiences of

Figure 4-14

visual images, as did Fritz Perls (1969), who considered them as an individual's "most spontaneous production." Art and dream interpretations are equivocal, appearing complementary to one another. Together, they allow deeper understandings into the inner psyche and heighten the potential for profound and stimulating insights.

The inclusion of drawings with dream expression and interpretation also furthers the intimacy of sessions. In these instances, the dream may not be as easily defended or consciously controlled

when expressed though drawings (McNiff, 1988). Dreams loosen expressive freedom and intensify the focus of the images produced. As a result, drawing the dream becomes an exciting enterprise that is full of surprises and possibilities.

Approaching dreams through imagery can open a different understanding by building a new relationship to them. Using drawings to respond to a dream changes how the dreamer perceives it. Thinking about the images conveyed in the feeling of the dream shifts the client into working with the dream, rather than ignoring the possible issues surrounding the remembered experience.

There is always a temptation when talking about dreams to attempt to reduce them to a message, that is, to figure out what they mean. While the dream may hold a message, honoring the dream by reproducing it through artwork tends to establish a shift of focus that preserves the dream's autonomy. Instead of solving the dream like a puzzle, the client can begin to create new associations to the dream. This participation and ongoing listening process establishes a visible framework and creative connection to the dream.

Most people have experienced nightmares or have gone through their day feeling haunted by a disturbing dream. Often, constructing visual images from these dreams by making them tangible can stimulate relief. Focusing on the dream through drawings helps to contain some of these unpleasant feelings.

Also, having another choice of how to express the dream seems to help individuals in treatment move from their fears toward curiosity. For example, markers or crayons may allow a sense of control, whereas paint may feel more expressive. Additionally, a sharp pencil may encourage a different kind of focus, that of detail.

Often the drawing is not just a response to the dream, but a continuation of the fleeting images. Some elements are emphasized, while others are added, left out, or diminished. This experience, the recognition of the possibility of interacting with the dream, is important. Participation can be empowering, as the dream did not just happen to the client. The client can now respond actively and creatively. As the dream is rediscovered, forgotten

parts are sometimes remembered and connections emerge as novel recollections shift into surprising familiarity.

In her classic book, *Art Psychotherapy*, Harriet Wadeson (1980) discovered that integrating dreamwork with art was especially beneficial to her verbally insightful clients. Borrowing on Perls's work in gestalt therapy (Perls, 1969), she instructed individuals to reexperience their dreams through drawing, then become each of the objects or people in them. This exercise has the opportunity of combining discussion and role playing with visual creations. Patients in these situations focus on the contradictory sides of the dream to explain differences in meaning from their own life perspectives. Through this process, a more thorough understanding of unresolved issues takes place, as well as an integration of distinct segments of the client's personality.

This collaboration between recalled dream symbols and the drawing of them offers individuals in therapy the opportunity to express themselves within a wider framework. Since dreams are complex entities with several layers of thoughts and feelings, they can be approached in numerous ways. One technique may add to another therapeutic approach, producing multiple avenues for possible exploration and interpretation. For example, a dream can be perceived within the context of current stressors, or it can be used as a platform to express free associations. A therapist can use dreams as adjuncts to gestalt encounters or as a starting point for other therapeutic activities, such as writing poems that describe them.

Enlarging the pathways for verbal and nonverbal expression by adding art expression to dreamwork gives clients the opportunity to experience novel approaches to gaining deeper meaning to their concerns. Introducing the drawing of dreams increases both the client's affective repertoire and psychological understanding. In providing an opportunity to draw a dream, therapists instruct clients to function more creatively and to gain profound insights into hidden aspects of their personhood (see Oster & Montgomery, 1996 for an example).

CATHARTIC RELEASES AND REGRESSION

Difficult issues confronted in psychotherapy often seem more approachable when they are embodied in a visual record. The image as expression of conflicts does not necessarily need description or explaining, but because it is tangible, it may be easier to talk about and look at. As the art becomes a container for overwhelming feelings, it is sometimes a safer place for cathartic release. It can be an important learning experience seeing personal anger being asserted visually and having those feelings witnessed and accepted. A powerful catharsis may also be at a deep, image level of the psyche and may not include a change in affect, but can be seen through the drawing.

Cathartic releases and regression through art are often dependent on the type of media being employed. These therapeutic processes do not present themselves as often when pencils or markers are the primary art medium. They are more likely to occur with less malleable mediums, such as finger paint or clay. Even when drawing with a pencil, displays of cathartic release and regression can occur. For example, individuals may lose control in their drawing, scribbling furiously. When this action occurs, the therapist can still demonstrate acceptance by encouraging their clients to create something out of their scribbles. This interaction strengthens the process of sublimation, which has as its goals the mature expression of overwhelming feelings.

The medium of drawing introduces another aspect of the therapeutic relationship. Primarily, clients are given materials that increase their independent functioning within the relationship. Judith Rubin (1978), an eminent art therapist, hypothesized that the therapist becomes "feeder," "seducer," and has "expectations" for the patient in the therapeutic relationship. She believed that when art materials are used, it becomes more difficult for the therapist to remain neutral in the transference relationship because of the nurturing effect of giving the patient materials.

PORTRAYALS OF TRANSFERENCE

The Drawing of Transference

Transference within the therapeutic relationship occurs when clients shift their intense, immature feelings from childhood onto the clinician. Freud (1963) acknowledged this occasion as intrinsic to the therapeutic exchange — a reliving of strong emotions within the psychosexual stage. The therapeutic use of transference is to interpret these earlier experiences by integrating and understanding them so that they become a part of conscious work (Case and Dalley, 1992).

As in verbal therapy, it becomes crucial for the therapist to remain aware of transference issues when introducing drawing directives into the sessions. A theme within the drawing, or even a chosen color when using markers, crayons, or paints, can symbolize a client's earlier experiences. Additionally, the process of creating the image establishes three lines of communication between (a) therapist and patient, (b) patient and drawing, and (c) therapist and the resulting product.

These bridges that drawings represent become the focus through which the transference relationship is explored. The drawings contain important feelings, as they become receptacles for fantasies, anxieties, and other unconscious processes that are emerging throughout therapy. Thus, the act of drawing holds parts of the transference relationship, in addition to other released tensions elicited by the drawing itself.

Transferential themes are sometimes visible in the drawings themselves and, occasionally, even by the behavior expressed during the art production. For instance, a therapist might perceive the aggressive use of art materials as symbolizing a patient's anger at authority figures. Clients may also attempt to construct a representational figure of the therapist as a direct expression of the transference, or draw themselves with some personal part changed to resemble the therapist. An increased awareness of what is being expressed in these drawings can enhance and enlarge the scope of individual psychotherapy.

Amelia

Amelia was a 7-year-old girl who was placed in foster care as a result of severe neglect. She had memories of eating dog food out of the dog's bowl because her mother, who had substance abuse problems, had not cooked anything in a while and there was no food in the house. Also, as a result of being the older, "parentified" child, she was accustomed to taking care of her younger siblings. All of her unmet dependency needs were almost immediately transferred to the therapist in the initial stages of therapy (Figure 4-15). Because of Amelia's insecurities and strong needs to have to prove her love and affection, the therapist got a drawing like this one almost every session.

Figure 4-15

Dual Drawings

When introducing art into the therapeutic relationship, it becomes important to consider whether to draw alongside the client. When therapeutic work is done in this manner, it is possible that the client may feel ignored (just as other significant figures in their lives may have rejected them). Therefore, the therapist must take into consideration the message being delivered when engaged in these types of dual drawings. This strategy is quite helpful when clients are unusually guarded or withdrawn or are having difficulty establishing a connection.

When therapists participate in dual drawings, they are basically lending their own ego strength to the client. If dual drawings are indicated, therapists must be cognizant of what and how much they contribute. When the constructed drawings are realistic, the therapist needs to only draw objects that support the patient's ideas and not attempt to compete for artistic excellence with the patient. This caution generally limits the therapist to only assist in constructing ground lines, trying not to be overly controlling about the direction, and encouraging the patient's own creativity. In abstract drawings, the therapist has identical considerations, but has to be even more careful. In this instance, abstraction tends to increase freer expression and has the potential of reducing the therapist's objectivity (Oster & Gould, 1987; Oster & Montgomery, 1996).

As in other therapies, individuals engaged in collaborative ventures primarily feel safe and willing to share painful material when a supportive environment has been created. Only through positive and nonthreatening interchanges will clients allow themselves involvement in a transference struggle with their therapists. This connection allows the therapist more opportunities to confront immature and self-defeating defenses that need to be abandoned before healthier functioning can emerge. When this phase of therapy is complete, newer behaviors for everyday interactions can be attempted. By using drawing methods, various parts of unconscious material are seen and under-

stood more fully and then resolved and integrated into a mature ego.

RESOLVING CONFLICTS

Gaining productive insights and resolving long-standing conflicts are central to the working-through stage of psychotherapy. This process has been described as an ending to unconscious problems through the attainment of recognizing and understanding maladaptive behaviors that lead to increases in adaptive and satisfying everyday experiences (Dalley et al., 1993). Success in working through these obstacles and hurdles provides the client with experiential evidence that interpersonal resolution of problems can be both gratifying and rewarding.

Overcoming problem areas permits clients to reexamine their feelings, anxieties, and past situations repeatedly in relation to both the therapist and to various people and situations in their present lives, as well as to their memories of past experiences. No matter how painful, uncomfortable, or confusing these encounters, when clients are willing to focus on these difficult feelings, richer understandings can be acquired and resolutions can be obtained. When clients begin to see that their typical reactions of avoiding conflict to block out the emotional pain only compounds their problems, they begin to accept direction in forming new beliefs and empowering themselves with new skills to break through their self-defeating patterns of thoughts, feelings, and behaviors.

Sandler, Dar, and Holder (1973) stated that this working-through process is more than just uncovering conflicts or confronting resistances. They regarded intellectual insight as not sufficient in this pursuit, since there still remains a tendency to repeat old patterns of functioning. The actual working through of problem areas means that only after the transference relationship has been recognized, can the possibility of breaking old patterns of maladaptive behaviors be realized. Before, during, and after drawings of the therapeutic experience is one example of a directive that can

assist clients to view this phenomena in a symbolic and systematic form.

Tyler

When Tyler, age 10, first came into therapy he was unable to sleep because of his fear of "the monster in his closet with the big green hand coming to get him." The monster came back every night and only went away when his mother came and turned the lights on. His before drawing (Figure 4-16) depicts the monster and his fears. His during drawing (Figure 4-17) shows his goals, the things he worked for during therapy — playing ball, being with his friends, sleeping at night, and getting rid of the monster. His after drawing (Figure 4-18) is of himself "happy" at the end of therapy with these goals accomplished.

THERAPEUTIC ENDINGS

Final sessions with clients, especially with children and adolescents, strip away all the camouflage obscured the fact that this special relationship between therapist and patient is at the heart of psychological treatment. The feelings of sadness, anger, and fear that are produced when ending the relationship underscore that therapeutic bonds are extremely important and very fragile. These emotional reactions highlight the fact that therapy can never be reduced to just another person talking (Cangelosi, 1997).

Termination is a time that can yield even richer understandings to the therapeutic experience. The end of therapy generates deeply rooted feelings about commitment, separation, and even death to surface. Exploring these areas of concern can help individuals in treatment resolve many other relevant issues, especially the principle that human relationships do change, and always end at some point.

Figure 4-16

Taking the time to discuss the possibility of endings or to plan a solid termination experience offers numerous and creative opportunities for alternative perspectives to be gained. This final segment of the therapeutic process allows for an expansion of a client's personality by offering new opportunities to practice skills and to

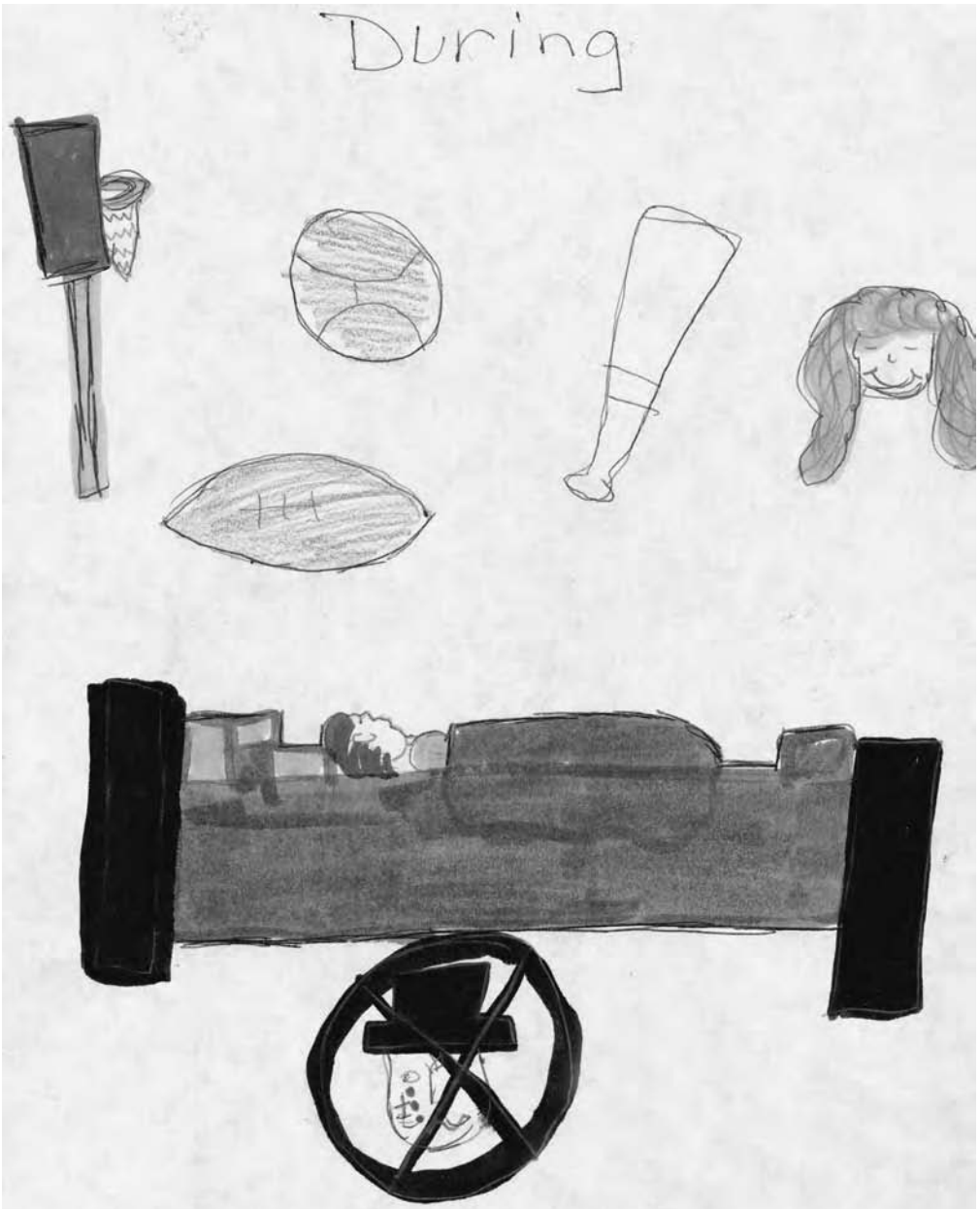

Figure 4-17

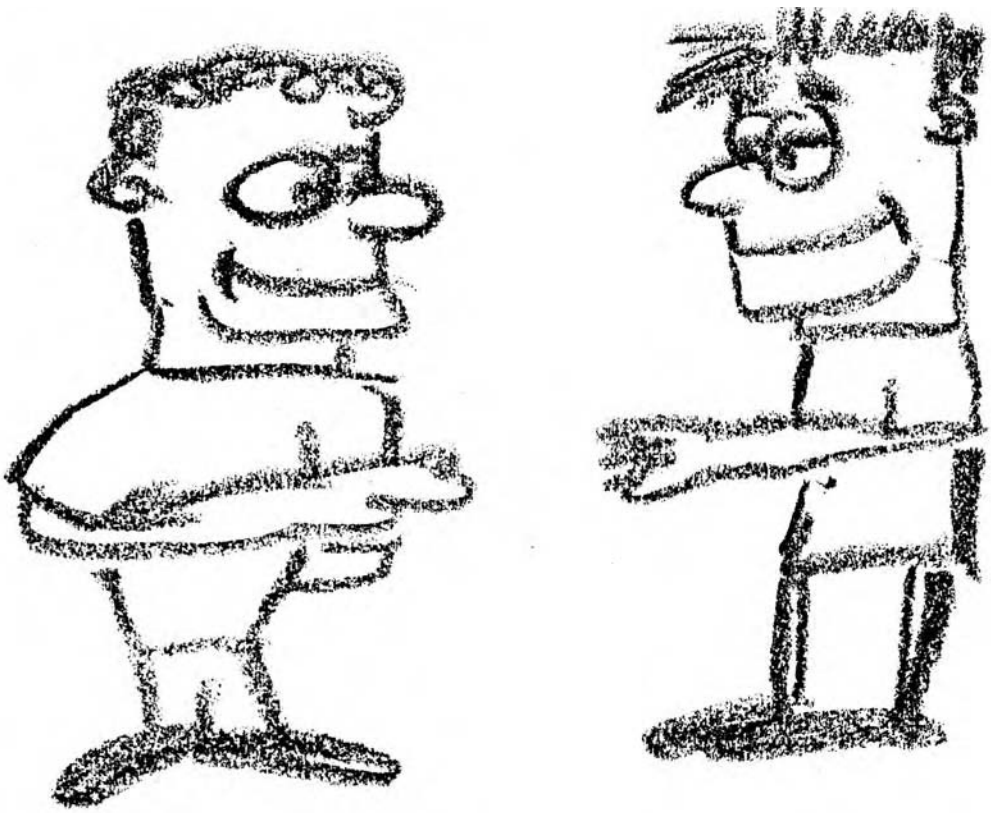

Figure 4-18

gain insights of varying attitudes, thoughts, and feelings. By ensuring time to review the entire process and speak about future issues, the whole adventure in therapy is made more fruitful and underscores its uniqueness.

George

George, aged 13, was moving to another locale after being invovled in regular therapy sessions for approximately six months. Although his initial presenting difficulties surrounded open hostility, especially toward adult figures, he was easily

engaged through drawing activities. These directives allowed him to release tension and to communicate more effectively, as he was reluctant to just sit and talk.

At the time that he introduced the subject of moving to another city, he had matured considerably through his therapeutic efforts. As the subsequent discussions led toward his leaving, his expressed concerns were focused on his immediate friends and wondering whether he would be able to replace them in a new neighborhood. Besides talking through these issues and practicing behaviors in different imagined scenarios, he attempted to describe his concerns through his drawings.

Figure 4-19 portrays the day of his leaving. He is shown with a sad face waving good-bye, while his friends are offering their mixed feelings. One friend is putting up a good front and smiling

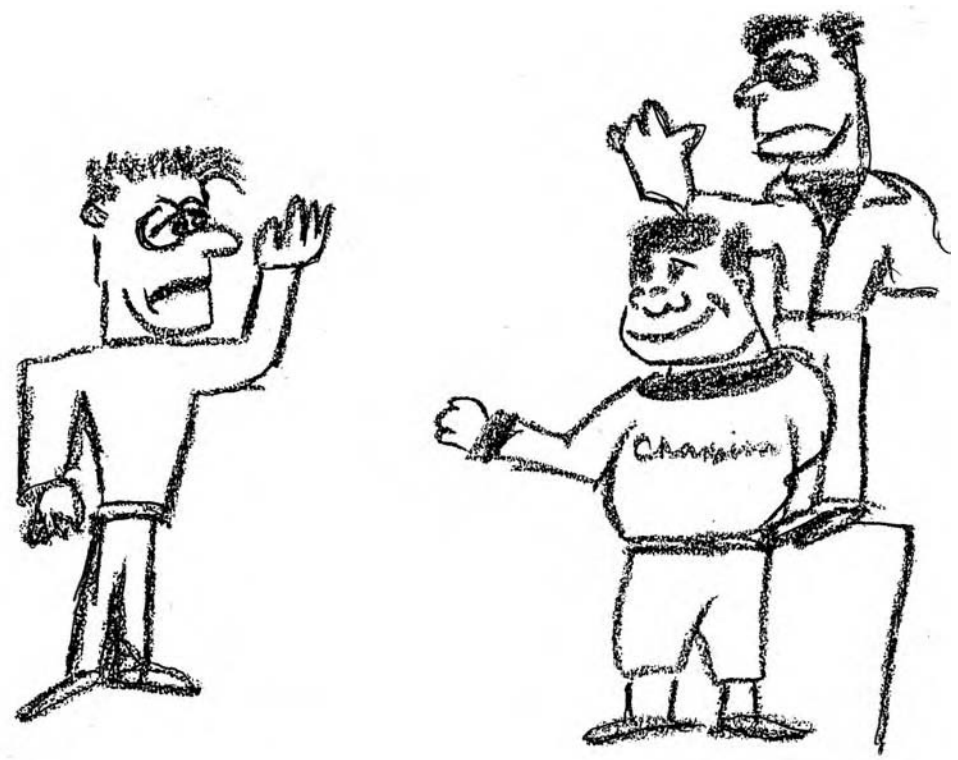

Figure 4-19

while offering encouragement; in contrast, the other is plainly upset at the loss.

Using this image to explain his own reactions, he spent much time reminiscing about how he was able to connect with these two peers and some of the activities they did together. (Note: This scene also elicited memories of his time spent with the therapist and the various tasks that they had undertaken.) The next picture he constructed (Figure 4-20) illustrated his hopes of gaining new friends and his newfound assertiveness that he discovered in learning social skills during the sessions. He appeared confident in these drawings, showing that he could

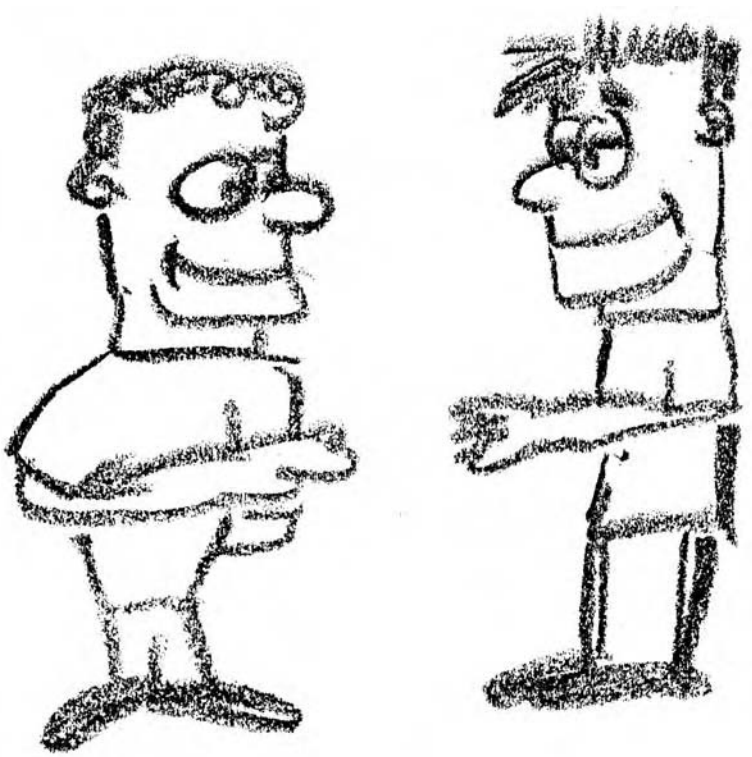

Figure 4-20

address problems matter-of-factly, share the feelings behind the experiences, and resolve the issues with support and practice.

This final phase, or termination stage of therapy, brings with it the opportunity to review all artwork and plainly see the entire experience. The permanent and enduring quality of the drawings offers a continuity to the entire therapeutic process (Hanes, 2001). This ongoing visual record of change serves as a lasting impression of the time spent in therapy and provides tangible evidence of recovery.

The ending in this evolving process also provides a time for new drawings to be constructed that underscore therapeutic progress. During these ending sessions, before and after drawings are helpful to measure these changes. This directive provides tangible proof of achievements and provides markers as to whether initial objectives have been mastered. They can also identify potential future pitfalls and resolutions to these hurdles.

To emphasize the client's independence from therapy and from the therapist, it is also helpful to ask clients to draw how they view themselves in the future or what other goals they may have in the future. During this ending process, it is not uncommon to observe the client's ambivalence about leaving being portrayed in the drawings. The depth of discussion surrounding the drawings is even magnified during these final sessions.

During this termination stage, it is crucial to save time to summarize all drawings that were kept during the sessions. Endings are never easy and they are often accompanied by mixed reactions and numerous responses. Gillman (1991) points out that regular therapy sessions, even those lasting for only a few weeks, require an awareness and sensitivity to issues that may emerge in ending treatment. When preparing for this termination process, clients often need the assistance of their therapist to address these ending themes of separations, mourning the loss, and emancipation (Cangelosi, 1997). Having graphic illustrations of the therapeutic progress available during this time solidifies the important markers of change and offers the opportunity to reminisce about the entire experience.

Additionally, if the client attempts to give the therapist credit for the majority of positive change, the therapist can point out the themes in the drawings and the client's own work as proof of the client's abilities in struggling to overcome his or her problems. This emphasis on clients' contributions empowers them as the major agents for personal change (Landgarten, 1981). This review process also reassures both therapist and client that the time spent together was beneficial, as well as a unique and significant experience.

SUMMARY

With the introduction of drawings during individual psychotherapy, clients have the opportunity to explore and transform conflicts and crises into new perspectives, healthy problem solutions, and broader outlooks on life. Drawings enhance the possibility of gaining meaningful insights into the reasons why various defense mechanisms are used and how they may have become maladaptive. Graphic images derived from various drawing directives provide a concrete platform for expressing underlying anger, anxiety, and fears and seeing how these troubling emotions can be overcome. Through these experiences, clients can better understand their feelings and reactions, gain control over their emotions, and channel them more effectively. Only then can they begin to integrate their inner turmoil with reality-based interventions.

Drawings can also be used to underscore that a transference relationship has been established, which allows clients to acknowledge undesirable feelings and to express their difficulties in establishing trusting relationships. The directives and acts of drawing allow them to graphically display and symbolically confront these fears, making them less overwhelming. Throughout the therapeutic process, clients begin to recognize and acknowledge their maladaptive patterns of coping with stress and their illustrations demonstrate this gradual process of understanding. While language serves as a crucial vehicle for therapeutic learning, drawings can augment, enhance, and visually document this process toward growth and mature development.

5

Drawings in Family Evaluations

THE FAMILY ORGANIZATION

A family is a blending of generational and shared history that provides a sense of belonging, establishes early gender and societal roles, and offers the basis of commonalites as well as uniqueness. Being in a family identifies each individual as having experienced a long history of interpersonal interactions, rules, and expectations. Within these complex subsystems, there are linkages among the members that influence individual expression and either excite or inhibit its output. Each family member is part of these transactional units and provides varying roles within each (Sexton, Weeks, & Robbins, 2003).

When a family is functioning optimally, its members are flexible in managing a variety of everyday events and situations. The family, or its internal representation, remains for a lifetime and is different from later social groups that unite for a brief period of time, then separate into individual pursuits and lives. The ideal intervention for family therapy is to encourage individual growth and definition,

while providing a supportive healing environment and a continued sense of belonging (Minuchin, Lee, & Simon, 1996).

As all clinicians know from their varied caseloads, families come in all shapes and sizes and are far more than collections of individuals occupying a specific physical and psychological space together. A family serves as a natural social system with unique properties that has constructed an entire set of rules, including roles, power structure, forms of communication, and methods for negotiation and problem solving, that allow numerous tasks to be performed simultaneously and effectively (Goldenberg & Goldenberg, 1999). Within such a diverse family system, children, parents, and other related caretakers are linked to one another by reciprocal emotional attachments. These loyalties may fluctuate in intensity over time, but nevertheless persist over the lifetime of the family cycle. Entrance into such an organized network occurs through birth, adoption, or marriage. Despite a possible temporary or even permanent sense of alienation from one's family, one can never truly leave except by death (and even then, memories persist and still can influence the behavior of the surviving members).

Whatever the composition or structure of the family system — nuclear family, blended family (stepfamily), single-parent family, childless couple, common-law family, extended family, three generational unit living under one roof — all optimal families attempt to encourage (a) positive and encouraging relationships; (b) meeting the personal needs of all members; (c) successful strategies for dealing with external stress; (d) coping appropriately with maturational changes, as well as unexpected crises; and (e) healthy organizational structure to resolve the day-to-day duties of living (Goldenberg & Goldenberg, 1999).

When therapists approach a family unit, they initially need to acknowledge its rich uniqueness, as well as underscore the profound impact that the family structure has had on each member's behaviors and attitudes. By widening their therapeutic lens upon the family's interactions and history, clinicians can perceive problems in functioning as not merely individual challenges, but as difficulties being maintained by all members of the entire family.

The idea that obstacles in living do not lie in isolation are not modern notions. However, the emphasis on finding solutions within the broader relational system of the family, as opposed to the individual, brings the clinician into a fresh and dynamic setting. It is this expanded social context that a family therapist intervenes to facilitate lasting change. The path to healthy intervention is based on the increased awareness of the family system and the ability to rearrange functional interactional patterns among the members.

The practice of all family therapy is to assist each member, in the context of their family experience, toward making both positive and meaningful change (Hanna & Brown, 2003). Because much treatment focuses on the ability to override rigid or dysfunctional patterns in interpersonal relating, inclusion of all family members in therapy becomes a crucial step for promoting innovative and healthier behaviors. By strengthening the family through creating fundamental changes in its structure, clinicians can offer each individual participant newer opportunities to mature within the context of their primary caretakers. And by working with all members, the renewed emotional support and clearer communication can underscore all the accomplishments of therapy to its conclusion.

In general, family therapy is more active and of shorter duration than individual therapy. The initial expectation for the clinician is to shake up the family system and rearrange its hierarchies and coalitions (i.e., the family alliances). While some family members may welcome this change as a way to address specific problems or alleviate presenting symptoms, others may balk at this onslaught upon the usual family rules and alliances.

From this focused agenda and by initiating active interventions during sessions that attempt to redirect dialogue and interactions, the benefits of change become apparent to all participants. However, no family leaves treatment problem-free, nor are all members 100% improved in their everyday functioning. What has occurred during this style of active therapy are significant changes in organization that influence interpersonal dynamics and reduce tension. It is these crucial relational shifts and newfound skills that allow the family members to practice independently of the

therapist and make the necessary changes for smooth functioning to occur on a consistent basis (Goldenberg & Goldenberg, 1995).

THE FAMILY THERAPY MOVEMENT

Over the years, family therapy was spotlighted through a broad array of theories and interventions (Hoffman, 2001). Various disciplines recognized differing models of therapeutic input that attempted to realign behavior and communication within the entire family system instead of focusing on individual psychopathology. Although all family therapists shared a common perspective of viewing problems within the familial context, diverse theoretical perspectives emphasized unique aspects of the family culture and network.

Historically, the aftermath of World War II heightened the interest of academics and clinicians on the social context of emotion and behavior, and family therapy, as a separate discipline, evolved as a result (Gil,1994). It was during the 1970s that family therapy grew dramatically in range and depth and spread its influence on many graduating clinicians. Immersed in competing dialogues and philosophies, the family therapy movement incorporated many differing positions. It becomes important to review these distinctions to better appreciate their rich diversity and unique insights into family functioning.

In this chapter, readers will have the opportunity to review several of the classic theoretical schools of thought within family therapy. They will also be introduced to reasons why adding drawing directives to family sessions can enhance this broader clinical focus. Included in these discussions are descriptions of the earlier prominent viewpoints from the Bowenian (Bowen, 1978), structural (Minuchin, 1974), strategic (Haley, 1976), and communication schools of family therapy (Satir, 1972).

Although newer family therapy approaches that used theories of object relations (Scharff & Scharff, 1987), solution-oriented brief therapy (deShazer, 1985), and family-of-origin techniques (Framo, 1992) have added considerably to the study of the family system,

these approaches will not be elaborated upon here, but merely mentioned for the interested reader to pursue. Throughout these next pages, specific drawing directives will also be suggested to emphasize the creative possibilities of intervention strategies to overcome resistance and problem behaviors during family sessions.

Bowen's Theoretical Concepts

A pioneer of the family therapy movement, Murray Bowen (1978) viewed the family system in transgenerational terms. He postulated that individual members are interconnected in their thinking, feeling, and behavior. Thus, his model assumed that individual problems arise and are maintained by these relational connections to other family members, as well as to their histories.

Bowen (1978) offered the terms "differentiation" and "fusion" in describing the family structure. In his assertions, a healthy family has to maintain a delicate balance between these two polarities. He defined this optimum family functioning as one that could tolerate each member's needs for independence or differentiation. Within a smoothly operating family unit, parent and parent–child relationships are flexible and dynamic in adapting to changes in their developing expectations through the years without feeling threatened by abandonment. When family members cannot sustain this equilibrium between individual freedom and the need for basic attachments, safety, and comfort, strong reactions will undoubtedly occur that block the maturational process such as overinvolvement or leaving home prematurely (Weltner, 1985).

According to Bowen, the following eight characteristics comprise a well-functioning family (adapted from Fogerty, 1976, p. 149):

1. The healthy family adapts to change and even welcomes it.
2. Emotional problems exist in a collective unit, not totally within the identified patient.
3. There is a common connection across generational lines among all family members.

4. Each dyad within the family solves its own problems without using a third person as arbitrator or judge (i.e, the idea of triangulation).
5. Differences among members are encouraged and each member has a clear identity.
6. Each member is allowed to feel his or her own isolation (emptiness). Other members do not need to feel compelled to rescue this member.
7. The family is able to accurately assess when problems exist. If one or more members say there is a problem, then there is a problem (without ascribing blame).
8. Healthy families' members use each other as a source of feedback and learning, not as an adversary or enemy.

Even under the best of circumstances with flexible families, change can be viewed as a threatening experience, as loyalties to old patterns and structures impede adaptation to new ways of living (Oster & Caro, 1990). For instance, a single mother may continue to respond to her adolescent daughter as a younger child to secure and maintain her role as adult and parent. Allowing her daughter more freedoms may be threatening, in this case, because the mother would have to look for an equally satisfying replacement. This change would cause her to confront her own feelings of loneliness stemming from not having searched outside the dyadic relationship for friendship and comfort.

A therapist using Bowen's treatment model would focus the sessions on identifying the developing needs of the teenage daughter. Simultaneously, the therapist would encourage the mother to continue demonstrating her strong and supportive leadership within the household, while beginning to search for outside interests. When using artwork within this framework, the therapist would engage the mother and daughter in tasks that stress differential autonomous functioning, such as requesting both parties to create separate drawings of their current wishes or goals beyond their relationship (Landgarten, 1987).

Rachel and Patty (Mother and Daughter)

Rachel (age 13) and her mother Patty (a single parent at age 50) were having conflicts at home. Suddenly, Patty's sweet little girl was challenging her mother regarding her chores and staying on the phone (and Internet) with her friends. Even little things turned into huge arguments. In Figure 5-1 and Figure 5-2, we see they were able to draw their independent goals outside of their relationship. Rachel wanted to become a great guitar player and be in a band. Patty's goals were to do something creative, travel, and meet a new mate. In the process of sharing these goals, they were also able to talk about some of the things they missed about their old relationship and acknowledged that their relationship was changing.

Structural Family Therapy

Minuchin (1974) proposed a structural viewpoint that emphasized family organization and the rules that govern their transactions. His attention was devoted to family roles, alignments, and coalitions that constitute family subsystems. Major themes within this structural model of family therapy were the concepts of boundaries (rules of relating) and power hierarchy (who makes the final decisions).

A balance in family functioning is observed when parents are united in administering executive decisions (hierarchy), while remaining receptive to suggestions and displaying interest in feedback from their children (i.e., maintaining respect with clear boundaries). This division remains clear when boundaries within subsystems are well defined and each member is able to perform specific duties without unnecessary interference. By comparison, dysfunction results when family systems experience failures in their governing hierarchies. In these dysfunctional families, persistent intrusiveness exists between the parents and when the parents hinder problem-solving opportunities of their children through

Figure 5-1

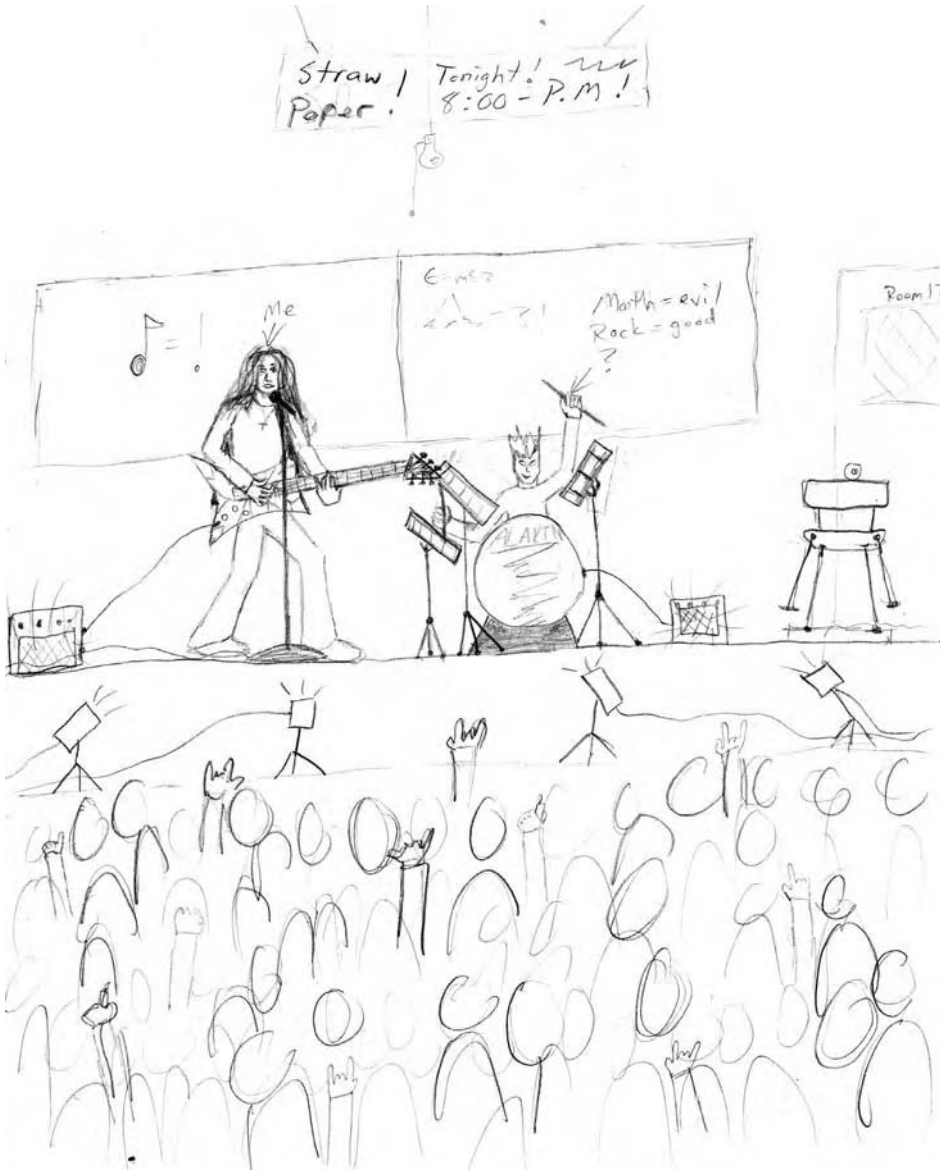

Figure 5-2

ignoring effort and not providing positive feedback and rewards when deserved.

Minuchin (1974) viewed healthy family functioning along a continuum, in a similar manner as Bowen's fusion-disengagement perspective. One extreme of this continuum is *enmeshment*, where family members are continuously dependent on one another. In this type of suffocating environment, individuality is resisted with a resulting overdependence on each member's actions and reactions. For example, one set of parents felt rejected when their teenage son considered taking a summer job that was outside the family business. In this case, the family interfered with this independent step by directly stating that the business could not survive without him — "I guess you don't value the rug business, go ahead, work at camp for the summer." The college-aged son, who then experienced profound guilt, obliged by working his sixth summer at the family carpet business (Oster & Montgomery, 1996).

On the opposite end of the continuum are interpersonal boundaries described by Minuchin as disengaged. These families are so isolated from one another that they cannot recognize when a member is in emotional pain. In extreme situations, a child may think that he must verbally express suicidal thoughts to receive even adequate attention.

An example of this isolative style was Elaine, a young woman who felt so angry and lonely after her parents separated that she became truant, acted out her sorrow in an oppositional and defiant manner, and withdrew from previously close friends. When no one acknowledged her profound distress, she ultimately cut her wrists in a cry for help. She could not view any other way to communicate with her parents, who were both successful professionals with little energy to expend outside of their jobs. Through her self-defeating and self-destructive actions, Elaine finally got their attention when they arrived together at the hospital.

The Peters Family

The Peters family consisted of John (the father), who was a workaholic and gone from the home a lot, Alice (the mother), and Eddie, their 8-year-old son. Alice was having problems controlling Eddie and was not getting much help from her husband who was always at work. She was referred for therapy by her pastor to gain assistance with these problems. The therapist requested they construct a dual drawing to see if there was anything revealed in their drawing that would assist the therapist in formulating goals for their therapy (Figure 5-3). The mother's marks are the darker, heavier marks made with a marker on the left. Eddie's marks are the lighter, pencil-drawn symbols on the right.

This drawing depicts their separateness and how they are disengaged. The mother drew symbols of blocks and pop-up toys, which were too young for her son. Eddie drew the family at a picnic and a cartoon character that was connected in the middle. These probably symbolized his need for attachment and feeling more connected to his family. The therapist was able to use this drawing to facilitate communication and some interpretation and invited them to try another dual drawing (Figure 5-4).

In this drawing, Eddie asked if they could draw a baseball field, as baseball was his favorite sport. By agreeing to this theme, his mother was able to simultaneously give permission and show interest in something that was an age appropriate activity for Eddie. In this drawing they still stayed somewhat separate, but there was much more interaction.

This step was the beginning of improved communication between Eddie and his mother. The therapist was able to see that at least part of the problem for Eddie and his mother was their disengagement and possibly his mother's viewing Eddie as immature. The drawing also stimulated her feelings of being overwhelmed and inadequate at having to be both mother and father in the father's absence. Further drawing directives

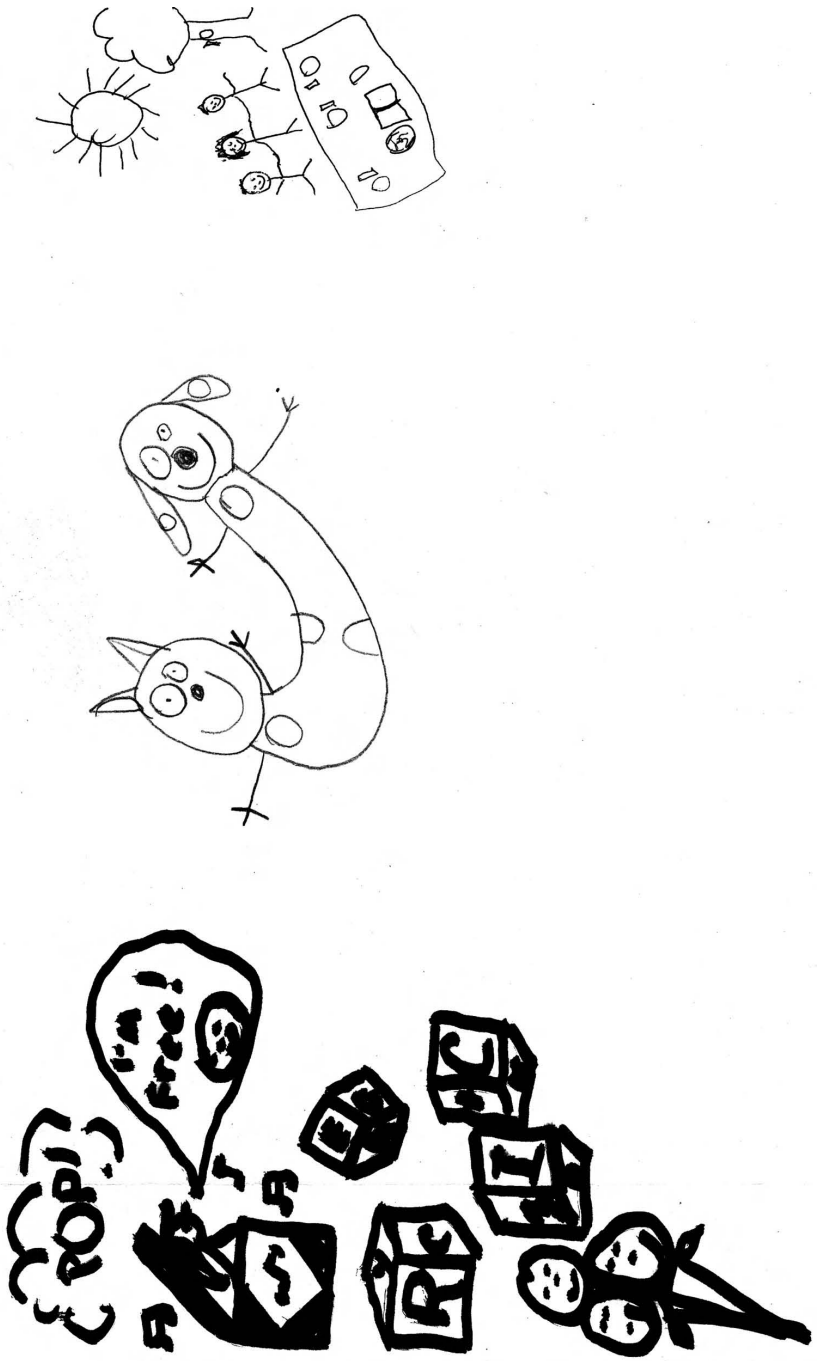

Figure 5-3

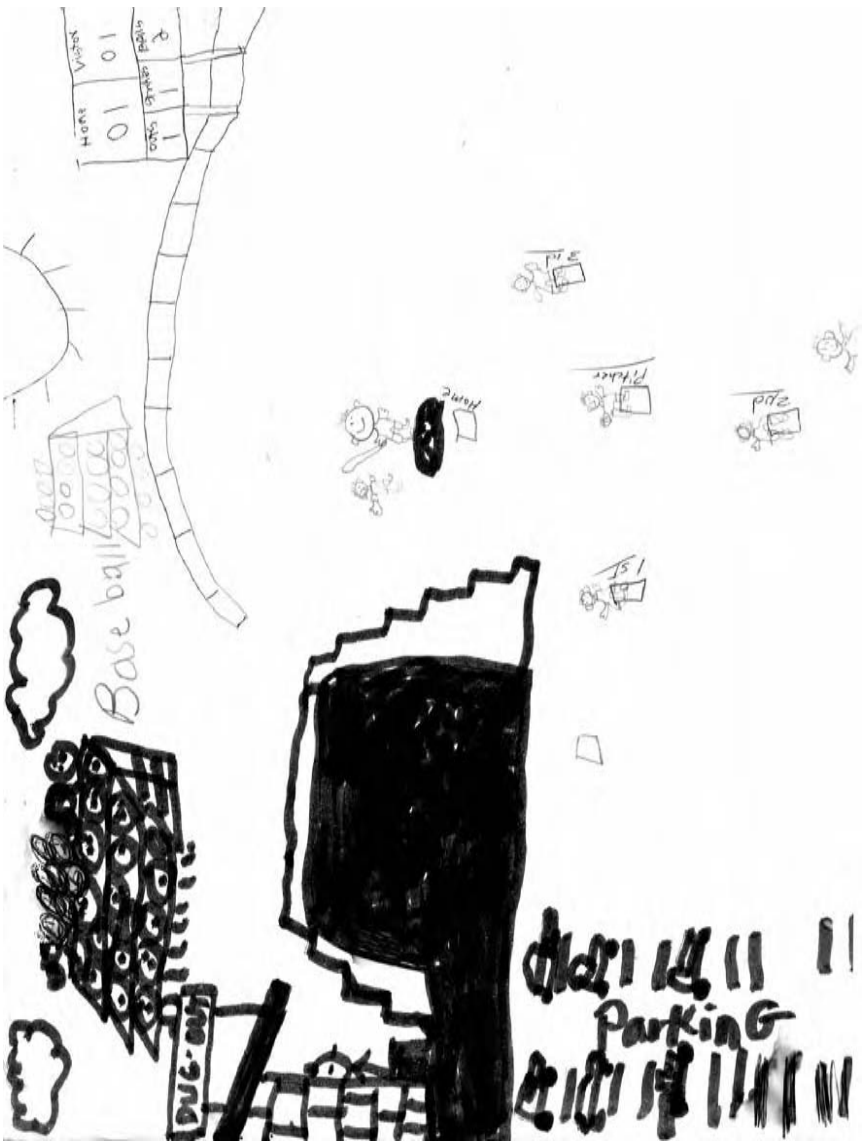

Figure 5-4

involved the father coming to sessions and having the family drawing together. In this way, the therapist was able to see how disengaged the father actually was from the family.

The ability of a family to discover a balance between these two extremes depends on the positive use of their skills to negotiate and survive life's stresses and crises. Minuchin and Fishman (1981) stated that "typical family development included fluctuations, times of crises, and problem solutions at higher levels of complexity." A major thesis of their reasoning describes the family to be a fluid, dynamic system, whose patterns and modes of adaption are continually being challenged and changed through various crises presented by new life-cycle stages. These developmental stages begin with the spouse "holon" (i.e., subgroup), then move toward the parental holon (those families with young children), to families with school-age and adolescent children, and finally to families with grown children, which includes multigenerational issues. Each stage is imbued with its own struggles and outcomes.

Therapeutic interventions assist families who are stuck at a particular point of maturational development to create workable crises with resolutions that will redirect the family toward its natural tendency of evolution (Minuchin & Fishman, 1981; Minuchin et al., 1996). Such interventions extricate the family from their unsuccessful patterns of problem solving and focus on more productive ways of negotiations. Using this structural approach, the therapist introducing artwork would purposely interrupt the family's typical transactional patterns and require each member to change roles. In this instance, the therapist would interject novel directives that would attempt new subsystem realignments (for example, father and daughter working together instead of mother and daughter), which would ultimately change family communication and boundaries (Landgarten, 1987).

Strategic Interventions

Strategic models of family therapy resemble the structural view in many ways, but also use a focal point of the here and now in their interventions and emphasize the expressed and covert communication among family members (Haley, 1976; Haley & Richeport-Haley, 2003; Madanes, 1981). This approach places the major impetus for change on the therapist to design novel and creative strategies to eliminate undesired behaviors within the family system. The crux of the strategies is to discover tasks that get families to change those aspects of the system that maintain the problematic behaviors, rather than to provide intellectual insights. Even indirect tasks, such as paradoxical interventions, are used to hasten clients to abandon their self-defeating symptoms.

The shared belief in strategic approaches to therapeutic change is that families have developed unworkable solutions to overcoming their problems. These solutions have become the primary difficulties in daily living. As a consequence, brief therapeutic procedures are employed during sessions that are aimed at changing these undesired interactive patterns. By introducing even small increments of change to alter the family's communication and organizational patterns, radical changes can occur that override stuck points and even chronic problems.

Drawings in a strategic modality serve as a vehicle for prescriptive and paradoxical interventions, with the target being the resolution of problem areas (Landgarten, 1987). The main principle from a strategic perspective is that behaviors are learned. Thus, they can be unlearned through slight alterations in the family dynamics that ripple throughout all interactions. In essence, patterns of behavior can be altered significantly through a change in only one part of a sequence of interactions.

Communication Theory

Therapists working from a communication model emphasize the importance of expressing and acknowledging feelings among

family members. Virginia Satir (1972), an originator of this school of thought, concentrated on the need to clarify interpersonal communication. In this model, four major elements signify healthy family functioning: (a) acknowledging each family member's self-worth, (b) effectively communicating with one another, (c) recognizing and understanding the rules of the family (i.e., what is called the family system), and (d) being cognizant of how family members relate to outsiders and to institutions (which she labeled a link to society).

In this type of therapeutic modality, family members are encouraged to "check out" with each other whether they are being completely understood. Satir (1972) stressed that in order to successfully navigate through the family's life cycle, thoughts, needs, and feelings at each stage must be clearly articulated and comprehended. When drawing directives are introduced in family sessions, the communication therapist would observe the family's relating patterns and methods of decision making during the artwork (Landgarten, 1987).

When using artwork in sessions, the therapist could also use drawings to help individual family members communicate their feelings and thoughts in a manner that is more fully understood. Since the graphic expressions are a novel medium to family interactions, much concealed material may surface through the activity itself and in the resulting images that would otherwise be avoided verbally. Roles and behaviors are put into action, conversations during task completion are heard, and alternative possibilities for problem solutions are displayed and respected. For example, when parents are placed in a task of working together to create a collage that would express "how they would feel if they could trust their teenager" and the adolescent children construct a drawing detailing "the specifics of how and when they can be trusted," the beginnings of communication and negotiations have begun (Riley, 1999).

Amy

Amy was livid! It was time enough, she thought. She was 17 years old and had seen her friends, one by one, all get their privilege of driving and, for some, their own cars. Her parents, by contrast, were not so understanding of this time of renewed independence. They had many misgivings. Amy had not been the most responsible or respectful of teenagers. Although she had been a joy to be around during her childhood, things had changed within the household during her middle school and early high school years. She had become very boisterous and moody. Her actions were provocative. Every day she would present with new challenges to her parents and they were exhausted and without answers.

During the first family session, Amy and her parents were timid about disclosing their all-consuming battles with a stranger. They were fearful of being embarrassed and losing control, especially of sharing their intense frustrations and anger. The family therapist was acutely aware of their constricted affect and thought that introducing drawings to the session would override any hesitation toward getting down to work.

Amy agreed to this novel approach without apprehension. Instead of clouding the issues by letting her parents get off task in explaining their other disputes and concerns about her, Amy immediately constructed the following illustration of her pressing problem (Figure 5-5). By presenting a picture of the car keys being passed onto Amy, her design clearly pointed to the crux of the family anxieties.

For her mother, the thought of Amy's independence was unnerving. She was not emotionally ready to see Amy as a separate person and as having so much potential freedom. She also felt threatened by the impending "empty nest" that to her was going to occur much to soon. For her father, the passing of the keys represented a true passage of time. He was proud that Amy could drive (after all, he had taught her himself) and

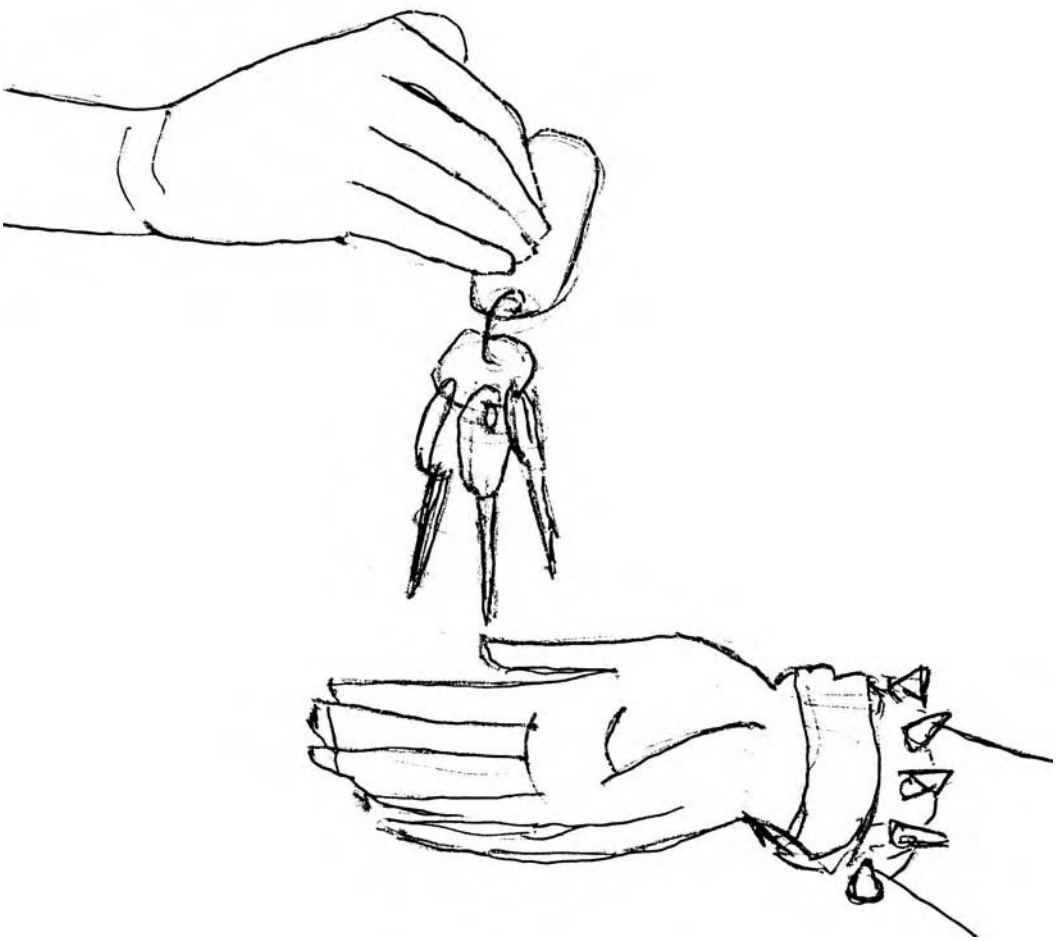

Figure 5-5

was not flustered that she could drive to her own activities. And for Amy, the drawing (and the keys) meant everything to her. It symbolized all of her mother's fears that to her were unfounded and confusing and showed that she was equal to her peers in obtaining her right to enjoy life as she pleased. With these issues out in the forefront of discussion, the therapy took on a focused direction with many acceptable resolutions.

THE THERAPIST AS DETECTIVE

Beginning family treatment requires the therapist to concentrate on delineating the family subsystems. The dyads and triads within the family structure define its organization and are the primary focus for therapeutic change to occur. Landgarten (1981) suggested that while the family is creating a combined drawing task, the clinician has the opportunity to watch and observe these family dynamics in motion. The family's approach to constructing a family mural, for example, provides the time necessary to examine the family's communication and problem-solving patterns. Recognizing that this observing time is essential establishes the groundwork for effective family intervention (Minuchin & Fishman, 1981; Minuchin *et* al., 1996).

In this discovery phase, the therapist must identify and select appropriate therapeutic interventions that would have the most impact on the family's unique relating styles. Addressing these family needs may be hazardous, as obvious distinctions may occur between the family's perception of their ongoing unit, which is trying to maintain the status quo, and the therapeutic stance of striving toward differentiation and competence among each family member. This disparity in objectives creates a conflict from the beginning and sabotaging treatment plans by various family members may be a primary goal. However, this resulting disequilibrium may actually be the central point where the therapist can begin making the most significant impact.

Before the family is led into alternative hierarchical structures to promote positive change, the therapist must take the time to understand and join the family's reality. Therapeutic joining happens when the clinician actively observes and accepts the family's present organization and responds appropriately and respectively to each member's unique perceptions. For instance, if a father's role is to limit the family disclosure to outsiders, the therapist may initially side with the father to gain permission for interacting openly with other family members. Only later, once trust has been established and maintained, can the clinician challenge this role and expand it without repercussion.

Through this family engagement, the therapist is offered a wealth of pertinent information that must be filtered through integral steps. There are boundaries to be observed, strengths to be emphasized, and conflicts to be noted. To be effective, the clinician must actively observe these dynamics among the family members, as well as remain aware of the overall mood in the session.

To manage these tasks and to orchestrate the sessions convincingly, family therapists and other mental health professionals need many creative intervention techniques at their disposal (McGoldrick, Gerson, & Shellenberger, 1999). These methods are used to enhance family interaction and expression, as well as provide enjoyment and increase feelings of mastery and accomplishment in their users. Because of their nonthreatening nature, ease of administration, and vast interpretive potential, structured drawing activities are ideally suited to explore the complex dynamics between intergenerational communication (Rubin, 2001).

ARTWORK IN FAMILY SESSIONS

Drawings as Diagnostic and Process Tools

Introducing drawings into family therapy sessions has two main purposes: (a) they provide a tangible assessment and evaluative technique, and (b) they become a therapeutic process tool (Safran, 2002). These functions usually overlap. By using drawings at the outset, the therapist can establish trust with the family by connecting with them through structured activities. At the same time, the therapist begins the process of assessing complicated interpersonal dynamics and roles. Both the process of drawing and the finished product itself assist the therapist in (a) comprehending the hierarchies and boundaries within the families; (b) viewing how members perceive themselves and the entire family organization; and (c) understanding how the family members communicate, support, and understand one other. All these elements are vitally important to a successful treatment outcome.

In regards to exploring therapeutic process, the activity of drawing brings a playfulness to the family session's interactions and overall tone. Drawings create shared enjoyment, provide a sense of intimacy, and assist the family to reestablish its sense of unique identity. The procedures also increase verbal communication through the sharing of ideas expressed in the drawings. Additionally, art directives can be introduced during sessions to help create or destabilize familial coalitions. Drawings are a method to make hidden problems visible to the family members in order to identify, understand, and resolve problem issues. Through their use, the creative therapist can use drawings to promote numerous interventions within any family therapy model (Oster & Gould, 1987).

Carla

Carla could no longer remember who she really was or ever wanted to be. Now 40 years old and the mother of four, Carla had no time for herself and no time to reflect on her own abilities and personal dreams. In essence, she was a mystery to herself and was beginning to feel lost within her family and her role as primary caretaker. When Carla attempted to describe her concerns to her family, they were bewildered and did not know how to react to her expressed feelings of ineptitude.

This open confession was confusing and fearful to the family. This could not be the active and multitalented wife and mother who was always on the go and involved in all of their activities. This reaction pained her husband, who thought that he had successfully secured everything that she had originally wanted — children, a nice house (all the good things in life). The children were equally perplexed for they loved their mother and could not imagine that their mother was not happy.

When her husband broached the subject of family therapy as a way for everyone to hear her wants and needs, Carla felt relieved that at least she was being heard and hopeful that an

objective third party could assist her in addition to the family. During one of the early sessions, the therapist asked Carla to create an image that might represent her primary problem, as well as convey to her family her inner experience. As a result of this directive, Carla created a visual projection that she could use to discuss and express her underlying feelings in a less threatening manner.

To her, the drawing said it all! As seen in Figure 5-6, Carla symbolized her feelings of anonymity through a picture of a mirror without a reflection. With this portrait as a tangible platform to be used repeatedly in family discussions, Carla was able to express her feelings of alienation and lost identity to her husband and children in a safe atmosphere and in a way that could be understood by all participants. Through this graphic portrayal, Carla was able to establish her core issue and had the opportunity to plan time for herself, with the assistance of her husband and children, which made her feel appreciated and less overwhelmed.

It is not uncommon for both the non-art-therapist clinician and family members to feel somewhat awkward when drawing directives are first introduced in family sessions. This feeling is typical, since the use of drawings is stepping outside the anticipation of usual verbal interactions. In reality, though, this alternative path toward relating can be quite beneficial when families find themselves rigidly stuck in their own patterns of ineffective communication. It can also be like a game in that parents can use drawings to interact and be playful with their children. Drawings alter these cycles and the resulting products create novel avenues of self-expression and add deeper understanding to their problems. By overtly recognizing the shared nervousness of expressing oneself through art, the clinician can better join with the family and model healthier ways of expressing complex feelings.

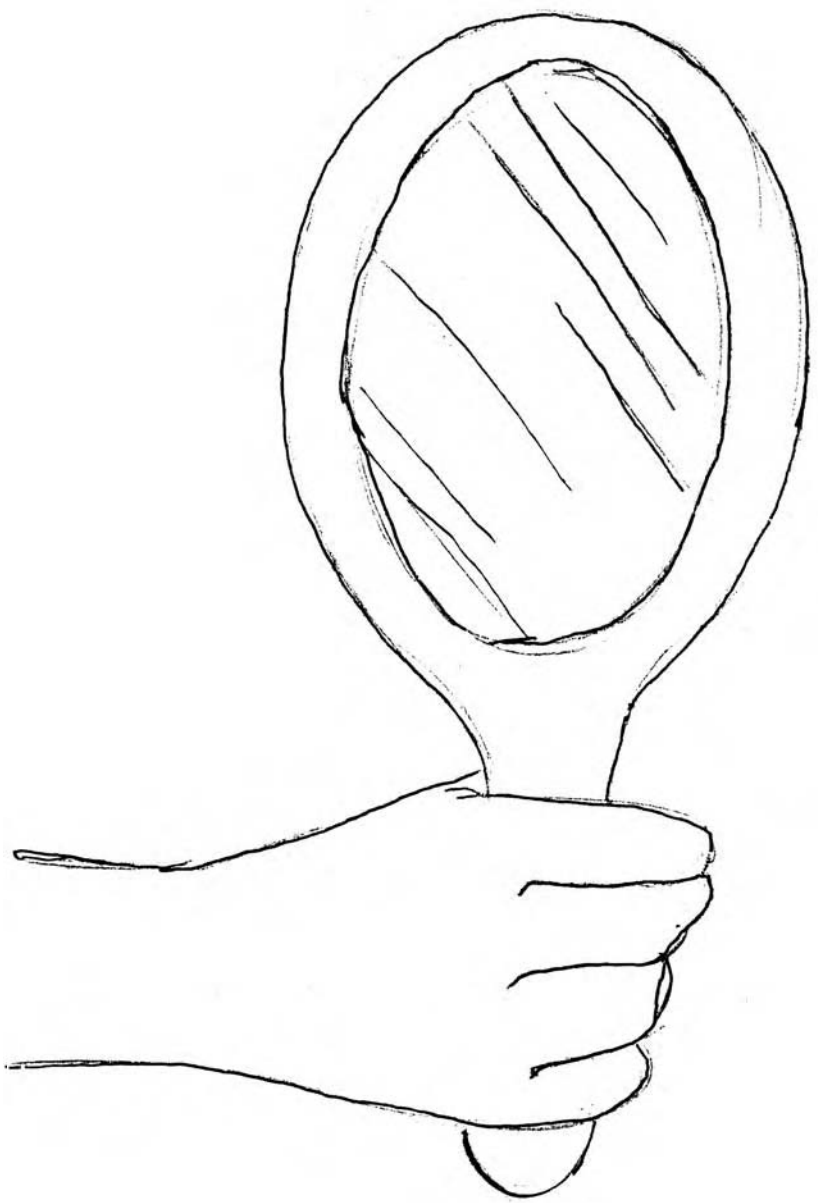

Figure 5-6

Discussing Conflict through Drawings

Drawings help the therapist and family members by providing a concrete point of reference for reviewing areas of conflict that may be too threatening to share openly during beginning sessions. They also lend themselves to the process of generating hypotheses regarding salient family worries. They provide the clinician with introductory themes that, when added to the broader scope of existing information, can begin to answer many of the referral questions and initiate a path toward the various aspects of treatment intervention.

When using drawings, families have the opportunity to portray their problem areas without talking. They can then confront them during subsequent discussions and learn techniques to gain control over them. The artwork serves as a focal point for this dialogue and provides a permanent record of the process. The drawings become visual records of family transactions that can be preserved and reviewed throughout treatment.

Leslie

Leslie, 38 years old, was seen during a marital session. Both she and her husband of 10 years were developing strong feelings of resentment toward one other due to daily stresses of raising three children, a broadening lack of support and communication, and intrusive extended family members, who were always interfering. It was Leslie's idea to seek counseling as a way to share her loneliness. She also wanted to alert her husband to what she needed from him if she was going to continue in the marriage. The theme of "you just don't get it" was often heard during the first several sessions.

It was decided by the therapist that perhaps a drawing of the problem would make the issue more tangible, as their verbal exchanges had become heated and at times hurtful. This alternative method to address this void in the relationship seemed

a suitable way to approach their disagreements in a protected manner. The idea of expressing her anguish through a drawing appealed to Leslie and she immediately constructed the following portrait (Figure 5-7). By using this observable platform,

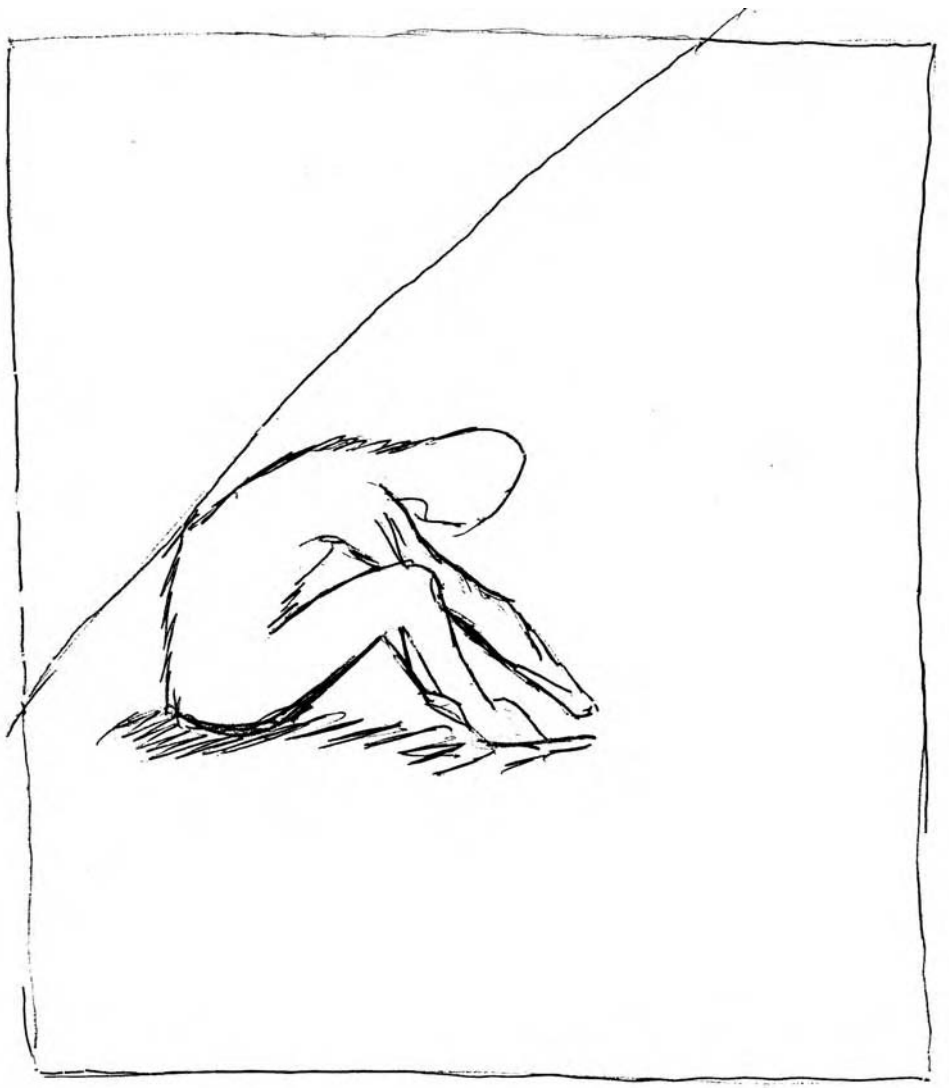

Figure 5-7

Leslie attempted to once again break through her husband's defensiveness and hoped that he could see her inner pain. In her explanation, she stated that "It feels like I'm burdened; I've hung my head in despair, but have braced my hands against the floor for support."

Leslie continued to speak through the drawing to her husband. For the first time, he began to realize that Leslie's floor (and support) was transparent, making her feel quite fragile, and that it was him whom she really wanted to be her foundation. This breakthrough for her husband enlightened the following sessions and allowed for a freer exchange of sharing as to what was needed to continue the family bond. Through subsequent drawings that reflected other salient issues at a more intimate level, Leslie was able to finally feel that her emotional needs were being shared and understood, and that her husband was willing to make the necessary changes in his attitude and behavior to enhance their marital status.

Art tasks offer the couple, or the entire family, the opportunity of working together and underscore the important message that mutual problem solving is a primary goal of their therapy. The communal activities also emphasize the important theme that the difficulties being discussed are everyone's concerns and that a family working together can be a forceful agent of change (Riley, 1999). The drawing methods often reveal therapeutic issues and creative solutions that are not always available through traditional approaches to information gathering.

The use of nonverbal techniques, such as drawings, are especially useful for exploring emotionally-laden issues with families of depressed teenagers, who discover that it is often easier to express uncomfortable feelings through joint products or experiences (Oster & Caro, 1990; Oster & Montgomery, 1995). Drawings offer a safer outlet for the destructive or angry impulses of troubled adolescents, who may otherwise feel overwhelmed by what is being expressed during the interview and who may be afraid of losing emotional and behavioral control. Additionally, the adolescent and

family, who may already be creative in their self-expression, have another basis for further enlightening explorations through these nonverbal procedures.

An Enhancement to the Practitioner

Clinical tools, such as drawings, offer considerable advantages to the practitioner during initial family therapy sessions. In these first visits, behavior and expression of feelings may be excessively rigid, fragmented, or unfocused. Because drawing directives have their own unique structure and facilitate selective information, they offer physical blueprints for establishing rapport and for building a bridge that provides direction for change. The activities initiated by drawing and the resulting products constructed send a compelling message to the family members that they are an active party of the therapeutic relationship and that they can use alternative methods, such as drawing, to increase their awareness to their presenting problems.

The following sections detail practical use of drawings during family evaluations. Their use is advocated as a structured technique that makes it easier to obtain clinical information from the family that otherwise might not be readily forthcoming through verbal exchanges. Because drawings are a novel approach to information gathering, families may be less guarded to disclose these personal details.

All families can benefit from the introduction of these procedures into an evaluative or therapeutic session. One point to mention, though, is that therapists may want to use terms other than "art" during sessions, since a family's likely knee-jerk response might be "We don't do art." Terms such as "talking through drawing" or "talking with your hands" may be less threatening and less likely to bring resistance to the sessions.

DRAWINGS IN FAMILY ASSESSMENT

The clinical use of drawings in family evaluative sessions promotes the exploration of complex dynamics between parents and children. Graphic illustrations offer all participants the opportunity to portray their unique perspective of the family subunits (e.g., dyads and triads or dominant versus passive members). By introducing these indirect methods to observe family interactions, clinicians increase their access to an undiluted expression of emotion than traditional procedures would likely produce.

When directions for drawing tasks are added to family sessions, they provide creative experiences that are usually beyond the everyday experiences of most family members. There are several reasons why clinicians may want to include such ancillary techniques during intake evaluations and early treatment sessions. These considerations include (a) disrupting maladaptive forms of family communication, (b) making therapeutic goals tangible through visual images, (c) enhancing and rearranging specific familial relationships through joint drawing activities, and (d) exploring those relational issues that inhibit family members from communicating freely (Rubin, 1978, 1997).

Max

Max, a distinguished college professor, was entering his tenure review year to obtain full professorship. Much to the chagrin of his wife and three children, he was rarely at home and on those occasions when he did arrive on time for dinner he seemed oblivious to the needs of everyone around him. Besides the tension that was escalating within the home due to his many absences, Max himself was feeling ineffectual and quite helpless when he entered the household. To him, it always seemed chaotic and busy with many appointments labeled on the monthly calendar. However, he rarely felt a part of the activities and when he would attempt to intervene with helpful sugges-

tions or exert his wishes, they would fall on deaf ears or angry retorts. His frustrations persisted, as did his wife's and children.

Always attuned to Max's feelings, his wife made an appointment with a family counselor to assist him in gaining at least perceived control in returning to the family functioning. Although reluctant, Max knew he was losing his place within the household and the respect among all family members. This loss of admiration he could not tolerate. Why, hadn't he worked exceedingly hard all these years to gain the esteem of his students and colleagues? Now, it seemed as though his identity was collapsing and his image of family bonding and safety was wilting.

During the initial family evaluative sessions, the counselor thought that introducing drawings into the mix would assist all members in expressing their apparent agony. This intervention was especially poignant for Max, who tended to verbally intellectualize everything when confronted about his behavior. Although he was uncertain about this novel approach, he thought it best to go along with the direction and did not want to create conflict at this point in the sessions.

When asked to demonstrate the fears that his ineffectiveness and invisibility were creating within him, Max created the following illustrations. At first, he displayed an image of his feelings when entering the household in the evenings (Figure 5-8). He explained that the string around his feet was expressing his helplessness and inabilities to share his own frustrations in no longer feeling a part of the family activity. To his children, it also provoked his isolation and incompetence to walk in the family shoes — they reiterated to him his lack of flexibility in his scheduling and his own unwillingness to praise their accomplishments (he was mainly negative and critical toward them).

In his second drawing, Max shared his hidden fears and feelings of panic. He truly believed that if he did not obtain tenure this year, his entire world would fall apart. He illustrated this inner anxiety through a compelling visual image of his deck of cards (his home life) falling down and him running away

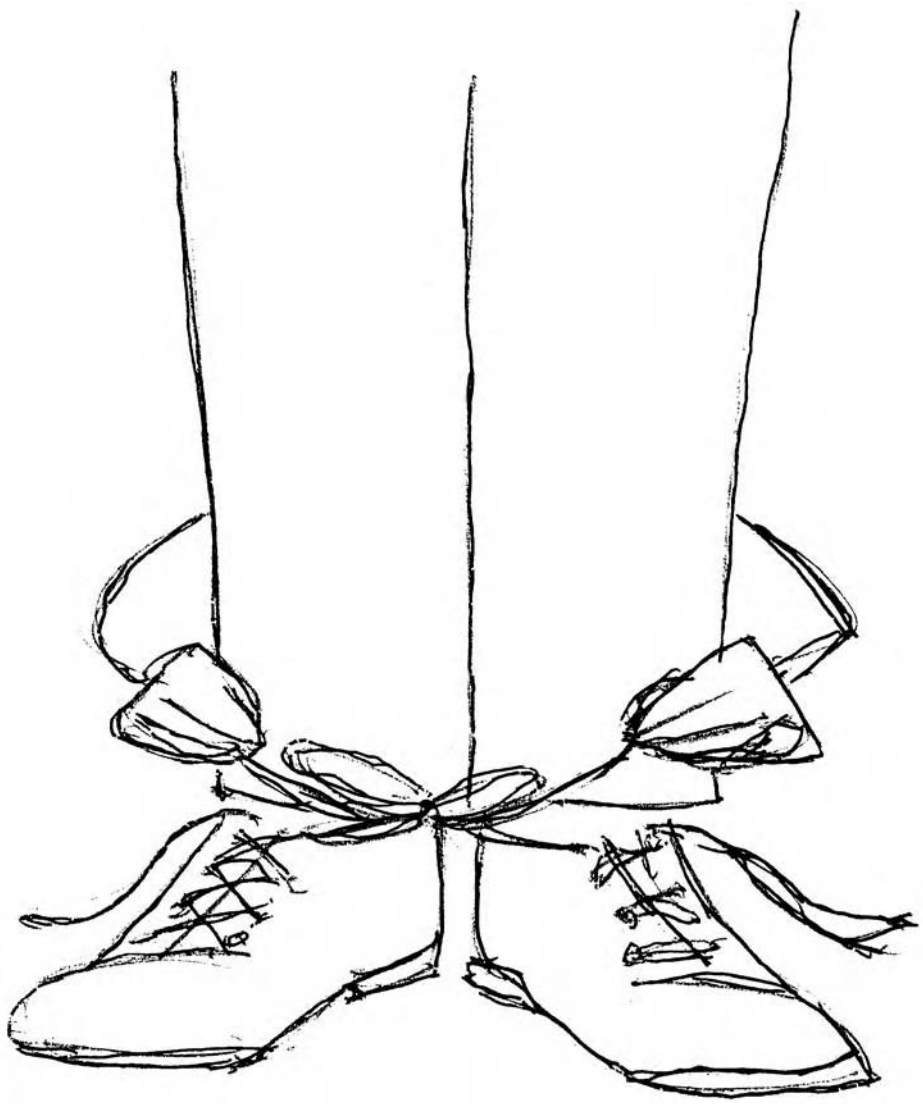

Figure 5-8

over his failure and defeat (Figure 5-9). Future sessions were focused on these overwhelming feelings and how they were expressed in his everyday reactions to the family members. Max's family was amazed and pleased that he could share these vulnerable feelings with them through these illustrations and

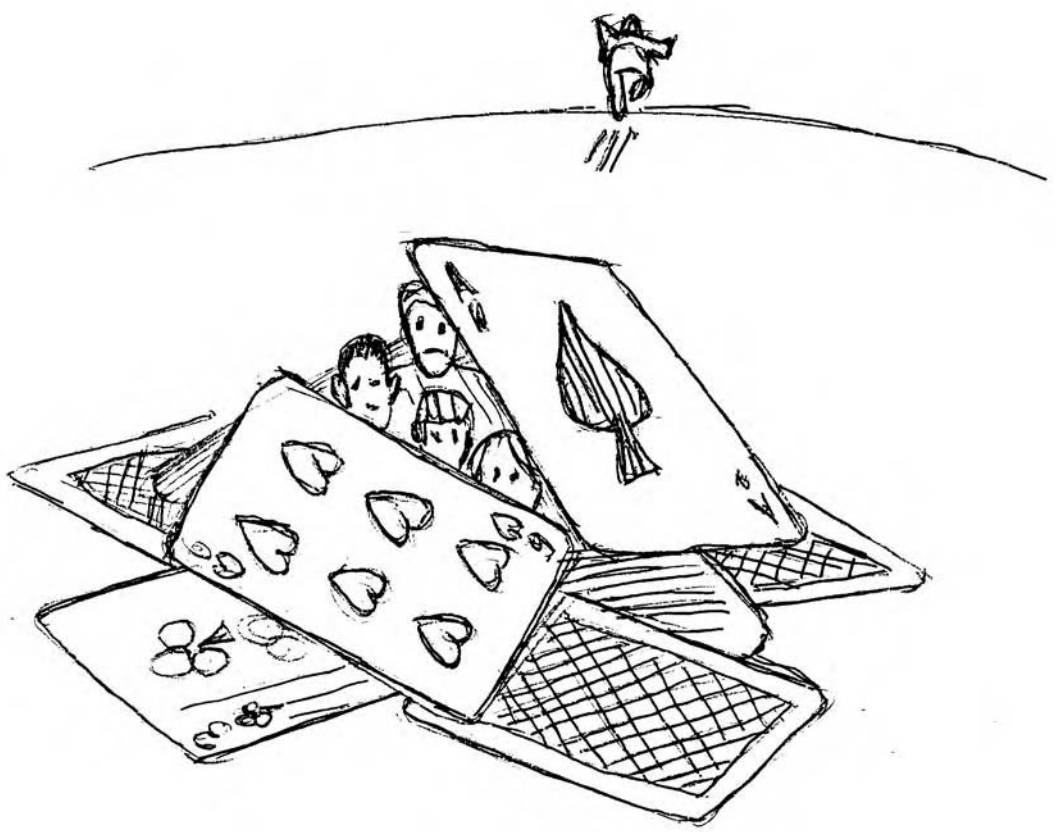

Figure 5-9

that he was in fact able to express uncomfortable thoughts with them through pictures, which were more easily conveyed compared to his usual lectures and rebukes.

Drawing activities encourage participation during the initial evaluative sessions because the primary focus of discussion surrounds a shared drawing instead of direct questioning. These one-step-removed features are especially relevant to identified patients, who usually want to divert attention away from themselves. They also become salient to withdrawn family members

who are reluctant to share personal information during the early assessment stages of therapy.

Working hypotheses regarding family organization and interpersonal dynamics are gleaned both during the execution of the drawing and the ensuing discussion of the resulting illustrations. Clinicians also gain increased insight by observing the verbal and nonverbal forms of behavior and interactions during the drawing constructions. Additionally, each member's description or associations to the drawings provides a wealth of valuable information in understanding the family's preexisting strategies for relating. For example, during family drawing activities, clinicians may begin to establish conjectures about whether one parent is actually portraying the spouse when the drawing and discussion are focusing on a child's problem (Oster & Montgomery, 1996).

Revealing Family Dynamics

Family configuration and everyday functioning are often revealed through features in the drawings, such as the content, quantity, placement, symbols, and process of construction (Rubin, 1978, 1997). Such aspects within the drawings are observed by noting the following questions during shared drawings: Who in the family takes the initiative by leading the other members? Who follows and in what order? Who is reluctant to participate? or Which member is most assertive?

The observations and resulting questions are endless. For example, in one particular family, an isolated member preferred to work on a joint drawing alone; while in another family, a shy, anxious member decided to make his contribution off to one side of the mural. Often during these projects, certain family members will be scapegoated if dissatisfaction occurs during the construction of the picture. Clinicians also get the opportunity to view family alliances when noticing members working in close proximity to one another, or observe familial conflicts when one member accidentally crosses through the drawing of another. This vast yield of working

hypotheses about the family and its functioning are all solicited through these careful observations made by clinicians during a family drawing.

In her book, *Family Art Psychotherapy*, Helen Landgarten (1987) indicated that it becomes imperative for the therapist to "be an astute observer and recorder" of each family member's contribution during evaluative sessions. She suggested that every "gesture and mark" in the drawings provide clues to the family organization and functioning, and it remains the clinician's responsibility to become aware of the drawings' implications. She noted 17 questions for therapists to ask themselves while observing the drawings and the activities surrounding them. Several of these points included: Who were followers or reactors? Was the family's working style cooperative, individualistic, or discordant? How much space did each person occupy? Were emotional responses made? (Oster & Montgomery, 1996).

By paying close attention to these interpersonal indicators of family style, much clinical material is gathered during the process concerning relational strengths and weaknesses, assigned roles, and patterns of behavior and communication. When therapists use these observations to facilitate perceptions of member roles within the family crucible, the process of introspective exploration has begun (Landgarten, 1987). The documented artwork then becomes a unique source to visually describe the family dynamics and offers a neutral platform that increases participation by all members.

The Oakley Family

The Oakley family was a blended family. The father had been previously married, but that marriage had been mutually abusive. His former wife had obtained custody and kept their three children (all girls) from the father for five years. He had tried unsuccessfully to find them. It was social services that located him to see if he wanted his children after they were taken from their mother for physical abuse. They were now

ages 12, 8, and 4. Now remarried, he and his new wife had a daughter. The father had completed court-ordered anger management and parenting classes following his previous abusive marriage and felt comfortable to try and make it work with his new family and his children from his previous marriage.

They were all referred for therapy by social services while with their father and remained in therapy for one year. Visits were also successful with the biological mother, who completed all court-ordered interventions. Eventually the two younger sisters returned to live with their mother and the older girl stayed with her father. Figure 5-10 is a family drawing done by the newly established family of father, stepmother, and 13- and 4-year-old half sisters. They all chose different colored markers and a theme of their house. It is important that each family

Figure 5-10

member chooses a different color marker so the therapist can easily distinguish among the drawings. The house and dog house were drawn by the 13-year-old daughter and the tree, person, and dog by the father. The grass and scribbled cloud were drawn by the 4-year-old, who was assisted by the father to help her outline the tree. The mother also drew the birds, butterfly, apples, flower, and clouds and assisted the 4-year-old with filling in and helping draw the cat.

In general, this family produced a cohesive drawing and interacted well during its execution. The father and oldest daughter tended to dominate somewhat and the youngest daughter and the mother tended to enhance and fill in. This probably reflected their tendencies toward different roles in the family. The therapist eventually had to set a limit as the family did not know when to stop and were somewhat competitive with each other, as evidenced by how most of the space is filled in with equal amount of markings from all individuals in the family. These drawings are excellent tools for the therapist to see the level of cohesiveness in a family, the different roles of family members, and how the family members interact.

Roles of the Family Therapist

When clinicians use family drawings as the primary focus within sessions, it is important to respect all constructions in a supportive, nonjudgmental manner (Kwiatkowska, 1978). The essential therapeutic targets during these art tasks are to encourage spontaneous expression and facilitate discussion among all family members. In these exercises, clinicians can serve as role models to enhance communication by directing leading questions surrounding the drawings or their process during the creations. These queries may include such questions as: What emotions were experienced during the drawing? Which family member worked hardest at the task? Were there similarities in the way that you worked on the drawing that also occur at home? The answers to these poignant questions offer a rich understanding

to family organization. The feedback provided to family members makes each of them more cognizant of the impact that their behaviors have on one another.

Clinicians can sometimes use drawings to disrupt typical patterns of communication by redirecting family members from their normal roles of relating. An example of such usage is to direct an uninvolved father toward becoming the leader of a joint drawing to engage him more directly. When drawings are used in this manner, therapists assist family members to experiment with novel roles of interacting to discover alternative means for reaching more mature levels of family equilibrium. Drawing activities can also maintain this revised homeostatic functioning after these initial shifts have been accepted (Landgarten, 1981).

Several prominent art therapists have created structured drawing tasks to use during initial family evaluations (Kwiatkowska, 1978; Rubin, 1978, 1997; Wadeson, 1980). Of course, there are endless possibilities of family situations and their reactions, and novel approaches are always being established. For instance, newer modifications of these drawing directives have incorporated group dynamic theories in their strategy to support family treatment goals (Linesch, 1999). Therefore, clinicians using these approaches will probably want to modify them according to therapeutic style and setting. However, the original sequence of drawing activities does provide a structured approach for planning family sessions and is used to enhance the interactions of various family members.

PSYCHODYNAMIC APPROACHES TO FAMILY INTAKES

Hana Kwiatkowska (1978), considered the mother of family art therapy, discussed several main advantages to art expression when working with families. She noted that drawings serve as a platform for evaluation and diagnosis that can be viewed as adjunctive tools for family therapy, as well as a primary method of family treatment. Her structured art format provided a foundation for the family to complete six exercises during their beginning sessions:

1. On separate paper, each family member is requested to construct a free association picture of whatever comes to mind. This drawing directive provides family members with the opportunity to introduce and describe themselves or to portray a salient feature of what they perceive as a family difficulty.
2. The next instruction requests all members to graphically depict their view of the entire family, including themselves. These separate family drawings often produce different angles of the family hierarchy (for instance, certain members placing themselves or others as more prominent in the picture) or distinctive characteristics in family arrangements (some members including only the nuclear family, while others incorporating close relatives).
3. The third request is to construct an abstract family portrait. This derivative of the traditional family drawing assesses the degree to which participants can portray themselves beyond stereotypical roles or perceptions. This aspect of seeing beyond the obvious is introduced within the evaluation by directing each member to symbolically represent the family through shapes, lines, or colors. Results from this directive are usually quite striking, as the family members are placed in a situation outside of their everyday frame of reference.
4. The fourth and fifth drawing requests are to complete scribbles on the paper. First, the family is asked to participate in arm exercises to enhance their freedom of movement, after which their sweeping motions are transferred onto the paper. The subsequent scribbles are then created into pictures based on each member's own internal projections or associations.
5. After these scribble drawings are completed, the family members are instructed to make separate scribbles, then to collectively choose one to complete together. This joint exercise gives the evaluator the opportunity to observe family roles and dynamics during a decision-making process.

6. Free drawings are then requested for the conclusion. This directive promotes freedom of expression and relaxation from tension. In combination, these drawing directives provide a structured approach for observing family functioning and begin to clarify many questions that clinicians may have prior to planning extended therapy sessions.

Judith Rubin (1978, 1997), another proponent of family art psychotherapy, has offered an alternative outline of directives to engage families during evaluations that involves fewer drawing tasks. In this model, clinicians first instruct each family member to complete a continuous-line scribble (where hands do not leave the paper). When this initial task is completed, everyone is asked to look carefully at the drawing and discuss what they observe. Each person is asked to title the scribble and then to exchange it with other family members for their comments. These exercises succinctly initiate the process of enhancing participation and positive interactions, as well as gleaning important evaluative information.

After completing this task, another drawing directive is then introduced in the session. During this phase, all members are instructed to portray the family in realistic or abstract forms. Each of the drawings is once again exchanged among all family members. In this more collaborative method of evaluation, the family is finally asked to construct a joint mural on a large sheet of paper taped to the wall. This combined art task again provides the evaluator with an excellent opportunity to observe family interactional patterns.

MARITAL EVALUATIVE DRAWINGS

Introducing drawing techniques may also be extremely valuable for marital evaluations. Harriet Wadeson (1980) suggested three primary drawing directives that can be advantageous during couples sessions. Beginning with a joint picture, this exercise requests the couple to construct a picture together, preferably without talking. Follow-up instructions invite each individual to create abstractions

that symbolize the relationship, then to compose a self-portrait that is exchanged between participants for amending. These drawings produce such key revelations as dominance within the relationship, conflicts being expressed, and degree of intimacy.

Stan and Mary

Stan and Mary came to therapy for help with their failing relationship. They felt their marriage was dying. Their chief complaint was that they no longer knew how to communicate with each other. The therapist requested they create a joint drawing (Figure 5-11).

Figure 5-11

Stan started the drawing with the boat in the middle of the paper without consulting with Mary about what she wanted to draw. Then Mary furiously drew the water, sun, and cloud. When the therapist invited them to talk about their drawing Mary blurted out, "It's all about him and his boat!" expressing her anger about his preoccupation with his boat and feeling like she is not important to him anymore. Stan was genuinely surprised, stating he had not known that Mary felt this way before they did the drawing. In this way, the joint drawing opened new doors for Stan and Mary and a way to start solving their communication problems.

Another useful directive in these couples sessions is to request a "picture from your youth of how your family home looked when you opened the door and entered." Upon completion, the therapist can pursue added informational material with the following questions: What were the sounds, the colors? Who was there? Was it peaceful? Was it raucous? Shirley Riley (1993) used this art instruction and leading questions with a diverse couple whose markedly differing cultural backgrounds greatly affected their contrasting world views. The wife's drawing depicted a door opening to a room full of chattering people, music blaring, and vibrant colors. Her husband's portrait displayed a peaceful room, calm and quiet — his family norm.

These pictures permitted the couple to concretely view the historical differences in their respective backgrounds. The structured art process permitted an enriched understanding of each spouse's reality through the other's varying perspective. This directive also provided a tangible visual platform to rid themselves of labeling these differences as right or wrong and gave them an opportunity to view them merely as part of each other's family history. This enhanced outlook paved the way for increased communication and less defensive reactions.

THE FAMILY SYSTEM

Observing Coalitions

Although the previous drawing formats were originally based on psychodynamic interpretations, newer approaches to family evaluation were better understood through a broader family systems perspective (Landgarten, 1987). The focus of this interpersonal method explained how all family members impact on one another. This emphasis on the entire family, as opposed to the illness of the identified patient, allows the clinician to observe how family coalitions evolved over time and are maintained in a rigid posture. Through a series of problem-solving drawing tasks, healthy and unhealthy aspects of family functioning can be observed and discussed to form workable interventions.

Initially in this sequence of drawing directives, family members are requested to draw their initials as large as possible and to discover a picture in them. Elaborations of the pictures are requested, then each family member places a title on the picture and exchanges the final product. The last direction in this drawing series is to instruct the family members to work together on a large, single piece of paper without talking to one another. By using this activity, clinicians can examine the family's nonverbal interactions and the members can more freely express their emotions within a contained project.

During this process, it becomes useful to use separate colored markers for each participant to differentiate individual contributions. If a large family is being evaluated, members can be divided into teams to construct distinct pictures, or to draw a series of pictures with various members of the family. In this case, the procedures enhance behavioral observations by having the opportunity to view how different working segments of the family communicate with one another.

Strategic Metaphors

Sobol (1982) offered an alternative model of using drawings as a vehicle during family therapy evaluations. Her technique combined a strategic framework for conducting assessments with specific drawing directives to generate and interrupt family hierarchies and alliances. Her work was based upon Jay Haley's (1963) original concept of metaphor as the foundation in family communication.

By using the natural symbolism of art, family members have the chance to represent their perceived problems in a less threatening manner. Also, the activity of drawings and the resulting products elicit a different kind of information that is beyond everyday language-based communication. The knowledge gained through the drawing tasks can then be used to establish therapeutic goals and treatment plans.

Steven

Steven, aged 45, was a successful insurance salesman and a good family man (in his eyes). He scheduled his work day to be at home when his children arrived from school. He was also actively involved in their activities, including sports and drama. However, Steven's oldest son was beginning to rebel over his father's rigidity and lack of risk-taking. Whereas Steven was always responsible, his 15-year-old son began to withdraw from organized sports, show less interest in school, and hang with his street peers who were often seen skateboarding at the local shopping center parking lots. To Steven, his son's withdrawal from organized activities was a waste of time and an affront to his values. His son did not understand his father's disappointment, and subsequently the tensions increased and arguments ensued within the household.

Although there was some questioning, reluctance, and resentment when Steven's wife became tired of the turmoil and called a family therapist to gain control of the situation, both

Steven and his son were eager for someone to hear their side of the story. When their verbal antagonism would not subside during the initial sessions, however, the therapist thought it best to explore their disagreements through a distinct and perhaps more entertaining approach. In viewing the father as too adult-like in his demands, she instructed the father to construct a drawing of himself at his son's age and to compare it with his perception of his son's current interests.

As Figure 5-12 suggests, the images were striking in their disparity. The father was eager to show and explain his life at 15 with its serious tone and accomplishments. He was proud of his

Figure 5-12

organized and defined childhood and his earning of Eagle Scout status. By contrast, the illustration of his son skateboarding reflected the son's casualness and fluidity in general direction.

With the father's background exposed to all, the children began to see his attitude more clearly and respected his choices in life. However, they were also able to point out that their approach was merely different and seemed to them less restrictive and more exciting — a fact that the father had to acknowledge. Through these alternative nonverbal activities, the initial tension of the sessions was broken and the family was able to work through successful solutions in their everyday problem solving by accepting and respecting each family member's background and uniqueness.

In one aspect of this structured method, the evaluator actively interprets a family member's drawing to crystallize this metaphorical information. For instance, the clinician may comment that one drawing may represent a dominant personality and begin to address that person with greater respect. Next, the clinician may determine the passive family member through a drawing and encourage that member to participate. Through this more direct approach, the clinician begins taking a more active role within the family session to shake up fixed roles and to offer better avenues to express frustrations and overcome rigid patterns that are maintaining the presenting problems.

Intervening through Family Coalitions

Another path the evaluator can take to strategically disrupt family coalitions is through disrupting interactional communication sequences. For example, when generational boundaries are blurred, therapists can stop cross-directional dialogue by instructing the parents to complete a drawing without interruption from the children. As mentioned previously, an advantage of this method is that it permits the evaluator to assist particular family members

in self-expression, especially when they are frustrated in their attempts to be heard.

The Oakley Family

Following the Oakley family drawing (see Figure 5-10), the therapist divided the family into various dyads to construct drawings together for evaluation purposes. The parents, particularly the stepmother, had been having problems with the 13-year-old talking back to her. The father had initially excused it as adolescent behavior causing a conflict between the mother and father. The therapist instructed the parents to do a drawing together (Figure 5-13). The father drew the outline of the "I love

Figure 5-13

you" and the mother filled it in. This drawing served to reinforce their relationship and their place in the hierarchy of the family.

A joint drawing completed by the father and the oldest daughter (Figure 5-14) revealed the confusion in their roles. In the execution, they both wanted to use black and broke the rules of sticking to one color by changing midway through the drawing. The father portrayed the motorcycle and the daughter the spokes and the road. She stated that the father drew better than her and, therefore, she could not draw with him. This possibly indicated her need for encouragement from her father and the father's underlying need to compete with his daughter and be in control. The issues that become evident through the dyadic drawings in families are valuable to explore as indicators of family functioning. They can also represent other possible concerns in the family that may need to be addressed.

An additional art directive that may help to clarify the family's goals toward treatment objectives involves asking participants to construct individual drawings that represent how each member would like to see the problems change. Other specific

Figure 5-14

drawing instructions that use this strategic family intervention framework include: "Do a drawing to represent why you think you are here;" "Do a drawing to represent the problem;" or "Draw how the family would look if the problem was resolved (and possibly draw some ideas on how to overcome the problems and present the solutions)". When attempting to delineate family roles or alliances, the clinician could also ask each member to "Draw how you see the family" (Oster & Gould, 1987).

Inner Resource Drawings

Another way to introduce drawings into family evaluative sessions is a procedure adapted from Joyce Mills and Richard Cowley's (1986) metaphorical art directives. This method, termed inner resource drawings, serves several functions during initial family meetings. First, they promote a clearer understanding of each member's perceptions of personal difficulties. Second, they furnish a feedback system by allowing each person a lens into another family member's perception of how the family functions. Additionally, the drawings emphasize problem solutions that can reinvigorate the family toward working together. Finally, the members have the opportunity to view these solutions through a common and tangible reference point. It is not surprising during this process that the family members become amazed over how similar their solutions are to one another.

Basically, this art task directs the family to construct several pictures. At first each member is asked to draw the core family problem. Following this drawing exercise, they are requested to draw the family when this problem was resolved. And last, they are invited to construct a drawing that portrays the differences in functioning that would help the family get from picture A to picture B (Oster & Montgomery, 1996).

FAMILY CRISES

Drawings are especially poignant when used during crisis situations and brief family therapy. Debra Linesch (1993) became a major proponent of demonstrating how drawing directives could become extremely useful in family work during crisis interventions. The drawing directives that she established assisted the basic goals of crisis intervention models at the time, which included (a) developing an understanding of the problem, (b) expressing appropriate emotions surrounding the event, and (c) deciphering the family's interactions and organization. The following examples of her drawing directives delineate the goals of treatment within the context of an outpatient mental health clinic:

1. Understanding the dynamics of the immediate crisis — Using art interventions, such as "Draw the events of the day" that culminated into contacting the clinic or therapist, or "Draw the last problem issue" before coming to the clinic or therapist, provides a concise jumping off point to determining therapeutic intervention. Another possible directive that elicits problem descriptions is to "Draw the family" pre- and post-crisis. Once completed, these portraits of the presenting problems often hasten the process of discovering the clues that detail the crisis situation.
2. Revealing the crisis-related emotion — Instructions that promote this kind of information gathering include having family members draw their inner feelings and their outer self-presentations that occurred during the crisis event. This technique provides a safe container for emotions and encourages everyone to express their feelings without fearing a loss of control.
3. Facilitating adaptive problem solutions — To enhance problem-solution thinking, drawings are requested from each member to visually describe how the family successfully managed similar problems in the past and to reveal all possible outcomes. This focus on positive solutions

enables the family members to emphasize what is possible rather than repeating negative cycles.

4. Anticipatory planning — To derive this future orientation, members are asked to construct drawings that identify potential obstacles that they can foresee and to create solutions for overcoming these hurdles.
5. Summary of gains made during the intervention — During the ending phase of this brief intervention, drawing directives focus on the family members reviewing their progress. This summary phase of treatment has the members constructing drawings as to how they viewed themselves at the beginning and how they perceive themselves now, at the end of therapy. Because drawings were emphasized from the beginning of this crisis intervention therapy, it becomes exceedingly useful to review the graphic images in chronological order from beginning to end of treatment to emphasize growth as a family and a successful outcome.

Although similar to longer-term therapy approaches, the above directives have been compressed and integrated into a shorter-term, crisis-oriented model of therapeutic intervention. Because of its nature, the crisis creates an imbalance in the equilibrium of the family. By using these powerful techniques, the family members are able to concretely *see* and confront their ongoing struggles. The drawing directives and the resulting pictures make it easier to focus on the most pressing problems among the family members and establish a platform to discover new avenues to communicate and overcome difficult obstructions.

DRAWINGS AS EXPERIENTIAL TECHNIQUES

A particular strength in using drawings during family sessions is that the exercises allow a structured format for the family members to engage on more or less equal footing (Gil, 1994; Malchiodi, 2002). In this case, young children usually have as much, and sometimes even more, facility with drawing (and therefore with

communicating the problem issues) as do older individuals. Drawings also become an alternative language that is relatively uncensored by the family system; therefore, they are not as likely to regress into habitual family scripts of redundant verbal exchanges in times of crises (Donnelly, 1992). Drawings are clearly a way of communicating one's inner world and personal experiences to the outside world. In essence, they become a bridge that connects one's private language to one's external reality.

During family therapy sessions, clinicians have the chance to use drawings to enhance this internal intimacy by allowing members to create and discuss images of themselves and their families. Usually, the ensuing expressed thoughts and revelation of feelings have rarely been personally acknowledged or verbalized to others. The process of creating drawings and elaborating on them allows therapists a ripe opportunity to educate family members of added possibilities for communicating their troublesome feelings. And by providing a safe environment to draw and reflect, therapists have established the beginnings of trust that can lead to a deeper and significant sharing among the family members. Through their metaphorical and symbolic quality, drawings allow people in therapy to communicate thoughts and feelings that would otherwise be obscured by their everyday emotional defenses.

Family Flags and Emblems

An example of these experiential exercises is to establish directives that help define family uniqueness and to increase family cohesion. One such method is to create a family flag. Used in this manner, flags can represent a sense of pride and self-worth and are known to portray the individuality of various groups (Oster & Montgomery, 1996). During this exercise, therapists provide the family with a rectangular outline of a flag. The members are then requested to work together on constructing their own family flag. Following this exercise, therapists can facilitate a discussion of the symbols and colors used in the flag through their meaning within the family system.

A variation of this drawing directive is to create a family emblem. An outline of an emblem is given to the family and they are asked to finish it. Upon completion of this task, the images are again discussed and explored for personal meanings. Possible directives toward this end are limitless. Creative therapists can use the beginnings of these art strategies within their own particular style and setting.

Toni

Toni, an 8-year-old girl, was being seen in the context of an initial family evaluative session. The second of three sisters, Toni was not the identified patient, but offered much information, both verbally and nonverbally, regarding the family dynamics. While her older sister was creating the most tension throughout the household, Toni seemed more attuned to the emotional climate and offered broader glimpses into describing the everyday likes and dislikes of the family.

As a way toward gathering and sharing perceptions and engaging the younger sisters, each member was asked to construct a family flag. By using this method, a subtle message was given that all participants were valuable in expressing their views of the family uniqueness. As Toni's picture suggests (Figure 5-15), the family was very active and her construction offered many entrances into the family's values and concerns.

In talking about her flag, Toni introduced the family as one that "loves" and "fights." Besides the daily activities of sports participation, grocery shopping, mall visiting, and gardening, Toni also portrayed the key stress that the family was confronting, that is, the family was going to be moving across country. This discordant theme had not been discussed within the context of the therapy until this time and the drawing offered a safe outlet for Toni (and eventually the other family members) to express their excitement in addition to their concerns. As the sessions progressed, it became apparent that the anxiety

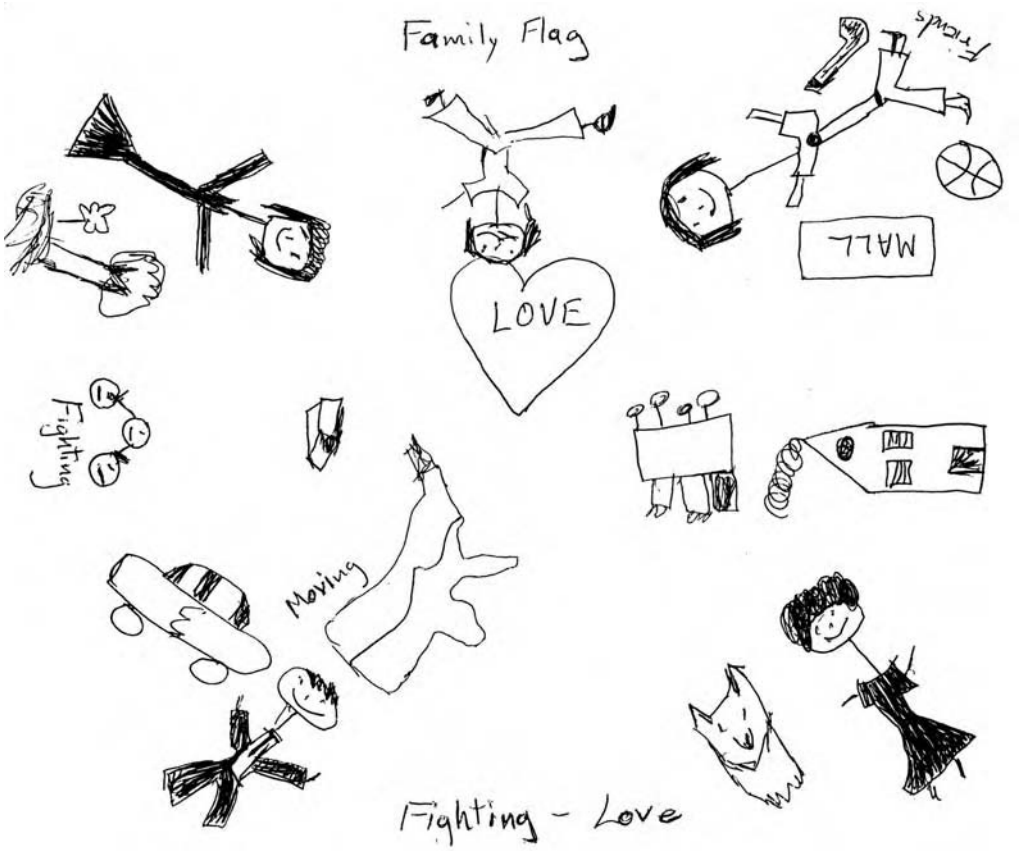

Figure 5-15

created by the move was the primary tension that was creating a schism between the older sister and her parents. However, it was Toni and her flag that brought this issue to the forefront for future discussions and resolutions.

SUMMARY

During initial observations of family sessions, alert therapists must be attuned to the family atmosphere, the affective states, and the patterns of communication. Through the gathering of this informa-

tion, clinicians begin to generate working hypotheses, or notions, that guide them in connecting with the family members, as well as provoking the established subsystem into active change. Through this family dance, therapists have the opportunity to assist the families in becoming more alert and understanding of their underlying tensions and faulty problem-solving or communication methods.

When therapists become empowered through the use of clinical tools such as drawings, they have the opportunity to structure and organize the sessions. As a result, the quality of gaining relevant information is enhanced dramatically. Nonverbal techniques, such as drawings, offer a different look at family functioning and permit a more clearly articulated picture of family interactions without the overt fear of exposure. Thus, the drawing directives mentioned in this chapter represent the communication between the family's "third voice" and the clinician who observes intently.

6

Using Drawings in Group Treatment

INTERPERSONAL ASPECTS OF GROUPS

During the process of group psychotherapy, individuals seek positive experiences and accurate feedback from peers to overcome maladaptive perceptions and self-defeating behaviors that contribute to everyday distress. Through this interpersonal give and take, personalities are strengthened and new values and attitudes are formed. As a result, these new "reference groups" can exert powerful impressions to change everyday views of their outside world (Frank, 1992).

A therapeutic group often recreates the social world, as it is a microcosm of each member's larger environment. As we are all social creatures, our personalities are jointly shaped by our families and by the groups we later join. Our values and attitudes are formed over the years by constantly checking the accuracy of our perceptions against these other group members.

As a powerful treatment modality, groups are found within a wide range of settings and used for varied purposes (Oster & Gould, 1987; Oster & Montgomery, 1996). In inpatient units, in day hospital programs, or in outpatient treatment, groups are used to increase social skills, to expand the realm of peer feedback, and to gain consensus of alternative problem-solving strategies. Group approaches are established through theoretical orientations (e.g., psychoanalytic or insight-oriented groups, gestalt, cognitive–behavioral) or formed to target specific problem areas (e.g., social skills deficits, anxiety reduction, grief and loss, or drug and alcohol abuse).

Groups serve preventative, as well as remedial purposes (Corey, 1992; Corey & Corey, 2001). Specific focus groups, for example, can emphasize educational goals, as well as concentrate on interpersonal processes that expand the person's behavioral and emotional repertoire. One such model of educational social skills groups using art as a framework has proven to be effective with ADHD populations, enabling clients to learn how to plan, organize, and share ideas and space in their everyday environment (Safran, 2002). This kind of social–educational group provides a supportive framework to supply the empathy and feedback that the members need to develop and evolve into better functioning individuals.

In gaining improved interpersonal skills, participants in groups have the opportunity to share conflicts and feelings and to investigate personal concerns that have interfered previously in their everyday lives. Through this enriched microenvironment, group members begin to establish trust and are able to share their personal distress. By overcoming their initial fears, they learn desirable behavioral alternatives that allow them to take greater risks and make their everyday lives richer and more worthwhile.

Anna

Anna, 13 years old, entered group counseling with presenting problems of parent–child conflicts, oppositionality at school,

and the beginnings of an eating disorder. Her sad and angry affect during the initial session suggested that she would be difficult to reach in conventional ways. After several sessions, she became more comfortable in the group interactions, especially after various activities were introduced to promote trust and spontaneity. Toward the end of the time-limited social skills group she, as well as her peers, were asked to construct before and after pictures of their experiences (Figure 6-1 and Figure 6-2). Although her drawings were basic, her messages were quite clear.

Figure 6-1

Figure 6-2

THERAPEUTIC GOALS OF GROUPS

There are many advantages to establishing therapeutic groups as a treatment modality (Alonso & Swiller, 1993). Primarily, groups are places where personal thoughts and feelings are shared within a larger framework. Members not only discuss their problem issues, but experience feedback regarding their personal difficulties with others who are having similar life struggles. The group setting allows members the opportunity to learn how others perceive them and provides the freedom to experiment with new styles of relating and interacting.

Through the interpersonal exposure inherent in groups, members can experience relief, connectedness, and valuable feedback when they reveal their secrets that have plagued them for years. They often learn that their hidden lives are not so unique; other group members have actually harbored similar thoughts or fears and have even acted out in comparable ways. This sharing on a deeper level is key to lessening the feelings of estrangement and alienation that so many people entering group treatment are likely to be experiencing.

Further, group therapy offers a unique opportunity for support of universal and existential human pain. The sharing of losses and disappointments helps individuals to feel less alone and to overcome their helplessness in attempting to lessen their inner wounds. For example, support groups for young widows allow these women to combat the isolation of their emotional and physical loss through sharing with others who have experienced similar trauma.

Finally, those thoughts that may have been unconscious or unavailable to a person for most of their lives can better be integrated through the reflected responses of others in the group. The expressed insights of other members can often consolidate thoughts or feelings that have been repressed or isolated. This exchange is accomplished through active listening and through the understanding of feelings articulated by other participants. By acquiring this new awareness, group members begin to feel more confident in their judgment and are then able to move forward in their respective lives.

The above points addressed by Alonso and Swiller (1993) are actually a compilation of the curative factors outlined in Irving Yalom's original treatise, *The Theory and Practice of Group Psychotherapy* (1970, 1995), and in his classic volume, *Inpatient Group Psychotherapy* (1983). Yalom, a main proponent for group treatment, also points to three other advantages to group process: the instillation of hope, the opportunities of discovering a mentor, and the possibilities of relieving experiences within the family of origin. He suggested that successful therapeutic groups provide members with a feeling of belonging, warmth, and support. His

pioneering work with groups showed how members react to others with their unique responses of unconditional acceptance and understanding. These factors made the process of group therapy an extremely valuable clinical tool in the future of treatment alternatives for a variety of individuals.

THE PRIMARY ROLE OF GROUP LEADERS

Experienced group leaders offer a myriad of verbal and nonverbal techniques to enhance the expression of feelings and thoughts. These leaders perceive their primary responsibility as being active facilitators in promoting multiple interactions among group members. This communicative role (a) enhances knowledge and awareness for all participants, (b) assists the accomplishment of attaining personal goals, (c) increases the willingness to take the required risks and actions necessary for symptom relief, and d) as a consequence, expands interpersonal interactions. For the leader, the emphasis of the group is for participants to become responsible for personal change. This spreading of the leadership role is the main difference between group and individual psychotherapy (Yalom, 1983).

MAKING PLANS FOR THERAPEUTIC GROUPS

Those groups that are deemed successful require much planning and energy from the start. This initial concentration demands many of the following details and is most helpful when documented and discussed among clinicians and supervisors. These particulars include (a) specifying the salient reasons for establishing the group; (b) describing those individuals who would benefit from this kind of therapeutic intervention; (c) outlining a selection criteria that specifies the group's uniqueness; (d) estimating the size, meeting frequency, length of each meeting, and duration; (e) determining whether to open the group to new members once established or keep it closed; (f) incorporating guidelines for follow-up services if needed; and (g) evaluating the effectiveness of the group upon ending. The ultimate success of the group will be greatly enhanced

by putting the necessary time into this preparatory phase (Corey, 1992; Corey & Corey, 2001).

When forming ideas to establish a group proposal, the type of clients to include depends on a clear statement of purpose. This decision usually relies on specific therapeutic concerns (e.g., a substance abuse group) where age may or may not matter, or whether the focus needs to emphasize problems common to a certain developmental stage (e.g., adolescents transitioning into high school). A mixture of group members is more appropriate when the main purpose is to receive varied feedback from diverse sources (e.g., social skills training). Other targeted groups include, for example, mothers of learning disabled children who may want feedback concerning the unique behaviors and frustrations of their children, grandparents involved in raising their grandchildren, or children of divorce.

In establishing new therapeutic groups, the leaders need to keep in mind that inclusion of certain kinds of group members will undoubtedly influence the characteristics and format of the group (Wadeson, 1980). For instance, participants who are verbally limited or hyperactive will need additional structure, reminders, and more direction compared to more verbally insightful and behaviorally mature individuals. Final selections of group membership and its size depends on such practical matters as type of setting, space available, and personal comfort and experience of the leaders.

Other ingredients to group composition depend upon the amount of time available and the predicted attention span of the group members. For example, clinicians working with hyperactive boys usually limit the group size and time to facilitate control and viable interactions. By contrast, a therapist working with depressed adults may manage more effectively with a larger number in the group to enhance breadth of feedback.

As Yalom (1970, 1995) proposed, cohesiveness of a group (e.g., its compatibility) is the core element in the final selection of group members. In determining the ultimate criteria for inclusion, the leaders must thoroughly discuss this vital factor regarding compatibility versus who is likely to disrupt the group. Ideally, group

members volunteer and are eager to express themselves verbally and nonverbally and can work together for the benefit of the group.

Frequency of group meetings is also contingent on the kind of group being created. Although many therapeutic groups meet routinely on a weekly basis, children and adolescents may favor multiweekly sessions of briefer duration. These considerations in group planning need to be clarified from the beginning. When attentive care is placed on preplanning, both leaders and participants will have a clearer understanding of the group's purpose and structure with success likely to ensue.

STAGES OF GROUP PROCESS

Initial Stages

Successful beginnings of a therapeutic group stem from the thoughtful planning that has occurred. Once the group starts, the early phases are characterized by shared disclosure among members. These revelations become central in establishing initial comfort and a sense of belonging. These initial exchanges usually reveal each participant's expectations, concerns, and potential fears. Without allowing the necessary time for this inquiry, everyone's worries may become magnified and acting out of these uncertainties may occur, sometimes resulting in members not returning.

This beginning stage provides a structured verbal format for the sharing of different viewpoints and for getting acclimated to the interpersonal rules and general format of the group. During this time, group members begin to express their respective anxieties, create common goals, and search for identity within the group structure. This period of early interaction provides the opportunity for the group to construct safe foundations on which to develop and build trust. Without trust, the group will have a difficult time moving past superficial interactions and onto a deeper and more meaningful level. When trust is firmly established, participants are more likely to take risks and accept feedback, which allows for experimentation to result. As a consequence of this collaborative

atmosphere, a sense of cohesiveness emerges. And within this supportive structure, productive work and positive change will occur.

Controlling Defensiveness

Before groups can begin to resolve individual and process problems, a transitional stage occurs where much guardedness and resistance is usually observed (Corey, 1992; Corey & Corey, 2001). During this potentially conflictual phase, interpersonal struggles are created by the ambivalent feelings emerging, resulting from a need for safety and security versus wanting freedom and openness of expression. This vulnerable time in group formation becomes the central point where the group leaders must effectively and poignantly acknowledge the expressed anxieties and respect the acting out of feelings to increase active participation. As part of this balance, the therapists must firmly establish clear guidelines and boundaries, especially with children, about what behaviors will and will not be tolerated.

Another likely occurrence that surfaces during this transitional step in group process is focused on disagreements surrounding dominance and control (Schutz, 1961; Yalom, 1970, 1995). A struggle for power typically ensues during this period and is often displayed by negative comments, jockeying for leadership, competition for attention, and the establishment of a rudimentary social pecking order. Throughout this potentially discordant period, the group leaders will most assuredly become challenged and perhaps criticized, and they need to be keenly aware of this natural process so as not to feel discouraged or allow the turmoil to disrupt the group process.

For the leaders, this difficult phase is critical to the success of the group and it becomes essential to (a) intervene actively when necessary, (b) be ready to assist in recognizing and expressing anxieties, (c) confront defensive posturing in a nonthreatening manner, and (d) assist participants to resolve their conflicts in a timely manner. By predicting these occurrences and being actively engaged in the process, the leaders can facilitate the establishment

of a comfortable and productive working environment for the group. This subtle influence by an experienced leader permits further personal reflection and insight, as well as enhances the possibility of group cohesion.

The Essential Work

The real substance of therapeutic group process occurs when each member is willing to share on a deeper level and attempts to change significant problem areas. By discovering workable cognitive and behavioral strategies for problem solving, group members are given the opportunity to increase personal insight and make effective interpersonal changes. Achievement at this juncture in the group process occurs when the leaders (a) encourage the goals previously established for both independent growth and group cohesiveness, (b) assist each participant in making active contributions within the group, and (c) allow interpersonal feedback to broaden existing beliefs and assumptions.

After these steps have been assimilated into the ongoing functioning, the group evolves into its own leadership role and the responsibility for change shifts to the involved members. During this segment, the leaders perceive an open acceptance and caring for one another within the group context. When a group begins to accept its own direction, the leaders can then relax and be less active as the group increasingly produces its own work format. During this phase of membership cohesion, (a) shared beliefs are held that meaningful changes will occur, (b) strategies for turnabouts are discovered, and (c) intimacy is accepted with more willingness to self-disclose. As a result of this group collaboration, enhanced spontaneity of expression is observed and an emotional togetherness is formed.

Defining the Success of the Group Experience

The defining curative moment comes for group members when they are able to successfully practice their new perceptions and

behaviors in the outside world. This defining phase of group process requires reflecting, summarizing, integrating, and interpreting all the experiences that have taken place. During this ending period, positive experiences and fruitful feedback will most assuredly leave a final impression on all participants.

Ultimately, these final sessions will be instrumental in determining the success and failure of the entire experience. If personal and interpersonal issues are left unresolved or if the participants are unable to generalize their newly learned skills in their respective environments outside of the group, disappointment and frustration will likely result. Additionally, if feelings about leaving the group are not expressed openly and the meaning of the experience not emphasized, the members will leave with many questions unanswered, unresolved feelings, and uncertainties about the results of their participation.

Thus, it becomes critical for the leaders to once again take an active stance in these closing sessions. Topics that need to be reviewed and discussed, include (a) the feelings surrounding similar separations and losses, (b) the acknowledgment that the participants were primarily responsible for the accomplishments that have occurred, (c) the possibilities that different reactions may occur from significant others outside of the group, (d) the identification of actual gains that all members have made, (e) final feedback from all group members (including the leader) that suggests positive and critical points that can be evaluated later, and (f) resolving unfinished business. For the leaders, this final conclusion means providing a thoughtful format that permits a greater understanding of the experience and enhances a more confident transferring of the new learning into novel situations.

DRAWINGS WITHIN THE GROUP CONTEXT

Introducing drawings into the group experience adds a creative dimension that greatly enhances the interactive process. While the format of group therapy initiates much verbal sharing and revelations, drawings provide an alternative approach for establishing connections between individuals in the group. The addition of

artwork into the group context provides a tangible structure that promotes interactions beyond merely talking and communication about problems without having to talk about them.

The clinical use of drawings in group work is particularly valuable with those participants who are anxious, withdrawn, or lack sophisticated verbalizations (Prager, 1993), or for those who may hide behind a calculated or prefabricated protective persona or mask (Oster & Caro, 1990). Expressions through drawings also allow silent members to be heard, while confining verbally aggressive clients to their personal interpretations of their own products (Riley, 1999). Artwork can become a vehicle that assists in breaking the ice when resistance is being confronted in groups and makes it easier to see inner thoughts or secrets being revealed. The graphic images also create permanent records of group process that often speak thousands of words and become a bridge from within that closes the gap between the participants.

Sam

Sam, 14 years old, broached the initial sessions of group therapy in a very superficial manner. He was sullen and reticent to offer much personal information. He also seemed distracted when others were talking. Once in awhile, he would make seemingly insightful, but hurtful, critiques of other problems being mentioned.

To intervene in his disruptive attitude toward other group members, an activity was introduced where everyone would draw what was behind their social mask. Surprisingly, Sam responded affirmatively to this directive and did not hesitate to construct the following drawing (Figure 6-3). Although reluctant to verbally describe what was truly bothering him, he was relieved to use this outlet to channel the rage that he was obviously experiencing. By using this alternative approach to self-expression, he was better able to share his distress through this visual description.

Figure 6-3

Jason

In a similarly structured group, 13-year-old Jason composed the following illustration after the participants were asked to "Draw a problem" as a way to introduce therapeutic direction. This procedure became a catalyst for Joseph to reveal uncomfortable feelings about his school performance, but was too embarrassed to share with others (Figure 6-4). With the success of these kinds of drawing directives, this particular group was stimulated to use other creative outlets (like role playing and psychodrama)

Figure 6-4

to emphasize diverse perceptions of distorted thinking and problem behaviors, as well as possible solutions. Through these exercises, each of the group members found their respective voices and became more active and knowledgeable about group process and, in turn, about themselves.

Graphic illustrations can be used within groups for numerous reasons, in varying formats, and in a wide array of settings. For example, within hospitals or within crisis situations, drawings can identify precipitating events that preceded the trauma. Artwork can also be used in game form to assist in overcoming initial discomfort. For example, a piece of paper could be passed around and each group member encouraged to make a mark or symbol for themselves. Collective murals can be introduced into group sessions to promote group cohesiveness and to encourage mutual sharing and responsibility. They can also be used to reinforce group cohesiveness that has already formed. The group therapist could also use this technique to facilitate and interpret the group's dynamics.

All these drawing experiences can be used as vehicles to promote communication, especially in groups where members have difficulty expressing themselves verbally. The drawings offer a concrete way to clarify confusing thoughts and feelings, and the finished products increase a sense of self-worth and accomplishment that enhance further interpersonal relatedness. Probably the most important use of drawings within a group format, however, is the sharing of the visual images with group members, in which thoughts and feelings are made visible to others at a profound and personal level (Wadeson, 1980).

Drawings add structure to groups by providing an enjoyable task through the introduction of a tangible point of reference. In this way, the drawings are focused upon directly and are deemed as one-step removed from the participant; thus, making interpretations less threatening. Additionally, the use of drawing in group work provides an effective tool for the clinician to reduce resistance. The act of drawing is not only pleasurable, but provides an outlet for individual creativity and uses personal and age-specific meta-

phors that allow control over verbalizations and interpretations that could potentially be intrusive or threatening (Riley, 1999).

Adding Creative Methods to Group Process

The introduction of varied art directives promotes the possibility of a different kind of group process. For instance, members within the group can divide into smaller subsets to work on individual or dyad/triad drawings. This simple, alternative direction could powerfully influence and reshape the group dynamics (Case and Dalley, 1992). Therapists could use additional art directives to create a balance between independence and interdependence within the group, as well as conformity and individuality. Also, by using directives of broader joint projects such as group murals, separateness in the group could be minimized.

Using drawings in group psychotherapy is often viewed on a continuum: from working individually with one's own materials to working on individual issues but with shared supplies, and finally, to working collaboratively on one project that symbolizes group thought. For example, in one ongoing group of teenagers, the therapists used joint drawings to build cohesiveness during the initial phases of treatment, but later switched to individual drawings when the group was more trusting of one another (Oster & Montgomery, 1996).

Duties of Group Leaders

As in individual treatment, the key roles of the therapist in groups, even those that offer drawings as an added method of communication, are to reflect or clarify the issues raised and to maintain a psychological climate of acceptance and understanding. The leader becomes an appropriate adult model whose stance is one of interest and supportive curiosity (Cecchin, 1987). By adding drawing directives, though, the therapist needs to provide suggestions and beginning supportive structure. This supportive organized framework usually reduces anxiety, provides direction, and subsequently produces

greater verbal interactions by using the drawings to assist in disclosing underlying feelings and conflicts.

Similar to most traditional group transitions, transitional stages also occur when drawings are introduced to stimulate participation. For instance, self-disclosure in groups that use drawings may initially occur between the therapist and group member on an individual basis. After interpersonal comfort and trust have been established, the therapist easily transfers attention and encourages participation among all group members.

Drawing in a group format increases spontaneous expression and encourages feedback. When introducing alternative approaches, therapists must be cognizant of maintaining a nonjudgmental environment of mutual support and respect by ensuring that art supplies and artwork are viewed as valuable tools, not to be lost or destroyed. Through this caring, supportive framework, it becomes essential to encourage members to establish their own group guidelines and visibly display these rules so all can review them before each meeting. Making this display a creative group art project could reinforce this idea. This action places the onus of the group on each member and expands the group process.

Additionally, therapists need to promote responsibility for the group's ongoing existence by requiring that members help maintain the materials and the orderliness of the room. With these simple expectations, participation, responsibility, and commitment are strongly emphasized. Drawings must be kept in a safe place by the therapists to ensure confidentiality; this demonstrates trust and the value of the artwork. It also is a good idea to date, sign, and title the drawings for future reference and review, especially during times of termination.

ENHANCING THE GROUP THROUGH ART DIRECTIVES

Definable stages occur during the beginning sessions of group therapy. These phases of group process include (a) an introduction and clarification of goals, (b) a step where enhanced sharing occurs, (c) an awareness of group roles, and (d) ongoing review through

termination. During each of these discrete stages, various drawing directives can be introduced to highlight the specific tasks associated with these stages (Oster & Gould, 1987). Such possibilities of drawing directives may include (a) introduction of group members and clarification of goals, (b) sharing with other group members, (c) revelation of group roles through drawings, and (d) reviewing drawings during termination.

Introduction of Group Members and Clarification of Goals

The ways to accomplish these beginning tasks include (a) the use of self-portraits; (b) requests for symbols that represent problems and possible solutions; (c) suggestions of self-disclosure through graphic images of personal strengths, weaknesses, likes, and dislikes; or (d) specific directives, such as construct a large circle with the instruction "Draw your world" or other approaches like "Draw why you are here" or "Draw something you would like to change."

One example of the above would be a self-portrait (Figure 6-5) done by Wanda, who had previously been a school teacher who was physically assaulted by a student's parent. She was traumatized by the event and was never able to return to teaching and had become increasingly withdrawn. Her primary individual therapist had referred her to group therapy. In her drawing she included the word "stress" to indicate her main problem. It is significant to note that her drawing portrays her as being attractive when she was a noticeably unattractive woman. This perspective may have indicated that she lived in a fantasy world. Another example of a self-portrait was completed by Alice (Figure 6-6). She described her drawing by titling it "Beginnings" and wrote from left to right what she wanted to gain from the group.

Sharing with Other Group Members

Drawing is an active and creative catalyst for group interaction. For instance, an activity suitable for this beginning stage is to

Figure 6-5

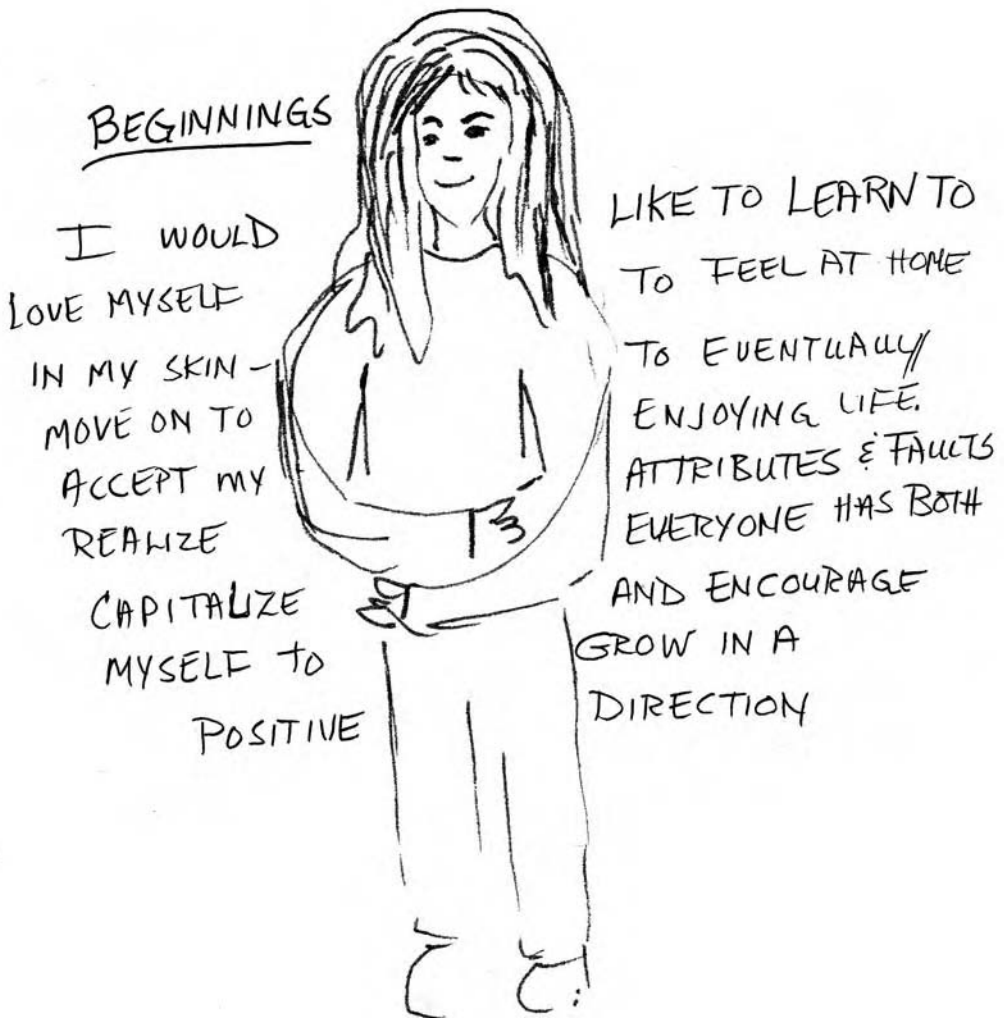

Figure 6-6

circulate a starting drawing and have other group members complete the work. Another possibility to encourage participation is to direct the members to construct a group mural on a large sheet of paper placed upon a wall. This collective poster or graffiti board permits everyone to symbolically place their mark, or identity, onto the group formation, becoming an integral component of a larger

project. During this period in the group's development, the members usually become more cohesive and active, and the therapist can become less directive.

An additional technique borrowed from individual therapy that often assists the clinician who introduces drawings into groups is to employ the instruction, "Draw your mask and what is behind it." Although participants may initially balk at such a direct reference to their public image, motivated clients will probably appreciate the opportunity to explore their daily masks in an uncritical and supportive atmosphere. As cohesion in groups usually forms and evolves in a gradual manner, therapists must not anticipate a prescribed time line for sharing and participation to occur. However, it is oftentimes possible to hasten this process through the addition of drawing directives.

Charlotte

During one group for adolescent girls, the leaders introduced a structured drawing activity to overcome the initial anxiety and resistance. As the conversation turned toward personal images that members were trying to express in school and in their neighborhoods, the leaders grabbed the opportunity to provide the directive of "Draw your mask and what is behind it." Initially, there was disbelief at such a request for disclosing such personal matter. Soon, though, an astute young woman of 17 years (Charlotte) constructed the following two pictures.

The first drawing (Figure 6-7) portrayed Charlotte's view of her school experience. The image focused on her self-consciousness and feelings of aloneness, as she emphasized herself in the middle of many ill-defined peers. The second, more personal and revealing illustration of what was behind her mask (Figure 6-8) really displayed more of her inner self in an unusual format. Charlotte revealed to the group that she actually had many moods, though her outward appearance seemed rather aloof.

Figure 6-7

By entitling her picture "Many Faces," she noted that she could be outwardly calm and distant, but "seething underneath."

This revelation surprised the other group members and prompted those who were less willing to share on a verbal level to explain through other symbols and visual images how they

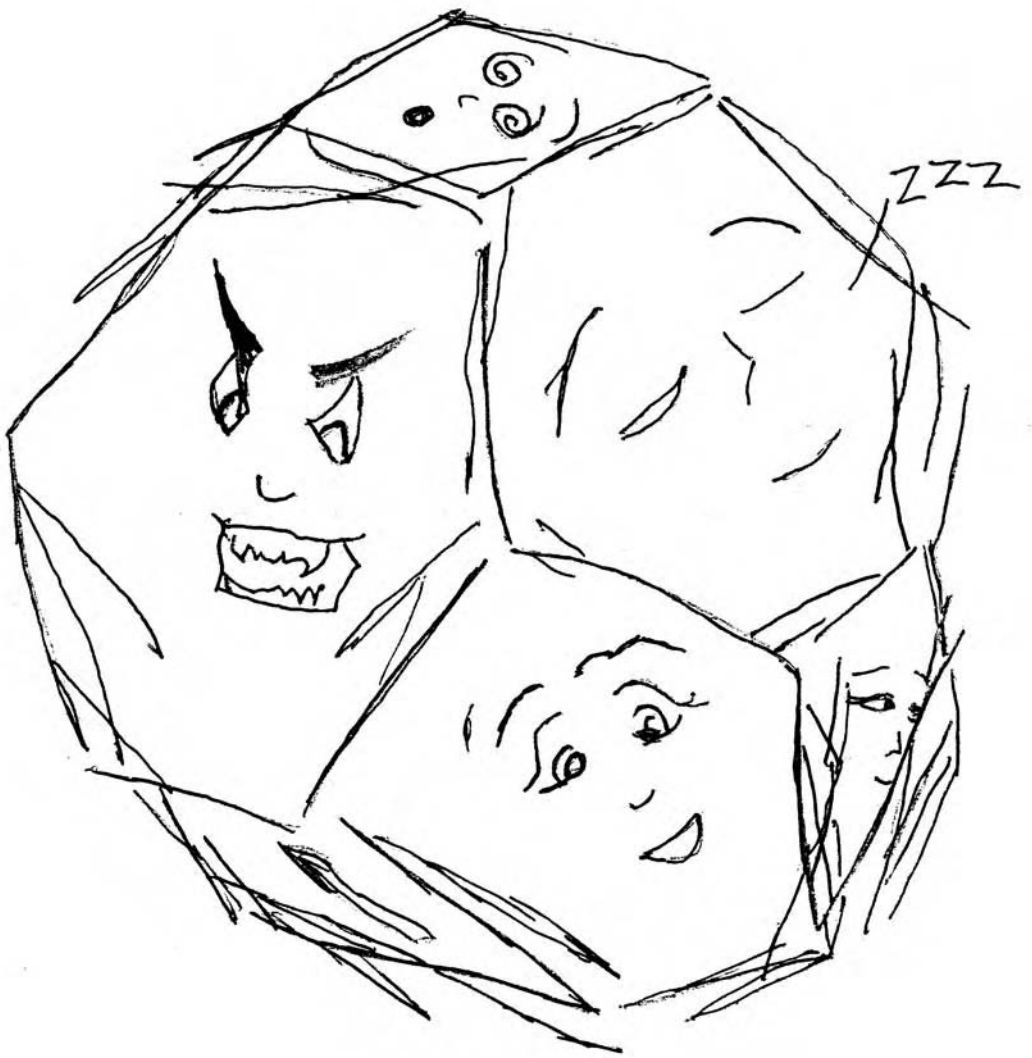

Figure 6-8

felt underneath. This simple exercise promoted group cohesion and initiated the interactive functioning of the group in earnest. The art activity also allowed for the sharing of deeper feelings, as other group members pointed out to Charlotte through their

own experiences the downfall of holding back many of their personal feelings.

Revelation of Group Roles through Drawings

Certain indicators within drawings constructed by group members can be used as a "lens" to better view the dynamics of group functioning. For example, the therapist may notice that a dominant member may produce a high frequency of marks or produce large, centrally located objects on a joint project. By contrast, a more ineffectual, withdrawn member may draw on the edges of the paper, or merely offer fewer or very constricted markings. Behavioral observations may also become important during this process. For instance, group members who become more assertive in deciding themes and designs for a joint project may reflect their emergence as potential leaders, or as obstacles if they become too insistent on asserting their preferences.

Closer attention should be paid to those individuals who attempt to undermine the cohesiveness of the group; they are often the ones who cross or mark through another member's drawings. In these cases, the therapist must take an active role; for example, by asking them to construct drawings of how they see themselves in the group or to request them to provide two separate drawings — how they see themselves and how others perceive them. It may also be helpful to ask other group members to draw how they feel regarding the group member's aggressive marks. These alternative directives allow for enhanced insights concerning the roles of individual group members. One helpful hint to the therapist who is gaining this observational information is to instruct each member to use different color markers for identification purposes.

An example of a group drawing can be seen in Figure 6-9. The group decided on a group issue for a theme. This issue was dealing with stress. They decided they would entitle it a "Guide to Stress-less-ness." They also decided (as a group) that the place where most of them experienced less stress was at the beach, so

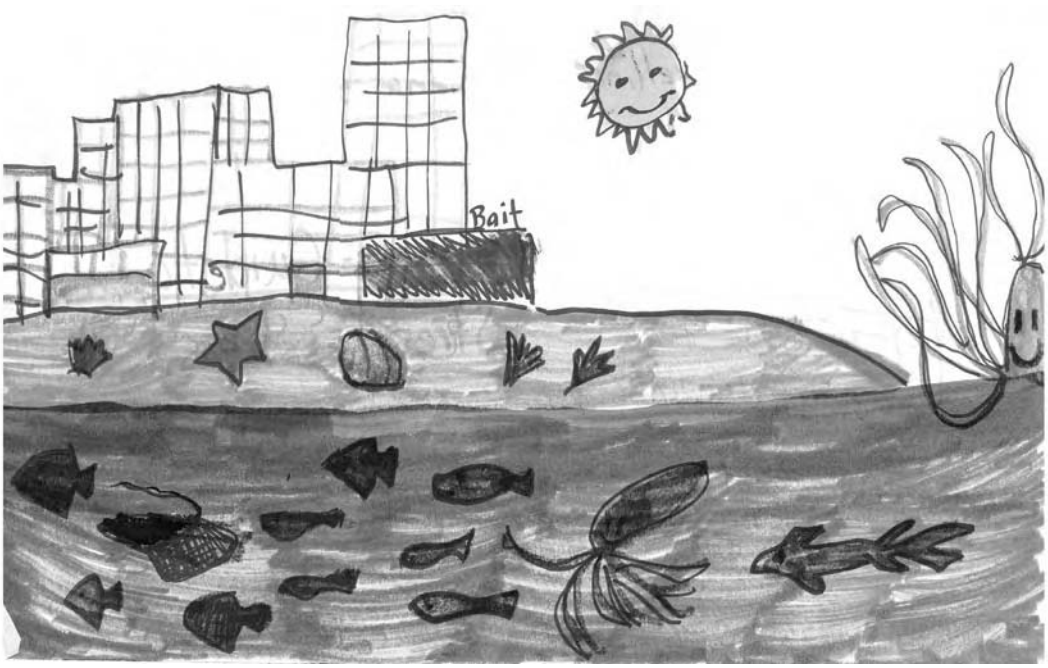

Figure 6-9

they drew it. There were four group members. The colors of markers chosen were orange (the beach, octopus, and some fish), blue (the water and buildings), green (the grass on the beach), and black (the bait shop). Again, it is important for the therapist to easily identify who drew what figures by noticing what colors each member chooses.

The therapist was asked to collaborate and allowed to use whatever colors she chose. She chose red (the starfish), purple (the shell), and yellow (the sun). It is important that the therapist generally make marks or symbols that add to or enhance the group's preexisting theme and symbols. This drawing represents a fairly cohesive group. The participant who constructed the water and buildings was a fairly dominant member of the group. The members who drew the bait shop, beach, and octupus primarily made enhancing marks and symbols, and the member who portrayed the grass was fairly resistant to contributing. However, the

group member who drew the large octupus to the far right attempted to become more dominant but gave up and made aggressive symbolic marks (such as the shark and stingray), possibly expressing anger over not being able to become more dominant in the group. This group was able to discuss the drawing and talk about the members' anger at the dominant member that they had been unable to verbalize before. All of the group members were able to address the resistant member's tendency to withdraw and invited her to participate more, realizing she was merely shy. This exercize was a very productive group drawing in terms of facilitating communication and further developing awareness of group roles and cohesiveness.

Reviewing Drawings and Termination

Drawings need to be saved in separate portfolios throughout the group experience to review periodically. An important consideration in retaining the drawings comes during the final sessions of the group, or when one group member must leave prematurely. The review process allows for emotional closure to individual members, as well as for the group, and signifies vital milestones that have been visually revealed throughout the group process. There are several art directives that have been suggested for this ending phase of group therapy (Oster & Gould, 1987):

1. Make three separate drawings — draw yourself at the beginning of the group, during the group, and at the present time.
2. Make drawings that represent another group member at the beginning and ending of the group.
3. Draw a memory of another "leaving" or "ending" in your life.
4. Draw the feelings you have about leaving this group.
5. Draw symbols that describe your gains from this group.
6. Draw your future goals beyond this group.

If one member is leaving, but the group is continuing, additional directives might include:

1. Draw a picture of the group after your departure.
2. Draw a picture of something that each group member has "given" you.
3. Draw a picture of a "gift" you have given the group.
4. Draw a picture of how the group will remember you.

Another possibility for a meaningful ending is for the group members to construct a box or container and have each member draw an image of what they value about the departing member. The group then wraps this "gift" as a traditional present and the departing member leaves with a transitional object from the group. This gift enables the member to review his or her therapeutic work in the group and provides a special feeling of being valued (Landgarten & Lubbers, 1991).

SPECIFIC DIRECTIVES FOR VARYING AGE GROUPS

A salient consideration in forming groups that introduce drawings as a vehicle of communication is how they will impact on members of different ages. During the latency years (ages 6 to 9), children typically do not have extensive insight into their drawings. In this stage of development, more time is usually spent on learning how to work and interact socially with others. Keeping this in mind, therapists need to appoint a leader, rather than allowing for a natural leader to emerge, which would be more appropriate for an older group. Also, in a younger group it is necessary to allow members the opportunity to exchange leadership roles to promote social interactions and reduce conflict. It should be emphasized that the group will not be judgmental regarding each other's artwork and promote expression of feelings if this should occur. As children develop into teens and adults, the facilitators of the group provide less structure and permit the group to unfold with less leader input.

Young Group Members

Young children's groups need more structure and to be task-oriented. A lack of organization and structure at the beginning can create increased anxiety and self-doubt, which could undermine the attainment of group cohesion (James & Freed, 1989). An effective way to provide this framework is through art tasks and drawing directives.

When introducing drawing directives to young children, it becomes crucial for therapists to actively observe the constructed drawings. Examining the execution of drawings and assessing the drawings themselves carefully for underlying emotional or developmental problems can offer many clues to problem areas that may later become important for providing group direction. This supplemental information can be used to meet future therapeutic goals and to change the format of future art directives for maximum benefit.

For example, the therapist may see a child with impulse control problems drawing quickly, becoming easily frustrated, and finishing with a messy product. By observing these signs, the therapist could offer this child simpler tasks that gradually increase with complexity to enhance the development of self-control. Therapists can also detect signs of poor impulse control by simply viewing a completed mural. When children with low frustration levels are trying to lead the group, the mural tends to end up being messier. This lack of internal mastery of feelings could then be addressed in later sessions.

In Figure 6-10, a drawing was completed by Kelly. The directive was to draw anything that would tell the group members something about themselves. Kelly was a 10-year-old boy who was referred to group to enhance interpersonal skills. Six months before, he had been sitting in the back seat of the family car when a truck hit them head-on, killing his grandmother instantly. He had been traumatized severely, but had made significant progress over his sleep problems and grief in his individual therapy. However, he was still doing poorly at school. His drawing details a recurring bad dream where he is shot and killed without knowing the perpetrator. The drawing has obvious signs of poor impulse control in the way it is executed and, has content of overwhelming emotional material.

Figure 6-10

These signs alerted the therapist that Kelly needed more structured tasks to share a sense of appropriate boundaries and feel accepted and be successful in the group.

Graphic expression in groups of young children offers them an outlet for expressing personal problems that they may otherwise be unable to communicate verbally. Examples of such issues may include exposing conflicts at home between the parents, or revealing abuse or neglect by relatives (Kaufman & Wohl, 1992; Malchiodi, 1990, 1997). With this younger age group, it is usually helpful to use drawings metaphorically to resolve fears stemming

from these difficulties. For instance, therapists may observe these conflictual issues being expressed when the child repeatedly draws monsters. Interventions in this case could be made by having the child draw a safe place where the monsters cannot enter and discuss the feelings surrounding this newfound comfort during group sessions (Oster & Montgomery, 1996).

Holly

Holly was a 4-year-old who was afraid to go outside and play. She repeatedly drew "monsters outside playing" (Figure 6-11). She also talked about monsters in her bedroom at night and

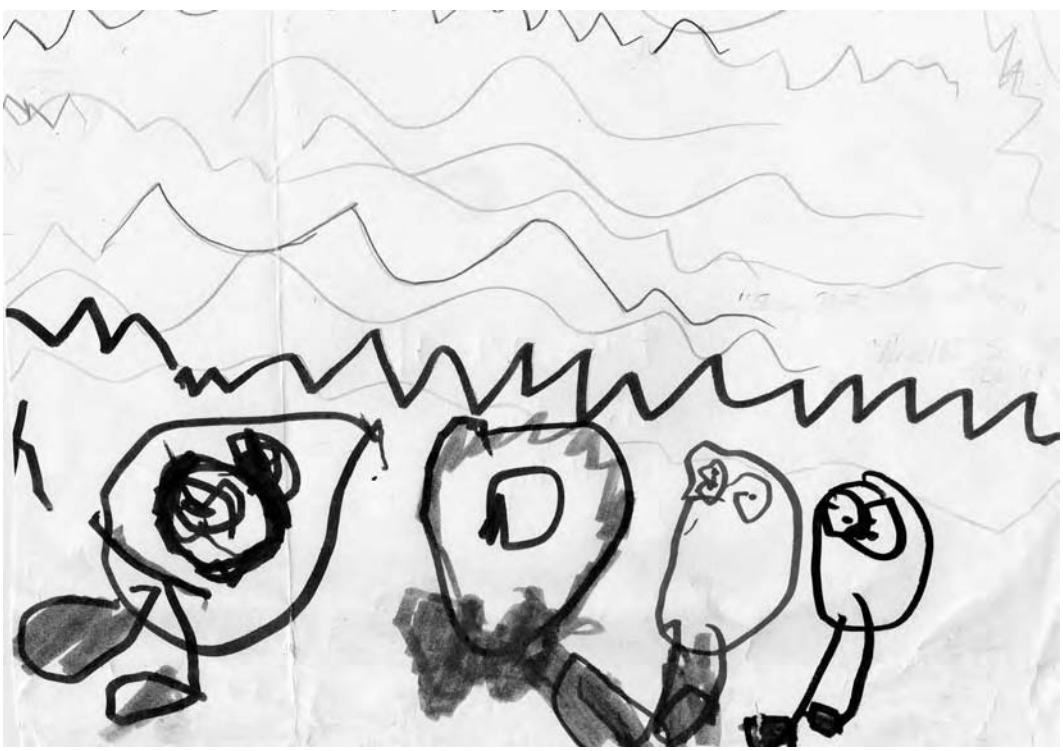

Figure 6-11

she had difficulty going to sleep at night. Later in group therapy, she revealed that her father had sexually abused her in her bed at night when he lived with them. The parents were separated, but Holly had continued to see her father pass by their house when she was outside playing. Holly used her drawings to communicate her underlying secrets to the group leaders.

Gary

A good example of a safe place can be seen in Gary's drawing (Figure 6-12). Gary was 7 years old and in foster care as a result of severe neglect, physical abuse, and suspected sexual abuse. His safe place was a room with invisible walls (so he could see out) and a door with a lock so he could control who came in. You had to know the magic word, "abracadabra," to get in.

Latency Age and Preteen Groups

For the latency and preteen age groups (6 to 12), drawings provide an invaluable therapeutic procedure to assist in the identification of internal feeling states. For example, many children need help to appreciate how their physical bodies and their emotions are interconnected. Children, in particular, often complain of stomachaches or headaches, not realizing that these symptoms of possible stress may be connected to their feelings.

Group leaders can be quite helpful in creating drawing exercises that increase this awareness of mind–body connections. For groups of latency age children, the leader (whether clinician or member volunteer) can draw a body outline on a large sheet of paper or even on the blackboard. Then the leader says,

"Everyone has feelings. Your parents have feelings, your gym teacher has feelings, your mail deliverer has feelings. A lot of people get aches and pains in their body when they have

Figure 6-12

strong feelings. I want each one of you to color in where you feel your feelings."

In one such latency-aged group, children delineated almost every area of the body — from clenched teeth when angry, stomach cramps when nervous or excited, headaches when parents fight, and heart racing to tightness in their limbs when panic-stricken (Oster & Montgomery, 1996). The children were next directed to talk about their feelings and provide examples of times when they had experienced similar feelings. Ensuing discussions led to an examination of emotions that members had felt on their first day of the group and what part of their bodies, if any, experienced the reactions.

A similar activity that encourages group participation and increases body awareness is to unroll large sheets of paper and assist the children to trace each other's bodies: to make life-size outlines of themselves. When this task is completed, children attach specific colors (red for anger, yellow for nervousness, and so on) to where they might experience their feelings most intensely. These images are then placed on the wall and shared by the entire group.

The Teen Years

Group therapies are especially beneficial for teenage populations, since this span of years is mainly characterized by concerns of social interaction and self-definition. This therapeutic format actually takes advantage of an important developmental need of adolescents (the peer group), as confiding in friends takes the place of talking to parents (Riley, 1999). By this age, teenagers can tolerate, value, and usually prefer feedback from peers rather than from adults. They will use the peer group as a replacement for parental influence and structure (Linesch, 1988). Additionally, their acting out behaviors of personal emotional experiences and problems may have inhibited crucial socialization experiences. As a result, many teenagers remain in a cycle of unfulfilling and dysfunctional interactions and opportunities. Inclusion in the therapeutic group experience allows an important opportunity to break through this socialization block (Yalom, 1983).

For adolescents, the framework for group process allows many possibilities for acquiring enriched personal and interpersonal insight from both clinicians and peers. When drawing directives are introduced, teenage clients are offered the freedom to create expressive products that graphically speak to their overriding emotional issues surrounding their ambivalence toward independence and, at the same time, address the relevant concerns within their everyday world (Riley, 1999). With the addition of drawings, participants in the groups can use images to symbolically express internal conflicts, as well as clarify a deeper understanding to their problems. Because the main developmental issues in this age group encompass identity concerns, sexual conflicts, and strivings for independence, various drawing directives have been created to address these themes:

1. Identity confusion/formation issues — Possible directives are (a) Draw who you are (e.g., likes, dislikes, strengths, weaknesses, feelings); (b) Draw a problem; (c) Draw your world; (d) Draw your goals; and (e) Draw how you see yourself five years from now. Also, directives such as "Draw a picture of yourself in the group" or "Draw how others in the group see you" help to explore critical issues of self-perception and acceptance in the group's beginning phases.
2. Sexual identity problems — Directives to address conflicts in this area may include drawings of the ideal boyfriend or girlfriend to encourage discussion about relationships. Other drawings to reduce discomfort in exploring sexual themes and enhance general discussion may include (a) Draw your body, (b) Draw what sexuality means to you, or (c) Draw symbols that might represent what sexuality means to your parents.
3. Authority (rebellion/anger)/independence conflicts — For these issues, it may be prudent for therapists to allow more free drawings in the group to enhance the aspect of perceived control; that is, for the

members to feel in control of what is to be drawn as opposed to creating power struggles over particular themes directed by the leaders.

Suzanne

Suzanne, a 16-year-old young woman, was referred to a social skills group by her individual therapist who believed that the experience of being with other adolescents over a short period of time would prove beneficial since she was reluctant to go beyond surface issues with adults. Even within this structured group situation, Suzanne was initially reluctant to share her personal struggles so freely. However, when the therapist suggested an art task to "Draw a problem," Suzanne jumped at the opportunity to portray an area of concern without having to use words.

In providing this illustration (Figure 6-13), Suzanne noted that her picture represented the intense uncertainty in herself. While she desired many things and even had numerous opportunities knocking at her door, she was, at the same time, very frustrated at her inability to motivate or structure herself to achieve her goals. This expressive image elicited much discussion among the group members about their own personal roadblocks. Stories of problem-solving successes were shared as ways to overcome these kinds of problems. Although Suzanne had formed the belief that her problems were unique, the responses, from her peers demonstrated that this notion was not true and provided an excellent example of the value for group feedback.

Groups with Older Adults

Older individuals are often struggle with numerous emotional and physical losses, regarding the deaths of friends and family, loss of independence, and declining physical capacities. Also, there is an ever present fear of illnesses, such as senile dementia, especially

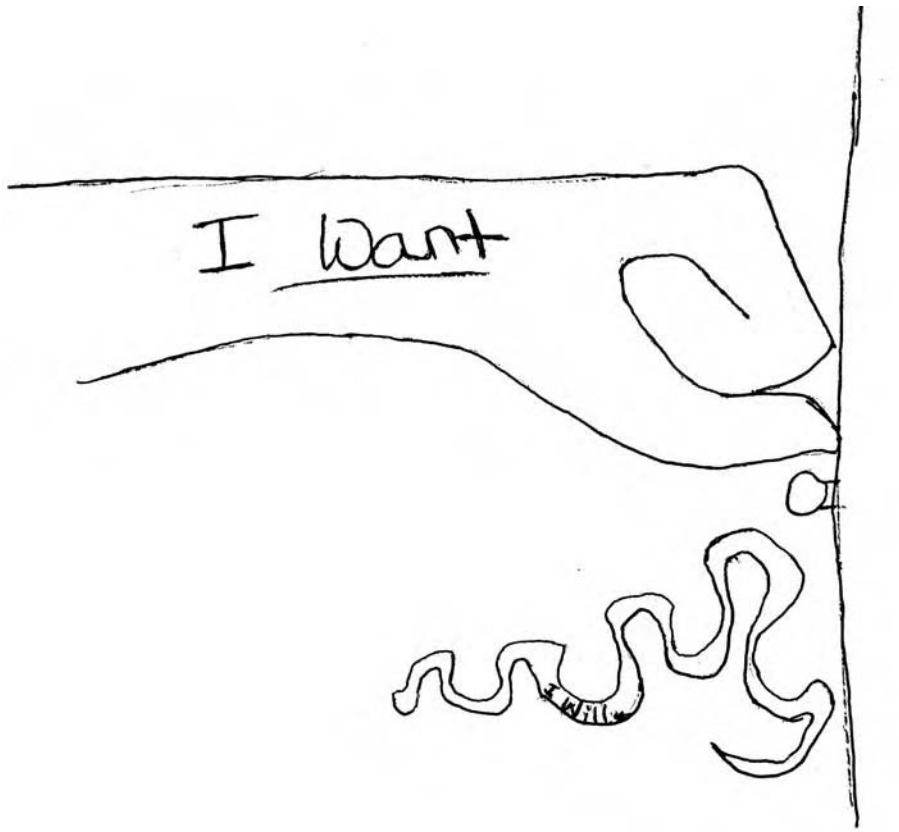

Figure 6-13

when suffering temporary memory lapses (Wilkes & Byers, 1992). The conflicts and worries created by these concerns are important issues within group structure. Introducing drawings into a mixture of group activities provides an alternative method for exploring these feelings and fears.

Older clients, however, may be more hesitant to use drawings as a means of self-expression. This resistance may partially be due to the length in time since they last used drawing as a medium for self-expression. Some aged individuals may even feel insulted, feeling that by introducing such a vehicle of expression they are being treated like children. In some cases, the older group members

may just be less open to change. With thoughtful encouragement, this opposition to using drawings as a clinical tool should be easily overcome.

An excellent introduction when using drawing directives within the therapeutic format of older adults is to ask everyone to draw their memories (both good and bad). By recalling past events, group members can support their own life review process (Landgarten, 1981) or add to the format of "reminiscence therapy" (Wilkes & Byers, 1992). For the elderly, identities are consolidated by demonstrating remembrances of the past. Through the graphic recording of these events, forgotten memories can come to life.

The examples in Figure 6-14 and Figure 6-15 were Eleanor's "good and bad" memories of her childhood. Eleanor was a widow, 70 years old, and in relatively good health. However, she had recurring depression and believed that her friends who still had spouses did not understand, so she had joined a support group to cope with her mood problems. During group activities, she drew things she had not thought about in years. These constructions helped her gain insight into her depression and prompted much discussion among group members. She had good memories of her pets and parents with her at graduation. Bad memories consisted mostly of her father when he drank, as he whipped them with a switch, beat her mother, and held her at gunpoint.

When confronted by elderly populations who are themselves in poor health, anxieties may arise over chronic pain and death, which creates added isolation and inhibits free expression. During these times, it becomes more difficult for members to listen to the worries of other group members, as they are likely turning inward toward their own struggles and away from active participation. Drawings in these situations can assist those elderly persons who are either in poor health or terminally ill and are unable to verbalize their fears and thoughts about death. By distancing themselves through the drawings, the interpersonal process may be less threatening, as they can use the pictures to portray their anxious thoughts and feelings (Miller, 1984).

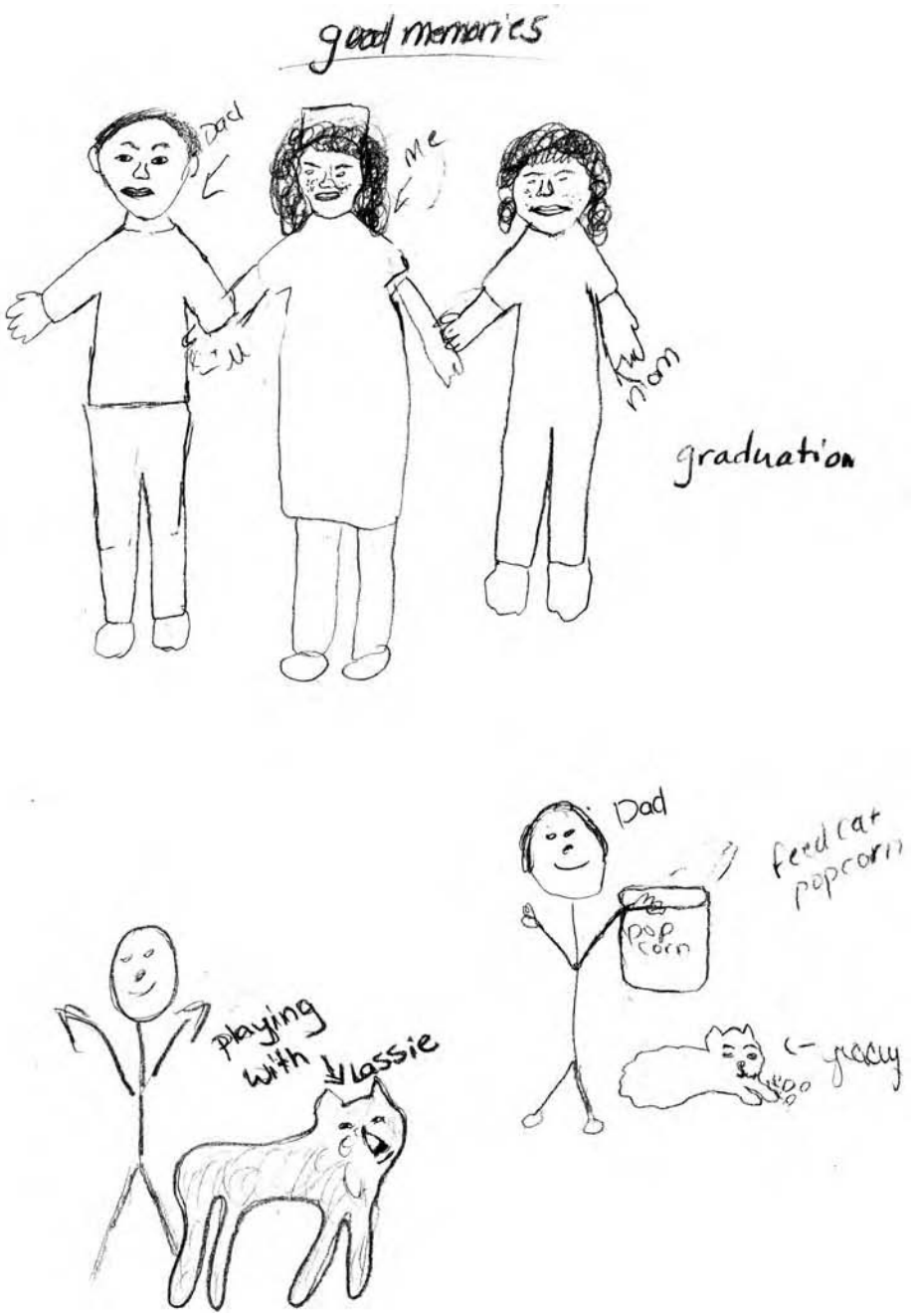
good memories
Dad
Me
Mom
graduation
Dad
feed cat popcorn
pop corn
playing with Lassie
Lassie

Figure 6-14

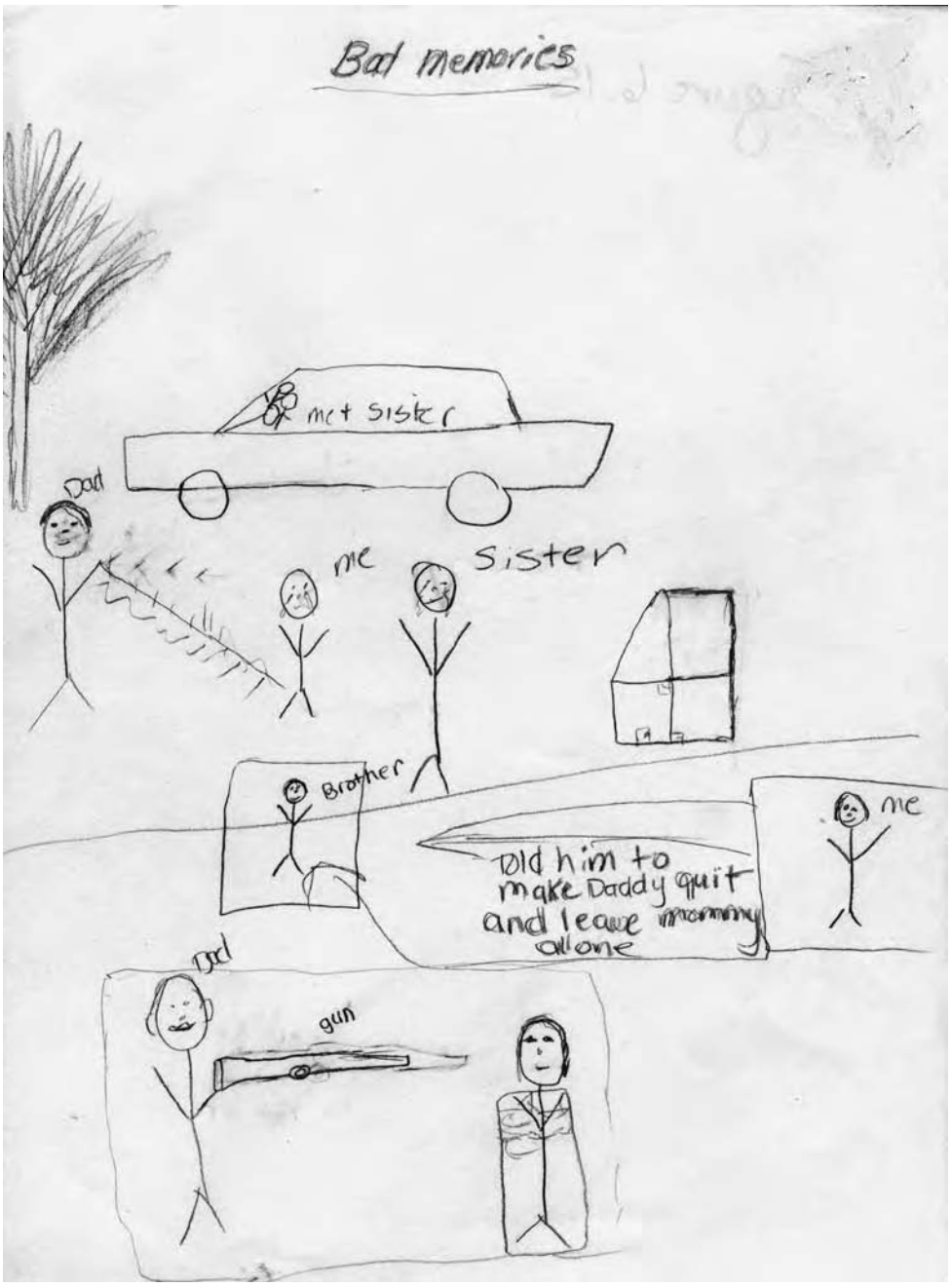
Bad memories
me + sister
Dad
me
Sister
Brother
me
told him to make Daddy quit and leave mommy alone
Dad
gun

Figure 6-15

Therapists can also expand the frame of group therapy sessions by introducing drawings with elderly clients. They can direct older individuals to complete drawings that stimulate more open expression, such as scribbles. Additionally, clinicians can request drawings that express some of the frustrations that accompany growing old (e.g., being dependent on others) and use these pictures to enhance sharing and problem solving.

For older individuals, the medium used for drawings becomes a crucial consideration. Finger dexterity may be constricted (e.g., an arthritic older person may have difficulty applying pressure with a pencil); therefore, it may be better to use oil pastels or felt-tipped pens, which transfer easily to paper (Landgarten, 1981). It is also extremely important for therapists to be sensitive to the struggles and subsequent feelings that will arise when losing fine motor skills.

The structure that a group therapy experience provides offers an excellent setting to help older members share and connect with one another about these struggles and losses. Toward the end of a group, it becomes helpful to promote positive aspects of the process by identifying some of the strengths of growing older. Asking the participants to draw a joint mural of the gift of growing older, such as wisdom, self-confidence, or greater leisure time, can help members reframe their personal meaning of growing older to include these enriching aspects.

GROUPS WITH SPECIFIC FOCUS

The remainder of this chapter will examine several problem-specific groups and how drawing directives can be used to enhance and energize these types of group therapy. Although these examples of drawing directives are for particular target groups, they can also be adapted for use in many genres of groups. It is always important for therapists to use their own creativity and adapt current ideas that best meet their own therapeutic styles and the needs of their particular clients.

Incident Drawings with Focus on Substance Abuse

In their book, *Trauma Resolution Therapy* (Collins & Carson, 1989), the authors developed an effective method termed "incident writing" that focused on reading educational materials and writing about substance abuse and writing reactions to behaviors that resulted in a particular traumatic event. This introductory tool for their groups was the basis of change for the participants. By using drawings instead of writing, this technique can be adapted for the same beneficial therapeutic goals.

This adapted method of "incident drawing" was developed in an effort to (a) bring unconscious issues to awareness, (b) express true emotions that were previously masked by intellectualization, and (c) help overcome the primary defense of denial (Cox & Price, 1990). The creators of this art technique discovered that their work was particularly suited for inpatient adolescent substance abuse groups. They found that the inclusion of incident drawings, which they had demonstrated as powerful techniques for individual treatment, became exponentially more compelling in group situations.

By sharing their incident drawings in group formats, members were able to see more clearly the devastation caused by substance abuse. Also, by receiving vital feedback through this visual sharing, the perspectives on their behavior were enlarged. As participation and interactions ensued through the use of their drawings, members became even more aware of their common dilemma and felt less alone.

When using this drawing directive for group therapy, it is best to request each individual to construct a picture concerning an incident that had occurred to him or her while under the influence of drugs or alcohol. Participants are encouraged to experience any feelings that arise during this nondiscussion phase. The drawing materials are then collected and members are asked to tell their story using the portraits as a highly visible illustration and as a springboard for self-disclosure. Intragroup feedback and responses are encouraged and clarified. Group members are then instructed

to explore the following topics (Cox & Price, 1990; Oster & Montgomery, 1996):

1. What was your thinking pattern at the time of the trauma?
2. What were you feeling at that time?
3. What were some values that were contradicted?
4. What relationships were effected?
5. What would a sober person have done in that situation?

Group members are asked to write the answers to these questions on the opposite side of their drawings. The therapists then facilitate a group exploration of the drawings and written answers. The addition of drawings in this group format usually overcomes initial resistance and provides an experience outside the usual expectations of verbal process.

Children's Drawings in Grief and Loss Groups

The death of a parent, guardian, or sibling is one of the most devastating and profound losses a child can experience. All children grieve this loss, but the process of mourning may differ due to the circumstance of the death and the child's level of maturity. Research studies, as well as clinical experience, have shown that supportive therapy groups are instrumental for children attempting to express and process their deep pain and confused feelings after such losses (Huntley, 1991).

When used in this capacity, therapeutic groups can serve as a holding environment for the emotional pain associated with the death. Sharing with peers in this circumstance seems more tolerable and creates an atmosphere for hope during the healing process. Incorporating drawings as a structured framework in these groups becomes a dynamic resource in assisting children to exchange their emotional experiences. The interactions produced

through the sharing of drawings enhance their connectedness to peers who are facing similar obstacles in their lives.

Nathan

Nathan was a 12-year-old youngster who had entered group therapy at the request of his school counselor. Nathan's school performance and overall demeanor had declined appreciatively following the death of his uncle. This man had contributed much nourishment to Nathan's life and he missed him dearly. Together, they had listened to music, played video games, and gone hiking. At the time he entered group treatment, Nathan appeared distraught. He was withdrawn, had lost weight according to his parents, and had been withholding the tears that they knew he wanted to shed.

During one early session, Nathan and the other group members were asked to make a drawing concerning the remembrances that they held for their deceased loved one. Drawings for this age group were particularly useful because prior to their introduction, the anxiety revolved in discussing death-related matters created too much tension and the ensuing acting out of this discomfort became too distracting for these boys. With this safer approach to expressing their grief, the boys were able to contain their feelings and talk through their illustrations.

For his part, Nathan produced the following drawing (Figure 6-16). In its simplicity, he was able to reconnect with the pleasures that he had experienced with his uncle. He designed symbols that represented his uncle's identity (a musician) and related to his peers the times and activities they had shared. With the assistance of these types of drawing directives, the boys in the group were more willing to openly discuss their feelings surrounding their losses.

Research has shown that drawings created by younger grieving children appear to be noticeably different from the artwork constructed by nongrieving children. Bereaved children's art frequently

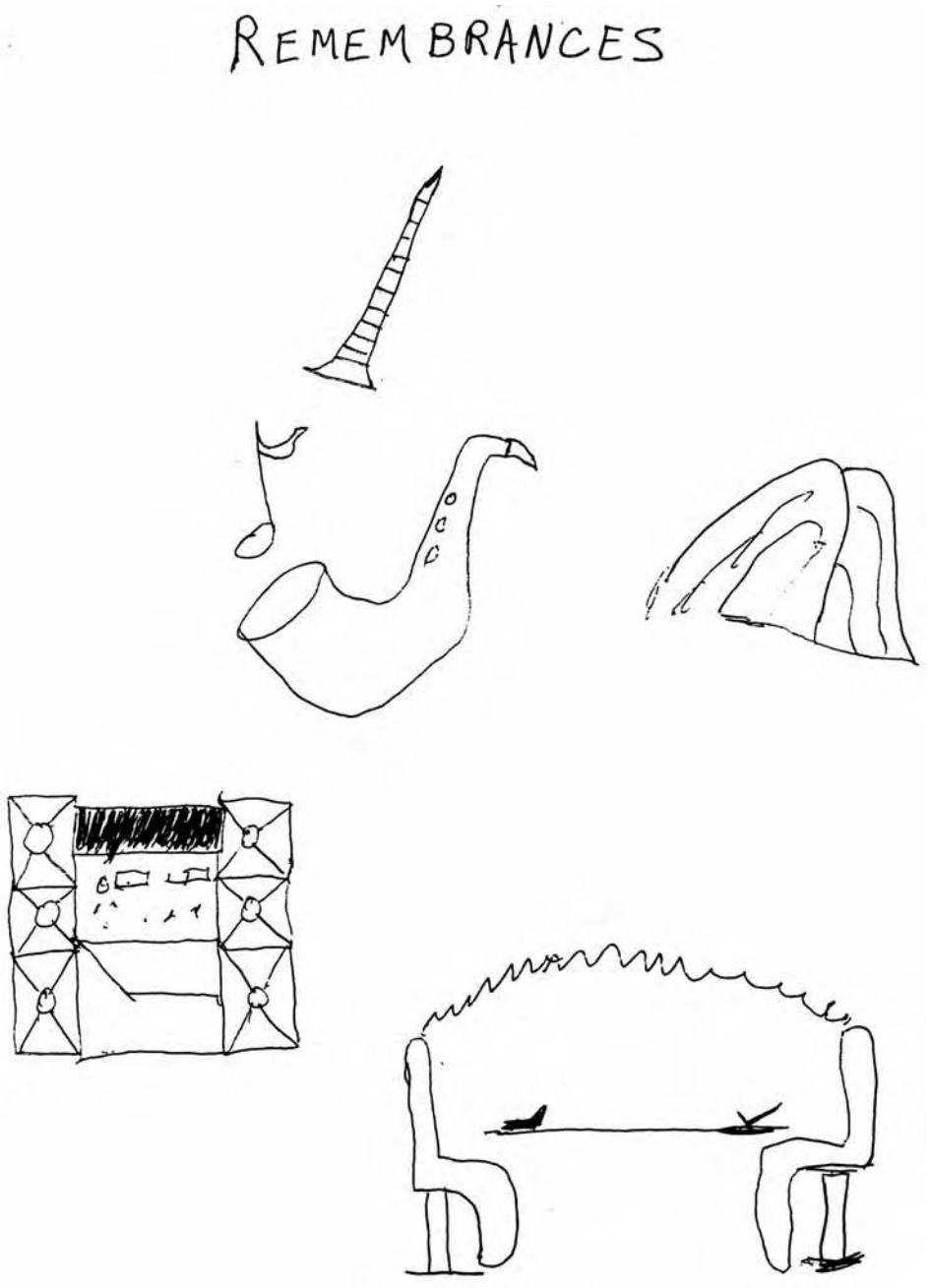

Figure 6-16

contains more symbols of grief and death and often includes funerals (Zambelli, Clark, & Hodgson, 1994). Therefore, children in these groups are likely to draw pictures that include coffins, crosses, flowers, tombstones, angels, and wakes. Through these graphic images, children begin to communicate their pained feelings and express their reactions to the death that they have experienced.

Zambelli et al. (1994) also discovered that images of ghosts are common themes in bereaved children's artwork. They were able to use these pictures as springboards for discussions surrounding facts and fantasies of death and dying. Concrete as well as abstract drawings of ghosts were seen as transitional characteristics of the grief process. These creations aided in the movement from child with loved one to child without this loved object. In one such case, a 9-year-old girl's art reflected her gradual acceptance of her mother's death over the period of a year following a fatal car crash. Ghost imagery, paramount in her first few drawings, became less significant (reflected in decreasing size of ghosts in her drawings) as other emotional supports increased (Oster & Montgomery, 1996).

Zambelli et al. (1994) detailed salient elements for clinicians to emphasize when children's drawings reveal ghost images. The most important consideration is for clinicians to view any discussion of ghost images as healthy and positive. Such talk serves as a valuable vehicle for revealing the presenting conflicts and concerns in a child's life through a less threatening form. Symbols of ghost images allow children to explore their meanings without the pressure of explanations for the inexplicable.

In this way, clinicians are offering a structured and safe method for discussing children's fears. In this format, the clinicians can ask such questions as, "What does the ghost want to say?" or "If the ghost could understand, what would you like to say to the ghost?" These questions stimulate children's participation and enhance their understanding without pushing them beyond their developmental readiness to accept the reality of the loss. If the group members seem to fear their ghosts, a possible directive may be to request them to draw another picture confronting the ghost or

have them draw themselves with some form of protection — a ghost shield or spray, for example (Oster & Montgomery, 1996).

Using Drawings with ADHD Populations

Diane Safran, an art and marital/family therapist, has demonstrated the success of drawing introductions into the framework of ADHD populations (Safran, 2002). Through the ongoing work at her ADD Institute, she has been able to describe how creative interventions can became an integral part of group work with children and adults, as well as for parents of ADHD children, in better understanding and coping with this frustrating disorder. For individuals and families dealing with the bewildering effects of ADHD, drawings offer an active medium that uses this population's often strong visual learning skills with structured directives as a way to elicit expressed feelings.

The completed artwork becomes a visual record of the experience to relive thoughts and feelings repeatedly, so as not to be easily forgotten. This graphic benchmark documents progress from beginning diagnostic impressions within the group to the ending sessions. The major goals of this kind of group therapy are educational as well as social. The common focus for all groups is to experience a clearer understanding of the ADHD diagnosis and its impact on everyday functioning and interactions, in addition to learning strategies that could assist in relieving symptoms. Success in these groups allows members to practice new social strategies, enhance their self-esteem, and become assertive advocates for their condition.

Specific drawing directives are used through the process of short-term, as well as longer-term groups. Introductory exercises may include illustrating things and activities of interest, or to list things they can do under the words "I can" to promote a more positive self-concept, which is often missing from ADHD individuals. Early sessions are more focused on the specific problems related to ADHD and requests are made to draw responses to the questions: "How do you feel about having ADHD?" "How does ADHD get in your way"? and "How do you feel about taking

medication?" For many participants, this will be the first time that these feelings have been expressed openly to peers and the uneasiness may produce more distracting behaviors. Ultimately, this freer exhange will lead to meaningful discussions.

Later sessions begin the process of discovering how ADHD impacts home and school life, in addition to maintaining friendships. Drawings often portray the emotional pain, social isolation, and unhappiness due to the symptoms of ADHD, such as inattention, impulsivity, and hyperactivity. Final sessions on how to resolve problems can be structured through drawing personal and interpersonal obstacles and creating images and symbols to illustrate their resolutions. Through peer feedback and role playing suggestions of problem solving for acceptance or rejection, new behaviors are formed and social risks are taken between sessions. Endings of the groups use such directives as (a) creating a garbage can to throw away things about ADHD that are difficult, and (b) constructing a bridge drawing that allows participants to cross over with new ideas gained from the group experience while leaving old thoughts, behaviors, and feelings behind.

CONCLUSIONS

Group therapy is a powerful therapeutic technique for both prevention and intervention with individuals who need feedback from a variety of sources. The group becomes a microcosm of the family and in its extension is found the accurate feedback needed to grow within an interpersonal world. When a functioning group is formed, individual members gain strength through its support, insight, and creativity, a depth that supplants feedback from a single therapist. With the addition of drawings, an excellent therapeutic tool is added to the mix that can (a) portray group dynamics, (b) build group cohesion, (c) provide alternative ways for expressing one's inner reality to others, and (d) make feelings and experiences readily observable to better understand and communicate them.

This chapter has emphasized the many advantages of interjecting the use of drawings into group therapy sessions. Illustrations

from long-term treatment or within crisis situations have attempted to demonstrate the value that drawings can produce. Using drawings as a clinical tool in group work provides a special means for individuals to share their inner experiences through visual images and interact with others who are experiencing similar conflicts on a different and very personal level.

Drawings allow group leaders an avenue to obtain important information that participants may otherwise not have expressed. For members of all therapeutic groups, artwork allows the freedom to state conflicts and concerns in a relatively secure, safe manner and as a means to channel intense and uncomfortable feelings with less anxiety and fear. Adding graphic expression to verbal interactions can broaden awareness of treatment goals, in addition to being used to achieve these objectives.

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Further Reading

Furth, G. (2002). *The Secret World of Drawings: A Jungian Approach to Healing Through Art* (2nd ed). Toronto: Inner City Books.

A succinct explication of Jung's ideas as they apply to the symbolism of imagery from the unconscious. Both text and illustrations show the healing path found through the expression of the self in drawings and paintings.

Hammer, E. (Ed.). (1997). *Advances in Projective Drawing Interpretation.* Springfield, IL: Charles C. Thomas.

A comprehensive, edited work on the latest theories and techniques in projective drawings interpretation, plus classic essays in the field. Highlights include differentiating schizophrenic from organic brain syndromes, predicting acting out behaviors, and investigating personality characteristics in drawings. A must for all serious diagnosticians.

Leibowitz, M. (1999). *Interpreting Projective Drawings: A Self Psychological Approach.* New York: Brunner/Mazel.

This book discusses the value in drawings to discover emotions, attitudes, and personality traits. In this book, the author offers a highly practical introduction to the use and interpretation of projective drawings. Through a theoretical

framework of self psychology, Dr. Leibowitz provides detailed information on how to interpret common house, tree, man, woman, and animal drawings. Through clinical case studies combined with general interpretation guidelines, the book offers a thorough examination of projective drawings (both achromatic and chromatic) with adult patients from beginning treatment through their one-year (or more) status, making it a valuable text for beginners and an important reference source for the seasoned clinician.

Malchiodi, C. (1998). *Understanding Children's Drawings*. New York: Guilford Press.

This widely acclaimed book demonstrates how all clinicians can broaden and enhance their work with children by integrating drawing into their therapeutic styles. This volume offers a wealth of guidelines for understanding the intricate messages embedded in children's illustrations and within the therapeutic process. Over 100 examples integrate extensive research and clinical experience to provide understandable direction in assisting children to work through their everyday problems.

Malchiodi, C. (Ed.). (2002). *Handbook of Art Therapy.* New York: Guilford Press.

This edited text presents 30 professional contributions via case illustrations from a wide range of settings and explains how art therapy can be used to provide fresh views of conflicts and solutions for clients of all ages. Presenting problems include sex abuse and trauma, developmental and learning difficulties, adolescent depression, drug and alcohol abuse, problems specific to elderly populations, family conflicts, and severe mental illness. This edited volume provides an overview of art therapy procedures from varied theoretical perspectives, including analytic, cognitive-behavioral, and developmental models.

Oster, G. & Montgomery, S. (1996). *Clinical Uses of Drawings.* Northvale, NJ: Jason Aronson.

A concise guide that introduces non-art therapists to the value of drawings during initial evaluations and subsequent therapy sessions. A practical manual for clinicians that provide useful drawing directives when working with individuals, groups, and families in both inpatient and outpatient settings. This book was a sequel to the first edition of *Using Drawings in Assessment and Therapy.*

Riley, S. (1999). *Contemporary Art Therapy with Adolescents*. London: Jessica Kingsley Publishers.

In this book, Shirley Riley draws upon her many productive clinical experiences and teachings to share creative approaches that work to engage troubled

adolescents. In understandable prose, she is able to integrate theory with practical suggestions to explain how she connects with teenagers who may be resistant to change or provocative in their behaviors. She offers many possibilities that work in various settings and provides numerous case illustrations that explain how the process unfolds. The contents of this volume and observations by the author are refreshingly realistic, reflecting both the successes and failures inherent to adolescent therapy.

Rubin, J. (Ed.). (2001). *Approaches to Art Therapy: Theory and technique* (2nd ed.). New York: Brunner-Rutledge.

An edited volume that describes art therapy within varied theoretical approaches, such as dynamic, humanistic, and psycho-educational frameworks. Specific topics include views of sublimation, symbolism, Jungian analytic and gestalt art therapy, as well as assessing cognitive abilities. This second edition adds six chapters to the original book and includes topics of cognitive-behavioral, systemic, and integrative theories and consolidates the foundations of art psychotherapy with clinical practice.

Safran, D. (2002). *Art Therapy and AD/HD: Diagnostic and Therapeutic Approaches.* London: Jessica Kingsley Publishers.

This book demonstrates how art therapy not only assists with the diagnosis of ADHD, but also provides a valuable means of improving such related skills as concentration, self-esteem, and social skills, and coping with the results of impulsive actions. This very readable paperback edition is written from a personal and professional context. It is replete with exquisite illustrations and common-sense interventions that fascinate the reader. The various examples used throughout the book provide clear-cut strategies than can only strengthen the clinician's toolbox in working with ADHD children, adults, and families.

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PSYCHOLOGY / EXPRESSIVE THERAPIES

"Oster and Gould Crone are to be commended for their thorough and well-integrated compilation of information related to the use of art in assessment and therapy. This revised edition clearly distills the vast knowledge that both psychologists and art psychotherapists bring to the field of psychotherapy. All clinicians who are intrigued by the intrinsic value that art making offers to both the diagnostic and therapeutic process should read this important contribution to enhance their current thinking."

—Diane Safran, PhD, author, *Art Therapy and AD/HD: Diagnostic and Therapeutic Approaches*

"This revised edition provides a comprehensive and practical overview of a variety of drawing methods used in evaluation and treatment. This book cogently explains how simple drawing tasks assist and enhance work with children, adults, families, and groups and is a welcome addition to every clinician's library."

—Cathy A. Malchiodi, ATR, CPAT, LPCC, author, *Understanding Children's Drawings* and *Handbook of Art Therapy*

"This is an excellent educational and insightful book. I was impacted by vivid case descriptions, enriched by assessment guidelines and delighted with the visual images that make this text a highly stimulating and valuable resource. I strongly recommend this book to all mental health professionals who want to enhance their work by introducing drawings into their therapy sessions."

—Marcie Brooks, MA, LPCC, internationally recognized psychotherapist

This completely updated and revised edition of the highly regarded *Using Drawings in Assessment and Therapy* condenses and synthesizes a broad spectrum of clinical applications of drawing that aid clinicians in both the initial assessment process and subsequent therapy sessions. Providing a unique blend of assessment techniques and therapeutic uses of drawing, this text is a practical resource for clinicians working in a variety of treatment settings. This new edition updates literature reviews and provides new case studies and illustrations that highlight the ease of using drawings during diagnostic and beginning therapy sessions, as well as focusing on termination. Chapters focus on family systems theories and group therapy, placing emphasis on timely issues such as trauma, family violence, and substance abuse.

Gerald D. Oster, PhD, is former Clinical Associate Professor at the University of Maryland Medical School as well as past Psychology Internship Director at the Regional Institute for Children and Adolescents. Presently in private practice in Olney, Maryland, he also provides evaluations and consultations at the Expressive Therapy Center, Montgomery General Hospital, and the Sheppard Pratt-Jefferson School.

Patricia Gould Crone, MA, CPAT, is a Kentucky Board Certified Professional Art Therapist. She has been appointed by the governor of Kentucky to serve on the Kentucky Board of Certification for Professional Art Therapists for two consecutive terms and is currently the Chair of this Board. As Designated Regional Coordinator of Child Sexual Abuse for Kentucky River Community Care, she provides evaluations and assessments for the Child Advocacy Center. She also sits on the regional multi-disciplinary teams and provides supervision and training region-wide.

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