CHAPTER 1

Overview

Background

A Psychiatric Hospital

In 1963 I became the first art therapist at the Western Psychiatric Institute and Clinic, working individually with youngsters who had been diagnosed with childhood schizophrenia. Although the label today might be different (e.g., autism, pervasive developmental disorder, or Asperger's disorder), there was no question that they were severely disturbed children.

Before I started seeing them, there had been some anxiety on the part of the staff about whether the children would be able to use art materials appropriately, rather than eating or throwing them. Happily, each child was able to find a way to use the art sessions productively, given a choice of media and surfaces. The many different ways in which they responded to the opportunity were impressive, ranging from performing calming repetitive movements with body and brush, to graphically organizing their perceptions, to expressing previously unknown feelings and fantasies.

It was soon apparent that some of those whose language was hard to understand were able to communicate remarkably clearly through art. This was dramatically true for Dorothy, a 10-year-old whose speech was frantic, garbled, and virtually incomprehensible (DVD 1.1). She began by drawing very competent pictures of birds (1.1A), then painting them (1.1B). But until she drew and painted first a monster (1.1C), then a bird devouring a human being (1.1D), the treatment team had been unable to decipher the fantasies behind her bizarre behavior of flapping her arms and making squawking sounds. In fact, it was only after her bird and then her cat fan-
tasies (1.1E) were expressed and explored in visual form that Dorothy began to draw human beings: the other children on her unit (1.1F).

Despite her social isolation, it was evident that she had been observing these youngsters, who were instantly recognizable to everyone who knew them (1.1G). Although her group portraits were rather stiff at first, they soon included a good deal of action and a clearly defined environment (1.1H). It was during this period that Dorothy began, for the first time, to relate to the other children, and we can only speculate that making the drawings was a rehearsal for live social interaction.

Even the few children on the unit with normal speech began, in their art, to express feelings and fantasies that helped the staff to understand their often puzzling symptoms. This was true for Randy, a 12-year-old who suffered from Enuresis (DVD 1.2).

He was a sweet and affectionate child, whose aggression—which he denied but which was manifest in his explosive symptom—first came out symbolically. After drawing a picture of Mars (1.2A) with constellations named “The King” and “The Queen,” Randy embarked on a book, “Our Trip through Outer Space,” (1.2B) in which a Martian and I traveled together from one planet to another.

This was followed by some realistic paintings, including one of his “School on Fire” (1.2C), one of the “School Burning Up” (1.2D), and one of a “Dinosaur and Volcano” (1.2E). After expressing some of his pent-up rage, Randy turned to an elaborate oedipal fantasy in which he and I went on a trip, this time on Earth, and as clearly romantic companions.

In the course of this second journey, the Randy character became less Martian and more human, appearing at one point to have won me, who I believe represented his mother in the transference. This was evident in a picture of Randy as a Scotsman holding me on what looks like a leash (1.2F), presumably to keep me from falling while dancing. The eventual resolution, however, was a healthier one. In the final picture/story (1.2G), the woman rejects a sailor, “because she already had a boyfriend,” the boy accepting the reality that mother belongs to father. What was interesting was that during his work on the picture series, Randy’s symptom gradually went away.

Because his psychiatrist was also seeing him for both individual and family therapy, we cannot be sure what role, if any, the art had in his recovery. Both his doctor and I felt, however, that art therapy had had a positive impact on Randy and on his progress in treatment. Since Dorothy’s severe language problems had prevented her from communicating effectively
with her psychiatrist, the role of the art in her case was clearly vital. When Professor Erik Erikson was presented with her history and that of her treatment at a grand rounds 4 months after art therapy had begun, he felt that it had been critical to her increasing relatedness, and urged that it be continued.

A Child Study Center

At the same time that I was seeing the schizophrenic children, I was working with after-school groups at a child study center run by the Department of Child Development. There, we found that some children who were very shy were able to whisper in paint what they could not say in words. Youngsters who were impulsive were often able to settle down and focus, and some of the boys and girls whose self-esteem was low, blossomed artistically in this nonjudgmental atmosphere where, unlike in art class at school, there were neither assignments nor grades.

My colleagues—at both the hospital and the child study center—soon began asking for help in using art themselves. They wanted to know what materials to buy, as well as how to get the children to use them. It wasn’t long before I also found myself, in addition to working with the youngsters, training other staff members. Some requested individual consultation, while others wanted to meet as a group and to work with materials. My first adult students in 1963, therefore, were teachers, child care workers, occupational therapists, social workers, psychiatrists, and psychologists.

An Institution for Disabled Children

In 1967 I started an art program at a residential treatment center for orthopedically disabled youngsters (DVD 1.3). The staff members, like those in the hospital, had been extremely pessimistic about the capacity of these severely impaired children to use art materials with any degree of success. We were pleased to discover how very many of them were able to be creative through adaptive modifications of tools, media, and work surfaces (1.3A). It was soon evident that art provided these youngsters with a pleasurable outlet, as well as a place to learn new skills, to develop their potential, and to enhance their fragile self-esteem.

Although the staff had feared that art would discourage them because of their poor fine-motor control, the children’s excitement about the art sessions was evident from the first (1.3B). In fact, because it was so popular, an extra period in the art room became one of the most frequently chosen rewards in a newly instituted behavior modification system, even though it cost the most tokens.
Art was also a place where both conflicts and capacities were revealed—as with the deaf-mute girl (DVD 1.4), thought to be profoundly retarded, who first demonstrated (1.4A) her normal intelligence in pictures (1.4B). As a result, she was able to return to the classroom and to speech therapy, using a “talking book” of drawings to communicate with others (1.4C), long before she was able to master sign language (1.4D).

On the basis of her success, the psychology and speech therapy departments both requested in-service training so that they, too, could use art with the children they were treating. Soon, sessions on art activities were requested by the child care workers, the occupational therapists, and the nurses, all of whom found that it helped them to better achieve their goals.

A Child Guidance Center
When I became the first art therapist at the Pittsburgh Child Guidance Center in 1969, the psychiatrists, psychologists, and social workers on the staff were naturally curious about this new clinical modality. I invited them to watch the art sessions through the one-way observation windows used for trainees. I also let it be known that I was interested in our working together, and eventually did so with some of them as co-therapists with families or groups (cf. Chapter 14, pp. 230–233; Rubin, 1981b).

After several months of a part-time pilot program, there was steadily growing interest in referring patients for assessment and treatment. In addition, however, some clinicians were eager to learn how to incorporate more art into their own work. I therefore ended up consulting with many of my colleagues, to enhance their comfort in using art with the children and parents they saw.

In 1970, a psychologist and I designed a family art evaluation and presented it at a general staff meeting (Rubin & Magnussen, 1974). The interest was so keen that we soon formed a family art study group in which we trained other clinicians to conduct the evaluation, reviewing their videotaped sessions at our 2-hour weekly meetings. Observing their ability to use what they learned, and to modify the procedures to fit their needs, was an important learning experience for me (cf. Chapter 10, p. 152).

Pretty soon, the social workers requested a course in using art materials with the activity groups they were leading. There was also a series of meetings with the psychologists on the use of projective drawings in assessment. The psychiatric consultant to the clinic’s therapeutic preschool requested an art therapy group for the mothers (DVD 1.5), to which the latter (1.5A) responded more positively (1.5B) than they had to a purely verbal group (1.5C). The teachers of these severely disorganized students...
wanted consultation in helping the children, whose controls were weak, to use art materials constructively.

Responding to requests from people working with troubled adolescents in the community, a psychologist suggested that we design a course in art for self-awareness (DVD 1.6). We did so, training workers from many different fields to use art activities with groups of teenagers—first experiencing the exercises (1.6A), then trying them out with teens, then returning for group supervision on their work (1.6B).

The director of research invited me to work with his department on what became a series of studies of children’s drawings related to diagnostic issues (cf. Chapter 14, pp. 233–234). These were all two-way situations, in which I learned at least as much as they did.

Consultation to Other Institutions

My job at the Pittsburgh Child Guidance Center was half-time in Direct Service and half-time in Community Service, otherwise known as Consultation and Education. That meant that I could consult to other institutions in the community, which greatly expanded the clinic’s ability to reach parents and children in the wider geographic area.

In the hospital across the street, which, like the center, was run by the Department of Psychiatry, the occupational therapists soon requested a series of classes. They wanted to deepen their use of art media, which at that time were central in their work. Because they had excellent art and craft supplies and equipment, and were seeing most of the patients in the hospital, helping them to be more creative and reflective in their approach to art activities had an impact on the majority of those being treated on the inpatient units.

Shortly after that, the staff of the then-new day hospital asked for consultation on the use of art in group therapy. We began by having the patients make collaborative murals, inspired by an early book on art therapy in a New York day hospital: Murals of the Mind (Harris & Joseph, 1973). I ended up both observing the social workers leading the groups, and working alongside them.

The work of an art therapy intern at the children’s hospital next door to the center stimulated a long-term collaboration with the pediatricians on art activities for their waiting rooms, something we had already instituted at our clinic (see Figure 1.1). For a number of years, I met for a series of workshops with the graduate students in child development and child care who conducted evening play programs for the children in that hospital. Their interest was in making the recreational art activities as therapeutic.
as possible, especially for those youngsters who had long hospital stays. Later, when a Child Life Department was formed, I conducted regular training sessions on the use of art media for its staff members.

I eventually found myself giving talks and workshops, as well as teaching courses for those who worked in other mental health centers (see Figure 1.2). They were offered not only at the clinic, but also in the community, in a wide variety of settings, including universities. For those who attended, I created a mimeographed handout entitled “Some Ways to Use Art in Therapy,” which listed basic art materials; how to offer them; how to decide what to do, depending on diagnostic and treatment goals; and how to look at the art work that was evoked. I had forgotten that handout, which I used with other clinicians for many years, until I started work on this book. *Artful Therapy* is clearly a logical extension of those early efforts to share the wealth (so to speak) with those in other fields who wished to add a creative dimension to their therapy.

Perhaps the most important thing I learned from these experiences was that if people are well trained and knowledgeable in their own disciplines, they are able to incorporate art activities in ways that are therapeutically relevant. And, as is true for art therapists as well, they inevitably do so in
ways that fit their theoretical outlooks as well as their preferred styles of relating.

**Where Can You Use Art?**

The kind of basic materials recommended in this book, most of which are only minimally messy, can be used in almost any place where you might be helping someone. In addition to using them in an office, you can offer art to people of all ages not only in clinics and hospitals, but also in schools, shelters, prisons, and rehabilitation centers, even in their own homes (DVD 1.7).

Just as art is possible with people of all ages—as soon as a child can hold a marker and not put it immediately in the mouth—so it is possible to make it available in virtually all kinds of settings, including outdoors, as with the wall mural done by adolescent gang members in a project facilitated by their leader (a woman who had also been in a gang). The theme of the mural is their dreams for the future (DVD 1.8).

Naturally, as with any kind of psychotherapy, it is ideal to have a space that is private, protected, and quiet—and if there’s a sink in the room or
nearby, it helps to allay anxiety about getting dirty. Even when there is no private work space, however, and even if the table is mahogany and the floor is carpeted, you can easily protect both work and fallout surfaces with newspaper or plastic cloths.

Although some settings, like a shelter or a hospital ward, are unavoidably noisy, crowded, and full of interruptions, it is really amazing how people of all ages can concentrate on making a drawing or a collage when they are genuinely engaged in the process (see Figure 1.3). I once had a book called *Art Is a Quiet Place*, which is what often happens, even with otherwise disorganized individuals.

I once had the good fortune to accompany my colleague, art therapist David Henley, on a visit to a zoo where he had been going for weekly art sessions with the animals. While there, I had the pleasure of observing a gorilla named June create a crayon drawing, which I treasure as a memento of the visit (DVD 1.9). June’s drawing itself was unremarkable, like any young child’s scribble (1.9A). But watching her concentrate on the activity for a full five minutes in a large cage full of noisily playing apes was astonishing (1.9B). Although I have often seen human beings similarly absorbed in the act of drawing, I felt like I was witnessing firsthand the primal pleasure of a deep engagement in the creative process. This organization
of the organism’s faculties in such purposeful, focused activity is one of the broadly therapeutic aspects of art activities.

It is therefore not surprising that art has always provided a refuge (DVD 1.10), and that making even a simple drawing can be a way of escaping a painful situation (1.10A). The children in the Nazi concentration camp of Terezin were enabled to create by a teacher named Friedl Dicker (1.10B), whose art classes were an island of peace in a sea of despair1 (Jewish Museum of Prague, 1993; Makarova & Seidman-Miller, 1999; Volavkova, 1962; 1.10C).

Frederick Terna, one of the few child artists surviving the death camps, spoke about the experience during a reunion 50 years after he was liberated from Auschwitz:

It was one of the moments of total privacy—when one is in front of a piece of paper, that rectangle or square, the world does really not exist. That is, I am the total master of that little paper; I can do with it what I want. My oppressors here—the Nazis, and the Gestapo, and SS—could do whatever they wanted. When I was in front of that little piece of paper, I was my own boss. (1.10D)

Even now, people of all ages spontaneously turn to art to cope with overwhelming traumatic events (see Figure 1.4). This was evident in the many art expressions—such as community shrines, murals, and picture-messages by individuals of all ages—following the terrorist attacks of September 11, 2001.
When Can You Use Art?

With _when_, as with _where_, the possibilities are virtually limitless. Like words, art materials can be always available, to be used as desired. This is common in child therapy, where art media are among those normally present in a well-equipped playroom. Art can also be introduced selectively, as indicated by your own notions of how best to further the therapeutic work.

Art is often found in assessment because it is quick and, when intelligently utilized, can be a rich source of diagnostic information. It is also helpful in the course of therapy, regardless of whether the treatment is long or short term. Because of its efficiency and its ability to tap rapidly into important concerns, art is especially well suited to brief therapy.

Whether it becomes an always-available mode of expression or a selectively introduced intervention, art can be used at any stage of treatment. The decision about when, how, and why in any particular clinical instance is up to you, just like a decision about whether to request specific memories or to introduce any other adjunctive technique, such as hypnosis.

Art is especially helpful in _crisis intervention_. Some events are so devastating that words fail, and images become the best way to say what presses for release. Because art is portable, it is possible to take crayons and paper anywhere people need help, whether in a home, a hospital, a shelter, or a school.

Here are a couple of examples in which art was useful in helping people cope with crises: After the 1995 terrorist bombing in Oklahoma killed and injured hundreds of innocent people, survivors experiencing posttraumatic stress found that art was especially therapeutic (Jones, 1997). When a brushfire destroyed many homes and injured a number of people in northern California, the team that did group therapy with the children at a local school found that art was especially useful in helping them get in touch with their feelings about the event (DVD 1.11).

With Whom Can You Use Art?

Although as an art therapist I can see potential benefits for many different kinds of patients, there are people for whom art is especially helpful. While words are inadequate for all of us in trying to express certain ideas and feelings, for some people, words are less easily available, and for others they often get in the way. These are the people for whom using art materials can definitely open up new possibilities in therapy.

A variety of patients cannot or will not speak, whether the cause is organic, as in aphasia, or psychological, as in elective mutism. Those who are
painfully shy might be able to talk, but can be so frozen with inhibition that precious little can be accomplished in verbal therapy. For all such patients, adding art can open a vital avenue of communication.

Paradoxically, another group of patients for whom art offers a welcome channel is those who are highly verbal—who use words to hide, and who do it all too well. Intellectualization and rationalization are wonderful defenses, but when they don't allow people to know what they're feeling and what their fantasies are, they can get in the way of psychotherapy. Similarly, for those who isolate affect, who talk about it but do not actually feel it, art can help them get in touch with the unruly emotions of which they are so afraid.

Just as children find making art easy and natural, so do adults who are temporarily or permanently regressed. When my colleague and I started a program of creative arts therapies throughout a large psychiatric hospital in 1981, we found that art was the most popular modality, probably because it was less threatening than movement, drama, or music, in all of which people felt more exposed.

As we had expected, art therapy was welcomed on the child and adolescent units. But we had not anticipated that it would be so appealing to adults who were in an acute phase of their illness—those suffering from various kinds of psychoses, including schizophrenia, depression, bipolar disorder, and serious personality disorders. This is not so surprising if we recall the universal phenomenon of the spontaneous art of the mentally ill (DVD 1.12)—presumably, an effort to stay in touch in some way (1.12A)—long before the advent of antipsychotic medications or art therapy programs in mental hospitals (Jakab, 1998; MacGregor, 1989; Morgenthaler, 1921; Prinzhorn, 1922; 1.12B).

A similar motive is probably present for most of those doing what has come to be known as “outsider art” (Cardinal, 1972; Hall, Metcalfe, & Cardinal, 1994; DVD 1.13). There seems to be something that relieves tension and provides grounding, in the very making of something concrete. The impulse to create is a compulsion for most of these self-taught artists, like Howard Finster (1.13A), and is evident in their use of any available material, whether it be Nellie Mae Rowe's chewing-gum sculptures, or Jimmy Lee Sudduth’s mud paintings with natural dyes from grass and flowers (1.13B).

Since creating art seems to be an inborn human capacity, it is possible to add the option in your work with almost anyone. As noted, it is especially useful with those whose language or reality-testing is limited. It is also remarkably helpful for those whose mastery of verbal expression actually gets in the way of their efforts to feel better through psychotherapy.
Children of All Ages

Although the majority of children you see for therapy have probably developed some language, they do not have the vocabulary or the expressive range of adults. Moreover, most are comfortable with drawing, painting, and modeling, which they do quite naturally. Thus, like playing with dolls or toys, making art is a familiar expressive activity, and one in which a great many youngsters are quite fluent. For these reasons alone, it’s important to provide even the most articulate children with a broad range of possible media.

The quality of materials like crayons or paper is important, because youngsters press hard and scribble vigorously. And since their verbal abilities are more limited, the variety of materials offered needs to be greater than is necessary with adults and older adolescents. Chapter 9 focuses on the use of art in work with children and adolescents.

Adults Young and Old

While adding art may not seem as compelling when you are working with articulate adults, I think you will be pleasantly surprised at the many ways in which it can enhance treatment. Just as art in therapy is not only for children, so it is not only for those who are regressed. The worried well, the average neurotic, and those who suffer from dysthymia, cyclothymia, personality disorders, low self-esteem, and anxiety disorders are as good candidates as those who are nonverbal or psychotic.

Older adults, whether they are suffering the normal losses of aging or have a specific disability, enjoy the opportunity to have a visual as well as a verbal “life review” (Butler, Lewis, & Sunderland, 1998; DVD 1.14). Photographs from the past are helpful, and can be placed in collages, arranged in sequence, or used in memory boxes (1.14A, 1.14B).

Drawings of memories are another way to look back, and to put things in order. Anna Shafer, an elderly woman who attended an art group at a local community center, became quite excited about drawing, doing it every time she was free. She used it not only to reminisce, but also to fantasize (DVD 1.15).

After all, you can do anything you want to in art, unbound by realistic considerations. Age brings inevitable losses of loved ones, of societal roles, of health, and of mobility—all the more reason that being able to imagine freely in art is extremely therapeutic. Moreover, if there is any neurological deficit or memory loss, drawing can be used not only diagnostically, but also as a way of organizing otherwise confusing perceptions and events.

Indeed, I hope that you will consider using art with all people who are
willing to try, whether they are in their 20s or their 80s. In fact, I suggest that you experiment with offering materials to all of your clients, so you can see for yourself who might benefit and how. The following are some groups not mentioned earlier who respond well to art, though the list is far from exhaustive.

**People Who Are Resistant and Suspicious**

Those who are able to talk, but who are openly resistant to verbal therapy, may be somewhat more receptive to drawing. Despite the anxiety of most adults about their artistic abilities, even wary and hostile patients can become engaged, especially if the art activity is presented in a nonthreatening way.

When I worked in the outpatient clinic of a community mental health center, as well as on the inpatient units of its hospital, I found that people with less formal education were often suspicious of verbal therapy, fearing that a therapist could play with their minds, so to speak. Yet they were sometimes more willing to use markers than to talk. The indirectness of art has an appeal for many, perhaps because it is concrete and thus makes it easier to see things.

**People with Developmental Delays**

Those suffering from delays in development, whether they are of organic or psychological origin, can often benefit significantly when you add drawing and other art activities to your behavioral, cognitive, or psychodynamic treatment. In fact, including art can sometimes make psychotherapy possible for those for whom it would otherwise be inaccessible.

As noted earlier, art can be used with anyone who can learn to use materials constructively. If you are working with people who, for whatever reason, are unable to symbolize, you will find that drawing can be helpful. Making images can even be an avenue toward higher functioning (Wilson, 1999, 2001). Certainly, there are many times when words alone are of limited value.

**People with Communication Problems**

Anyone who has problems with verbal communication, whatever the cause, is a good candidate for “art as a second language.” This includes those who are autistic, hearing impaired, or brain damaged. Elective mutes and deaf-mutes may be able to speak to you only through drawings. And the universal language of art can be a godsend with recent immigrants when you do not speak the same language.
Those with chronic mental illness can often tell you even more about how they are feeling through art than in words. In the 1960s, psychiatrist Mardi Horowitz (1983) discovered that “interaction painting” enabled him to communicate with acutely regressed catatonic patients.

When people’s capacities for speech are temporarily or permanently impaired due to a trauma, it is especially vital to provide them with other ways to communicate. It does not require any special training or skill—you don’t need to be an art therapist to offer an aphasic patient a pencil after he or she has had a stroke. Nor do you need to be an art therapist to give crayons to a person with Alzheimer’s disease.

**People with Eating Disorders and Substance Abuse Problems**

Patients suffering from eating disorders are obsessed with a distorted body image, which can be represented concretely in a drawing, a painting, or a sculpture. Being able to externalize such imagery is, in itself, helpful. It is rare that an anorexic, for example, is able to see how emaciated she is; but she can sometimes perceive what has happened to her body when she represents it (see Figure 1.5).

In addition, as they frantically pursue an attempt at magical control of
the body, these patients are usually not in touch with the powerful feelings and fantasies they are working so desperately to master. Because what is repressed can be expressed in images more easily than in words, art is one way to get in touch with the affects and ideas behind their symptoms. Moreover, using art materials can satisfy the intense need of such patients to be in control. The availability of media can also be experienced as a kind of feeding, with the therapist as provider of something taken in and then used by the patient for him- or herself.

Those who suffer from the equally oral and addictive problem of substance abuse also respond positively to the use of art as part of their therapy. There are probably good developmental reasons that people with such disorders, often due to unresolved issues from early periods of life, find nonverbal modes of expression to be so congenial. Since art therapy is very popular with both of these groups, it is worth adding art to your treatment of such patients.

Victims of Abuse

Whether the abuse happened in childhood or adulthood, it is often repressed and unavailable to both patient and therapist. Even if they might remember, victims have usually been threatened with reprisal if they tell anyone what happened. The traumatic events may be totally unconscious, or they may have been suppressed out of fear.

With repressed memories of physical, psychological, or sexual abuse, the image can be a gateway to what was largely a nonverbal event, especially when it occurred before the person had language. Psychiatrist Mardi Horowitz (1983) found that the common posttraumatic stress symptom of flashbacks could sometimes be alleviated by drawing the unbidden images and then discussing the drawings.

You can also suggest drawing significant places, people, or events related to the trauma, as a way of helping people reach beyond repression for what they want to remember. Although some therapists fear opening up such tender subjects, it turns out that survivors often welcome the opportunity, because they are able to process and come to terms with such events only by reexperiencing them. Art offers a safe and concrete way to begin the reexposure necessary for ultimate healing from Posttraumatic Stress Disorder (PTSD; Steele, 2003).

People with Dissociative Identity Disorder

(Multiple Personality Disorder)

If you read the story of Sybil (Schreiber, 1974), you may recall the drawings made by her “alters” of different ages and personalities, each with his
or her own artistic style. Christine Sizemore, the woman whose story was
told in the film *The Three Faces of Eve*, also found painting to be very help-
ful in the work of integrating her subpersonalities (Sizemore, 1977). In
Chapters 11 and 14 you will find descriptions of therapy with Elaine, whose
art helped her to express, and then to work through, the traumas that had
fragmented her personality into many alters—each formed at a different
age in response to a traumatic event that was, by definition, too much for
her ego to handle.

**People with Medical Problems**

Patients’ drawings can sometimes provide a useful window on the mind
for those involved in their treatment. For example, the structural (formal)
aspects of drawings can help identify the extent and nature of organic im-
pairment. Judy Wald (1989, 2003), who worked with people suffering from
Alzheimer’s disease, observed that their progressive cognitive deterioration
(DVD 1.16) was often hidden by their ability to mask symptoms with well-
learned compensatory behaviors, but was painfully visible in their drawings
(1.16A), especially when viewed over time (1.16B).

Drawings can also help others to understand patients’ feelings about
their illnesses and the treatments they are undergoing. A child psychia-
trist, for example, asked a boy with juvenile diabetes to make a picture
about his disease. By making the drawing and then describing it to the doc-
tor, Eddie was able to say much more than he could have using words alone
(DVD 1.17).

A pediatric neurologist invited children to represent their migraine
headaches in pencil drawings. He eventually offered them colored pencils
and markers, recognizing the expressive value of color. What is most prom-
ising is that these drawings helped his colleagues in the differential diag-
nosis of migraine, which is hard to determine in these youthful sufferers
(Carl Stafstrom, personal communication, May 15, 2002; cf. also DVD
8.1).

A speech therapist invited stutterers to draw pictures of their feelings
before, during, and after a stuttering episode (Bar & Jakab, 1969). As with
showing what it’s like to wheeze (Gabriels, 1988), or drawing one’s asthma
as a creature (as proposed by art therapist Robin Gabriels; DVD 1.18), mak-
ing such pictures evokes ideas and feelings that the patients could prob-
ably not have verbalized. In both instances, repeating the task at intervals
allows the treatment team to monitor the progress of patients’ abilities to
cope with their disorders.

The new field of alternative or integrative medicine is discovering that
the shamans who made fetishes and created sand paintings to heal the sick
were onto something significant. From the early work of physicians like Carl Simonton (1978) and Bernie Siegel (1986) with cancer patients, to the studies of Jeanne Achterberg (1985), to the present developments in psychoneuroimmunology, there has been considerable support for the possibility that both mental imagery and drawing directed toward the disease and the healing process can affect the immune system (Malchiodi, 2003a & b).

**People Who Are Bereaved**

You might not have thought of using art with patients who are dealing with unresolved grieving, but if you consider how often images are part of normal mourning, it makes sense. A Toronto psychologist, working with a group of children who had lost family members, asked each child to make a picture of the person who had died (DVD 1.19)—a powerfully evocative task (1.19A). As with most uses of art in therapy, she then invited them to share their pictures with the group (1.19B). She also asked them to draw “the weather inside” (1.19C) and to talk about it (1.19D).

Young children often turn to art spontaneously (DVD 1.20A), as do some adults. Adults who have lost people can also be helped by such art tasks, especially in a group of other mourners. Memorials are found in all cultures. Thus it is not surprising that creating something concrete would be helpful, like the clay head of my father made by my nonartist mother the summer after his death (1.20B), or the totem carved out of a tree trunk by a rural man (1.20C) after the death of his young wife (see Figure 1.6).

In a New Jersey town that had lost many people to the terrorist attacks of September 11, 2001, an artist invited survivors to participate in a sculpture in memory of the victims (DVD 1.21), which he called *The Memoria Project*. The mother of one young man expressed how good it was to be “finally doing something.”

Another local artist made portraits of those who had died (DVD 1.22), using photographs supplied by their families. It is noteworthy that, even though the color photos were accurate visual records of their loved ones, there was something uniquely valuable for survivors in the colored-pencil drawings.

**The Purpose of This Book**

Although I know of no data on the frequency with which non-art therapists invite art work, I suspect that many of you have done so in the past, perhaps while in training, and that you may still do so, either routinely or occasionally.
If you have never explored having patients create images, the purpose of this book is to persuade you to give it a try. And if you already do so, the aim of this book is to help you to invite art-making even more comfortably and effectively.

Almost everyone who treats children uses art, though unfortunately, not always with ease or effectiveness. Without guidance, it is all too easy to buy inadequate materials, or to feel stuck over what to do or say once something has been made with them. Even though children are usually willing to create, they are often quite disinterested in talking about their art.

I have known many therapists who have attempted to solicit art from adolescents and adults with little or no success. I have also known many
who, though they persuaded their patients to create, were then uncertain about how to help them learn more from the experience. While it can be extremely fruitful, interviewing patients about their creations in a productive way is not easy.

This book is not neutral. In fact, it is rather evangelical. To the uninitiated, the message is: “Try it, you’ll like it. The water’s fine, and you can walk in slowly or dive in, whatever suits you best.” To those who already have art materials and are using them, the message is: “Don’t be afraid to explore the use of art in your work even more fully.” To both groups, it is: “You don’t have to be an art therapist to add art materials and activities to your clinical work.”

The questions of where, when, and with whom are, however, not the core of this book, which focuses on why and how you should include art in your work. In the next chapter, I will note some of the many reasons for adding art to your clinical armamentarium; and in the subsequent chapters, I will focus on how to do so effectively.

Notes

1. Friedl Dicker, in addition to being an artist and teacher at the Bauhaus, was also the mentor of Edith Kramer, one of the pioneers of art therapy, who escaped from the Nazis at the very last minute. Dicker was not so fortunate; she died in Auschwitz.

2. Art therapist Susan Orr gave this title to a videotape she made some years ago about her work with a girl who had been sexually abused. She also uses it as the name for her practice (personal communication, June 9, 2000).