The Art of Art Therapy:
An Exploration of Past and Present Roles of Art in Art Therapy

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ABSTRACT

The Art of Art Therapy: An Exploration of the Past and Present Role of Art in Art Therapy

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As the profession of art therapy continues to grow and evolve, more and more questions and concerns seem to arise regarding the use of art in its professional practices. This paper is an exploration of views in this regard. Beginning with a discussion of the use of art in clinical settings by early psychiatrists, this paper proceeds to explore literature pertaining to the use of art in three subsequent periods of art therapy's professional development. These include art therapy's early days, middle period, and present practice. These chapters are followed by a section outlining questions articulated by current art therapy authors regarding potential problems in the profession and possible causes. Also included in the paper is a subjective analysis of information about art and art therapy. This paper is designed to inform and educate present and future art therapists, and to shine light on potential areas of concern in the profession.

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"Affectus, qui passio est, desinit esse passio simulatque eius claram et distinctam formamus ideam"
Emotion, which is suffering, ceases to be suffering as soon as we form a clear and precise picture of it.
Frankl quoting Spinoza (Frankl, 2006, p. 74)

INTRODUCTION

I believe the more one practices art therapy, the more evident it becomes that what we do as professionals is serious clinical work. The magnitude of effect that we can, and do, have on our client's lives is potentially immeasurable. However, just as much as we have the potential to help facilitate our client's healing, we have the potential to facilitate hurt if we do not know what we are doing.

As I enter into the next phase of my professional life, a soon to be Art Therapist, I find myself searching for where I fit and ways to be a better therapist. Like many others in this transitional phase, I look to my colleagues and peers for answers and advice regarding these questions. Not always being able to speak in person to other professionals, I refer to their written words for wisdom. I read books and articles that convey the history, present state, and future of our profession. It is regarding the future that I am concerned.

During my research, I discovered an article written by Allen (1992), in which she discusses the subject of what she refers to as art therapist "clinification". This term refers to an art therapist taking on characteristics similar to those of a traditional clinical

therapist, as well as a lack or misuse of art by the practitioner within therapy. Although the term "clinification" was put forward by Allen as a syndrome in the profession of art therapy, the ideas and concerns she expresses in her article have also been discussed by other authors, such as Acosta (2001) and Thompson (1997). Both authors comment on a potential lack of art in art therapy practice, and a shift in the profession towards a more verbal approach to treatment. Reading about this bothered me, as it made me question the authenticity and longevity of art therapy as a profession.

Allen (1992) implies that art therapy exists as a profession because art therapists are specialists in art. However, if art therapists are not using art in therapy, then what is the point of the profession? With Allen's comments in mind, I began to wonder if other art therapists are discussing similar issues, and if so, what are they saying? What is really happening in the profession? Therefore, the primary research question for this paper is: Where is the art in art therapy? Subsidiary questions are: What place does art hold on the continuum between art and psychology/psychotherapy? Who are the main authors writing about the importance of art in art therapy? What are they saying? Is there a lack of art in the profession?

Using the literature of art therapy as my guide, I present to you a theoretical paper based in the Historical–Documentary method, combined with a subjective analysis component. My hopes are that this paper will educate and inform other students and professional art therapists as to the status of art in our profession. Also, my intention is to

draw attention to a potential problem within the field, and explore what can be done to fix it.

This paper will explore past and present views of art in art therapy. It will begin by presenting a chapter on the use of art in clinical settings by psychiatrists and psychologists before art therapy existed as a profession. This will be followed by chapters regarding the origins of art therapy, its continued growth by the next generation of art therapists, and current beliefs surrounding the use of art in art therapy in the United States. The next section will highlight what various authors may believe are the potential problem areas in the profession, as well as the causes of this potential lack of art in art therapy. I will end this paper with a subjective analysis of the views presented in the paper and, lastly, my conclusion.

I believe that the question of art's role in art therapy is central to the profession. As therapy it is a reasonably young profession, I feel that an exploration into the status of art in art therapy can aid practitioners and theorists in finding the professional identity we seem to lack. A synthesis of the literature can give clarity to the subject, and possibly reveal a problem area in our profession. Research about art in art therapy would provide insight into what experts in the field believe art's function in the profession to be. This insight may reveal a better way to use art when helping clients, as well as help gain much needed respect for the profession within the clinical world.

EARLY USES OF ART IN CLIENT TREATMENT

Long before Adrian Hill claims to have coined the term "Art Therapy" (Hill, 1951, p. 13), art had been used as a tool for human healing. Looking at the history of art therapy, authors such as Junge & Asawa (1994), Malchiodi (1998), and Rubin (1998) all link the therapeutic practice of art making to prehistoric humans expressing themselves through art on cave walls, as well as to biblical times, Buddhist Mandalas, Navaho sand paintings, and a wealth other artistic practices carried out by virtually every culture on earth for millennia.

Art Therapy, as we classify it today, seems to have its roots planted deeper in the more recent past. Its clinical origins seem to have grown from the work of the world's early psychological and psychotherapeutic masters, such as Freud and Jung. One of the major influences in the birth and development of art therapy as a profession was psychoanalysis (Vick, 2003, p. 7). Both Freud and Jung recognized the therapeutic value that is inherent in art (Lanham, 1989; Moon, 1997; Rubin, 1998, 2001). Freud's theories and concepts regarding symbolism, the unconscious, and dreams, as well as Jung's theory of a collective unconscious potentially shared by all humans across cultures and generations, had a direct influence on art therapy (Junge & Asawa, 1994). The ideas and concepts of Freud and Jung provided a theoretical basis for clinical work being done by art therapists (Junge & Asawa, 1994, pp. 2-3). Although authors like Rubin (1998) comment on the importance of Freud, others like Junge & Asawa state that he never actually engaged his clients in the art making process. Interestingly, Lanham comments

that Freud believed art represented, "...an expression of unresolved conflicts," and that these conflicts could be effectively worked on in psychoanalysis, therefore rendering the artistic expression unnecessary (Lanham, 1989, p. 19). Still, Freud is important, as authors like Vick, MacGregor (1989), and Rubin all attribute him as being one of the professionals who helped other clinicians see that images created by mental health patients were potentially more than marks or colour on paper. They were, in fact, a potential gateway into their minds. Conversely, Jung supported the use of art in therapy, and would at times encourage his clients to draw (Junge & Asawa, 1994, pp. 2-3).

While the original value regarding the importance of art in clinical treatment may be attributed to Freud and Jung, there were other clinicians who are believed to have helped in starting and continuing the path for art therapy as a profession, as well. Contemporaries of Freud and Jung also began discussing the use of the arts as a clinical tool. Their case studies and clinical work focused on the specific use of art as a clinical tool, rather than an adjunct to treatment (MacGregor, 1983; Junge & Asawa, 1994). The number of books and articles by European psychiatrists and authors, such as Lombroso, Tardieu, and Simon, which focused on the art of people deemed insane (MacGregor, 1983), began to increase. This development of literature on the use of art in clinical settings was another "primary factor" in art therapy's evolution as a profession (Junge & Asawa, 1994, p. 4). According to MacGregor (1989), Junge & Asawa (1994), Rubin (1998), and Vick (2003), the recognition of the clinical value of art continued to grow, and more clinicians began to write about it, thus spreading the word. For example, Morgaenthaler (1921) and Prinzhorn (1922) published works about the art of patients

committed to asylums in the early 1920's (Rubin, 1998, p. 92). These professionals started to believe that there was something valuable about the use of art in client treatment. Naumburg (1950), states that clinicians saw art work created by patients as an untapped resource for gaining knowledge about these individuals, especially in the context of using art as a clinical tool for diagnosing conditions and disorders (Naumburg, 1950, p. 10). Regardless of this progress, art was not yet accepted as a distinct form of treatment, in and of itself.

Up to this point in the profession's history, it appears that a more verbal than artistic approach to images in treatment was the 'norm' of the day. Images were not often made in sessions, but were discussed as having potential for clinical use. Those writing about the art work of patients in clinical environments (Morgenthaler, 1921; Prinzhorn, 1922) focused more on the aesthetic value of the works, rather than their clinical potential. According to the literature (MacGregor, 1989; Junge & Asawa, 1994; Rubin, 1998; Vick, 2003), the trend of client images being used for diagnosis and analysis, and being discussed aesthetically, continued for decades in various mental health facilities and hospitals in both Europe and America. While this application of the arts in client treatment may be an important part of art therapy's history in terms of laying a foundation for what we do today, these early clinicians exploring art's usefulness were not art therapists. Art therapy began to clearly emerge as an accepted treatment with the next era of clinicians.

ART AND THE ORIGINS OF ART THERAPY

Junge & Asawa state that various people began to identify themselves as art therapists before the year 1940. However, the first person to use art as a treatment, and a unique form of psychotherapy, was Margaret Naumburg (Junge & Asawa, 1994, p. 22). For this reason, it is with Naumburg that this section on the origins of art therapy, with specific emphasis on the evolution within the United States, will begin.

Naumburg had been an educator and patron of the arts before focusing on the use of art in a psychotherapeutic manner. Vick (2003) writes that Naumburg also possessed a great understanding and knowledge of the psychoanalytical work and theories of both Freud and Jung. Based on this knowledge, Naumburg (1966/1987) developed what she classified as "dynamically oriented art therapy". Its' function was similar to the work done by other psychoanalysts who were influenced by Freud and Jung (Vick, 2003, p. 9). This seemed like a natural development for Naumburg, who underwent psychoanalysis with both Freudian and Jungian analysts herself, to help develop her theories and understanding in regards to the psychoanalytical practices of the day (Junge & Asawa, 1994). From what is written about Naumburg and her use of art in sessions, it is believed that she viewed the client's creations as being an integral part of the therapy, and that "...images more easily escape repression by what Freud called the mind's 'censor' than do verbal expressions" (Naumburg, 1973, p. 2). Naumburg encouraged her clients to interpret their works of art through free associations. Her basis and understanding of practices surrounding free association were taken from psychoanalytical practice. However, unlike other Freudian therapists, Naumburg did not support placing a strong

emphasis on having clients verbalize their subjective experiences. Instead, she had clients make art as an expression of their experiences (Junge & Asawa, 1994, p. 159).

In reference to Naumburg's therapeutic beliefs and techniques, it was her contention that art therapy required a few key components to be provided by the therapist. These included the provision of uncomplicated art activities, showing the client how to engage in these practices, being empathetic, and encouraging the client to make free associations to their work (p. 163). Junge & Asawa write that, to Naumburg, the role of the therapist was to facilitate these associations and provide encouragement as a way to help clients achieve a better understanding of their own inner worlds, "for it is on the basis of each patient's response to his own symbolic creations that the importance of us using spontaneous art projections as a primary mode of therapy can be established" (Naumburg, 1950, p. 34).

Naumburg (1950) also stressed the importance of the therapist not to emphasize any form of aesthetic need in regards to the art made in the session. She noted this could lead to tension in the client, and work against the client feeling free to express him or herself. She believed that it was important for the therapist to facilitate a judgment free environment in relation to the client's artistic representations. This would then enable the client to unabashedly use art as a form of expression. The art could then represent the client's thoughts and feelings in a visual form, and depict aspects of their inner world that they may be unable or afraid to verbalize to the therapist (Naumburg, 1950, p. 2). This idea of the aesthetic nature of the art work of clients not being important to treatment

could also be attributed to Naumburg's Freudian background. According to Arnheim, it was Freud's contention that, in art, aesthetics were "...a mere sugar-coating, intended to make the receiver accept the fulfillment of instinctual needs" (Arnheim, 1980, p. 249). Naumburg did believe that verbal expressions were important in art therapy sessions, but it was the art that provided a cathartic experience that helped release unconscious conflicts, in turn helping the client move towards autonomy.

Junge & Asawa write that, for Naumburg, the amount of session time dedicated to the art making process could vary, based on the client's investment in the art making process, as well as how a client chose to integrate it into the sessions. Although Naumburg viewed the practice of client art making as being important, she "...focused on the therapy part rather than the art aspect" (Junge & Asawa, 1994, p. 25). Because of this, "critics of Naumburg's theory have suggested that for her, art becomes merely an additional tool for verbal psychotherapy..." (p. 26). As Naumburg began to establish the practice of "art psychotherapy", others moved towards the method of "art as therapy". It is along this train of thought that we now move to discuss Florence Cane and Edith Kramer. Cane and Kramer are credited as being the main figures in our profession's history to view the creative process itself as being therapeutic. They helped to originate what we now call the 'art as therapy' approach to client treatment.

Florence Cane was Margaret Naumburg's sister, and, according to Junge & Asawa (1994), she was also greatly influenced by psychoanalytic thinking in her art as therapy approach. Cane also underwent psychoanalysis, but solely from a Jungian

approach. Cane was an art teacher who saw an importance in the depiction of emotions. This belief contradicted those of her contemporaries, who tended to focus on realism in art making. She developed techniques for working with children that employed art making in sessions for the purpose of "...loosening defenses, evoking a type of free association, and tapping into fantasies and the unconscious" (Junge & Asawa, 1994, p. 15). This specific application of art with the intention to help clients resonated with others who were also using art in clinical practice. Cane believed that her role was not of an analyst, but "...as the creative teacher, perceiving the meaning of the pupil's work, but leaving the analysis to the psychiatrist" (Cane, 1983, p. 10). Although she is generally not given credit as being one of the founders of the profession, Cane's concepts were used as a starting point in the evolution of another aspect of our current professional practices, the art as therapy approach.

Picking up where Cane left off was Edith Kramer. Like Naumburg and Cane, Kramer was heavily influenced by the psychoanalytic beliefs that were popular in her time. Kramer's therapeutic beliefs were also based on the work of Freud. Unlike Naumburg, however, Kramer is said to have developed her approach and art as therapy model by emphasizing and adapting the ideas surrounding Freud's personality theories (Vick, 2003, p. 9), as opposed to his psychodynamic principles. Rubin (1998) writes that Kramer viewed the client's engagement in the creative process as the most important aspect of an art therapy sessions. She believed that the creative process and art was the "royal road" that facilitated sublimation, thus helping the clients' egos to heal, as well as enabling them to come to terms with inner conflicts and turmoil (Rubin, 1998, p. 99).

Kramer, an artist and art teacher, focused her theories on the use of art as a form of treatment, as well as on the act of art making as being the healing factor in session. In her view, it was the goal and job of art therapists to provide "... the pleasures and satisfactions which creative work can give...", and to use their clinical skills and training to help the client find insight and personal meaning in the work they had created (Kramer, 1958, pp. 5-6). It was Kramer's contention that art therapy was not only a valuable tool in psychotherapy, but also a form of treatment in itself. However, she did not believe that art therapy should replace psychotherapy, but instead act in conjunction with it (Kramer, 1971, p. xiii). Kramer, as opposed to Naumburg, believed that the aesthetic nature of the client's artistic projections was very important. The more involved, in-depth, and visually pleasing the client's art was, the more effective the treatment would be as a method of providing sublimation (Junge & Asawa, 1994, p. 36). Kramer wrote that in sessions, the

> therapist assists the process by substituting his skill and insight where the student's own resources fail. Since the artistic quality of the production is an indication of the depth of strength of sublimation, the art therapist will encourage a high artistic level of performance within the limitations of the student's talents. (Kramer, 1958, p. 23)

Kramer, like Naumburg, believed that in order to be a good art therapist, one must have a rich background and understanding not only of art, but also a solid grasp of psychotherapy, psychological concepts, and principles of education.

Although this paper is not meant to provide a history of art therapy, but more to explore the use of art and views that pertain to art in the profession, it is necessary to mention that many people were developing creative art theories and engaging clients in art making during this era in addition to Naumburg and Kramer. These included professionals whose backgrounds ranged in influences from psychology and/or art. Regardless of their individual specialties, many were realizing the potential art had in a therapeutic setting.

Art therapy as we know it today was also influenced by British artists like Adrian Hill, Rita Simon, and Edward Adamson. These artists all saw therapeutic benefits in art making, and were involved in facilitating the practice within both in-patient and out-patient settings (Junge & Asawa, 1994, pp. 50-52). Adamson's work with art focused on research and diagnosis. Hill and Simon focused on the expression of feelings in a communicative sense (pp. 50-52). Another important, artistically-based author and theorist working during the same era as Naumburg, Kramer, and these other professionals was Elinor Ulman. In terms of the development of art therapy as a distinct profession, Ulman's contributions were profound.

Ulman, whose background was originally in art and architecture, developed a psychoanalytical approach to clinical theory (Junge & Asawa, 1994, p. 171). She is credited as having taught art therapy, helping to create training programs, working to develop art assessments, and, in 1961, creating "...the Bulletin of Art Therapy, the only art therapy journal at the time" (p. 171). Ulman's views appear to have been similar to

Kramer's, with a focus on sublimation through the creative process. Together with Kramer, Ulman theorized that art therapists can help clients in ways that other therapists and psychoanalysts, who focused more on "talking cures", could not. These two professionals believed that what is offered and achieved by a client through the act of making art is something that can only be provided by engaging in art and creative processes, and no other form of therapy. When it comes to effectively facilitating this type of healing, Kramer and Ulman both stated that art therapists are the experts (Kramer & Ulman, 1976, p. 2).

Ulman recognized that, while the theoretical basis for the work of Naumburg, Kramer, and herself were all rooted in Freudian theories and principles, it had begun to spiral into a multitude of directions. Regardless, all have influenced the professional development of art therapy (Ulman, 2001, p. 289). An important contribution to our profession made by Ulman, was her attempt to not view the work of Naumburg and Kramer as being separate entities existing in the world but rather as being two sides of the same coin. Ulman noted that some interpreted Naumburg's viewpoint as art being a tool for advancing and enhancing psychoanalysis, and that her focus was not on the creative process or the benefits of art therapy as a treatment. However, she also argued that this interpretation was not entirely accurate. According to Ulman, Naumburg, who often did discuss and advocate for the psychoanalytical benefits of art in sessions, also viewed art therapy not only a means of enhancing psychoanalytical work, but also as a form of treatment in itself (p. 291). For example, Naumburg stated that "...creative expression is, in itself, a source of growth and sustenance..." (Naumburg, 1973, p. 89).

Ulman (2001) has suggested that Naumburg and Kramer may have developed different approaches to the use of art in treatment due to their different backgrounds, as well as their individual views of their primary roles. Kramer viewed herself primarily an artist, while Naumburg's identity is primarily rooted in education, psychology, and art therapy. Regardless of this, both believed that art offered an alternative to, and advantages over, a more verbal based form of treatment. Ulman agreed with both approaches, and she factored this into her attempts at defining our profession. She did her best to present art therapy as including both the art psychotherapy and art as therapy approaches to treatment (Ulman, 2001, p. 292). Junge & Asawa (1994) write that Ulman would alternate between these two approaches of art therapy. Even though Ulman had entered into art therapy based on her influences and experiences as an artist, it was her contention that incorporating and understanding the work, principles, and beliefs of Naumburg and Kramer regarding art psychotherapy and art as therapy were important for art therapists. The ability to use both approaches when needed allows for "flexibility in actual clinical work" (Junge & Asawa, 1994, p. 175).

One of the most interesting aspects regarding this early era of development of art therapy as a profession is the fact that so many people of differing cultures and professional backgrounds were using art in a variety of ways to work with clients. Based on the literature, it seems as though art 'in' therapy was preferred over art 'as' therapy. This preference may have been due to the profession being young, with practices and beliefs that were still evolving. According to Vick (2003), early on in this era, there were

no real standardized training programs for art therapy as an individual profession. This meant that the early authors and practitioners "...were trained in other fields and mentored by psychiatrists, analysts, and other mental health professionals" (p. 8). This may have contributed to the type of work and clinical focus of art therapists of this time. Does this make art's use as a resource for verbal therapy and as a tool for diagnosis the correct way to practice art therapy? Would this change with advances in training? The next chapter will allow us to see in what ways the field advanced, if these practices persisted or if other trends developed.

ART AND THE EVOLUTION OF ART THERAPY

From the seeds planted by our early pioneers, especially Naumburg, Kramer, and Ulman, art therapy grew as a profession. The next few decades saw an increase in practitioners of art therapy. Some art therapists focused specifically on the creative process in sessions, while others focused on a more verbal approach to the art work of clients. As more art therapists began to practice, so did new ideas in relation to the definition and application of art therapy. Unlike the early years that focused mainly on the approaches of Naumburg and Kramer "...with adherents choosing one or the other, in the 1980s, art therapists began to see the benefit in being able to use either approach depending on the patient's need" (Junge & Asawa, 1994, p. 175). It appears as though most of this next generation of art therapists came into the profession with a solid foundation in both fine arts and psychology. Like students of today, they relied heavily on the writings of the first generation of art therapists to gain a better understanding of how to use art in working with clients. While it would be easy to break down the beliefs of each of the next generation of therapists one by one, literature related to this subject suggests this would become redundant. While each art therapist was unique in his or her own way, their methods, principles and ideas were basically the same and fell into two very familiar categories: art as therapy and art psychotherapy. It seems important to note that this next generation of art therapists was vital to the growth and success of the profession. Perhaps, to date, the professionals from this era provided the largest increase of credibility to the field of art therapy. For these reasons, I find it necessary to state that I do not mean to discount their accomplishments, as they are in part the reason why I am

here. However, based on MacGregor (1989), Junge & Asawa (1994), Rubin (1998) and Vick (2003), who all write about the history of art therapy, it seems as though most of the work in moving the profession ahead during this era focused on the psychological, as opposed to the artistic, aspect of art in treatment. The importance of the art component, while still the focus of some theorists and art therapists of this era, was almost taken for granted, or understood as a 'given' in treatment. Rubin provides one possible explanation for this: art therapy was "a technique in search of a theory" (Rubin, 1978, p.18).

According to Junge and Asawa (1994), it was at this time that art therapists like Myra Levick and Helen Landgarten began to develop training programs in art therapy. Their work included educating other professional clinicians on the skills possessed by art therapists that would qualify them as capable and competent primary therapists, including their unique specialization in the use of non-verbal techniques. They also wrote about the importance of having a solid understanding of art materials to facilitate the client's art-making process, and strongly emphasized the importance of having a thorough clinical understanding to effectively help clients. Levick also took the undisputable stance that whatever is best for the client is the best way to practice art therapy. This view was shared by Arnheim, who wrote that "the practical approach does not take off from art but starts with the needs of the patients, with human beings in trouble" (Arnheim, 1980, p. 247).

Other professionals of this era, like Betensky, Rhyne and Wadeson, began to bring forward ideas and concepts based on psychological models other than those of Freud and Jung. They began to theorize on how these other models could be put into practice in art therapy sessions (Junge & Asawa, 1994, pp. 210-234). These theorists never devalued the importance of art in regards to client treatment. As with earlier art therapists, they commented on the art therapist's need to have a solid understanding of the use of all art materials and techniques. Also, they wrote about the ability of art to provide emotional distance and move past client defenses. Art therapists like Arthur Robbins and Judith Rubin introduced discussions focusing on the functions of art as being cathartic and acting as a safe container for the client (Junge & Asawa, 1994, pp. 194-210). Interestingly, during this time, there was not much focus on the actual techniques. While Birthchnell discussed the importance of art in art therapy sessions, he disagreed with the views of the importance of aesthetics.

> Psychotherapists use art in a pragmatic and crude sort of way...Art therapy has little to do with artistic creation...Both art and drama in psychotherapy are consciously contrived strategies for getting through patients' defenses and letting them be more unashamedly themselves...it enables one to bring into the room, in pictorial form, people or situations from outside or from the past. Though these people and places can be described in words, having just a crude outline on a sheet of paper enables the patient to focus his emotions on them...An important use of art therapy is the possibility of presenting in pictorial form something the patient may not normally feel able to do. (Birtchnell, 1981, pp. 16-17)

It seems as though much of what is currently believed and practiced in regards to the function of art in treatment, as well as what makes an effective art therapist, was put forward by the theorists of this era. However, it also appears that, while advances were made regarding clinical applications of art therapy, views surrounding the role of art were regurgitated from the previous generation of art therapists. Based on this research and the work of Junge & Asawa (1994), it appears that authors and art therapists of this era focused more on the clinical component of treatment, as well as on how to use art therapy with differing populations. Literature on art and art therapy from this time focused less on the importance of making art, and more on the question of whether or not it was, in fact, art. For example, Lanham (1989) writes "Is it art or art therapy?", and Birtchnell (1981) questions "Is art therapeutic?" Wadeson (1980) focuses on creativity as being important and puts forward the notion of a therapist's background (hers being in art) as influencing one's professional path. What effect did this apparent lack of focus on the importance of clients making art in art therapy sessions have? Could it shift the profession towards a more verbal approach to treatment?

MODERN DAY PROFESSIONALS AND ART

As art therapy continued to grow, and more professionals wrote about it, it seems there was a shift in the focus of the literature. Authors (McNiff, 1988, 1989; Allen, 1992, 1995; Wix, 1996) began to focus on the role of art in therapy, as opposed to the clinical and theoretical understanding of art therapy itself. While articles and books being written on the clinical components of the profession continued to appear, there seemed to be more questions being asked in relation to art and to a professional identity. It appears as though some art therapists became increasingly concerned with the use of art, commenting on a potential shift towards more verbal trends in the practice of art therapy (Allen, 1992; Wix, 1996; Thompson, 1997; Acosta, 2001). They began to propose more arts-based approaches to treatment (Allen, 1995; Moon, 1998, 1999), and began to write about a need to keep our practices based in art (McNiff, 1988, 1992), to ensure the continued growth of the profession. Others questioned and attempted to define the professional identity of an art therapist. Unfortunately, the list of authors who engaged in these pursuits during this era is small. This section will discuss these authors and their views in more detail, beginning with Pat Allen.

Pat Allen is an artist, author, and art therapist. She writes about the importance of therapist and client art making, and appears to keep the focus of her clinical work rooted in art. Allen (1992) believes that art therapy as a profession exists because we are specialists in art. Therefore, art should be one of our main clinical tools. One of the advantages to the use of art in art therapy is its potential to help to build a therapeutic

alliance with the client (Allen, 1995). By using the client's art, rather than the therapist, as the central focus of the therapeutic relationship, the process can become less about a transference relationship with the therapist, and more about the client's relationship to the art. This is believed to help empower the client (Allen, 1995, p. 163). Allen is a co-creator of an art therapy approach referred to as an "open studio" based approach to client treatment This approach was created in response to her feeling stifled while working as a therapist with other, psychologically based clinicians in more medically based mental health facilities (Allen, 2001, p. 181). In this open studio approach to clinical work, the therapist engages in art making as well as the client. It is believed that the therapist's own artistic work can have a motivating effect on the client. Allen does warn that this type of approach is not perfect, and caution needs to be taken as "...such practice can exist side by side with destructive behaviors as well." (Allen, 1995, p. 163)

Within art therapy literature, Allen's appears to be one of few voices of concern in the use of art in art therapy. She believes that somewhere along our professional path, art therapists tend to lose sight of what they do. Instead, they seem to become more focused on being recognized as the clinical equals of other mental health professionals. In Allen's opinion, one art therapist who did not follow this trend, but kept his focus on art, was Shaun McNiff (Allen, 2001, p. 181).

Shaun McNiff is an author, educator, and art therapist. He has written countless books and articles, designed to educate art therapists and other mental health professionals about art therapy, thus contributing to the evolution of our profession.

Unlike many authors who preceded him, McNiff places a great level of importance on the role of art in art therapy as a profession. He is a practitioner of an arts based approach to therapy that stresses the importance of not only the use of fine arts, but also other creative arts therapies, such as drama and music. McNiff sees all creative art therapies as methods of facilitating healing, referring to this practice of a combined approach as "expressive arts therapy". McNiff feels that the origins of this approach are rooted in a more "cross-cultural and anthropological perspective", and places an emphasis on the artist as healer (Junge & Asawa, 1994, p. 237). This differs from many other approaches in that it is not primarily based in psychology. McNiff (1981), looking at the bigger picture of our profession and of human history, writes that art as a form of human healing and understanding existed long before today's more clinically and psychologically based approaches to therapy. He seems to imply that it is not so much that the practice of art therapy grew out of psychology or psychiatry, but that they grew out of man's early uses of art as a tool for expression, understanding, and healing (McNiff, 1981, pp. ix-x).

In his writings about art in art therapy, McNiff states that it is not a finished work of art that is important, but the expression itself. The expression is a way of knowing and representing the inner thoughts, feelings and experiences of the client (McNiff, 1981, p. xxii). Like previous art therapists, McNiff believes that art in sessions serves a multitude of purposes, including catharsis and improved feelings of confidence and self worth. The art can also be seen as a tool for client associations and the expression of thoughts, feelings, or ideas too difficult for a client to verbalize (McNiff, 1981, p. 155). He believes that while dialoguing can be a valuable part of treatment, caution must be used,

as it can also be a form of avoidance (McNiff, 1986, p. 136). Along this vein, McNiff also writes about an apparent trend of professionals viewing "pictures as resources for verbal therapy" (McNiff, 1988, p. 21). He reiterates his view that, even though language and discussion have a place in art therapy sessions, talking can be used too much, and can have negative consequences. To McNiff, the practice of art therapy is about art and images, and "language and interpretation serve the image" (McNiff, 1988, p. 122-123).

In regards to art, McNiff and Allen (1992) hold a similar view that art therapy as a profession exists because of its roots in art. As art therapists, we can rationalize the profession having a place in the therapeutic community due to our education and understanding of art and artistic techniques. Art therapists can offer something different than other clinicians (McNiff, 1988, p. 31), and because of this rationalization, we have an obligation to art. McNiff (1988, 1992) also stresses the importance and need to keep the focus of our endeavors as therapists rooted in art. He says that art therapists must continue to develop and discover new arts based theories and techniques, as a great amount of what we deal with as art therapists are art related issues.

Holding similar beliefs to Allen's and McNiff's regarding an artistic focus and art's importance in our profession is Bruce Moon. Moon is an artist, therapist, author, and educator whose work seems to stay based in art first and foremost. As with Allen and McNiff, Moon believes that art is the basis of our profession, and a focus on art is a necessity for the work we do as art therapists. Moon (2003) writes about the heart of our profession being based in art and claims that, in order for us to become better art

therapists, we need to be more focused on art in our sessions. As opposed to some authors previously mentioned, Moon believes that there is a connection between art and science and, together, they work toward facilitating human expression and growth (Moon, 1997, p. vii). Moon does not choose a side in the art psychotherapy versus art as therapy debate. Instead, he attempts to unify the sides, believing that it is not an issue of one versus the other. Instead, it is by embracing both that one becomes an effective art therapist (Moon, 1999, p. 78).

Moon (1998, 1999) stresses the importance of art therapists to not only encourage clients to make art in sessions, but to make art work in their professional lives. He writes that "it is the process of making art, particularly in the clinical employment context, that one's identity as a therapeutic artist is forged" (Moon, 2003, p. 11). This emphasis on art seems to touch on multiple aspects of professional importance. Moon (1995) writes about the importance of therapists gaining knowledge through art and using these experiences to help them become better therapists, as art can provide a deeper understanding of what the client experiences. He also writes that, in order for art therapists to be effective and trusted by adolescent clients, they must first be artists. This will help show their clients the authentic nature of the therapy in which they are engaging. Additionally, art can serve as the basis for the therapeutic working relationship (Moon, 1999, p. 78). Along these lines, Moon (1998, 1999) puts forward the "artist-as-therapist" model of client treatment. In this model, the therapist and client take part in making art, and the alliance is rooted in this process. Responsive art making by the therapist is an important aspect of this "artist-as-therapist" treatment model. The therapist

creates a visual response to the client's images, designed to serve as a therapeutic intervention within the sessions. Moon believes that this is an effective clinical tool, especially with an adolescent population.

Moon, McNiff, and Allen are readily referenced by other art therapists currently working in the profession (Wix, 1996; Vick, 2003); however, what these authors have written regarding the importance of art does not always paint a perfect picture of the present condition of our profession. Despite a consistent evolution of the use of art within the art therapy profession, there still remain problems that many write about today.

PROBLEM IN OUR PROFESSION?

As more literature focusing on art in art therapy began to surface, authors who commented on its importance, like Allen, McNiff, and others, also began to identify potential problem areas in the profession. One such problem is what Allen (1992) calls art therapist "clinification syndrome".

Allen (1992) uses the term "clinification syndrome" in her writing to represent "a dual development process" that she believes happens with art therapists when there is a shift in their clinical focus. They move away from artistic healing, and towards a more traditional (i.e. verbal/clinical) form of working with their clients. During this process, the use of art making as a clinical tool seemingly becomes neglected, and the art therapist begins to act and approach clinical work more like a verbal therapist would. According to Allen, art therapist "clinification" occurs when creativity and the actual art making component of an art therapist's sessions are seemingly pushed to the side. This may include inadequate time allotted for art making, the lack of proper and/or adequate art materials to facilitate exploration and creative growth, and the absence of encouragement, or even introduction, of artistic practices in the sessions. In this 'clinified' approach to working, art making and creative exploration loose their place. Instead, they are replaced with a more verbal approach to treatment, aimed at interpreting the client's 'artwork'. Insight into an issue or image is the focus of the session, with the client's representations being viewed as "...a means to an end of insight into a problem the client is having" (Allen, 1992, p. 22).

Allen writes that a clinified therapist's approach is more directive and suggestive. The therapist's train of thought relates more to the client's clinical diagnosis, as opposed to what Yalom (1995) refers to as the "here-and-now" of the session. More time is spent in discussion with the client. Image-related meanings are given and encouraged by the therapist, and this comprises the majority of interventions made in the sessions. Allen believes that having an understanding of clinical skills and the various complexities that are involved with treating a client is vital for all art therapists. However, in her opinion, art therapists who focus more on the clinical aspect of the work are doing damage to the profession. This more clinically based approach "...has led to a stunting of the development of art therapy as a discipline in its own right" (Allen, 1992, p. 23).

It is Allen's contention that "clinification" is a growing problem area in art therapy. She believes that there are four main professional areas that can be affected by art therapist "clinification syndrome": "1. burn out, 2. career drift, 3. lack of art therapy research, and 4. lack of theoretical depth" (Allen, 1992, p. 25). All four of these areas inadvertently contribute to the profession either remaining stagnant or being viewed as some form of activity, as opposed to a form of therapy. Although Allen acknowledges the therapeutic benefit of discussing an image created by a client, she notes that this clinified approach is doing a disservice to the profession, thus putting art therapists at a disadvantage. An art therapy session based mainly on the discussion of a client's art products is not something that can only be done by professionals trained as art therapists. A verbal approach to images requires the therapist to know the client, more so than requiring knowledge of art or artistic techniques. This knowledge of the client can be

gained through ways that have little to do with art therapists' unique and specialized skills (Allen, 1992, p. 23).

Allen terms this observation of a trend in our profession to move away from art as "clinification". Other authors have also discussed similar insights and observations regarding this problem area, holding similar beliefs as to the ramifications it may have on our professional identity. Wix (1996) states that she has frequently witnessed art therapists, opting to use what she refers to as the "talking cure", and leaving art out of the therapy sessions (Wix, 1996, pp. 174). Thompson (1997) also states her belief that the profession is being pushed into more verbal areas. McNiff (1998) discusses "pictures as resources for verbal therapy" (McNiff, 1988, p. 21). Acosta (2001) speaks about a phenomenon in which art therapists begin talking more like psychiatrists or social workers, possibly in reaction to the influence of their clinical work environments and coworkers. In this instance, art therapists will often shift their clinical focus to that of diagnosis, and away from artistic healing. In regards to the over use of verbal communication in art therapy sessions, Kramer and Ulman (1992) write that:

> No more than others can the art therapist successfully serve two masters. Certainly he must deal with words and with all the complexities of human interaction, but if his interest in the process of psychoanalysis or other primarily verbal therapies comes to outweigh his passion for therapy-through-art he will do well to change his profession. (Kramer & Ulman, 1992, p. 43)

According to Allen (1992), the healing power of art is what enables our profession to exist. Our profession does not just use art as a means to engage clients in verbal therapy. Louis Van Marissing in McNiff (1988) is quoted as saying that the medium art therapists utilize within a clinical setting is what makes art therapy a distinct profession, as opposed to being "... just like all of the other therapies" (McNiff, 1988, p. 210). Wix (1996) believes that art is at the centre of our profession and that using art in sessions, as opposed to adapting our practices to fit into a more medical model of treatment, will help us to serve our clients the best we can. She writes that losing our professional identity is not a new concern, and that early professionals like Edith Kramer believed it was possible. Wix says Kramer suggests that, in order to not to lose our identities, art therapists should work only part-time as therapists, thus allowing time for personal art making to keep a connection to art (Wix, 1996, pp. 174-175). Considering these concerns from the practitioners and theorists mentioned in this section, is there a chance that we are losing our profession? If so, where does this problem originate?

In her article on "clinification", Allen (1992) implies that this problem potentially originates in current art therapy training programs, and is unknowingly promoted by the American Art Therapy Association. She notes that while the criterion for admission into a graduate studies program in art therapy does require some artistic experience, she does not believe that there is enough of an artistic requirement. She writes that perhaps a higher standard of artistic integrity needs to be displayed in the portfolios of students accepted into graduate training programs. Allen also writes about the difference between making art for art's sake, and taking a more psychologically based mindset when working

artistically. She believes that the psychological aspect of art is not in the realm of facilitation by most art school instructors, especially if the classroom/studio focus is on technique and critique. According to Allen, the typical undergraduate art program is nothing like what is done in art therapy. This being the case, therapeutic skills need to be developed in a different setting (Allen, 1992, p. 23). Allen also writes that art therapy training programs are demanding and time consuming, and that it appears as though there is little emphasis placed on personal art making by the interns. This structure does nothing to ensure that students carry creativity and art practices are carried with them professional world (Allen, 1992, p. 24). These views are shared by Wix (1996), who frequently quotes Allen (1992), and agrees that there is a need to encourage art making in both the personal and professional lives of art therapists. Along this line, Wix also questions whether we are destroying our profession by not placing more of a focus on art making in training programs, or providing adequate opportunities for students to create art as part of the curriculum (Wix, 1996, p.180). Is this the only area in which training programs need improvement? Does a more artistic focus make better therapists? Or is there also a problem with a lack of provision in regards to clinical skill?

McNiff (1988) quotes a conversation he had with a recent art therapy graduate. In this conversation, this young professional questions her own readiness, ability, and understanding of what it is to be an art therapist. She says that based on her reading, training, and experiences, she understands what it is that she is supposed to do as an art therapist. However, understanding how to facilitate an actual session with the most appropriate intervention seems overwhelming to her. These questions led her to doubt

her clinical skills, and additional reading only added to her confusion. This fear, as well as seeing how well other mental health professionals navigate through similar situations, added more doubt to her belief in her own ability as an effective therapist. She began to believe that there was something that she was missing in regards to specific skills within our profession (McNiff, 1988, pp.21- 25).

Allen (1992) and Wix (1996) view current training programs as having a major influence on what they view as a lack of art in the profession. However, they are not the only ones who have offered opinions about the possible cause of our professional problems. Another problem within art therapy appears to be a potential lack of professional identity.

McNiff writes that art therapy is a hybrid profession. He uses the analogy of art and psychotherapy having a child to describe our origins. In his opinion, if the child grows up and chooses to live as the product of his parents, then it is not being true to himself. Rather than developing a unique identity, the child becomes something he is not, something disingenuous (McNiff, 1989. p.97). Other authors like Vick (2003) and Rubin (1998) also use this parent and child analogy in discussion of our professional identity. Although this idea may sound eloquent, the effectiveness of art and psychotherapy's marital union is called into question by authors like Allen (1995) and Arnheim (1980). Arnheim believes that our profession can help show that the arts are an effective clinical tool, and that art therapy deserves more than just being viewed as a "stepchild of the arts" (Arnheim, 1980, pp.150-151).

According to Wadeson (1980), it is inside the profession of art therapy that a "polarity...with one extreme placing emphasis on the art and the other on the therapy" exists (Wadeson, 1980, p. 13). Wadeson (2001) puts forward the question of whether we are artists or art therapists. Arrington (2001) responds that she is both artist and therapist. However, she also seems to present questions as to whether both can exist professionally. Lachman-Chapin (1993) writes on the difficulties of finding the balance between being an artist and art therapist, and discusses potential limitations of being an artist if one is also an art therapist. Considering these varying opinions, what is seen as being our professional identity as art therapists? Do we currently have one?

In his book, *Depth psychology of art*, McNiff (1989) repeatedly attempts to discuss the identity of the art therapist, believing it to be very confusing. McNiff claims that one of the problems facing our professional identity is the idea of "primacy". As art therapists, we are neither primarily a therapist, nor primarily an artist. In his view, the "primary artist" is a traditional view of an artist, in which artists create art. McNiff sees the "primary therapist" as being the more psychologically based therapists who have always been seen as therapists and who are viewed as having been "...primary from the start" (p. 97).

McNiff's notion of our identity being a confusing one, being neither artist nor therapist, is also referenced by other professionals. Arnheim (1980) and Lanham (1989) both comment on how art therapists are automatically placed in an awkward position, as

being viewed as neither artist nor therapist creates an unstable place for us within the professional world. Lanham states we are not always viewed as being competent by other mental health professionals in regards to the form of treatment that we offer. This causes therapists to question whether or not we belong in clinically based therapeutic settings (Lanham, 1989, p. 21). Arnheim believes that, unlike other therapists, art therapist must prove themselves to their professional peers and colleagues. They must not only show how effective they are as therapists, but also display a solid and credible theoretical basis for the work being done with clients (Arnheim, 1980, p. 247). The same type of reaction and experiences seem to be held on the artistic side of our identity, as well. Lachman-Chapin feels that we, as art therapists, are perceived by those in the art community as being inferior, due to the way in which we employ the use of art. She writes that, in her experiences, "...we (both faculty and graduate students) as art therapists are seen as lesser-or not quite real-artists" (Lachman-Chapin, 1993, p.145), by those in the field of fine arts.

These views seem to put art therapists in a tenuous position professionally, and according to McNiff, lead to other professional questions and dilemmas. McNiff (1989) wonders what will happen to us as therapists, as well as how it will impact us professionally, if we view ourselves as our client's "primary therapists". Would this, in effect, be negating the artistic side of the work we do, as we would be proclaiming ourselves to the world as therapists? Are we doing a disservice to our profession by accepting this role and saying that the art portion of our profession is secondary in regards to our clinical work? McNiff (1989) feels that "our identity comes from the

infusion of art into therapy, rather than bringing therapy to art" (p. 99-100). He also writes of a need to explore such questions in our profession.

From these types of concerns and questions came different ideas and theories regarding art therapists' uses of art in clinical settings and training. Authors such as Allen (1992, 1995) and Malchiodi (1998) write about "artist-in-residence" programs as a means of allowing more time and opportunities to make art. They believe that this approach could help to instill the importance of personal art making in professional art therapists. Allen (1995) puts forward what she classifies as the "open studio" approach as a way for art therapists to incorporate and use art in their ongoing professional development. Authors such as Block, Harris & Laing (2005), who have implemented the "open studio" approach in practice, seem to believe that this can be an effective form of treatment, depending on the goals of the session. Moon takes an "artist as therapist approach" in order to maximize the use and effectiveness of art in clinical work. These authors seem to have similar views to those expressed by Kramer (in McMahan, 1989) and Ulman (1987). Both discuss finding a balance in their clinical practice that involves using language and art as the best way of dealing with the needs of the client that could emerge throughout treatment. It is essential to the profession that more art therapists begin taking this stance, as well as implementing and developing new art based programs and methods of treatment.

According to Kramer, while art is important, being an artist is not the same as being an art therapist. An art therapist requires a solid, clinical base to be effective, as the

work sometimes involves verbalizations (Kramer in McMahan, 1989, p.112). In regards to the need for art therapists to choose one approach or the other (art "as" or art "in" therapy), Ulman argues that both approaches are valid and can be used at the same time, by the same therapist (Ulman, 1987, p. 286). In this present state of our profession, are the concerns expressed by Allen (1992), and questions pertaining to a lack of art in sessions new, or have they always existed?

Based on history and the early literature about the use of art in a therapeutic sense, the image or artistic creations of the client were often used as a starting point to engage clients in verbal therapy. This was mainly done by clinicians and therapists who were psychoanalysts with an interest in the clinical application of art (McNiff, 1988, p. 21). Vick states that in a study conducted in 2000 by the American Art Therapy Association, the results suggested most of the methods and practices of today's art therapists are rooted in psychoanalysis. He believes this has always been the case. Looking at the writings of previous and present therapists, Freudian principles and terminology exist in most of them (Vick, 2003, pp. 10-11).

Based on this, are any of these concerns about a lack of art in art therapy real, or are art therapists just using art as they have from the birth of our profession? Should we, as art therapists, be looking to focus more on art?

Birtchnell (1981) offers his opinion that artists do not, in fact, make good art therapists. It is his contention that having a background focused in art leaves art

therapists lacking. This is because these individuals often complete an art therapy training program's minimum admissions requirements in psychology. Therefore, they have limited exposure to, and experience in, psychological principles. In Birtchnell's opinion, this has led many art therapists with this type of background to overstate the importance art has in clinical treatment. All too often, these professionals focus on a belief system that one can only be a good art therapist if the treatment is centered on art. Birtchnell believes that this is doing a disservice to our profession. In his opinion, the perceptions of art therapists who believe that a formal education in fine arts is a requirement for being a good therapist is something that we need to step back from and reexamine (Birtchnell, 1981, p. 17).

With differing opinions and such a long list of professional influences on our background and professional practices, what does it all mean, and where does this leave today's art therapists?

SUBJECTIVE ANALYSIS

Like art therapist in the early days of the profession, today's art therapists look to the words and experiences of our predecessors, likening it to a professional map. They are hoping to find their clinical bearings, course of direction, and the most advantageous route. In some respect, early psychological masters, like Freud and Jung, having recognized the therapeutic usefulness of art, have been viewed as a boost of credibility to our profession. However, has this connection to the past created more harm than good? As I researched this subject, it became evident, that in its origins, the function of art used in sessions by early psychoanalysts greatly resembles the function of art used in sessions by our modern day, potentially clinified therapists. This being said, is a more verbal approach to art therapy in fact a new condition? Perhaps it has always existed and has evolved with our profession as an effective way to treat clients. If this is the case, is it truly a problem? Could a verbal approach to art in treatment constitute a professional balance, with some therapists focusing on clinical and others on art? Perhaps one reason why more literature seems to exist on the clinical aspects of our profession is that more clinically-minded art therapists are motivated to write these articles, while arts-based therapists are more inclined to make art.

It seems natural and understandable that, in the early days of the profession, there would have been a greater focus placed on establishing a clinical foundation for what we do today. A clinical approach was utilized more readily than an arts based one, as there was a lack of training programs, as well as a greater influence of psychology and

psychoanalysis. Also, much of the actual work was being done in clinical settings (Vick, 2003).

The art therapists of the next generation began advancing and developing new ways to practice and incorporating varying psychological perspectives. This was an important part of our professional development. However, by keeping a clinical focus in their work, did these authors paint a professional picture of art therapy as being less about the art in the sessions, and more about the clinical nature of our professional practice? Did their absence of focus on art lead others to view art as being less important to the work we do?

In regards to debates on the subject of what is the best way to practice art therapy, and the potential overuse of the verbal intervention and an under utilization of art, some of the founders of our profession, like Kramer (in McMahan 1989) and Ulman (1987), write that they have discovered a balance can exist between using art and verbal treatment in sessions. While art therapists tend to show so much respect for the contributions of Kramer and Ulman to our profession, why do we seemingly overlook this aspect of their clinical beliefs and practices? I believe that keeping art at the centre of our profession is the key to our survival and identity. However, I also believe that the pendulum can swing too far the other way. If a therapist's passion for making art begins to outweigh their passion for providing therapy, it would benefit this individual, as well as our profession as a whole, to consider new career opportunities. One aspect of our job as art therapists is to help our clients manipulate various mediums and art materials, but

art instruction is not the only service we provide. Even though authors like Kramer and Ulman seem to write and believe that a healthy balance can exist in our profession, it appears as though, instead of working towards this balance, art therapists are more concerned with questioning our identity and where if anywhere, we fit in (McNiff, 1989; Lanham, 1989; Arnheim 1980; Lachman-Chapin, 1993).

In terms of our lack of professional identity, as well as the view which mental health professionals may hold about art therapists, is this in fact an issue that has been created by other mental health professionals, or is this a position that art therapists have created for ourselves? By not having confidence in our own skills, training, and the services we provide, are art therapists, ourselves, doing more harm to our profession than good? By spending our time questioning where we might fit in, are we actually increasing ambiguity within our profession?

Questioning, and potentially denying, our origins in psychotherapy and fine arts in turn denies our very existence, thus adding to problems of professional identity. Rubin (1998) discusses art therapy as a child whose parents all have "legitimate claims". Along the same vein, McNiff (1989) writes that our "...composite profession does not have a claim, or birthright, to either the primary tradition of art or therapy..." (McNiff, 1989. p. 97). The parent child reference is a fantastical analogy and an eloquent way of describing our professional roots. In many ways, this analogy is true. However, can we accept what is being implied here as fact? Not questioning where we come from, but rather, what it means to our professional identity. What are art therapists and curious other mental

health professionals who read this to believe? Other professions potentially have "legitimate claims" to the field of art therapy. However, having no direct relation to art or psychology, do we, as art therapists, have no claim, no birthright? Are we artificial in our attempts to be who we are if we embrace where we come from? How are we supposed to develop the skills we need to secure our professional identity when we cast doubt on ourselves? How are we and our clients supposed to have faith in what we offer, when in some respects we do not even know who or what we are? Worse still, we seem willing to accept a role based on what others tell us we are allowed to be. The fact that we are the product of two distinct parents puts their essence in our professional soul. This does not mean we have to be them, but it means that we cannot fight the fact we are them, the combination of them. What they are is in our professional blood, and our bloodline is what gives us our claim to the therapeutic throne.

There are many questions regarding what it is that identifies us as art therapists, and I believe, as McNiff (1989) does, that there does need to be a primacy in our professional identity. I feel as though we should strive to be recognized as "primary therapists", because that is what we are. Our goal is to provide a therapeutic service to our clients. We strive to achieve this goal by implementing the use of various art techniques in our sessions, because we believe art to be therapeutic. The fact remains that the reason we are in the sessions is to help facilitate our clients healing through a therapeutic medium.

When it comes to "clinification" and a lack of art in art therapy, Ulman and Wadeson both comment on a therapist's background as influencing their professional practices. Therefore, I believe this justifies a standardized acceptance requirement for all graduate art therapy programs. Perhaps if program candidates were required to have undergraduate degrees in fine arts and psychology, we could then ensure that more of a balance existed in each student, and that all graduates would have a similar set of skills and training. Also related to our training programs and background, Allen (1992) discusses the idea of how the art school environment may not be the most suitable for future therapists. However, art in general may also contribute to the condition of a lack of art and "clinification". This may be due to personal failure with art. As artists, art therapists have experienced failures in their own art process, not just in critiques or art school, but in regards to the art made for themselves. As therapists, they want to protect their clients and may not encourage art making for fear the client will not be able to complete the task and feel badly, not only about themselves, but also about the therapeutic process.

Another factor that may also be contributing to therapist "clinification" and a lack of art making in sessions could be the fear and uncertainty of being a new art therapist. In regards to both the artistic and clinical skills we provide, this fear and doubt in new graduates could also be the experience of new professionals trained in other therapeutic models. Even though these thoughts and concerns were written by McNiff (1988) nineteen years ago, current art therapy students, like myself, still feel this uncertainty in how to be a good art therapist and truly help those with whom we work as clinicians.

Based on my experiences, it seems as though new art therapists feel as though other mental health professionals are more experienced, effective, and successful in their relationships with their clients. I believe the majority of art therapists enter into this profession to help people, not just to make art. Therefore, if we felt that there was a more effective way to achieve treatment goals, we should put art to the side in order to be better therapists. This would seem understandable, if one were keeping the need and success of the client at the forefront of the motivation for the work that is done. However, I disagree with the argument that putting art to the side would make us better therapist. This would be a disservice to the clients who come to us to receive our unique method of treatment. It would also obstruct art therapists from obtaining a sense of identity among the therapeutic community and in our profession.

CONCLUSION

From the earliest days of our profession, there have been countless discussions about what is the best way to be an art therapist. Our origins are rooted and continue to be based somewhere in between psychology and fine arts, and we must establish where the balance is. Our combination of these modalities is where our strength as professionals lies. We should look to our past and use that to create our future. It is the idea of a harmonious existence, as opposed to a separation, that should be taught to students. We should establish that we have a specific skill set, proper training, and a background that is proven to be an effective combination for clinical work. Our profession is still a relatively young one, and I believe that in order for it to grow, we must develop new ways of using art and clinical skills in tandem to establish ourselves to the rest of our professional peers. We must take our place in the therapeutic world.

As for "clinification", Allen may be correct in her assessment and diagnosis of a problem area in our profession. Art is a key component to what we do, however the other side of our training as art therapists is based in psychology. A balance needs to exist between the two. Focusing mainly on one aspect of our training would be a potential disservice to our profession. Based on my research, my experiences, and my opinion, there seems to be a lack of art in our profession. We as professionals must look at this issue and remedy it before it is too late and we have no longer have a profession to doubt.

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