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**Reviewing Certain Issues in Brief Therapy
in the Context of a Family Art Therapy Experience**

Vilma Reisler

A Thesis

In

The Department

of

Art Education and Art Therapy

**Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Art Therapy at
Concordia University
Montréal, Québec, Canada**

August 1987

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ISBN 0-315-44858-X

ABSTRACT

Reviewing Certain Issues in Brief Therapy in the Context of a Family Art Therapy Experience

Vilma Reisler

A limited theoretical review is presented of the development of brief psychotherapy, family therapy and art therapy in the therapeutic treatment of a family system. An attempt has been made to structure an assessment model developed over six separate sessions, with the contention that during this assessment process, limited goals are able to be achieved.

Observation of the family interaction during the assigned tasks suggested that all the members reacted spontaneously. It is hoped that this paper might clarify the possibility of integrating a model of brief therapy with a time-limited, six session art therapy assessment of a family unit. i.e. a therapeutic experience with the achievement of limited goals, as has already been demonstrated and recorded in the literature of art therapy.

ACKNOWLEDGEMENTS

I would like to take this opportunity to acknowledge and give thanks to my two supervisors, Julia Byers, M.A. and Pierre Gregoire, Ph.D., during my training years. I would like to express my gratitude to Julia Byers, with whom I entered into a close working alliance during my final intern year and who advised and counselled me on the procedures and practice of a therapeutic family intervention. She was always there to share her valuable experience of working with families, which was of tremendous assistance to me.

I would also like to express a basic indebtedness to my thesis advisor, Dr. Gregoire, who also supervised my clinical placement in my first year of graduate training in art therapy. I wish to thank him for his teaching, his rich intelligent reflections that were always forthcoming and his guidance, nurturance and support in the writing of this thesis.

Last, but most certainly not least, I wish to thank my husband and three children who respected my wish to continue my education and the encouragement and the support that was given to make my wish become a reality.

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INTRODUCTION

The literature is surveyed to document a limited overview of forms of brief therapy and family art therapy attempting to describe its current status.

This study aims to place this information in the realm of art therapy. A single family was engaged in a limited six session assessment model which incorporates the setting of limited goals to be achieved during the therapeutic process using the modality of art therapy. The intent of the study is to determine whether such a model of family art therapy can be integrated with a framework of unifying elements as outlined by Butcher and Koss for Brief Therapy (Budman, 1981).

CHAPTER 1

BRIEF THERAPY IN THE CONTEXT OF AN HISTORICAL PERSPECTIVE

a) Introduction:

Today in Canada and in the United States, there is an increased concern about the cost effectiveness of mental health treatment, which suggests that brief therapies will be in greater demand in the future. This concern has been morally supported by the fact that recent research has suggested that "less can sometimes be more" (Pardes, H., & Pincus, H.A., 1981).

The Group Health Association of America has proposed that fewer sessions of carefully planned, focused and well executed short term intervention may contribute more to positive change than does prolonged psychotherapy treatment. In the past, it had been assumed that the longer the family remained in treatment, the more complete would be the engagement process. It is now thought that if an engagement process takes place between the therapist and the family, it would develop early in the contact and be established by such variables as trust, influence and knowledge rather than determined by the time duration of the intervention. The planned brief therapy is organized to be maximally beneficial in a given period and to stimulate learning that can be applied to other troubled areas.

b) Historical Background - Review of Literature

Brief psychotherapeutic treatment is not a new concept. In fact, there are records of its existence in the primitive archives of earliest history. In ancient documents accredited to Egyptians and Greeks, are transcribed the elaborate rituals performed to heal the afflicted, to solace troubled souls and to assuage anguish and distress (Wolberg, L., 1980). It has been determined from these records that they treated such individuals with tranquilizing nostrums, bodily manipulation, trance incantations, persuasive suggestions as well as the rudiments of reinforcement therapy, emotional catharsis and the interpretations of fantasies and dreams (Wolberg, L., 1980). According to the literature, the original Freudian techniques were developed with short term methods of treatment and were used up until the twentieth century (Breuer and Freud, 1895/1955; Freud, 1905/1953; 1909/1953) (Gustafson, J.P., 1981).

In the beginning, the psychoanalytical model was structured with a time limit of a few months with the treatment aim to resolve neurotic symptoms. However, the variable of time was gradually extended as the goal of therapy was directed toward the task of resolving resistance to unconscious conflict (Wolberg, L., 1980).

This approach of structural change resulted in a sense of timelessness of procedures, allied with the establishment of far reaching goals which were not always explicitly stated (Horowitz, M.J., 1981). These changes were not accepted by all, and some of Freud's contemporaries - Adler, Ferenczi (1926), Stekel and Rank (1925) - unsuccessfully attempted to shorten this new protracted time of psychoanalysis. Nevertheless, the official analytical establishment repudiated their systematic methods of brief therapy as not being consistently reliable (Weilberg, L., 1980).

Therapeutic treatment in the 1940's, signified long term psychoanalysis and custodial hospital admissions for the severely disabled; electric and insulin shock and psychosurgical techniques were the treatment of choice for the organic treatment of the severely ill patients. Otherwise, the treatment for mental illness was limited; (Pardes, H., & Pincus, H.A., 1981) society was not focusing too much attention on mental health. At the same time, during World War II, short term therapy was again looked at as a means of affectively treating soldiers suffering from combat fatigue. A time-limited treatment model was needed to return soldiers to active duty as soon as possible. As a result of this development, new and effective therapeutic techniques

were explored.

In 1946, Franz Alexander challenged the validity of prolonged time as being a necessary component of the treatment method (Wolberg, L., 1980). A little later, while working with French, (Alexander and French; 1946), he published a pioneer report of the investigative exploration of methodological approaches.

Maintaining the dynamic principles, they were able to identify specific variables that would influence the therapeutic aims of the psychoanalytical model. They sought to secure a more harmonious environmental adjustment to enhance the development of self-esteem. In their report, they made the following suggestions:

a) Frequent interviews, as practiced in long term therapy, could establish regressive consequences that gratified a patient's dependency needs and at the same time, created a problem of termination.

b) It was a fallacy that analysis oriented around regressive material would be more thorough than that which focused upon the immediate life conflict. Since regressive material could be a sign of neurotic withdrawal from a difficult situation, an attempt was made to divert this "avoidance" approach toward an attempt at problem solving.

c) With frequent sessions of the analytical model,

there could be the tendency for the transference to become diffuse and consequently lessen emotional participation. Instead, they suggested that the frequency of sessions should be manipulated to intensify emotions.

d) Focusing on the present could avoid a transference neurosis with the substitution of the transference gratification derived from real life experiences (Wolberg, L., 1981).

This pioneer work (Alexander and French) provided the foundation for other developing systems of dynamic short term therapy and perhaps broadened the perspective of analytical concepts.

As an aftermath of the war, mental health care became the focus of concerned attention in the United States. This concern was precipitated by the statistics obtained from the selective service system which revealed that some five million men had been turned down by the selective service because of neuropsychiatric disabilities. Then, due to wartime shortages, the psychiatric care in the State Hospitals began deteriorating. The Press was responsible for making the public aware of the extent of mental illness in the country and the inadequate provision for psychiatric care at that time. The aroused public interest served

as the impetus to form the National Institute of Mental Health (N.I.M.H.) in 1949 (Pardes, H., & Pincus, H. A., 1981).

Obviously, the need for briefer treatment was influenced by many factors. Some of these were associated with the developments made in the field of mental health and others related to society as a whole, such as: the acceptance of limited therapeutic goals, the increasing development of new and varied treatments as well as the rapprochement of others, advances in classification of emotional disorders, the growing realization that lengthy treatments do not always meet the need of particular populations, an increasing concern with the cost and increasing access to treatment and the growth of prepaid health plans with limited psychiatric benefits (Pardes, H. & Pincus, H.A., 1981). Finally, the increasing number of patients requiring treatment from staffs depleted through shrinking budgets (Pardes, H., & Pincus, H.A., 1981).

The necessity to limit the time devoted to treatment, without destroying the effectiveness and quality of treatment, brought about the renewed interest in Alexander and French's original observations (1946), and other contributors who focused on time limited models (Wolberg, L., 1980).

Among the best known of other contemporary contributors to dynamic short term therapy are the writings of Balint, Malan, Sifneos and Mann (Wolberg, L., 1980). As chief of research of the focal workshop at the Tavistock Clinic (London), Balint and his successor Malan studied the complexities of brief psychotherapy to establish systematic methods that would be consistently reliable. Their valuable research has been cited as the source that structured the complete science of brief therapy.

In 1957, Balint published his book entitled "The Doctor, his Patient and the Illness" which was based on studies conducted in the G.P.'s workshop. This book became the model for the focal therapy workshops outlining a new concept of doctor/patient relationship whereby the illness becomes the "interpersonal construct". The patient offered the complaint and the doctor made the counter offer; it was from this exchange that the illness became organized. The aim was not to stop the patient's behaviour, but to bring it to conscious awareness (Gustafson, J.P., 1981). His model offered a choice of four different kinds of relationships which are still prominent in modern psychiatry and psychotherapy (Havens, L.L., 1973): 1) the psychoanalytic, 2) the existential, 3) the

interpersonal and the objective descriptive psychiatry, and 4) the behavioural conceptualization of using reinforcement. (Gustafson, J.P., 1981).

Initially, the concern was whether a brief psychotherapy model could produce clinical results that would favourably compare with long term psychoanalysis.

"The strategic aim" of Malan's general schema for brief therapy remained the same as psychoanalysis: the working through process of using transference and interpretation to bring into consciousness the unresolved childhood conflicts that still govern the adult life. Assimilating this repressed material with the adult life aimed to stimulate more appropriate solutions. The only difference pertained to the limitation of analysis of a single conflict as its objective as opposed to a series of different conflicts in full scale analysis. The tactical aims required two steps: 1) analysis of the defense and anxiety to allow analysis of the repressed impulse in one sector of the patient's life, and 2) The use of transference for interpretation, to mobilize the adult ego to assimilate the repressed for appropriate solutions. The early emergence of transference and the emotions of grief and anger being experienced upon termination of therapy were emphasized (J.P. Gustafson, 1981).

In 1955-56, Malan conducted a pilot study to determine whether brief therapy could produce clinical results that would be comparable to long term psychoanalysis. Although the results of this research were not considered successful, two major obstacles to brief therapy were effectively challenged. He had been able to demonstrate that stable psychodynamic change could be brought about in brief therapy and that subjective events of psychoanalysis could be handled objectively (Gustafson, J.P., 1981).

Malan's later research data (1976) confirmed his earlier conclusions regarding the utility of dynamic short term therapy. The criteria for selection of the appropriate patients is based on their ability to display the strength to stand up to "uncovering psychotherapy", to have the motivation for insight and ability to focus on significant material. In early studies, those patients deemed inappropriate were alcoholics, homosexuals, drug addicts or high suicidal risk patients and those suffering from incapacitating chronic obsessional or phobic symptoms. The reason for this rejection pertains to their difficulty in making contact with others, which is essential for the establishment of a good working alliance. The deep-seated issues require more time and depressive or psychotic

disturbances might be precipitated or intensified (Wolberg, L., 1980).

Short term anxiety provoking psychotherapy, known as STAPP was first introduced in the Psychiatric Clinic of the Massachusetts General Hospital some twenty years ago. The STAPP model used the technique of confrontation with later clarification and interpretation for the successful treatment of neurotic difficulties e.g. phobic symptoms. This therapeutic approach was found to be very effective with the resistant patient. Peter Sifneos used this type of intervention and developed a criteria for the selection of suitable patients (Sifneos, P., 1981). In the 1970's, he began videotaping the initial interview, the therapeutic sessions and the final session of treatment. This taped record enabled him to observe and assess the behaviour and response of his patients. This technique made it possible to scrutinize and study the therapeutic process with greater validity. In addition, this recorded information was able to demonstrate the effectiveness of short term dynamic psychotherapy (Sifneos, P., 1981).

Both the Malan and Sifneos model emphasized the importance of patient selection based on clear-cut criteria. This provided the optimal opportunity for a good working alliance between the patient and the

therapist to allow active and technical intervention. A good working environment is required if joint decisions are to be made regarding problematic issues that evolve during the therapeutic treatment and the establishment of rules pertaining to termination. Therapy is terminated when the patient displays insightful awareness of the conflictual problem and that tangible evidence of insight is observed in the patient's overt behaviour. (Sifneos, P., 1981)

The variable of "limits" in therapy either explicitly or implicitly implies time. While there is no unanimity as to what should be considered "brief", most definitions include treatment extending from ten to twenty-five sessions over a period of three to four months; others consider forty to fifty sessions in terms of being "brief therapy" (Fisher, S., 1981). However, Bernard Bloom asked the question "if you have only one session with a patient, how can you make it maximally beneficial?" (Bloom, B., 1981). He directed his attention to a single therapy session, nevertheless stating that the therapeutic relationship between the patient and therapist can be lifelong but intermittent. (Bloom, B., 1981) From a dozen published investigations on short term -vs- long term therapy, his results indicated that the short term outcome was equal or

superior to long term care (Bloom, B., 1981).

c) The Scope and Limitations of Brief Therapy:

The attested value of time-limited brief therapy has shown it to decrease waiting lists and increase the number of clients that can receive treatment. This reported evidence suggests that time limits may have beneficial effects on both the process of therapy and the service delivery system. (Fisher, S., 1981).

With the re-entry of the concept of "time" into therapy, there was a greater need to emphasize formulation of "the goal" of therapy, what is to be accomplished (Fisher, S., 1981). In order to assess the goal of treatment, other issues must be addressed, such as: what are the problem issues? what strengths does the patient have? what are the available resources? etc. What can be done? what are the positive and negative consequences? and how can changes be made?

Brief therapy examines the diverse strategies within the context of time. This creates the need to structure a balance between the the goals to be achieved and the treatment process that will enable the goals to be obtained. The variable of time is used as a therapeutic tool in some instances.

According to James Mann (1981), the critical principle of "time-limited" therapy refers to the

conscious and unconscious meaning of time and how this variable influences his particular method to arrive at the central issue. Once the therapist perceives the central issue, in other words has attained the knowledge and understanding of the underlying meaning of the patient's problem, defenses may be bypassed, anxiety controlled, and a good working alliance established. The course of treatment then becomes very focussed and guided by the limits of predetermined time. One to three evaluation interviews are required to determine the patient's problems (Mann, J., 1981). This is basically the same structure as the Malan and Sifneos' model, however placing more emphasis on the variable of time. Time "integrates" thoughts and feelings with what was, what is, and what will be. Thoughts and feelings are not restricted to a particular moment; time includes the past, the present, and the future. Time is "experienced" as an affect and experienced as a background presence. Time "structures" the appointment hour, the day, etc. in which the patient knows in advance how much time there will be to achieve the agreed upon goals. Time can be an issue when there are financial difficulties. Time can be an important issue when the therapist takes a vacation, causing some patients to suffer degrees of anxiety and depression,

while the vulnerable patients become psychotic, or suicidal. Time becomes a consideration when there is some positive feedback that the patient is beginning to move even though there is resistance to the treatment process. The patient committed to long term treatment experiences time in relation to their unconscious fantasies and their expectations of early, long wished for needs.

All brief forms of therapy propose a time limitation which is negotiated in advance of treatment. Mann found that with the specificity of a time duration, the patient exhibited less anxiety enabling the working alliance to be established more rapidly and decreasing anxiety upon termination.

d) The Relevance of Time-Limited Brief Therapy:

The burgeoning cost of medical care is only one of the many factors which prompted the renewed interest in brief therapy. Other factors related to the acceptance of limited therapeutic goals were: advances in classification of emotional disorders, the knowledge that lengthy treatments do not meet the needs of particular populations, and a related issue to the increased medical costs was the increase in the number of people requiring medical treatment.

With mounting evidence, the mental health providers

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concluded that not every person who seeks help requires long term psychological treatment. Many people suffer from specific symptoms related to a particular area of personality functioning. Therefore, restricted goals would be the appropriate plan of operation.

One of the principal findings of the President's Commission on Mental Health revealed that there were many groups in our society who go unserved, underserved and inappropriately served (Pardes, H., & Pincus, H.A., 1981). For instance, minority groups are not seen in mental health settings at rates considered appropriate to their needs. The growing population of geriatrics have a high risk of a variety of mental disorders, as well as a high incidence of suicide. This population, as well as children and youths, are seen in fewer numbers than their needs would warrant. People with chronic mental disorders requiring aftercare following their discharge from inpatient psychiatric settings are yet another group identified as being underserved (Pardes, H., & Pincus, H.A., 1981). Brief treatment has been proposed as an appropriate treatment for many of the disorders which are presented by such populations.

The patient's behaviour in terms of their utilization of service has also been reviewed. The findings indicate that many people seen in an out-

patient setting, terminate treatment after a short period of time. A variety of reasons might be proposed as causing this phenomena, such as those people who do have some limited resources in their environment may require only limited intervention to support them. Terminating prematurely or missing appointments is often related to anxiety pertaining to the sustained, financial burden of treatment. Investigative feedback has stimulated the need for effective treatment which would be available at an affordable cost within a limited time period. Within such a framework, it is believed that many more people would take advantage of the service and stay to its conclusion if such a therapeutic model was available (Parces, H., & Pincus, H.A., 1981).

e) Crisis Intervention

Crisis intervention is one of the most recognized models of brief therapy and is currently more available for treatment of specific populations. This type of therapy attempts to utilize the crisis to implement the change. Crisis is defined by Wolberg as a reaction to a situation that upsets the adaptive balance. The goal of the treatment is for rapid, emotional relief rather than focusing on personality modification or promoting ego oriented problem solving (Wolberg, K., 1980). The

expectation for this type of intervention is "insight"; the awareness of the underlying problems that contribute to the crisis situation. Evidence gained from research studies suggest that crisis states last for periods up to six weeks. The number of sessions and the projected achievable goals are negotiated in advance of treatment by the patient and the therapist. Therapy focuses on the strengths that exist in the individual's environment and the mobilization of these strengths to resolve the crisis as rapidly as possible and restore habitual balance in the existing life situation (Wolberg, L., 1980). No attempt is made to diagnose or formulate the psychodynamics. While the goals are limited, it is possible for the patient to undergo extensive change in behaviour patterns. The working through the crisis process may create changes in the personality structure.

Crisis groups have been found to be effective in spite of their brevity. The specific curative factors relate to the cohesiveness of the group and the knowledge that others have similar difficulties and need to seek help as they are seeking help. Fellow members may replace the loss for the abandoned patient. The age range of the members may represent family members to whom the patient might have turned to in former years. The exposure to terminating members can reinforce the

knowledge that problems can be solved (Donovan, J.; Bennett, M.J.; McElroy, C.M., 1981). The crisis group is not primarily insight oriented; the goals are problem solving and helping the patient to return to an independent life style.

The crisis intervention model has been successful with those patients who are experiencing acute onset of symptoms in connection with a precipitating event or stress, such as a loss of a loved one, a job, or the declining years, etc. However, the patient should not be psychotic, homicidal or suicidal. In most instances major characterological changes do not take place since the intervention is so brief (Donevan, James B.; Bennett, Michael J.,; McElroy, Christine M., 1981).

It has been hypothesized that timely, realistic intervention can rapidly and effectively ameliorate the symptoms of crisis. Wolberg's model for crisis intervention focuses on the following variables:

VARIABLE OF TIME: (how soon the patient is seen). The catastrophic symptoms must be handled immediately. Like the Sifneos' model, (Sifneos, P., 1981) crisis intervention uses techniques of confrontation and active interpretation.

VARIABLE OF THE EXTERNAL ENVIRONMENT: (Occupational, scholastic, etc.). The precipitating agent is often

initiated and sustained by the patient's environmental misfortune. They are encouraged to develop new adaptive, coping mechanisms that will sustain them when they are confronted by provocative events in their lifestyle.

VARIABLE OF THE DEGREE OF FAMILY SUPPORT: The research studies have suggested that a crisis reaction is often associated with the collapse of the family system, which causes an imbalance to the family system. Crisis theory assumes that "the family" is the basic unit of treatment rather than the individual. The family system is the focus of treatment with the aim to harness and expand the constructive elements for support and strength for each family member. Therapy is terminated when there is homeostasis of the family system (Wolberg, L., 1980).

VARIABLE OF UNRESOLVED CHILDHOOD NEEDS (Defenses and conflicts): The goals of crisis intervention are limited and prevent any extensive concern with operations of unconscious conflict. Yet, a great deal of data may be obtained from the patient and observing the family interactions. Such information is useful in crisis therapy planning or in a continuing therapeutic program for further work and exploration. (Wolberg, L., 1980).

A brief review of the approaches and early models

of brief psychotherapy has been presented with the aim of addressing the important issue as to whether the quality of clinical intervention could be maintained when the number of therapeutic sessions was reduced. Brief therapy models today offer a variety of approaches for psychodynamic and behavioural systems for the individual, couple, family and group interventions.

With the success experienced in shortening individual psychoanalytic therapy, it was not surprising that this application of treatment would be utilized for the treatment of families.

CHAPTER II

COMPONENTS OF FAMILY THERAPY

a) The Family

Much of the psychiatric research on mental illness has investigated to what degree dysfunction in the family relationships and family interaction can be cited as a determinant of mental illness. Assessment of a family within its environment implies the study of the "whole" unit: the totality of the relationships, the culture, and their adaptability to their environment which is influenced by the economy and technology of their society.

Family therapy has a relatively short history. The earliest publications by Rudolf Dreikurs (1951), Ackerman and Sobel (1950), would suggest the early fifties (Brown, S.L., 1970). The obscurity of family therapy treatment may have arisen from the difficulty of defining and distinguishing this method as a treatment model, and not a new way of conceptualizing the cause and cure of mental illness. The model of family therapy assumes that if an individual is going to change, the context in which he lives must change. This is the reason that the therapeutic process involves the individual within the enmeshment of the family relationships.

The young child learns about himself and how to live within his family. He learns the mores and cultural values of the society in which the family lives, and how the family accomplishes the tangible and specific tasks related to their self sustenance.

The evolutionary structure of the family begins with a marital coalition which forms the first steps toward parenthood with the birth of an infant. The infant is nurtured and then weaned to enable the child to exist apart from the mother (separation). There is the learning of language and the development of intrafamilial behaviour modes which are influenced by whether or not the oedipal phase is resolved. The child is introduced into society through the school and peer relationships, which provide the repertoire of required skills (formal learning, communication mastery and competence in abstract and symbolic thinking and expression) and behaviours. After puberty and resolution of oedipal issues that firm up the character structures and establishes his or her sexual identity, they will begin to form meaningful peer relationships (Fleck, S., 1979).

The family system is involved in all of these stages. An unresolved issue occurring during a developmental phase may burden and handicap the child and interfere in the normal process of emancipation from

the family (Fleck, S., 1979). The experienced emotions and expectations are continually influenced by one's past experiences and the family interaction. And while it is impossible to observe the individual's mental processes, it is possible to assess the family's interaction during the family therapy session.

A model of general systems defines the family typology by ordering and structuring the family's behaviour data; this can then be correlated with clinical entities and reinforced by family records. Scrutinizing the family as an open system has the advantage of sequential judgements which allow categorizations to be made. The general systems theory permits cross sectional and longitudinal examinations.

b) Systems of Family Therapy

Most schools of family therapy today accept the idea that families are systems, just as psychoanalytically trained clinicians who treated families have abandoned depth psychology of the individual for those of systems theory. In recent years, the main stream of psychoanalytic thinking has become dominated by object relations theory and self psychology. Some of the other systems of family therapy are: extended family systems theory; communications family therapy; and its offshoots of strategic family therapy and structural family

therapy (Nichols, M., 1984)

One of the most useful concepts in family therapy is that of boundaries, a concept that applies to the relationship of systems within systems. The individuality and autonomy of each system (individual, siblings, parents, nuclear family) are maintained by a semipermeable boundary between it and the supra-system (Nichols, M., 1984). Emotions and feelings bind people together in relationships that establish invisible boundary lines. Boundaries maintain order and provide each member with the appropriate space and time to develop a sense of "I" as well as "WE" within the family unit (Fleck, S., 1979). Boundary management must be appropriate to society's mores and the subcultural norms. There is the crucial boundary related to the generational dominance of the parents who are the teachers and role models for the children; they allow the children to cross their first boundary by entering school. Boundaries can be overcontrolled and rigid, instead of being permeable and transgressible. Boundaries can be mismanaged intrafamilially by imposing emotional distance and extra familially, by pushing the members beyond the family sphere before adequate individuation and separation mastery have been achieved. Good feelings and mutual fondness for one another is

interpreted as being an outgrowth of the initial physical closeness of the parent to the child. Maintenance of this positive affect can only be achieved through the harmonious functioning of the family group. (Fleck, S., 1979)

Because the family is a system, coping involves the simultaneous management of various dimensions of family life, such as the maintenance of organization, promoting member independence and self-esteem; to maintain coherence and unity in family bonding; developing and maintaining social supports and the control of stress and change within the family. Coping is thus seen as a process of achieving a balance in the family system that facilitates organization and unity while promoting individual growth and development.

c) Classification of Families (Wertheim's typology, 1973)

The family system's dimension is divided into three types (Wertheim, E.S., 1973).

1. The open family systems are articulated families with a network of subsystems connected by permeable boundaries.
2. Closed family systems are rigid settings where rules are dogma and boundaries are not open.
3. Externally open systems operate freely within the environment; nevertheless, communication is

minimal within the system. It is opposite to the internally open system.

The closed system describes the type of family relationships whereby boundaries could be characterized as a closed container (Bradt, J.O. & Moynihan, C.J., 1971). Activities, events and experiences are constricted and as a result certain role relationships are developed. The containment of the family by an emotional boundary can restrict the potential for growth and individuation of its members. In such a model, all social supplies come from each other.

Clinical literature supports the view, that psychological disturbances that develop in a single family member, often fulfills the dynamic function within the family system. Thus the intrapsychic needs of the other family members may be satisfied.

d) Family Therapy

Families' attitudes change relative to the resolution of the presenting problem. This criteria can be used to govern the length of therapy. Even though other issues beyond the symptom problem might surface, it has been noted that most families stop when the symptom has subsided or disappeared. Research (Trotzer, J.P., 1982) has shown that where success relative to resolution of the problem occurred, the family would disengage itself

in spite of the therapist's efforts to focus on issues dealing with other problems. Therefore, the therapist must make the commitment to the limitation of the agreed upon goal. Brief therapy (Andolfi, M., 1983), when used as the therapeutic approach for a family system, should be directed toward the elimination of a single symptom. 1984).

CHAPTER III

REVIEW OF ART THERAPY TECHNIQUES

Brief Historical Background - The Application of Art Therapy in the USA

The late Margaret Naumberg is considered to be one of the foremost pioneers in the field of Art Therapy in the United States. According to the literature, she was responsible for convincing the field of psychiatry of the value of using imagery as a reflection of the unconscious (1940). Her dynamically oriented art therapy theory remained consistent with the psychoanalytical approach to transference content and the transitional stages of development. Her clients were asked to draw spontaneously and to free associate within the framework of their pictures. Defense mechanisms that had become a mode for coping with anxiety arousing situations or the resolution of conflicts became clearly evident in a patient's art expression. The client's imagery, or their symbolic speech became a record of general progress which afforded the opportunity for patients to gain insight into their behaviour.

Margaret Naumberg was followed by Edith Kramer who worked extensively with children (1950's). She emphasized the integrative and healing qualities of the

creative process. (Wadeson, H., 1980). From its early psychoanalytic beginnings, the profession has branched out and diverged and today encompasses many frameworks and approaches. In the 1960's, art therapy became a recognized profession (Wadeson, H., 1980).

Family art therapy began when Hanna Kwiatkowska joined the intramural staff of the National Institute of Mental Health as head of the Art Therapy unit in the adult psychiatric department. In this capacity she had the opportunity of working with Lyman Wynne, (chief of the Adult Psychiatry Branch National Institute of Mental Health), who was primarily interested in family relationships and the role that the family plays in the etiology of mental illnesses such as schizophrenia. Presumably, it was here that she gained the experience and the interest which stimulated and motivated her to develop a model of family art therapy assessment (Wadeson, H., 1980). At the George Washington University, she synthesized the practice of art therapy with theories and techniques of family therapy. Her hypothesis was that by combining the two disciplines, the underlying dynamics of the family structure could become visible and recorded. The modality of art therapy would provide the family members with a safe space to participate, learn and play together while

6
providing a graphic record of their progress. Hanna Kwiasowska has said that family art therapy originated as a natural developmental program of the well established technique of analytically oriented art therapy.

In 1969, family art therapy was officially brought into the channels of psychiatric literature. The Kwiatkowska model of art therapy was recognized as a therapeutic method and its description was included in the new and different trends in family therapy.

In her book, she states that her family art therapy model evolved as an accidental discovery. The psychiatric department in which she worked, required that all in-patients be involved in conjoint family therapy. Therefore, family members were more frequently on the ward and consequently more familiar with the art therapist and her department. Their interest was often aroused by the work that she did with the patient. However, as the viewing of patient's artwork was discouraged, she urged the family to participate in their own art sessions. It soon became evident that a lot of pictorial and behavioural material could be gained from this source especially from those families who had difficulty in verbally communicating. From her observations, she began to formulate and define

techniques to be used in programmes for family studies, adolescence and the family twin and sibling studies, school projects, short term family therapy, and a special project on schizophrenia. Her research programmes included both short and long term therapy, ranging from three months to several years. (1962, 1967, 1971).

She developed three basic family art therapy models for working with the family unit: (1967)

- 1) Family art therapy as an adjunct to conjoint verbal family therapy.
- 2) Family art therapy as the primary mode of treatment (both types of family art therapy could be short or long term).
- 3) Family art evaluation.

In her book, she states that it had been her experience that using the art therapy techniques in a family therapy model accelerated the therapeutic process which is highly desirable when working in a time-limited framework. To support this statement, she gives the following reasons:

- a) The informality of the art session creates a non-threatening environment for the patient.
- b) Within the safe environment, the family members appear to be less resistant to the therapeutic

process.

- c) The family's recorded response in the art space was found to be more spontaneous than that which was verbally communicated.
- d) The exciting discovery of a family member's artistic skill which can provide the positive, rebounding effect of a shared experience as opposed to individual gratification.

Reactions ranging from ego building, support behaviour to destructive mockery, subtleties of family interplay that create the balance of power, may be observed in the creative space. The goal of each session is to record the family system interaction within the task. Each individual maintains their autonomy over his or her selection of imagery.

One could say that art therapy has particular advantages. Despite vagueness of a family's ability to interpret their artwork, unlike their words, the creative imagery remains in evidence. The imagery becomes the reality which can confront their denial. Kwiatkowska viewed the art products as stepping stones toward communication. The reflected imagery has the potential to draw back the curtain of distortion and denial of meaning (Kwiatkowska, H., 1967).

The permanence and tangibility of the art products

ensure that the therapist may direct and maintain the family's attention toward a subject until it has been sufficiently explored, and a degree of continuity achieved.

The Art Content

In some instances, the imprint of imagery may contradict verbalizations. Any distortion of an individual's perception is revealed, enabling the facts to be clarified. In other words, while people have the ability to verbally defend feelings and thoughts, they lack the skill to conceal information in pictorial form. Nevertheless, while the creative space permits the client the opportunity to reveal, it at the same time sanctions concealment until the appropriate time. Therefore, unblocking family communication in this non-threatening, shared environment has both the capacity and potential to accelerate the therapeutic process.

The Kwiatkowska evaluative model of family art sessions require six different pictures of the family to provide interpretation based on the viewpoint of symbolism and family dynamics.

Since systematic research in the art therapy field has been rare, her contributions have been considered as a pioneering effort. Today, family art therapy is used as a primary mode of treatment at the National Institute

of Mental Health. It is used for both short (3 months) and long term treatment (6 months) with the projected length of the hospital admission determining the techniques and therapeutic goals to be achieved.

An important advantage of the family art therapy assessment is that reciprocal interaction of the family members can be observed at the behavioural and verbal level and reflected and recorded in the individual and shared creative imagery. Within the therapeutic space, the subtleties of family interplay, their daily habitual transactions may effectively be recorded in the conjoint family mural.

Kwiatkowska believed that only a minimal amount of information should be gathered prior to the therapeutic intervention in order to observe and be objective (Krevelen, J.Arn, 1975). Artwork has been referred to as the stark testimony of an inherent approach to the problems found in reality (Harris, J.Y., 1973). If this perspective is used, one correlates the reality events within the art products. Each sequence begins with the mural portraying a problem in reality and optimistically ends with the mural portraying the resolution of that problem.

SUMMARY OF THE FIRST THREE CHAPTERS

Chapters I and II briefly review the historical

perspective and evolution of forms of brief therapy and family therapy. Chapter III presents a limited perspective of two of the early proponents of art therapy in the United States, including some of their definitions and citing the beneficial aspects of using this methodology for primary and conjoint therapy, and assessment. In addition, there is a brief description of one particular model of art therapy in the treatment and assessment of a family and of the development of this model.

CHAPTER IV

FAMILY PERSPECTIVE

a) Introduction:

This section reviews the structured six session assessment of a family system undergoing the reintegration of one of its members (wife) back, into the family environment after a lengthy hospital admission.

The family dynamics, structure, and communication patterns are explored at the verbal level and observed in the imprinted artwork of the family members created and experienced in the therapeutic sessions using an adaptation of Kwiatkowska's art therapy assessment model.

Butcher and Koss (1978) incorporated a list of nine important elements that unify the various forms of brief therapy and called them the common technical characteristics of crisis oriented and brief psychotherapy systems. Although these unifying elements refer mainly to short term, individual, dynamic approaches to therapy, it was thought that they would apply equally well to brief family treatment and could be used to structure the framework of this time-limited art therapy model.

b) Unifying Elements in Brief Therapy:

1) Utilization of Time: (Brief therapy model is defined

as less than twenty-five sessions).

2) **Limited Goals:** Specific symptoms, problems, sectors of disturbance which have become the focus of the treatment.

3) **Focused Interviewing and Present-centeredness:** the patient is directed to focus on one particular problem at hand as opposed to an open-ended interview.

4) **Activity and Directiveness:** More verbal discussion and more interpretation by the therapist; advice and suggestions.

5) **Rapid early assessment:** Assessment and treatment begin almost simultaneously in brief therapy.

6) **Therapeutic Flexibility:** The theoretical ability of the therapist to focus on an eclectic theoretical affiliation .

7) **Ventilation:** The opportunity to express and ventilate emotional tension is an important element in the treatment.

8) **Therapeutic Relationship:** The therapist and the patient must quickly develop a therapeutic alliance in brief therapy.

9) **Selection of Patients:** Considered the most important single element in brief therapy. The results of research indicate that brief therapy is more suitable to less disturbed patients (Budman, S.H., 1981).

Basic criteria for determining whether the engagement process occurs; the extent of the therapeutic alliance developed with the therapist and the therapy were:

- a) Whether the family continues to come for sessions.
- b) Whether the perspective of the family broadens from viewing the problem narrowly i.e. identified patient or individual problem, to viewing it as a family problem (reframing, broadening or refocusing).
- c) Whether goals emerge which are clearly defined and causally validated by the family and therapist.
- d) Whether family accepts therapist.
- e) Whether family accepts responsibility for initiating change (Trotzer, J.P., 1982).

c) Introduction to Family Assessment Model

The chosen study group was a family in which the wife had just been discharged from the hospital and needed to be followed during the transition which can be a difficult and vulnerable period for the post discharge patient. While in hospital, she had been seen by a staff psychiatrist and upon discharge she would return to her private psychiatrist for follow up treatment. The treating team of staff members referred the patient to the author for brief family therapy with the goal of

opening lines of communication between family members and forwarding an assessment of the family's present functioning to the wife's primary therapist.

The family was engaged in an art therapy assessment program to determine whether therapeutic goals could be generated and whether this family could benefit from long term therapy (a copy of the clinical assessment is included in the appendix).

d) Communication:

As stated by Lidz, Piaget and Schefflin, the linguistic competence of the family members is considered to be crucial to the evolvement of individual integrity and social participation. (Fleck, S., 1979).

When one observes the family communicating, one is focusing on the process rather than the content. One is examining the systems within the functioning family system. The leadership, communication, boundary management and the affective bonds can be witnessed from behaviour in the family therapy sessions (Fleck, S., 1979).

Definition:

Communication describes the exchange of information that takes place within the family unit defining their relationships stabilized by homeostatic processes of the family's input and output of communication (Bateson, G, 1956).

Some aspects of communication that can be assessed are whether communication is a) clear or masked, b) direct or indirect; c) to focus on whether the message is clear or camouflaged and, d) whether the message is directed to the appropriate target or deflected. These are the four different styles of communication that have been observed and identified. (Epstein, N. B. Bishop, D.E.; Baldwin, L.M., 1978).

clear and direct -vs- clear and indirect

Masked and direct -vs- masked and indirect

Clear -vs- camouflaged

Directed -vs- deflected

Most effective: Clear and direct

Least Effective: Masked and indirect (Epstein, N. et al, 1978).

e) Utilization of Time:

The variable of "limited time" created the framework for this art therapy model. During the first meeting, the therapist had to negotiate the variable of time of appointment and the length and number of therapeutic sessions. It should be pointed out that when working with a family, this can become a little more complex than working at the individual level. In this instance, four people were required to make a commitment with the therapist. The appointment time plus the number of

sessions were negotiated with the family members during their first meeting. While the family may agree to operate under the therapist's terms, they retain the responsibility for making their own changes. With such an agreement comes the knowledge that the predetermined number of the therapeutic sessions of allotted time are for the achievement of therapeutic goals.

f) Structure and Goal of Therapy:

The family assessment was structured within six separate sessions, over a period of four weeks. This was done in order to accommodate the normal family life style, as well as any individual resistance encountered.

The first session required a period of one and a half hours to enable the therapist to:

- a) familiarize the family with the art therapy process, the expectations required of them (the family), and the therapist, etc.
- b) create an environment of trust that would allow the family members to feel free to share their private thoughts.
- c) Establish such a relationship within the first session that would hopefully motivate the members to make a firm commitment to attend the following five sessions.

The following pre-established one hour sessions (5)

were strictly maintained by the family, as one member had school commitments following the sessions.

This planned assessment model required six separate sessions and specific goals were negotiated at the commencement. Therefore this therapeutic intervention can be defined as time limited treatment. This is similar to crisis intervention whereby a time of termination is contracted by negotiation at the onset of therapy. No attempt is made to formulate psychodynamics; instead, therapy focusses on the mobilization of strengths in the family environment to resolve the crisis issues.

Upon termination, the progressive art assignments are reviewed with the family for their own interpretation not primarily insight-oriented. They discuss what goals they have achieved such as problem solving during this therapeutic process not unlike the Malan and Sifneos brief psychotherapy models.

g) Limitation of Goals:

In this therapeutic model, the therapist is the newcomer and the family is expected to accommodate this newcomer into their private inner space (Barnard, C.P. & Correles, R.G. 1979). This private inner space refers to each family individual's life space composed of regions representing all states of affairs, persons, goals,

objects, desires etc. For this to happen, the therapist must blend with the family, accepting their organization and style. It is thought that the family begins to move only when the therapist has harmoniously entered their system (Trotzer, J.P., 1982).

The initial goal of therapy was to focus on the family's commitment to come to the therapeutic sessions. Only when a family continues to come is the therapist given the opportunity to set the conditions for working together (Minuchin, S., 1974).

It was the therapist's intention that the wife (former patient) should discard her previous role of "patient", and once again assume her role of wife and mother in the sessions. In order to establish an environment where this transition could be achieved, it was necessary to develop a good therapeutic relationship with all the family members. The wife was discouraged from referring to past, shared experiences in the hospital setting which would have allowed her to align with the therapist while isolating the rest of the family members. While the working through of unresolved childhood needs and issues was not an operational goal of this intervention, such information was included in the family assessment, for future exploration.

h) Goals of Therapy:

- 1) Family agrees to commit themselves to attend six art therapy assessment sessions.
- 2) Family perspective broadens from viewing their problem narrowly i.e. family members should discard the wife's previous role of patient and begin to focus on problematic family issues.
- 3) Increase communication between family members, through increasing the amount of time spent together and learning new ways to negotiate their individual differences (Trotzer; J., 1982).

Because of the limitations imposed in brief therapy, change is implemented by focussing on the family's strengths as opposed to confronting defense mechanisms which serve to protect against individual vulnerability. Like crisis intervention, the variable of unresolved childhood needs or unconscious conflicts would not be worked through in this intervention. Instead, it is a process to arouse the family to be cohesive and develop the balance to facilitate organization and unity to promote individual growth and development.

i) Utilization of Space:

It is the author's understanding that the modality of art therapy enables the private experiential space of the individual to be reflected in concrete form within

the spacial context of the art product. Thus, the individual's spontaneous reactions and responses are captured and recorded.

From the first session, the individual's behaviour and verbal interaction are observed within the immediate spatial context of the family system. How much space is given to the individual? How much space is utilized or desired? Are these needs communicated to other family members? What is being defined? Is the individual's private space where relationships are maintained and negotiated for closeness or distancing? One example is who will sit next to each other, who will wish to be by themselves and who seeks to sit close to the therapist?

Within the therapeutic art session, the individual is invited to learn to use the contained space of the art media in the capacity of a personalized territory for expression. Experiences, conflicts and emotions of his/her inner world may be imprinted and dramatized in the concrete, metaphorical form of creative imagery for his/her own visualization. The visual structuring of fleeting or fragmented thoughts, when contained within the creative boundaries, serves as a buffer allowing the therapist to act as a mediator who facilitates new information that will reduce anxiety. As well, the objectification and the distancing that occurs can

reduce the enormity of the problems within this micro-space, making stressful issues less encompassing.

As has already been stated, the spatial placement of the family members in the session is highly significant. Insightful information can be gathered concerning the family alliances, designations, centrality and detachment. The family's organization, rules or patterns of interaction can be captured in the concrete imagery which can provide guidelines for diagnosis and treatment (Minuchin, S., 1960). The family's active participation in the learning and playing together becomes a graphic record of their progress.

The art therapy process provides the space and the methodology to view the family's habitual patterns of transaction. This valuable recorded information affords the opportunity to assess the appropriateness of their reactions and responses and a learning experience for beneficial change in their daily lives.

CHAPTER V

SYNTHESIS OF SESSIONS ILLUSTRATING THE ART THERAPY ASSESSMENT MODEL

According to the early studies of brief therapy, the criteria for a successful intervention is dependent upon the selection of a highly motivated patient, an enthusiastic therapist and the establishment of a good working alliance. This family was highly motivated and cooperated fully throughout the assessment period and the therapist, a final year Master's student, was surely zealous and optimistic.

The family could be described as being tightly knit, outwardly respectable with excessive parental concern for their children. The parents appeared to be having difficulty in preserving their leadership and maintaining limits. Fixed transitional roles were not questioned. The family was resistant to change and to any expression of individuation of family members.

The family history was obtained from the former patient and her hospital chart. In order to respect the confidentiality of individual family members, pseudonyms will be used in this presentation.

a) Family Description:

MRS. S.: The former patient was a 44 year old, married white Jewish woman, mother of two, who looked younger than her stated age (as per chart). She was

admitted to the hospital with a provisional diagnosis of depression with agitation, loss of weight and sleep, some confusion and psychotic mood. She complained of feelings of helplessness with periods of body weakness. On occasion, she was observed slipping off her chair and crawling on the floor of the dayroom of the ward. When told to stand up, she would tearfully reply that she was unable to stand on her own two feet.

What appeared to be a precipitating factor in causing the first admission, was the extensive separation from her usual role of caretaker in the nuclear family. A threatened marital breakdown of her husband's parents had prompted her to intervene as a resource to support and hold things together. This episode was quickly followed by her own mother experiencing a brief period of depression upon the placement of patient's father in a foster home. She once again extended herself to maintain the parental home, while maintaining her own. Such stress has been labelled as transition points in the family developmental process (Haley, J., 1973). One should also bear in mind that a psychological disturbance that develops in a single family member often fulfills the dynamic function within the family system, satisfying the intrapsychic needs of the other family members.

MR. S.: A white Jewish male in his mid-forties. He was co-operative, his disposition was pleasant, although he was observed as being restless and uptight. He appeared to have a strong need to be in control of the situation at all times. (If the ego cannot manage the external world, the individual may experience anxiety. Therefore he uses resistance to protect the ego). He has worked as an accountant with a company for a number of years. He plays no sports and has not developed any hobbies. From the wife's chart, it was learned that he might have a sexual dysfunction.

JANE:: A white Jewish female of twenty years. She is a student majoring in education and will graduate next year. She is softly spoken, passive and somewhat withdrawn from the other family members; it was later learned that she does align with the father in the home situation. She has a steady boyfriend and although she presently lives at home, she is actively considering moving out within the next couple of years or when she can afford to do so.

JOHN: A white Jewish male of sixteen years. He is a student who lives at home. It was observed in the family sessions that he has a better relationship with the mother than with the father. It was learned that he is having some problems in maintaining his school grades

and he is having difficulty in adhering to the parental limits (in the home. He constantly makes demands, such as wanting to use the family car, wanting to stay out late at night. He is outspoken, confronting, and his manner could be described as being "cocky".

b) Methodology:

The brief therapeutic assessment program (six sessions) was designed for the purpose of evaluating the transitional stage of the patient's return to the family system after an absence of two to three months.

First Session:

The family was given three task-oriented assignments:

- a) A non verbal conjoint family mural. No assigned theme and complete freedom in choice of subject (opening process).
- b) A planned conjoint mural with a title: The "Homecoming" (more structured).
- c) An individual drawing expressing personal feelings emanating from the shared experience of creating the conjoint mural.

Second Session:

The family was required to create a sculpture using construction paper, pipe cleaners and glue. This exercise was designed to assess their ability to be attentive, to follow instructions, to organize and

produce jointly a three dimensional object.

a) Mother and Jane worked together (sculpture of themselves). Father and son working together (created a "games house").

b) A planned conjoint family sculpture with title ("The family ice skating in the park").

Third Session:

The space was provided for each family member to perform a scribble exercise. The focus of this exercise is on integration - to transmit organization and unity, to convey content and meaning.

It should be noted that John did not attend this session. Nevertheless, he voluntarily sent a drawing to the therapist of himself balancing on skis at the top of a mountain which the therapist has labelled "a plea for help". The therapist perceived this message as a strong statement pertaining to his role in the family dynamics and his own needs for direction towards resolution of oedipal issues.

Fourth Session:

A private space or a couple session for Mr. and Mrs. S. was included in the assessment model. It was designed to give dimension to their expressive and social behaviour by focussing on the important events that they have shared in their lives together. It was a

non-verbal task and upon completion, they were instructed to reveal and communicate to each other their symbolic meanings and associations, rather than to the therapist.

Fifth Session:

A space provided to focus on the nuclear and extended family.

- a) Each family member was required to draw the family from their own perspective.
- b) Conjointly, they would create a family tree.
- c) Individually, an ideal family was to be drawn.

Sixth Session:

The family members were requested to separate themselves in such a way as to provide privacy for their final assignment.

- a) Each family member was required to draw each family member as they themselves perceived them.
- b) They would reveal their own problematic issue associated with the family environment.
- c) Each family member was asked to express what they felt they had either gained or not gained from being involved in the six structured sessions.
- d) A family mural to express how they, as a family, could play and enjoy each other today. (This

mural is not included).

Termination:

The accumulated artwork from the six sessions was exhibited in this final session. This enabled the family to be visually aware of the process that had taken place and provided the impetus for the open discussion that followed. To bring about closure, they were invited to once again create either individually or conjointly an art product that would symbolize what they had learned or experienced during these sessions.

c) Commencement of Therapeutic Assessment:

The family initially displayed some hesitancy to commit themselves to become actively involved in the art experience. Because of the family's strong desire to be supportive to the patient during this transition period, they agreed to cooperate. The lack of artistic skill appeared to be one source of concern. Their attitude quickly changed after the first session and in the sessions that followed, they displayed their willingness and eagerness to perform their tasks of evaluation. Mrs. S. began praising her husband's skill (second session) and the family discovered and praised John's creative talents.

d) Description of the First Session:

The family was seen in the solarium of the hospital

ward. The space is large and the family and therapist sat around a coffee table. Mother and Jane sat opposite to father and John, with the children seated on either side of the therapist. The first session took place in the early evening. Then this time was later changed to Saturday morning to accommodate the academic programs of John and Jane.

First Session: (First task) [See figure 1A]

The family members were each instructed to select a different coloured crayon and together, they would create a spontaneous mural without benefit of verbal dialogue. This family mural exemplifies that the problem is often portrayed within the first mural.

As seen in figure 1a, they focused their attention on the theme of "the family meal". Interestingly, many social service home visits are scheduled at this particular time to observe the family's interaction during what might normally be an optimal experience in the home environment.

Initially, Mrs. S. and John selected the colour red with just a slight variance of tone causing fusion between John's outlines and mother's boundaries (symbiotic relationship). They were both hesitant to change their chosen colour; however, a little later, John retracted and changed to the colour brown. With

the borwn in hand, he tried to redefine his initial outline trying to separate from that of his mother's. Unfortunetely, his second choice of colour perhaps was not distinctive or strong enough to allow this to happen.

In this first mural, each family member depicted their own behavioural pattern within the context of the framework of the family evening meal.

The problem portrayed was the son making a request for a car. The mother provided the structure of a round table in which the family members established their familiar seating arrangement. It should be noted that only Jane allowed her imagery to penetrate her mother's space of the round table.

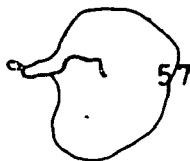
John displayed an organized place setting occupying an adequate amount of table space. His chair and back were turned away from his father, who was placed on his right. He faced and directed his demand "I want a car" towards his mother on his left. His sister occupied the space opposite to him.

Though the mother provided the family with the structure of the table, her imagery of "self" depicted a small child's helplessness of trying to climb upon a chair. Her statement "do you like supper?" seems to reinforce the childlike role of playing "mommy", as if

talking to her dolls and not expecting a response. Her drawing portrays a sense of isolation from her family perhaps emanating from her fears and anxiety of whether she will be able to perform once again in her role of wife, mother and housekeeper.

The mother's role of housekeeper was taken over by Jane in her absence of three months. Perhaps some of the satisfaction and nurtured self-esteem she experienced from her success and performance is seen in her imagery of "self". She alone appears to be prepared and waiting at the table to be served, her place setting neatly before her and a smile on her face. She makes the comment "dreamer". While this conscious message is in response to John's demand, it may also project her feelings denoting her dilemma of being caught in a nightmare of paradoxical communication. This proclamation of "dreamer" is enclosed as if within a balloon that is attached to herself. The imagery creates the illusion that the balloon might have the capacity to float her away from this environment.

Mr. S. positioned his imagery of "self" as if he had turned away from the family. His imagery gives one the sense that he is trying to disengage himself from the chair at this family setting. However, the back of the chair appears to be reinforced, creating a barrier which



prevents his departure. His statement "no way" might very well confirm his inability to free himself from this family circle. Nevertheless, like Jane's message at the manifest level, it is a response to John's demand of wanting a car. Distanced from the family drawing and placed in the bottom right hand corner of this page, is a small bodyless head drawn in the colour orange (Mr. S.'s chosen colour) [figure 1AA]. This imagery reinforces the notion that he wishes to escape, in thoughts if not in body, not unlike his daughter.

When John switched to the colour brown, he tried to reinforce his own imprint, but he succeeded in reinforcing the boundaries of the territorial structure as drawn by mother. By fusing his colour with mother's, her structure became more dominant and his more diffuse. He proceeded to divide the table in two, splitting the father and daughter from the space occupied by himself and his mother. This may have been a reaction to the triad relationship that had developed between father, sister and himself during the mother's absence. It should also be noted, that nobody partook of the mother's food which occupied the central space (no imagery of food was included at the individual place settings).

The evening meal portrays a sequence of behaviour

which according to the family members is enacted at every meal suggesting a circular pattern that is self-perpetuating. For instance, the content of John's message "I want a car" conveys information and suggests a command that is directed toward mother to intercede with father. Father has turned away making the statement "No way" and Jane escapes to her dreams. Limiting the focus to what goes on between the family members as opposed to what goes on within the individual, we are looking for the cause and effect.

First Session: (second task) [Figure 2b]

It required the family to discuss and select an appropriate theme for a second mural. In response to the mother's urging, they agreed to record her homecoming from the hospital. Unanimously, they all agreed that John be given the responsibility to draw the home as he possessed the required skills. In this vein, he was given permission to monopolize most of the family space while they stood back and watched admiringly. His structure provided safe compartmentalized areas where each member could impart their individual input. In addition, he invested energy in drawing a car (phallic imagery and his desire for mobility) which his mother proceeded to contain within her space outlined in her chosen colour. He placed Jane's imagery and her pet

guinea pig within a window frame.

Jane displayed more dominance in this second task. Although she used less structural form, she claimed more territorial space with her chosen colour of blue. She placed herself in the central position of the family space in the act of reading (perhaps dreaming or expressing resistance to become involved).

Mrs. S. took little space; nonetheless, it was she who provided the theme of growth in the picture, by drawing a tree, flowers and a large sun in the sky (reflecting the need for the healthy facade to be exhibited to those outside of the family system, a denial that problems exist). Most of her imagery was placed within the territory claimed in her daughter's colour reflecting the regression of reversal of mother and daughter roles that was evident at this time.

Mr. S. created most of the people imagery within the picture: himself, John, his upstairs' neighbour and her children. The inclusion of this neighbour and her children in this family space suggests the possible involvement of a relationship with value. This assumption was later confirmed by the wife's frequent statements that "she was much more than a good neighbour and more a good friend". The husband was responsible for adding the drapes and blinds to the windows and it

was he who included the handles on the doors to the family space, and the neighbour upstairs. This inclusion of detail seems to reflect his obsessive compulsiveness and his need for privacy that suggests resistance and denial).

Upon conclusion of this mural, it was exhibited on the wall, and everyone talked and reiterated their pleasure of "the doing" process. The family interaction that appeared to be missing in the first conjoint drawing was being experienced spontaneously in this instance, and it obviously felt good. Each person stated that "everything was there... they had forgotten nothing, and how well they had done it!" Then toward the end of the discussion, when all the people in the mural had been identified, it was discovered that Jane's imagery had been duplicated. She had drawn herself and John had also included her (duplication of roles; sister and mother) and Mrs. S.'s imagery had been overlooked. The therapist asked the question "where was the mother's imagery in this record of her homecoming?) they responded with an explosion of embarrassment, with everyone talking, or attempting to correct what may truly have been a Freudian slip (they were experiencing no void in their space, and their immediate problem seemed to be where they could place her).

John got up and drew a light over the doorway and Mr. S. provided a doormat. The light might suggest John's desire to reveal everything to his mother, such as the locked door. Is what goes on inside hidden or an attempt to facilitate her entry back into the home environment? Mr. S.'s production of a doormat might be an association to Mrs. S.'s role in the family to be walked on, to be of service to others, etc. Or is it a welcoming gesture... like rolling out the red carpet on her arrival to the family stronghold? After displaying obvious difficulty, Mr. S. faintly drew his wife on the pathway, outside of the home. This imagery lacked the lower extremities of her body, making it impossible for her to enter the house. As the wife's image is placed upon the path, there is also the added suggestion of her being barred from entry at this time. It perhaps captures Mr. S.'s anxiety and concern related to her discharge from hospital where perhaps she had been perceived as being "behind bars" and lacking freedom. The imagery was also reminiscent of her frequent complaints in the hospital that she "could not stand on her two feet". During this time, Jane made no effort to contribute, other than to pose the question of "Why father should take the responsibility to draw mother, why can't she draw herself?" Her question seemed to

imply some hesitancy to relinquish her esteemed position within the family space - an unconscious wish for mother to remain absent allowing her the central position in the family space as illustrated in the mural (figure 2B). Father's investment in the mother's image would reinforce her dominance and credibility (not unlike John's attempt in the first picture) (figure 1A), something that she, the daughter, would have to adjust to in the weeks ahead. It was the mother who wrote the message "welcome home mom".

As the family learned and discovered how they functioned as a unit or a system, their lines of communication were re-established.

e) Description of the Second Session:

Mr. S. and John were required to work together on one task and Mrs. S. and Jane on another. Then the four family members were asked to work together on a single project.

During the discussion, Mr. S. made the following comment regarding the experience: "It was like playing and it felt enjoyable". It was observed that Mr. S. and John worked well together, both giving and receiving at the appropriate times and as a result were able to construct a sturdy "games' house" out of construction paper. On the other hand, it was Jane who had to assume

the dominant role in the preparation and creating of the mother/daughter task.

When the four family members worked together on the final task, it was the children who set up the structure with Mr. S. assuming the role of overseer. He gave advice and assistance whenever needed. Mrs. S. supplied the theme of this joint project and was happy to let the children bring it to fruition. Later in the discussion, the children said that they had enjoyed the opportunity of working with their individual parent more than working as a whole unit.

f) Description of the Third Session:

Only the parents and Jane attended this session. On this occasion, Mr. S. stated that he had some difficulty in performing the task without the support and aid of John. This statement was shared with John in the final session. John had gone skiing and had sent along a drawing of himself balancing on top of a mountain. It surely projected the dangerous position he felt that he was occupying in the family at that time.

Another problem in reality was the inference made in the hospital chart that Mr. S. might be impotent. The possibility that this information would emerge in the family sessions no doubt caused Mr. S. some concern and contributed to his initial resistance. Therefore, upon

commencement of this intervention, the therapist and her supervisor made the decision not to highlight or make Mr. S.'s problem the focus of this brief family intervention believing that it would be more appropriately dealt with in ongoing individual or couple therapy in the future. Still, this may have been the stressor that precipitated the regression observed in the family dynamics of unresolved oedipal issues and also mirrored in their art work. One might hypothesize that Mr. S.'s projection of his loss caused him to withdraw from his authoritative fatherly role and ultimately strengthened the symbiotic relationship between mother and son. This alignment was evident in the first family mural [figure 1A] where John looks toward mother as he makes his demand for a car - the reinforcement of mother's boundaries (table) and their shared choice of the coloured crayons. It was also noticed in the early sessions that Mrs. S. directed herself and her questions toward John making him feel omnipotent and more powerful than father. Yet, as a consequence of this feeling, he was both fearful and anxious. His imagery expresses this ambivalence, [figure 21], which illustrates that even though he reaches the summit of the mountain, there is no joy; there is only sadness as reflected by the teardrop falling upon his cheek. One has the feeling

that this drawing sent to the therapist was a plea for help, a request for direction and guidance to descend from this metaphorical peak, a need to separate and individuate from mother and alleviate the anxiety related to his growing sexual identity.

As the family began to address issues dealing with their relationships to one another through the structure of the creative imagery and the follow-up discussion, it was observed that Mr. S.'s behaviour was undergoing change. He aptly began to fulfill his role as the interested and caring husband while reinforcing the rules and limits in the role of father. His self-esteem was growing and one might assume that he was once again omnipotent.

Perhaps in reaction to the manner in which her husband now responded, her personal fulfillment as a good housekeeper began to emerge. Mrs. S. became an active social directress for the family, planning outings and extending invitations to their many friends. This newly experienced success of her womanly role and her husband beginning to fulfill his role of dominancy, appeared to bring them closer together. Their mutual respect for one another became more evident in the latter sessions. At first, she preferred to sit beside John, who was opposite to Jane and Mr. S. After the

third session, she began displaying overt affectionate behaviour toward her husband whenever the opportunity permitted. They sat side by side and body contact was often noticed. She began to address her questions and queries toward him as opposed to John.

As this paper is a theoretical review of brief therapy in a context of an art therapy experience, not all sessions of the clinical study are described. Nevertheless, most of the artwork created has been included with the exception of the paper sculptures and one final mural from the sixth session.

It was the author's decision to include a description of the first session, believing that the problem is generally presented at this time and that the final session will reflect the process that has evolved during the intervention.

CHAPTER VI

COMMITMENT, PROCESS, AND OUTCOME

a) Initial Observations:

Ground rules were established through the utilization of time in and out of therapy.

Factors that precipitated termination:

The structured art therapy assessment model brought the family together to negotiate the availability of their time and soon the weekly sessions became a constant and the family's top priority. They implied that the sessions stimulated and increased their verbal interaction in their home environment. As the therapeutic session involved the togetherness of the family, they also shared the reduced space of their car in transit to and from the hospital setting. This time was spent fantasizing on what type of tasks they would be expected to perform in the forthcoming session and on the return trip, they would often extend praise to one another for their creative skills or for their perceptive insight revealed in the session. On occasion, it was necessary for Mr. S. to drive either John or Jane to their academic class which provided additional time for father and child to share. In order that no family session would be forfeited, he also made himself more available by doing the family shopping with his wife;

he was thus exposing himself to new shared experiences and developing new adaptive behaviours.

As can be seen, the family spent more time together in constructive planned ways in the confines of their shared family space.

At times, other issues were expanded upon that were not central to the initial goals, and reframing and refocusing of the foreground and backgrounds occurred constantly.

Termination occurred when the agreed commitment of time, that is, six sessions had been completed. The family viewed the therapy positively feeling that any major issues that had been there at the commencement of therapy had been resolved. They greatly valued their newly acquired freedom of sharing their thoughts and dreams together for the future.

When a family such as this particular family experiences beneficial results from a brief intervention with limited goals, it is hoped it will serve as the impetus for further learning and perhaps activate a snowball phenomenon of breaking the vicious circle (Koffman, M., 1963).

B) Post Treatment Observation:

A follow-up phone interview took place four months after the termination of treatment to determine the

level of goal attainment, satisfaction with treatment and the family's current perception of problems and recidivism.

The major objective of the family therapy outcome study was to determine whether using the modality of art therapy for purpose of assessment and brief therapy would provide beneficial results and whether characteristics of change would be evidenced within the recorded artwork that might suggest goal attainment.

One year later, the wife contacted the therapist by phone to request permission to send a photo of the family honouring the occasion of their twenty-fifth wedding anniversary. At the same time, she reported on what might be interpreted as an open family system with the lines of communication more firmly entrenched. They are apparently learning to share their expectations and in return receive the required responses. The therapist has since learned (1987) that the daughter graduated and recently married and moved to another province. The son has moved out of the home environment and is working in a car business with some success.

c) Discussion (Art Therapy Experience)

The presented study reviewed certain issues in the context of a family art therapy experience. The therapeutic model was adapted from Kwiatkowska's assessment

model which used art therapy methods to structure, assess, and provide brief therapy for a family within the limits of six sessions.

The art therapy process evolving from the assessment model was a therapeutic experience and family dynamics were concurrently evaluated.

The family members quickly learned to depict graphically their individual needs for growth and future separation and individuation. Here in the safety of the creative process, they learned and explored the boundaries and space of the structured assignments. This exercise served as a model which could be applied to their present lifestyle and would generate the energy for the desired mobility for change.

It should be emphasized that while unresolved issues did surface during this process, defenses, repressed needs and impulses were not always confronted or interpreted. Only those issues deemed appropriate to the goals of clarifying communication in the family system were pursued in this intervention. Therefore, the therapist also worked within a model of limitation.

d) Results:

Their shared experience of discovering John's creative skills and the evidence of some destructive mockery by Jane were noted. The conjoint murals reflect

the family myth of harmony that was used to regulate yet unfortunately restricted genuine transactions between family members. Looking at the first mural, the family meal [figure 1A] and the homecoming [figure 2B], we may observe the family's interactional performance, which displays their denial and repression. These defense mechanisms characterize the enmeshment, overprotectiveness, rigidity, and lack of conflict resolution. It is thought that overprotectiveness retards the development of autonomy and competence while rigidity restricts age appropriate autonomy.

e) Evaluating the Dimensions of the Art Process and the Art Product:

The family's artwork can be analyzed from the viewpoint of the process of the drawing and the finished product. While the instructions were direct with tasks assigned, they allowed for variability of response in structure and performance. Relevant categories which could be variables of the family's functioning were: 1) who organizes the drawing? 2) who takes the first turn and who takes the last turn? 3) the relative size of the person presented 4) the choice of the person represented 5) the isolation of persons 6) the specific content and unusual themes (Bing, E., 1970).

Initially, the organizing role was placed upon the son and then gradually the father assumed a more

dominant role.

Leadership in organizing the family's activity and taking the initiative to draw was divided. It was the mother who verbally encouraged the children to perform, so the children took the first turn more frequently. Conversely, the parents were more often the last to take their turn.

Relative Size: if we assume that the family portrait reflects the family pattern, then the size might reflect an individual's subjective value placed upon each member within the family structure - e.g. in figure 14, Jane subjectively perceives herself as being larger than mother. This would certainly require further research. Democratically each family member shares the total area of the art paper and occupies as much space as they feel they can handle (Bing, E., 1970). However, it can reflect the family boundaries, denoting the behaviour of those who receive and those whose needs are overlooked. For instance, in the homecoming [figure 2B], John was allowed to occupy and structure most of the family space and no limits were imposed by either parent.

Choice of Person Represented: Family members have the right to choose to draw themselves or someone else in the family. In this family, we saw Mr. S. take the responsibility to draw Mrs. S. as she and no one else

drew her. He also drew his neighbour and John drew Jane (preoccupied with others other than themselves). Mrs. S. initially had problems with drawing herself (some difficulty with accepting her own existence - the patient's viewpoint) (Bing, E., 1970). Initially Mr. S. displayed some difficulty in bringing the family together on figure (1); then the family imagery became connected in figures 4, 5, 6, and 7.

Content and Unusual Themes: Organizing roles, sequence, relative size, choice of person drawn and isolation are some of the dimensions that could reveal family function and results could be explored and quantified for research. While the therapist primarily focussed on the manifest of the art productions in this brief therapeutic intervention, it enabled the family to spontaneously communicate their emotions to one another in their drawings, something that they had stopped doing at the verbal level. Thus they established a starting point for future family insight.

To establish a good therapeutic contract with a family is dependent upon the accuracy of the information obtained in the assessment phase of therapy (Andolfi, M., 1983). Nat Epstein also concurs that at least 80% of the therapeutic session time should be focussed on assessment of the family. (Epstein, N., et al, 1972).

According to Kwiatkowska, one of the advantages of using the art therapy methodology for assessment or therapy is that the patient feels less threatened, displays less resistance and exhibits more spontaneity than in their verbal exchange.

Within the creative imagery, one is able to view the structure of the family system and its functioning as a system of relationships. It demonstrates how each individual is affected, how the wholeness of the system is perceived, and how the self-regulating process and transformations are experienced. A global assessment of a family at work, leisure, and play, provides 1) an overview of their strengths and weaknesses through their observable behaviour and their activity performance (cognitive process), 2) a guide for future goals, 3) identification of their individual needs, and 4) identification of type of intervention required.

PRESENT SYNTHESIS OF THE FINAL SESSION

The wife's dysfunction has now been placed in context with the patterns of the emotional system of the family and its members have started to focus more on the changes they wish for themselves. The parents were encouraged to support each other, for together they become capable system movers able to initiate actions for change within the family. It would appear that the brief therapy was able to reactivate communication within the family system.

CHAPTER VII

TRANSFERENCE AND COUNTERTRANSFERENCE

a) Introduction

The literature was reviewed to gather information concerning the therapeutic use of the transference and countertransference phenomenon in the context of a brief family therapy model. The paucity of published material on this topic suggests that we define this subject matter according to the psychoanalytical theory. A brief discussion will follow on how important the art therapy productions are in the exploration of transference dynamics by including a brief description of the final family mural which records the family's projection of the transference and countertransference phenomenon upon termination or closure of therapy.

b) Transference

Basic to intensive psychoanalytic psychotherapy is the recognition of transference and countertransference phenomenon. As one might expect, there are as many interpretations and definitions as there are therapeutic systems. In its simplest form, transference has been described as the therapeutic relationship that is established between patient and therapist which enables the patient to relieve and relive the gratification and trauma experienced with the significant figures from

early years (Max Rosenbaum , Therapists handbook, 1976). To put it in another way, a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the therapist in the present moment. (Searles, H.F., 1978). The repetition of regressed infantile attitudes directed toward the therapist eventually develop into the transference neurosis. The feelings may be either positive or negative in nature. The positive transference refers to emotional attachment and idealization. The negative transference takes the form of hostility expressed in criticism, acted out by patients with ambivalent feelings toward their parents. Patients show admiration for the therapist, seeking love while at the same time distrusting and feeling hostile toward the therapist who symbolizes the authority figure. Resistance distorts the true connections, distorting the present in terms of the past with the wish to relive the past more satisfactorily than experienced in childhood - the transfer of past attitudes to the present (Fenichel, O., 1945; Searles, H.F., 1978). Freud said one must allow the patient time to get to know this resistance of which he is ignorant, to work through it and overcome it, by continuing to work according to the analytic rule (reductionism; to

reveal fundamental components or root causes).

The transference process serves two general purposes: The exploration of transference manifest projections to reveal and be aware of the meaning of the resistance, to bring unconscious feelings into the open in order to study and resolve the mental conflict. Secondly, it enables the therapist to provide the experiences that the patient may need such as the release of impulses which have been inhibited or the frustration derived from the parents. It can also provide the opportunity for the patient to feel accepted and esteemed so as to counterbalance former rejection and neglect.

c) Resistance

Resistance is a major component of any form of psychotherapy and has been described as residing in the unconscious and expressed in the context of the transference (Greenson, 1967). One must recognize, understand and cope with the complex way in which patients resist giving up their symptoms. Dealing effectively with resistance in family therapy is considered very complex for the following reasons: the number of people in therapy; the therapist's own behaviour, which in some instances may be seen as colluding with a family member and by so doing,

encourages and perpetuates the resistance to change within the family system. The therapist should not personalize evasions or attacks from family members but understand that it is part of a natural resistance to change. Without a certain amount of resistance, a family would be unable to provide the stability necessary for its members to grow and develop. So, while it is necessary to work through the resistance in the transference, to bring about changes in maladaptive life styles of family members, resistance can also be a sign of health and good judgement. (Anderson, C.M.; Steward, S., 1983). As therapy seeks to explore the projections, old conflicts are relived and anxiety increases, anxiety being the main reason for resistance, Resistance means the reactivation of motivating powers or drive which was responsible for the original repressive process.

d) Countertransference

Countertransference is a topic of major importance to understand the therapeutic engagement. Countertransference refers to the unconscious feelings both libidinal and aggressive which are incurred by the therapist in reaction to the attitude of the patient. The patient displaces or transfers his own repressed thoughts and feelings of anger or affection on to the

therapist and the therapist's possible emotional response to these emotions is termed countertransference. When this occurs, it is advisable that the changing feelings should be explored and understood, and in some instances it is advisable to seek professional assistance from a supervisor. It is essential that the therapist learn to understand how one's own reactions play a role in the therapeutic process and how to be continuously alert to the role of the emotional interplay between patient and therapist (Gurman, A., 1981). The experienced reactions aroused in the therapist by the specific qualities of the patient can become a valuable clue to what is motivating the patient's behaviour. Searles (1978) believes that the patient has the need to discover that he can evoke from the analyst all possible types of emotional responses and yet still allow for the continuance of the interpersonal relationship. All family therapy tends to activate the therapist's own feelings toward types of family members by feeling protective toward the children or identifying with the parent of the same sex or position similar to one's own family position. However with countertransference the therapist is particularly vulnerable and often not aware of such feelings until after the session is over. Therefore, it is valuable if

one has the opportunity to work with a co-therapist in the family intervention to maintain an overview of the family as a whole, and not become entangled with the individual or subgroup within the system. The co-therapist prevents the therapist from becoming part of the family (Gurman, A., 1981).

The literature reviewed on this subject prior to the family encounter focused attention on the family interaction as the system as opposed to the individuals that form the family. The family therapy was primarily a process to help them with problems in living rather than a treatment for individual pathology. The interpersonal interventions are based on "live" here and now data illustrating a here and now phenomenon in contrast to the reliance on transference phenomena of individual therapy. In family therapy, the significant others are right there. The role and role relationships that influence the parents' personality are both alive and acted out in the handling of their family role. The parent remembering their role as adolescent in their family of origin treats the child with reference to their own experiences and their perception of their parents' actions. The children may see their parents accurately but transfer their perception onto the therapist. The therapist does not need to use

transference as a tool in order to be effective in family intervention (Leckers, S., 1976).

In order for a transference neurosis to develop, the following three characteristics are required: a) a long course of treatment, 2) the limited participation of the therapist as a real object, and 3) the relative constancy of the therapist's behaviour (Gurman, A., 1981). Therefore, in a time-limited therapy model, transference neurosis is unlikely to occur.

What has been defined as the phenomenon of transference neurosis generally takes time to develop and analyze. However, transference (the passing on, displacing or transferring of an emotion in affective attitude from one person on to another person or object) occurs also in every day life e.g. any person in authority, a friend, or a relative can all become the object of transference. Transference in the opening phase of therapy may be identified by the patient with the repetition of feelings and attitudes from the past. On this coloured perception, the therapeutic working alliance between the patient and therapist will be established.

e) Projected Imagery into the Art Therapy

The phenomenon of transference and counter-transference is important for all art therapists to

know. The concept of transference is simply an extension to the human sphere of what is already suspected about the meaning of artistic symbols. People project meaning and feeling ideas onto other people and perceive new people on the basis of past experiences with similar others. As art therapists, we present in a structured media, a free situation to enable the individual to find and express his imagery. At the same time, if the therapist is presented in a relatively neutral fashion then he will become the container for projected feelings and ideas of inner conflict just as it will be projected within the art content. While the particular meaning of a particular distorted perception may not at first be apparent, like the meaning of a symbol used in the visual imagery, it must first be identified before it can be explored (Rubin, J.A., 1978). Art derives its symbolizing power from the capacity of the image to combine, condense and substitute disparate feelings, ideas, qualities, time, space and objects. These attributes permit the simultaneous expression of multiple, sometimes contradictory, meanings which create the ambiguity essential for the visual imagery to be revealing and yet concealing. (Kwiatkowska, H.Y. & Thomas, C.C., 1978).

During the termination of therapy, the sample family

viewed and discussed the process that they had been engaged in. Their final mural (figure 3C) which is utilized to bring "closure" to the therapy symbolized what they, as individuals within the family system, had learned or experienced during the six sessions.

Within the final mural, we view both the positive aspect and the limitations of a brief therapeutic engagement. In the picture we see the idealization accorded to the therapist, who outshines the celestial body of a star. The positive transference is hastened and strengthened through the art therapist's role as a "provider" in the therapeutic intervention, the person who gives, "the good mother". In this instance, the therapist is depicted as having star quality, which might translate as having the power to grant their wishes. The husband retained his masculine dignity while at the same time, regained his respected role as head of the family. The wife's wish of being reunited together with her family, the daughter's wish for more family communication which aired her future wish to move out of the family space and finally the son's wish for insurance... becoming aware that his father is there to give support when he finds himself in deep water (as depicted in the mural of the sixth session that has not been included). The other side of the "all giving"

provider is the withholding "bad mother" (negative transference) and as we see in this mural, the only one that stands on her two feet is the therapist. The family members, separated in space, lack their body imagery which suggests that they are merely mirroring their cognitive wishes for growth, independence and autonomy. They have not yet gained these attributes in this limited intervention. Therefore, their imagery reflects a sense of helplessness with the projected loss of ego support. It is at this point that the counter transference, or the specific emotional response aroused in the therapist by specific qualities of the patient that can interfere with the termination of treatment. As the patient has feelings of abandonment upon discharge, so too can the therapist feel that the patient is too vulnerable for discharge. Trotzer (1982) states that a family will terminate when the symptoms subside; nevertheless, the model of brief therapy imposes limitations that ensure termination at the appropriate time.

In this instance, the therapist welcomed the conclusion of therapy, and felt that it had been a worthwhile learning experience for herself and the family. The therapy process focussed on the strength that existed within the unity of the family to mobilize and restore habitual balance in their life situation

(Wolberg, L., 1980), and individual resistance was not confronted in this family engagement. Nevertheless, a report of the family assessment was forwarded to the wife's primary therapist for further evaluation.

CHAPTER VIII

FINDINGS AND IMPLICATIONS

a) Findings

(Unifying elements of brief therapy; Budman, S., 1981)

- 1) The utilization of time was adhered to in the structured (6) task oriented sessions.
- 2) The family contract to attend the six (6) assessment sessions was fulfilled by all members, with the exception of the son. He missed one session. His non-presence was seen as a strong statement to assert his need for control and independence; nevertheless, he simultaneously projected ambivalence in his form delivered to the therapist by the parents in his absence. This reflected the precarious position he presently occupies within the family system.

Within the contained structured environment, the family discovered that they could communicate with one another. Some unresolved issues that had been avoided were revealed in the family artwork. Subsequently, these issues did not appear threatening in this framework. Feeling less intimidated, it became possible for compromise to be negotiated.

The former patient assumed her role of wife and mother and she appointed herself, the role of "family

social directress". She began organizing family outings and inviting old and newly made friends for luncheons and dinner. She returned to the kitchen, taking pride in her culinary accomplishments which nurtured her self-esteem.

During the second session, the family conjointly participated in the creation of a paper sculpture. The theme provided by the wife was "a family ice skating at the park". The association made by the wife was drawn from an early childhood experience of having executed a figure 8 exercise on ice skates, and how good she had felt at the time. The conjoint family task was performed quite adroitly with lots of praise given to the father for his managerial advisory role. Each member exhibited a sense of pride in having been responsible for reviving this cherished memory, in a concrete form. It was in response to the good feelings aroused in the family members that the wife organized a skating night at Beaver Lake. This outing was duly reported to the therapist as having been successful and enjoyed by all.

With each session, the process of assessment and treatment took place. The family learned to participate on a new level of organization (experienced in the creative tasks and later practiced and experienced in

their daily life).

This family was strongly motivated to learn and experience from this program and little resistance was encountered in the task-oriented sessions.

The therapeutic relationship between the family and the therapist is, as previously stated, of primary importance and needs to be established in the first and second session for optimal results.

This family was a very appropriate choice for this type of therapy. They were highly motivated to make a contract of time and setting of goals. They were a family accustomed to working; it was a loving family and they had had past experiences of enjoying and playing together.

While little change is evident in the individual artwork, it was more noticeable in the conjoint family products and more observable in their behaviour.

Within this creative environment, reframing, broadening and refocusing did occur. The set goals were achieved with the shift away from the identified patient and the focusing of family issues such as the daughter's goals to move out of the family home in the coming year and the son's need for the parental support in order to develop his sense of autonomy. Other issues were not focused upon in this intervention as they were not a

mandate of the family's contract.

This experience confirmed Kwiatkowska's findings that using art therapy techniques in a family therapy model can accelerate the therapeutic process. The family quickly learns to express, reveal and clarify their feelings and thoughts to one another in picture form which elicits genuine responses. It would seem to be within this context that Kwiatkowska emphasized the value of the family's imagery to hasten the therapeutic process which facilitates the achievement of limited goals.

A brief therapy can offer particular advantages to those families who wish to engage in therapeutic intervention and yet have limited family time. It is doubtful whether the presented family would have agreed to be engaged in a long term commitment at this time.

b) Implications of Findings:

The application of clinical art therapy can be a unique experience. The individual family members and family as a group communicate with one another and with the therapist through their expressive art in content and product for diagnosis and treatment. As Helen Landgarten (1981) suggested, it gives the therapist the opportunity to listen with his/her eyes. Their pictures and sculpture embody the family process which may

reflect the etiology of the existing difficulties that are experienced in the family relations. The day-to-day transactions of the family are observed in their behavioural responses and reproduced in their art productions offering an unbiased view of the family system and its inter-relationships. Their individual and joint artwork have the capacity to provoke relations and changes, such as was evidenced in this particular family.

While individuals have the tendency to tune out that which they do not wish to hear, it is more difficult to block out the visual imagery, making it a powerful tool for treatment (Langarten, H., 1981). The art space can provide a platform for the understanding and the strengthening of the communication skills while providing micro-cosmic trials for improving the family's relationships (Langarten, H., 1981). Family art therapy is an effective source for therapeutic treatment.

The structured task-oriented sessions described in this paper utilized a here and now family interchange which was intended to assess the family's mode of functioning and credibility based upon the individuals.

c) Recommendation:

While the six session treatment model was able to achieve the contracted goals, the author suggests that

the session time of one hour could be increased to one and a half hours. Most of the allotted time of the session was utilized in creating art tasks, leaving little time for discussion and interpretation. In other words, the session time appeared to be restrictive and at times constricting. In some instances, it may have created stress within the working environment for the family and the therapist. Nevertheless, in retrospect, this same stress may well have fueled the energy used by the family members in the time shared in the car. It contributed to opening lines of communication by enabling them to verbally share their thoughts regarding their awareness of their multiple feelings experienced in the therapeutic session.

CHAPTER IX

DISCUSSION OF THE ART THERAPY ASSESSMENT MODEL

This study has sought to acquaint the reader, with some of the advantages of using the modality of art therapy for assessment and treatment of a family system, whereby assessment and treatment begin almost simultaneously.

Clearly, there are both potential and limitation as to what goals can be accomplished within such a model of time-limited, brief therapy. Nevertheless, bearing in mind that while the family system is being assessed, so is each member of that system. It is hoped that this assessment may define other central issues that may become the focus for either individual or family therapeutic interventions, short or long term, in the future. A copy of the presented family's assessment may be found in the appendix of this paper. This assessment was forwarded to the wife's primary therapist for future reference.

Early proponents of brief therapy have emphasized that the outcome of therapeutic, brief intervention is solely dependent upon patient selection for both individual and family brief therapy (Mann, J.; Sifneos, P.; Malan, D.H., 1981). According to Mann, an important criterion for this selection was the patient's ability to define the central issue or, as Sifneos referred to,

the selection of a single psychological problem to become the focus of the intervention. Other criteria which must be met in the patient selection for brief therapies pertain to the patient's ability to be flexible in his interaction with the therapist, and that the potential for insight and degree of motivation be experienced in the patient.

Another important factor for Mann (1981) was the patient's capacity to engage and disengage quickly (separation and loss) and the ability to tolerate separation at the end of the treatment phase. He felt that it was equally important that the therapist be aware of one's own reactions to terminating therapy. The therapist must also accept the limitation of the goals that may be achieved in brief interventions and remember that even though other issues may surface, in most instances, the family will stop when the symptom has subsided (Trotzer, J., 1982). The inclusion of the limitation of time in therapy created the need for the therapist to formulate what one could expect to accomplish during the brief therapy, that is, the setting of predetermined goals. Brief therapy has been viewed as a position statement about the balance between goals and the processes that will achieve the desired results.

In order to elucidate the usefulness of the thera-

peutic application of art, when used in conjunction with a model of assessment and brief therapy, examples of a family's creative tasks have been included. It is hoped that their creative case material can illustrate their capacity for abstract and concrete thinking, original and spontaneous expression as well as manifesting the family transactions. The recorded art productions retain the freshness of the original experience (frozen in time), which make the products invaluable for review when working through distortion, denial or resistance in therapy.

According to Kwiatkowska (1967), the informal situation - the indirectness of the communication in art therapy - lessens super ego defenses and controls. The symbolic images express the unconscious feelings which the individual resists expressing verbally because of intense feelings. It seems reasonable to believe that these are the factors that make it possible to commence treatment intervention during the structured assessment period.

The group activities with the follow-up discussions enabled each family member to begin to experience their own identity, their own space and their appropriate family role. One could say that they began to be more aware of themselves, not only as the family unit made up

of father, mother, daughter and son but as a family consisting of unique individuals that could function well and have fun together.

Within the very limited time of six sessions, through the use of the structured, creative tasks, they began to communicate with one another. The medium of art enabled them to depict graphically that which they felt threatened to express verbally. There was evidence that repressed feelings of anger and resentment could be dealt with when revealed in the art space. Within this frame of reference, the family members have the opportunity to perceive and respond appropriately, as opposed to their former behaviour of withdrawing to the privacy of their bedroom. Within the therapeutic space, they began to learn to replace coldness, dissension and rejection with warmth, understanding and affection. Initially, the husband was resistant to express his anxieties, depression, feelings of impotence at any level, and made the statement that the sun MUST shine. However, within the creative tasks he was able to once again validate his position of leader of the family. The early sessions revealed the wife as doing most of the talking with most of her demands directed toward the son and the husband's attempted responses falling upon deaf ears. After the fourth session which was

structured for the couple to focus on their courtship and their shared lives together, it was observed from their behaviour and their verbal interaction that they were again seeing and hearing each other; in fact, they were overtly affectionate with normal body contact.

No member of the family showed outstanding talent for drawing; nevertheless, their art productions are the evidence that the symbolic imagery can become a powerful channel of communication. Positive feelings were generated within the sessions and the evaluative testing provided an experience of mutuality in a task which opened the way to fruitful communication among the family members.

Observed and acknowledged changes took place in the family collectively as well as individually during this therapeutic intervention. One might assume that treatment did commence simultaneously with the assessment, that the recorded art sessions enabled the therapist and the family to see or follow the change occurring during each weekly session, a little like the STAPP - Short Term Anxiety Provoking Psychotherapy - (1982) model which confronts the patient with the evidence for clarification and interpretation. Changes can take place in the framework of the art paper, such as disintegration and integration mirroring the intrapsychic processes

that become manifest within the personality and in social contact.

On occasion, a client's picture may be loaded with rich symbolism (the unconscious process organized around association and similarities); nevertheless, it is important for the therapist to keep in mind the limitations of the brief therapy model. The manifest content (the problem-solving activities of the ego or self system), the manifestations of that which is acceptable to the individual, will become the focus of the intervention, as opposed to the repressed portion, the latent content. Not unlike the interpretation of dreams, if one penetrates into the unconscious prematurely, it will merely promote greater repression and distortion in order to avoid anxiety.

THE AUTHOR'S VIEWS OF THIS THERAPEUTIC EXPERIENCE

In the first session, the family saw the wife as the problem. Their family mural was meant to express feelings of pleasure in response to the wife's "homcoming" from the hospital. Instead, it appears to reflect the family "shut out", thus revealing some feelings of ambivalence.

Their expectations for the therapist might well have been to confirm their view and to proceed in alliance with them to work with the wife. The family's discovery

that concrete art forms projected their here and now living situation may have enabled them to shift their focus onto the functioning of the family system as opposed to the non-functioning of the wife. In addition, it is thought that the art methods develop a steady, consistent action-reaction process in the "doing" of the conjoint creative tasks which truly exemplifies the systems focus. Research has shown that significant change can occur in a system following the shift of one or more individuals, and it would appear that some movement took place in this intervention. (Bradt, J.O. & Moynihan, C.J., 1971).

Studies have also confirmed that treatment of approximately six sessions is as effective as treatments twice as long. Consequently, larger numbers of families could receive therapeutic assistance using brief forms of therapy (Fisher, S.G., 1981).

In conclusion, the utilization of family art therapy techniques in a six session assessment model offers a very challenging treatment method for the resolution of a presenting problem and the therapeutic experience for further learning. The brief family art therapy assessment model is a viable alternative for the family requiring therapeutic intervention but at the same time must contend with their own priorities of family time and family economics.

LIST OF FIGURES AND APPENDICES

<u>Family Member</u>	<u>Session Number</u>	<u>Title</u>	<u>Figure</u>
HUSBAND	1	We are a family again and I am happy to be here	(1)
	3	Scribble drawing	(2)
	4	Life together - Dating and Marriage	(3)
	5	The Ideal Family	(4)
	5	How family members are perceived now	(5)
	6	Three family images are placed within a heart	(6)
			Learning about ourselves ourselves
WIFE	1	I love you all	(8)
	3	Scribble drawing	(9)
	4	Review of life together - Dating and Marriage	(10)
	5	The happy gang (the family)	(11)
	6	Having fun at the beach	(12)
			Problematic Issues
DAUGHTER	1	Mother (left), Daughter (right)	(14)
	3	Scribble drawing	(15)

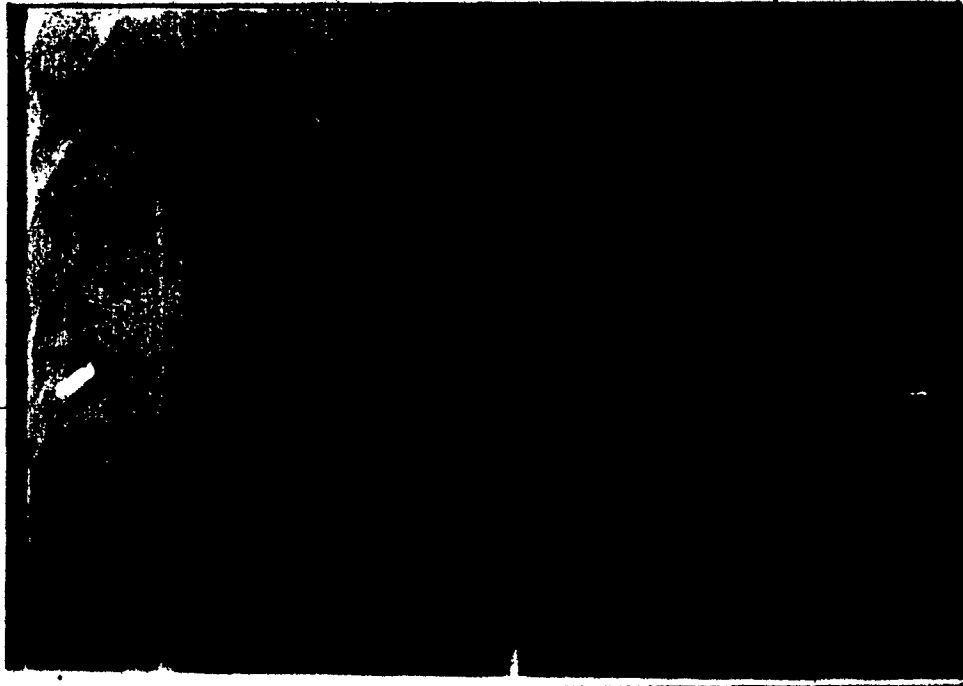
<u>Family Member</u>	<u>Session Number</u>	<u>Title</u>	<u>Figure</u>
	5	My future family in the park	(16)
		Our family at rest.	(17)
	6	How the family members are perceived.	(18)
		Problematic issues	(19)
SON	1	Family	(20)
	3	I went skiing, Sorry, but it is probably the last time this year. See you next week.	(21)
	5	Family playing outside	(22)
		An ideal family	(23)
	6	How he relates to the six sessions	(24)
		How he perceives the other family members	(25)
		Problematic Issues.	(26)
FAMILY MURALS		Non/verbal conjoint family mural "The Family Meal"	(1A)
		Small Head Appearing in the "Family Meal Mural"	(1AA)
		Planned conjoint family mural titled "The Homecoming"	(2b)
		Termination Session	(3c)
APPENDIX "A"		Report sent to the wife's Psychiatrist	Page 101

THE QUALITY OF THIS MICROFICHE IS HEAVILY DEPENDENT UPON THE QUALITY OF THE THESIS SUBMITTED FOR MICROFILMING.

UNFORTUNATELY THE COLOURED ILLUSTRATIONS OF THIS THESIS CAN ONLY YIELD DIFFERENT TONES OF GREY.

LA QUALITE DE CETTE MICROFICHE DEPEND GRANDEMENT DE LA QUALITE DE LA THESE SOUMISE AU MICROFILMAGE.

MALHEUREUSEMENT, LES DIFFERENTES ILLUSTRATIONS EN COULEURS DE CETTE THESE NE PEUVENT DONNER QUE DES TEINTES DE GRIS.



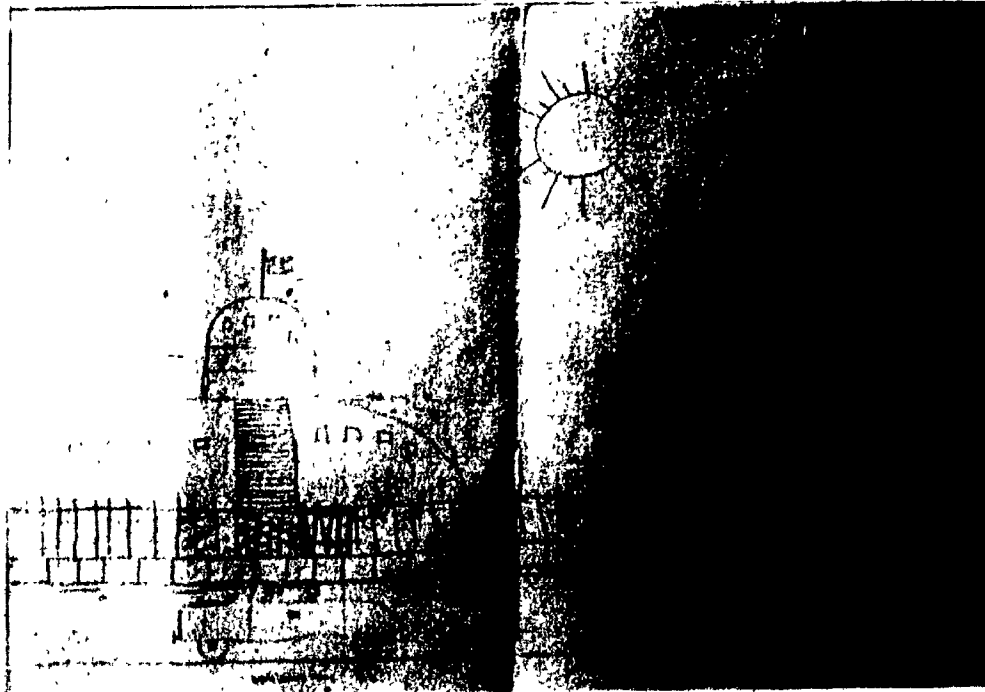
Session I (Fig. 1) Mr. S.

We are a family again, now and forever and I am
happy to be home.



Session III (Fig. 2) Mr. S. Scribble Drawing

Only the strength of the sun in its rightful place,
is a constant in this confused disorder.



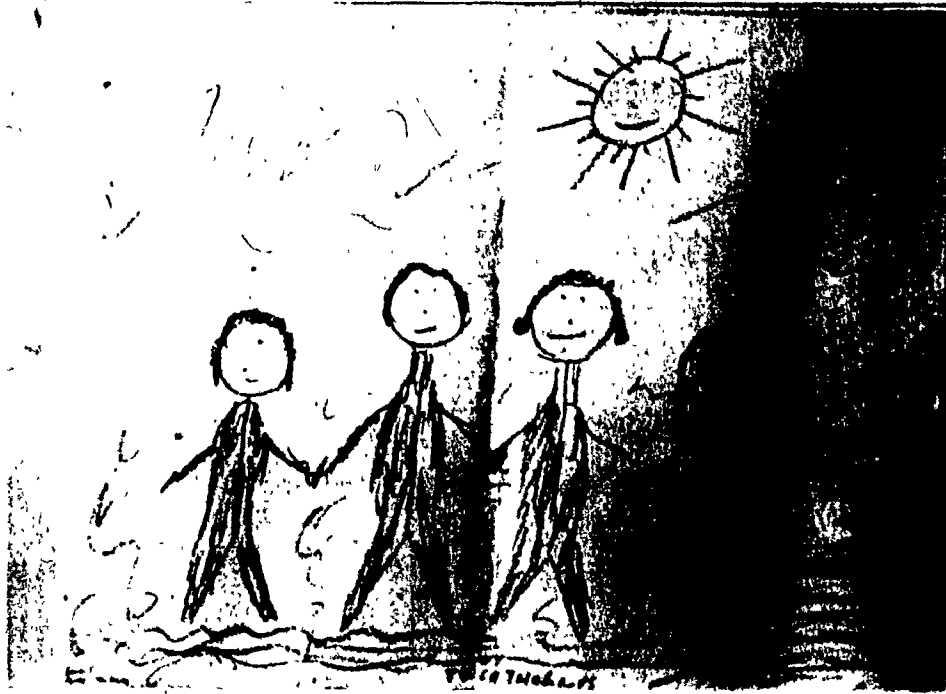
Session IV (Fig. 3) Mr. S.

Memories from the past, when he and his wife were first married.



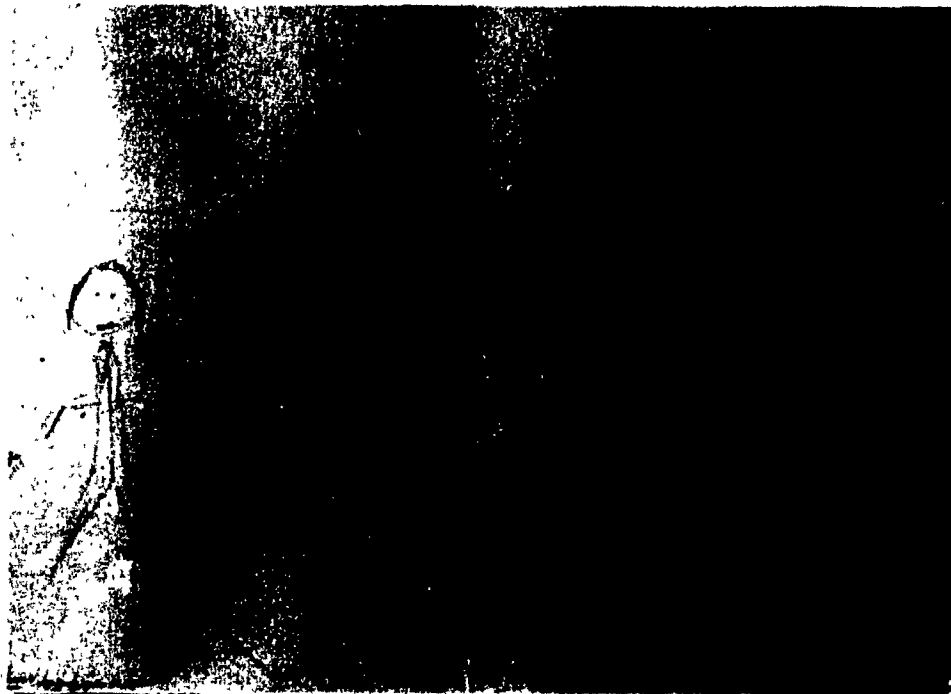
Session V (Fig. 4) Mr. S.

The ideal family whose children will have their children, who will have their ... etc.



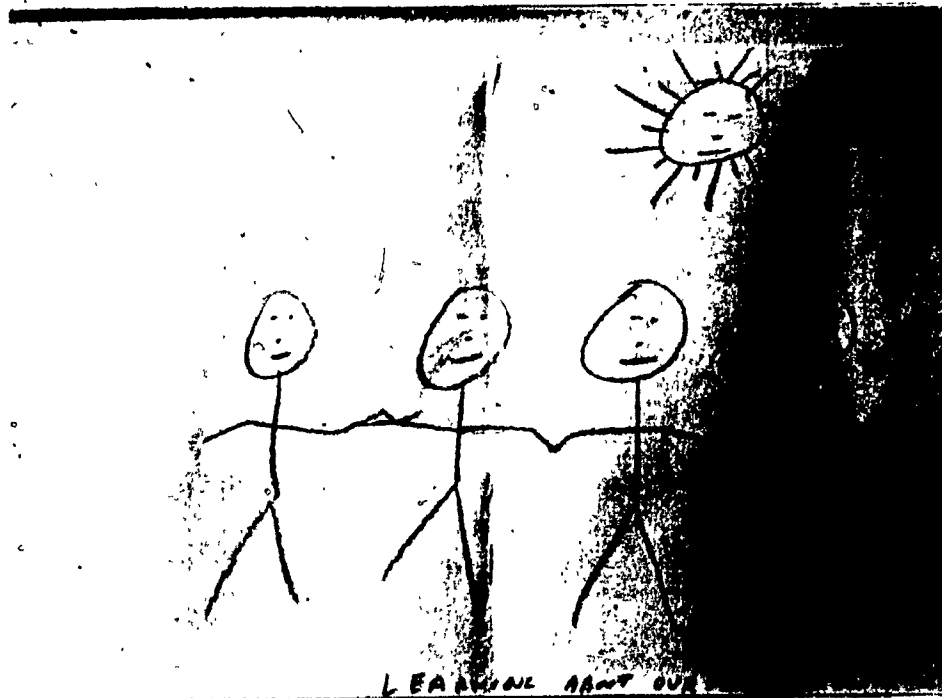
Session V (Fig. 5) Mr. S.

The family is stronger and in closer contact with each other.



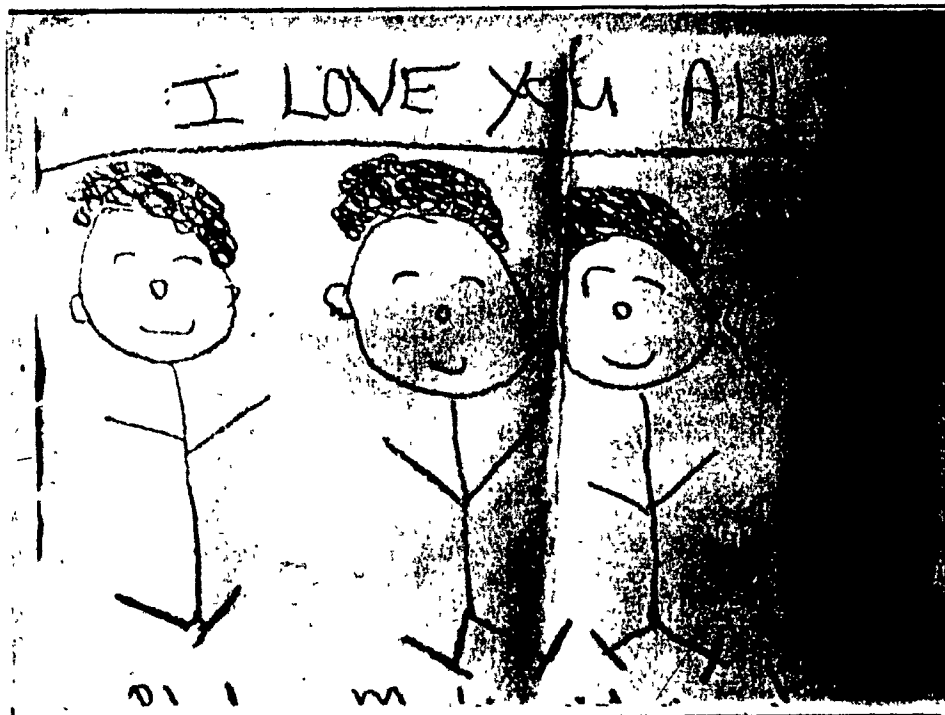
Session VI (Fig. 6) Mr. S.

His family is within his heart, and also occupies most of his space.



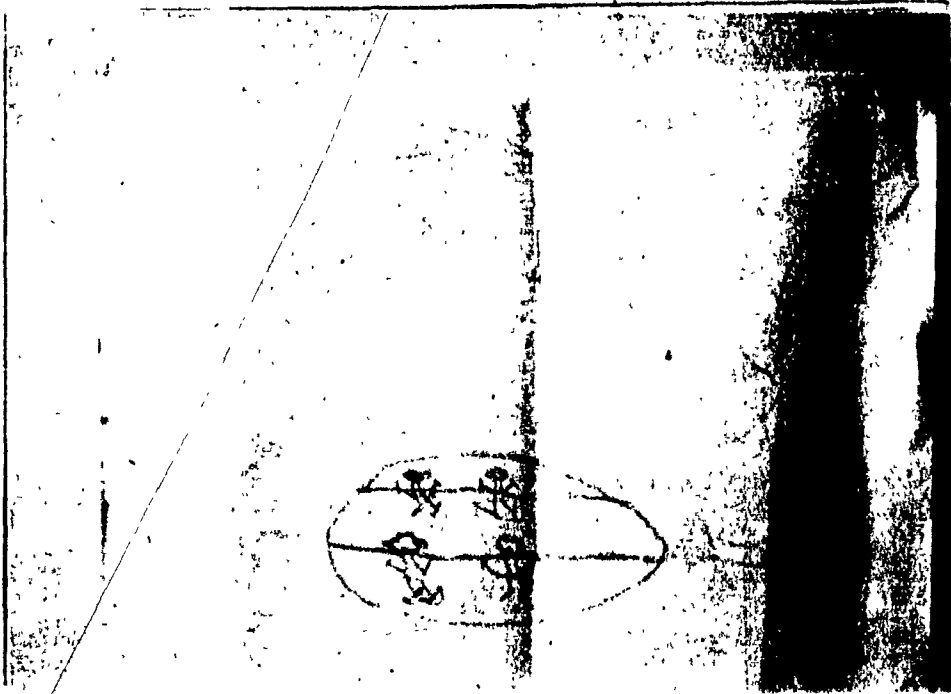
Session VI (Fig. 7) Mr. S.

The family learned about themselves and became unified.



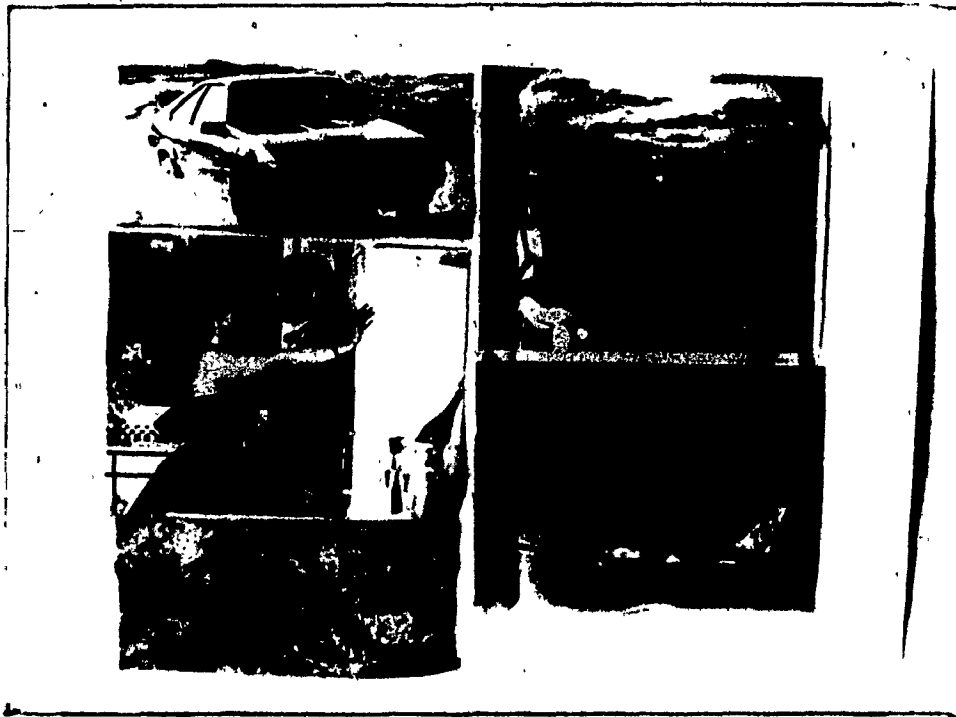
Session I (Fig. 8) Mrs. S.

An expression of her emotions for her family.
I love you all.



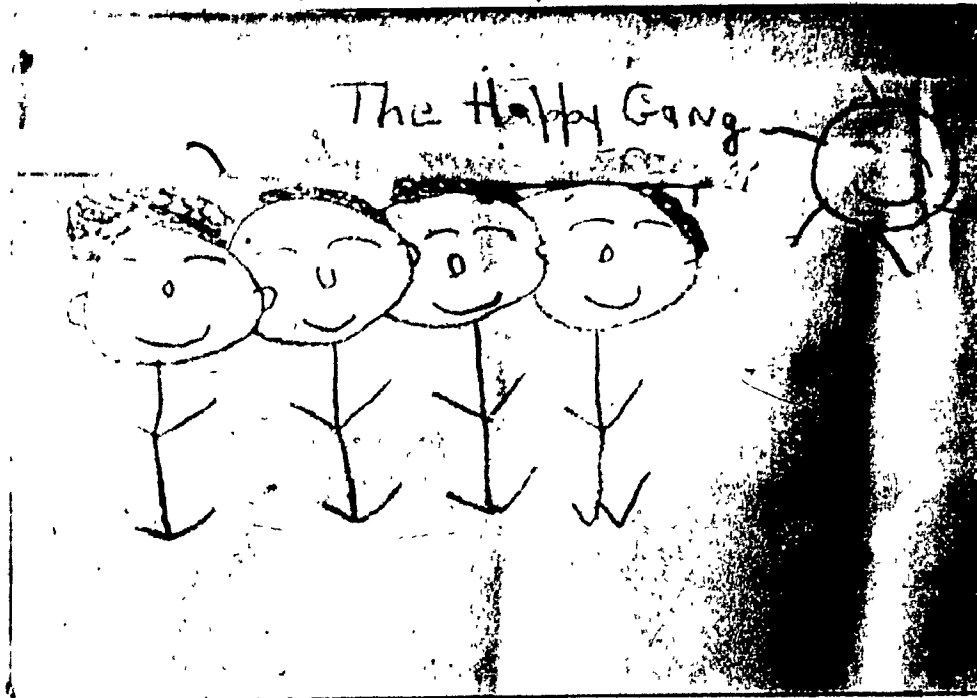
Session III (Fig. 9) Mrs. S. Scribble Drawing

A structured space for the family emerged from her confused disorder.



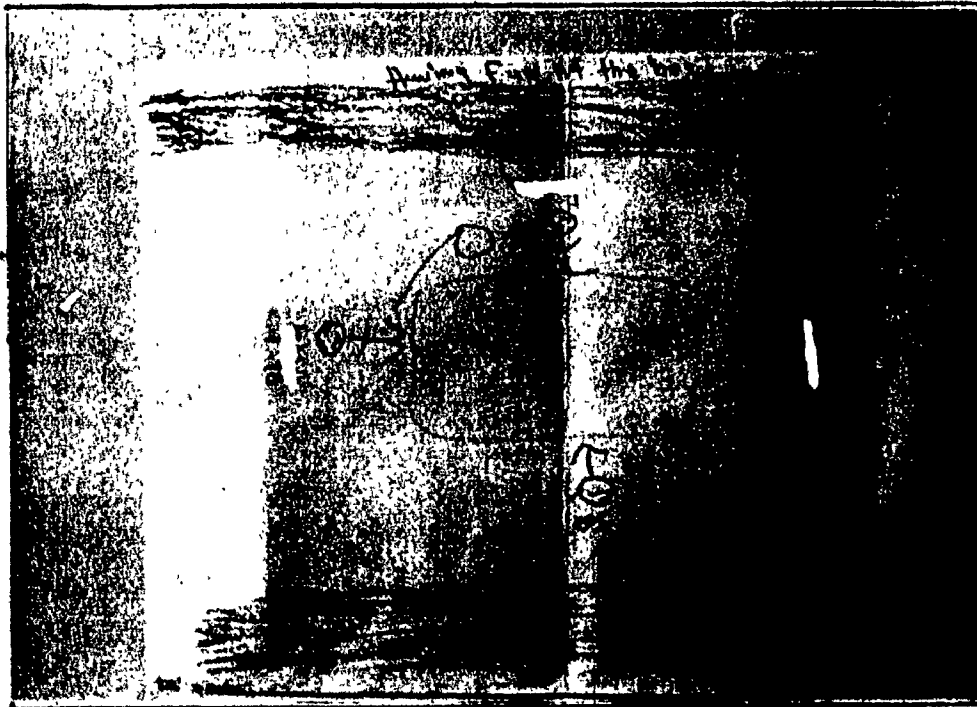
Session IV (Fig. 10) Mrs. S.

Their early romance together; her memories appeared to be very vivid.



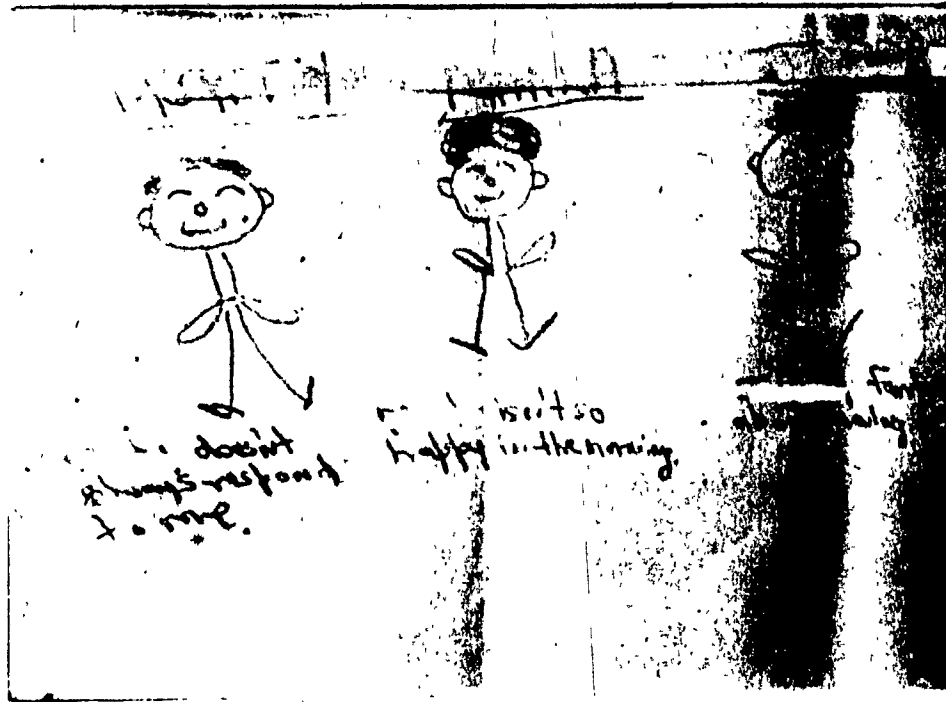
Session V (Fig. 11) Mrs. S.

Each member is a mirror image of the other;
The Happy Gang.



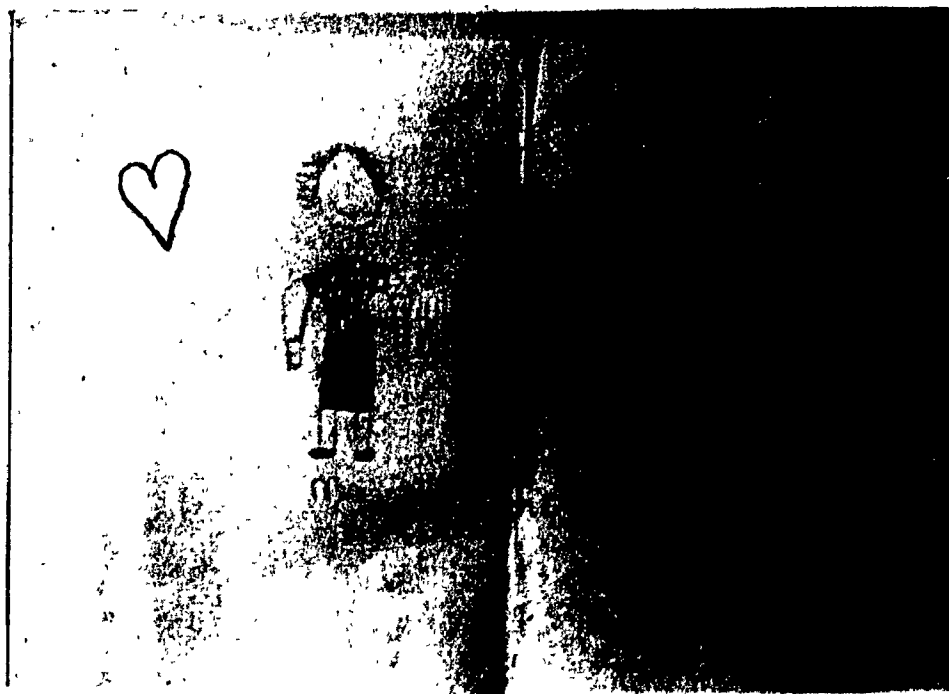
Session VI (Fig. 12) Mrs. S.

Having fun at the beach. Family structure similar to
the family meal.



Session VI (Fig. 13) Mrs. S.

Family criticism: Husband is inattentive, Jane is unhappy, and John fantasizes.



Session I (Fig. 14) Jane

She subjectively feels bigger and stronger than mother whom she loves.



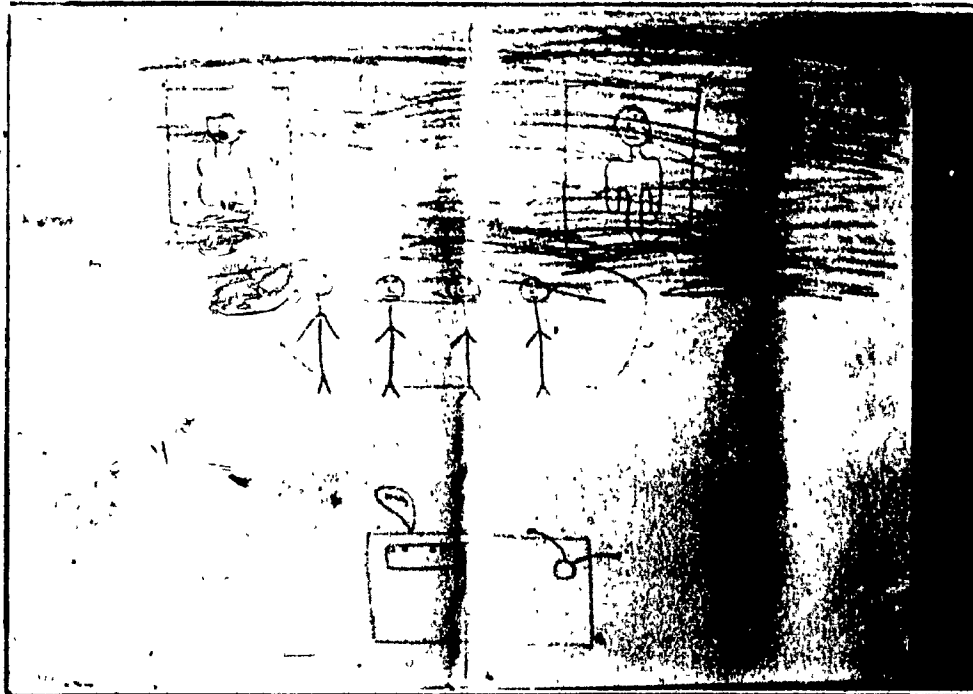
Session III (Fig. 15) Jane Scribble Drawing

Her own space, separate from her family emerged from the disorder and entanglement.



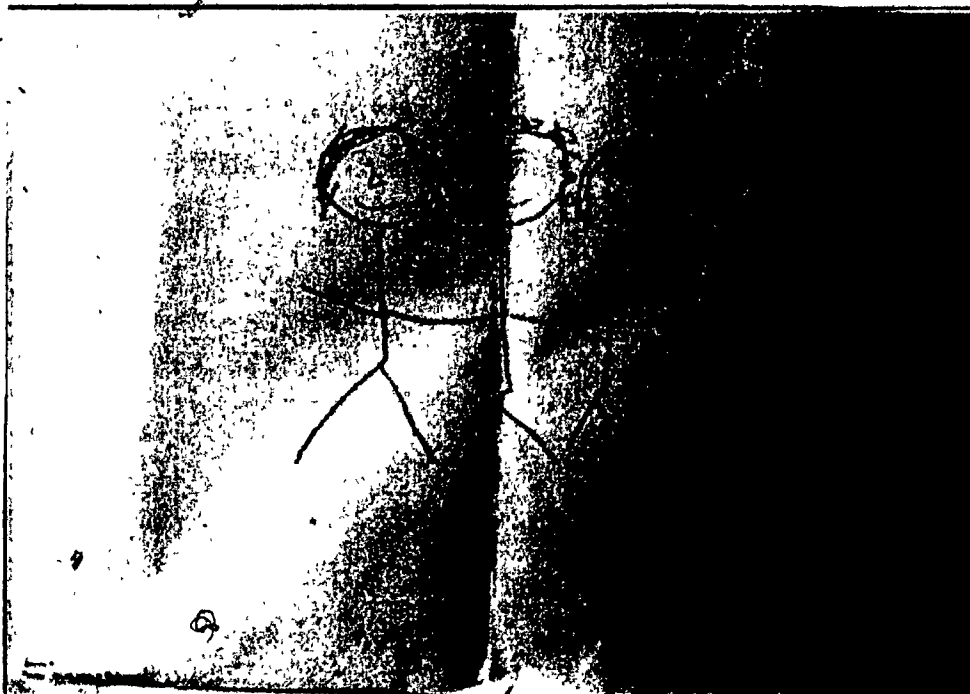
Session V (Fig. 16) Jane

The dream of her own ideal family.



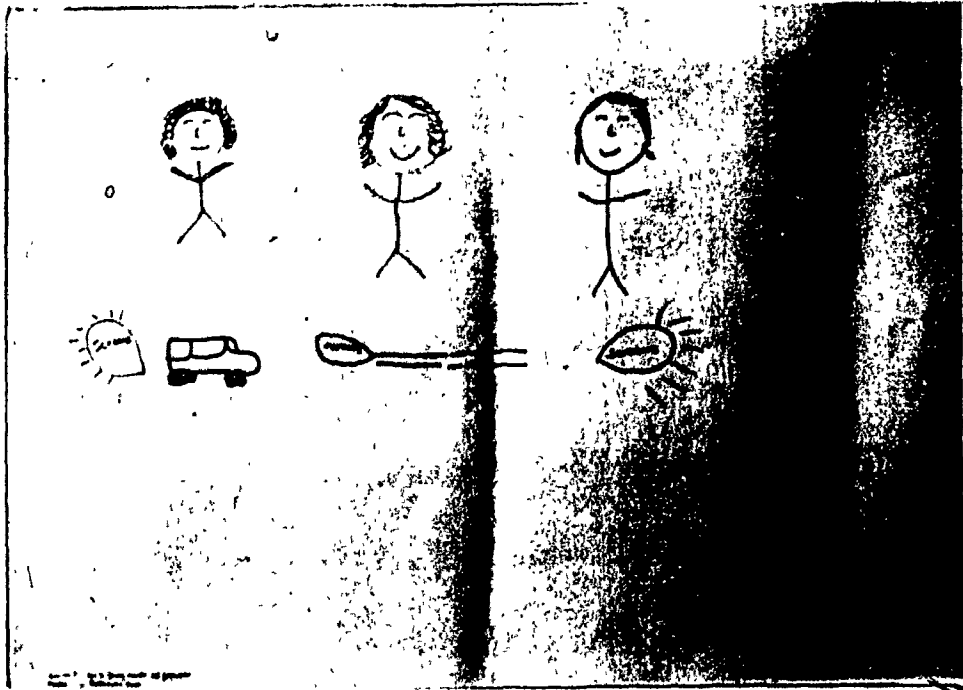
Session V (Fig. 17) Jane

The family at rest; a response to remembered losses in their family tree.



Session VI (Fig. 18) Jane

The family has joined together in unison.



Session VI (Fig. 19) Jane

Family criticism: screams, repeats, screams.
An ongoing interaction.



Session I (Fig. 20) John

A vessel of a fractured heart that is being held
together.



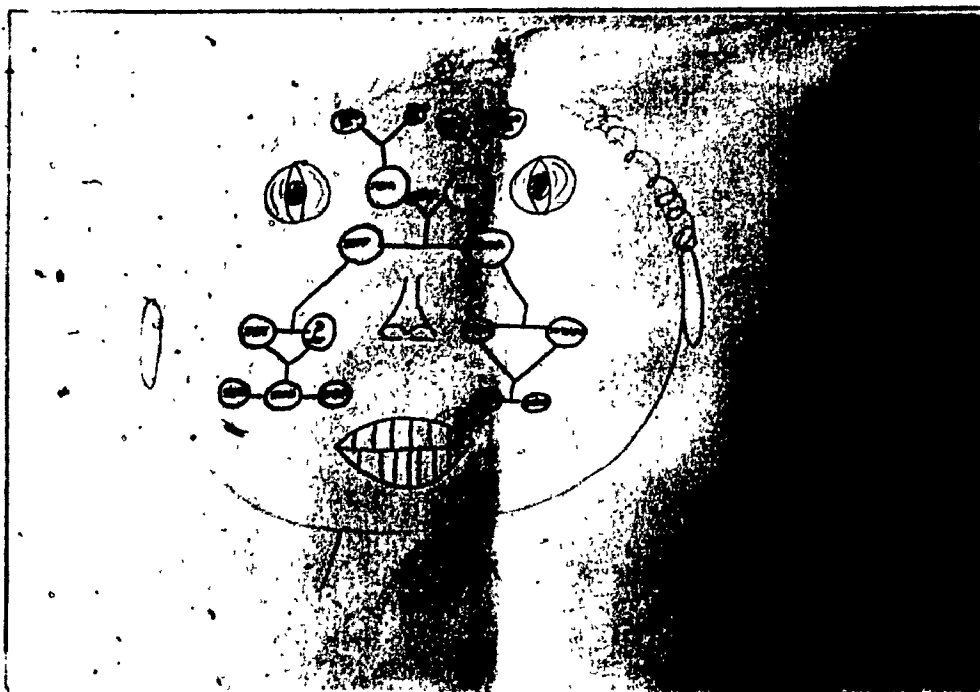
Session III (Fig. 21) John

Ambivalence of success from reaching the top or sadness projected by the teardrop.



Session V (Fig. 22) John

Parents prohibit the children's rights to surpass them.



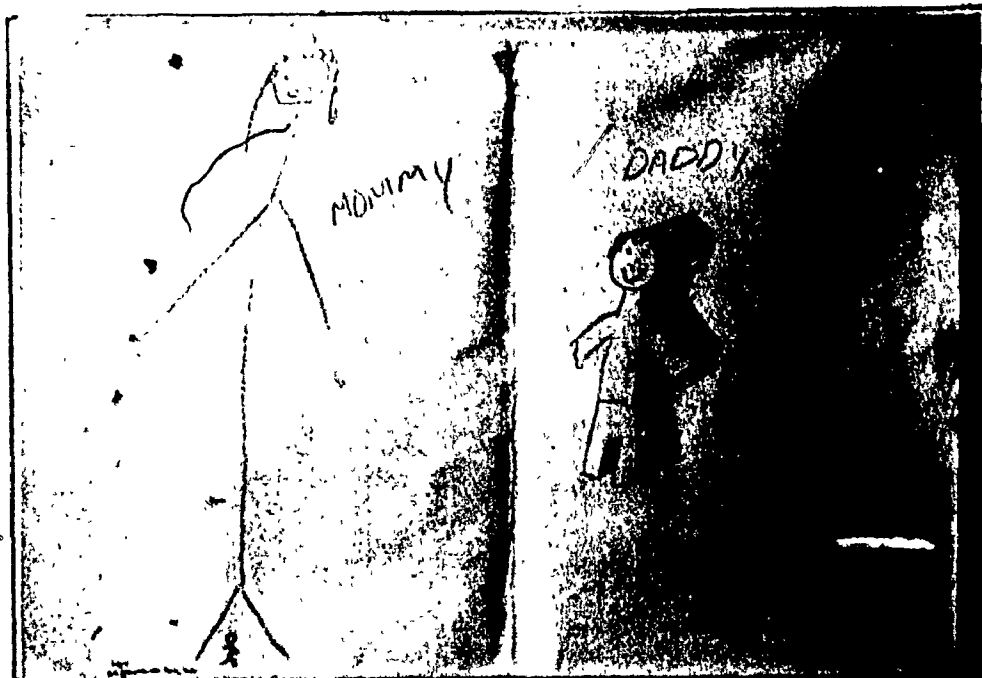
Session V. (Fig. 23) John

His genetic mapping of his family tree.



Session VI (Fig. 24) John

A fantasy; he is alone, he is autonomous.



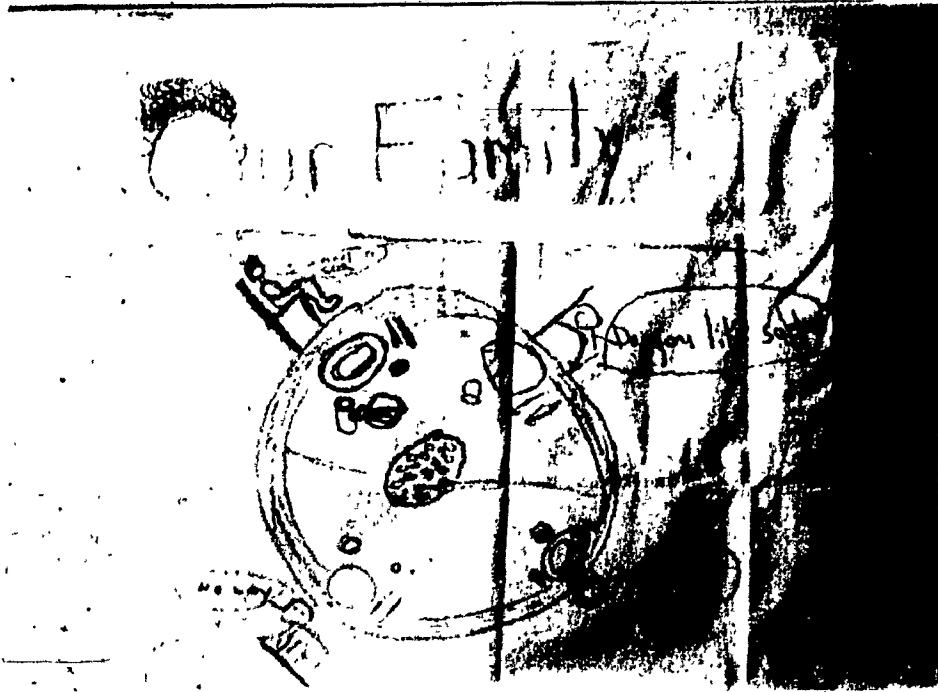
Session VI (Fig. 25) John

Mother is big and powerful; he is a molecule between her legs and father is a mere block.



Session VI (Fig. 26) John

Family criticism; mother is screaming; Jane is telling Dad who is trying to escape.



Family Mural (Fig. 1A) First Session.
"The Family Meal"

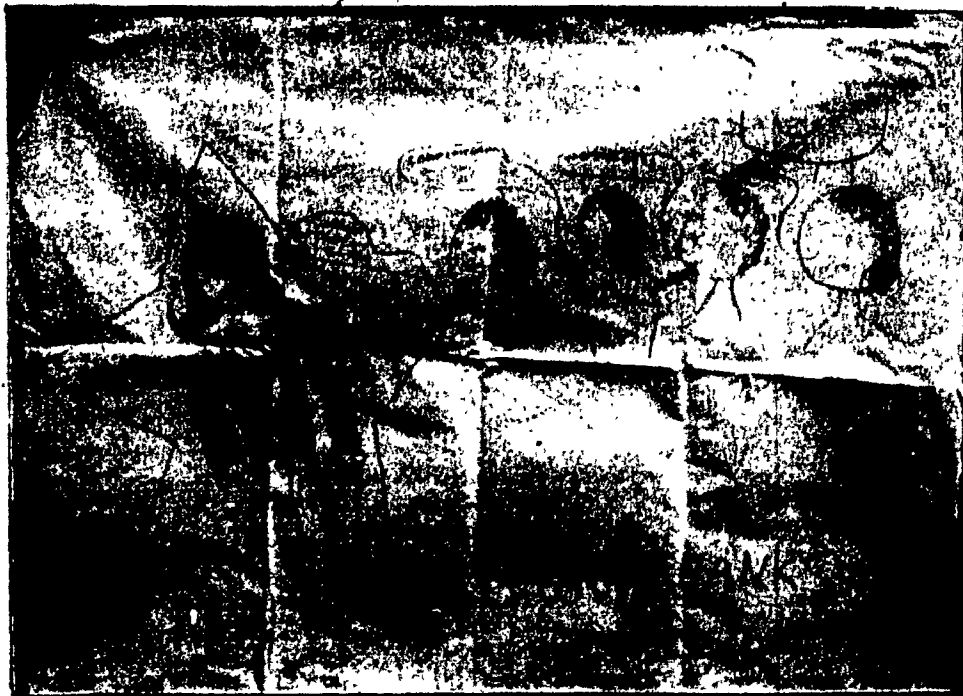


Family Mural (Fig. 1AA)
Father's small head appears in the lower corner of
"Family Meal".



Family Mural (Fig. 2B) First Session

"The Homecoming"



Family Mural (Fig. 3C) Terminating Session

"Our Thanks"

As John drew the therapist, one might assume he is ready to invest in a female other than his mother.

REPORT SENT TO THE WIFE'S PSYCHIATRIST

FAMILY CONSTELLATION:

Wife	44 years old	housekeeper
Husband	46 years old	Bookkeeper
Daughter	20 years old	Student
Son	16 years old	Student

REASON FOR REFERRAL:

It was suggested that the family might benefit from a brief therapeutic assessment program (six sessions) for the purpose of evaluating the transitional stage of the patient's return to the family system after discharge from the hospital admission.

SPECIAL CIRCUMSTANCES:

Initially, the family members were a little apprehensive, not knowing what would be expected of them in the assessment sessions. Nevertheless, a commitment was made to see the family for six (6) working sessions, plus a terminating session.

During the first two sessions, the wife tried to align with the therapist, by eluding to shared experiences that had taken place during her hospital admission. This behaviour was not reinforced in order that she would give up her identity of being the "patient" and become but a member of the family system.

THE ART PRODUCTIONS:

Session 1

- a. A non-verbal conjoint family mural. (a large drawing mounted on the wall)
- b. A planned conjoint mural titled "the homecoming".
- c. Individual drawing related to personal feelings emanating from the shared experience of creating the conjoint mural.

Session 2 - Creating a paper sculpture

- a. Mother and daughter created a paper sculpture of "themselves together". Father and son created a "games house".
- b. A planned conjoint family sculpture titled "the family ice skating at the park".

Session 3 - Individual scribble drawings

The husband, wife and daughter attended this session and the son who was absent, sent along a drawing.

Session 4 - The individual expression of important, shared experiences in their lives together.

This session was structured for the husband and wife only. The creative task is non-verbal; however, on completion, the symbolic meaning and the associated thoughts are communicated to each other, rather than to the therapist.

Session 5

- a. Individual drawings of "the family".
- b. The conjoint family participation in creating the "family tree".
- c. Individual drawings of "an ideal family".

Session 6

For this particular session, the family members were instructed to separate themselves to areas in the room (a large solarium) that could ensure them of privacy while performing the task.

- a. As they perceive the individual family members.
- b. Their own problematic issues associated with the family environment.
- c. An expression of what they personally gained from the sessions.

TERMINATION:

The accumulated artwork from the six (6) sessions was exhibited to enable the family to be aware of the progress that had taken place. After the family discussion, they were invited to create either individually, or conjointly an art product that would symbolize what they learned or experienced as an individual or as a family from the art therapy therapeutic assessment.

GROUP PROCESS:

The wife verbally dominated the sessions, which masked her anxiety. She designated herself as the "president", which entitled her the right to choose the theme of the task. The family was strongly supportive. The children were often the role models for the parents within the creative segment of the session, providing the needed structure; however, the husband quietly retained the leadership by overseeing and giving technical advice whenever necessary. At the end of each session, upon conclusion of the discussion, he would generally summarize what had taken place.

GOALS: It was suggested that it would be beneficial to the family to have the lines of communication opened between all members during this time of transition.

THEMES: The following themes were either selected or developed from the creative imagery achieved in each session:

- a. The homecoming and being back together as a family.
- b. The playing experience, and the experience of playing (Winnicott).
- c. The seeking of one's own space.
- d. The courtship and early romance
- e. The family boundaries
- f. Opening the lines of communication.

NOTABLE OBSERVATIONS

Wife:

She was highly motivated to have the family participate in this brief, therapeutic assessment program. A good therapeutic alliance had been established with the therapist and at times she needed this support to ease her anxiety. Initially, her drawings personified her feelings of separation from the family (due to the hospitalization) as evidenced in the first family mural titled "the homecoming" and in other individual drawings of the family she sometimes displayed a little distancing of her imagery from the rest of the members. She was the most dominant at the verbal level and seemed to enjoy "sparring" with her son. According to her daughter and husband, this behaviour is typical in the home environment. It would seem that the son is the only member ready to become so engaged; it allows her daughter and her husband the opportunity to withdraw to their own space. It is possible that the son's demands receive more impetus when relayed through the mother. This was seen in the first family mural of the evening meal, where the son directed his imagery toward the mother with the message "I want a car", rather than to his father, who placed himself turning away saying "no way!". Then in the

fifth session, the son illustrated his mother as a giant and himself as a minute, little figure between her legs. Certainly, between the legs of his mother, he felt less intimidated by the concrete, three dimensional illustrated block form of his father. - The wife enjoyed the experience of reflecting on her courting days; however, she was very resistant to focusing on more recent occurrences. Recalling the family members for the task of the "family tree" provided her with the structure to conceptualize her daughter's need for growth and autonomy. It was she who suggested that her daughter should include her boyfriend in a final family mural, along with the family members. At times, she was self-centered, focusing on her own needs and strength to enable her to obtain gratification. This was noticeable when she symbolized her own imagery instead of the family in the fifth session. She verbally expressed her pleasure of cooking in the sixth session in response to her husband's reference to her constant involvement in the cooking. Her message in the final family mural was to thank the therapist as opposed to expressing what had been achieved. This might be interpreted as meaning she was thankful that she had been allowed to drop the label of "patient", making the role of wife and mother more gratifying. It was noticed in the terminating session,

that her behaviour was more attentive to her husband and she seemed to take more initiative in the role of mother.

Husband:

His drawings suggest that he has some difficulty in relaxing. He would use colored pencils which implied he has the need for control. His behaviour could be described as being restless and "uptight." He was resistant to freely express himself in the artwork. This was very evident in the scribble drawing. He was instructed to close his eyes and allow himself to freely scribble all over the art space; from this unstructured form, a new picture was then developed. Instead, he tightly held the crayon making very controlled lines and expressed his difficulty in performing the task; he quipped that he needed his son for inspiration. Being unable to develop a theme within the chaotic lines, he added a non-smiling sun. The symbol of the sun with a smiling face became the family symbol (rejected by the daughter) or myth as it appeared in most of the pictures. He was later confronted as to what happens when the sun does not shine. He answered "it is always there, one just has to work a little harder to see it". In retrospect, this line drawing may well have expressed the chaos that he had felt at times when his

wife was in the hospital and perhaps anxiety related to the future. His metaphorical message being that he has had to work hard to keep the sun shining in her absence and has learned how to do it.

It was learned while structuring the "family tree" that the husband's family had been greatly reduced during the war years and those who had survived, became scattered with very little family contact. This may well be a factor in maintaining tight family boundaries. In this session, he was able to draw a picture of a family generating the growth of its members, each holding hands, keeping contact with each other. It would seem that the family is the only source of gratification. In an individual drawing done in the sixth session, he projected his wife as wanting to cook; his own subjected quote was "I want". When confronted as to what it was he wanted, he could not answer.

In the final mural that testifies what he felt was derived from the family sessions, he stated "togetherness". This fact was evidenced in the progression of his drawings with the symbolic imagery of the family members being placed in closer contact, touching or attached to one another.

Daughter

The daughter's major emphasis was centered on her

own space, outside of the family system. Her symbolic imagery of the family members suggested a lack of direct contact or interaction between family members (eye pupils, hands and feet were omitted). The exception to this was her first drawing of herself turned toward her mother where she projected herself as the stronger and more dominant figure. This possibly represented her feelings related to the caretaking role that she had assumed in her mother's absence..

The suggestion of withdrawal and non-interaction that is gained from her creative imagery is also evident in her behaviour when she is exposed to triangular family discussions. In the session, she would push back into her seat as if to withdraw and in the home environment, she apparently pushes back her chair and withdraws to her room to study. Her message in the final mural, related to what she derived from the sessions, was "communication". It might be interpreted as meaning that within the structured sessions she had been given the opportunity to communicate with her parents, mother and father. Without the need to withdraw from her mother sparring with her brother, her parents had heard that she needs to develop her own autonomous space, outside of the present family boundaries. In her imagery, she manifested her wish for

a husband and children.

Son

He also centered on his own space, redefining his new body image (sexual conflicts) and his need to extend his present boundaries, though still within the family system. For instance, in the fifth session, he depicted the family climbing two ladders. The parents, the authority heads, were positioned on rungs above the children suggesting that their pace to ascend is determined and controlled by the parents. He pointed out in the discussion, that if they (the children) proceed too fast, they will have their fingers stepped on (the punitive parents who restrict their freedom).

When working together on the conjoint family projects, he would occupy three quarters of the mural space where he would skillfully create the needed structure for the rest of the family. This was observed to be true in the family discussions. The mother would look to the son for direction, while turning a deaf ear to her husband's contributions and pressuring the son to produce an answer. This role would seem to be a burden for this young man at this time. In the family mural created in the sixth session (not included in artwork), he symbolically placed himself in the deep end of the swimming pool (labelled twenty feet), and inserted the

message "for help". Unbeknown to him in this instance, the father had also placed him in the swimming pool, however, he placed him in the shallow end and recorded the message to direct him "to come out". It was suggested in the session that perhaps the father allows him a certain amount of freedom to "explore"; nevertheless, he remains under the father's surveillance so that no harm will come to him.

As the son had not been present in the third session, the therapist repeated the father's statement that he needs his son's inspiration to perform. In response to such positive feedback, the son in turn told his father how much he had enjoyed working with him on the paper sculpture. It would seem that his positive feelings at this time were captured in his statement in the concluding mural. He felt he had gained "insurance". At the surface level, his message related to having obtained his valued "car insurance", which had been his problematic issue recorded during the family session. His father finally consented to allow him this privilege. Therefore, he acknowledged the therapeutic sessions as being relevant in resolving his problem. It could also be interpreted as meaning that, while his father deems him responsible, he has given him assurance that he is there observing, and giving the directions if

and should he be needed, as in the swimming pool drawing.

Conclusions

Overall, the family responded very well to the brief therapeutic assessment series, achieving the aim to open up lines of communication between the family members.

The wife's strong desire for approval, belongingness and response from others, especially her husband's, were evident and supported by the family. It would appear that her present self-centeredness relates to her need to achieve self acceptance of her strengths and capabilities. There was some concern during the final session (termination) when she employed an exaggerated, histrionic technique of crying (duration of about one minute) which appeared to be a manipulated attempt to gain ego support (loss of the therapist and her need for assurance of the family support). The family assured the therapist that her doctor was aware of this behaviour.

The husband would appear to have the capacity to utilize his inner resources. He responds to the environment reasonably well (surface level). As witnessed in the sessions, he appears to develop an overview of the situation while simultaneously dealing with the common sense aspects of the problem. Nevertheless, his defenses of denial and repression may at times put undue stress upon him as implied with his

remark that the sun "must" shine. It should also be noted that he appears to be devoid of interests outside of the family system - some activity where his tensions could be deflected while becoming an energizing source for self reward.

At the present time, the daughter is very involved in doing her own thing, a career and thoughts of a family of her own; this would appear to be of central importance.

There was some indication in the son's artwork and behaviour that he may be experiencing frustration and some hostility due to the limitations imposed by the parental framework. There was also the suggestion of a strong attachment to the mother figure seen in the artwork and noted in the verbal discussion. It is possible that ambiguous feelings emanating from this relationship are causing some conflict in his autonomous growth and normal sexual development. As has already been noted, there was a need for positive feedback and a working relationship with the father figure.

It might be beneficial for the family to be seen occasionally in the future to re-evaluate some of these issues, particularly with regard to the son's development.

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