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A Study of Art Therapists'  
Countertransference and Post Session Imagery

Joanne B. Kielo

A Thesis

in

The Department

of

Art Education and Art Therapy

Presented in Partial Fulfillment of the Requirements  
for the Degree of Master of Arts at  
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## ABSTRACT

### A Study of Art Therapists' Countertransference and Post Session Imagery

Joanne B. Kielo

This study explores some ways in which art therapists can use their own pictorial imagery to facilitate therapeutic progress and to understand their conscious and unconscious countertransference responses. The first phase of this exploratory study is based upon open-ended interviews with professional art therapists. An examination of their experience with art and the art therapy situation is presented. The second phase refers to some of the author's experiences with post session art work during her practicum with adolescents. The author's relevant experiences are reviewed and compared with the art therapists' who use their post session art work to clarify countertransference responses.



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## INTRODUCTION

This study sets out to explore the way in which art therapists can successfully use their own pictorial imagery to facilitate therapeutic progress and to understand the dynamics of countertransference in the art therapeutic relationship.

Whether the hub of treatment lies in the interpretation of the relationship through the use of art (Robbins, 1981; Rubin, 1981; Wang, 1981) or primarily within the artistic experience (Ulman, 1981; Rhyne, 1981; Wilson, 1981; Agell, 1981) art therapists agree that transference and countertransference exists within art therapy (Agell, G. et al., 1981).

It is my thesis that countertransference exists, whether it is defined in the classical sense as the therapist's unconscious reaction to the client based on the therapist's early object internalizations (Freud, 1905), or, in the commonly used sense, as that of the therapist's total reaction, unconscious and conscious, healthy and pathological (Racker, 1968). If the countertransference is unnoticed, therapeutic effectiveness will be substantially decreased. It is this "totalistic" aspect of the interchange that this thesis addresses; the art therapist's countertransferential position within the art therapeutic relationship.

The art therapist is presented with a complex dynamic with the introduction of art in the therapeutic relationship. This shifts the traditional psychotherapeutic emphasis of a dyadic relationship (therapist and client) to emphasis on a triadic relationship (art therapist, client and art), which effects the conscious and unconscious therapeutic interchanges.

By the very nature of the profession, art therapists are vulnerable to unconscious messages that constitute a large part of communication; these intrapsychic and interpsychic dynamics of art therapy have been described by Wolf (1985), Robbins and LaMonica (1980) and Lachman-Chapman (1979). They say that, in effect, the art therapist's approach opens the door to the pre-verbal world that has been experienced through images and sensations, as opposed to the experiences via direct verbal communication.

The art therapist attempts to recognize emotionally and understand intellectually the feelings and emotions of the client. Paradoxically, he is expected to avoid being "caught up" in the patient's feelings since this could lead to a reduction of his ability to understand and to communicate this understanding to the client. And yet, it is also necessary, as Winnicott (1971) stresses, for the therapist to remain vulnerable (i.e., open to feelings) in order to be helpful to the client.

As a means to avoid the subtle or primitive invasions of the ego, the art therapist will at times use defenses. Unconscious reactions are unavoidable as therapists travel with their clients into pre-verbal territory; there art therapists' past fears and loves are invariably touched, no matter how much analysis or psychotherapy they have personally undergone.

The art therapist's effectiveness will be determined partially by his ability to gain insight into his conscious and unconscious reactions, and also by his capacity to respond to the therapeutic relationship; thus, it can be seen that an understanding of the subtle interplay of projections, unconscious distancing, and the harnessing of feelings so that they may be used in facilitating the treatment process are a part of the art therapist's creative repertoire.

Too often the art therapist's faithfulness to the pictorial image is client-sided. He will often employ verbal means for the exploration of the art therapy interaction. The use of image-making by the art therapist himself as a way of examining conscious and unconscious reactions to the therapeutic interaction could perhaps deepen our understanding of conscious and unconscious communication.

## CHAPTER 1

## COUNTERTRANSFERENCE--AN OVERVIEW

The term countertransference has broadened from its initial description of the therapist's pathological contaminants within the therapeutic relationship to include a wide range of the therapist's feelings which become an instrument of understanding of the unconscious of the therapist and the patient alike. An historical overview of countertransference is briefly examined.

Therapists bring both the healthy as well as the pathological aspects of themselves to this relationship as does the client. The therapist's role in this relationship is defined by what Winnicott (1960) describes as a "professional attitude." Unlike as in social interactions, the therapist does not enact the patient's projections; or, if there is an enactment, it is done with awareness and with therapeutic intention. This attitude, in part, is one which can and does recognize the transference situation.

Freud proposed the idea that the eroticized gestures directed at the therapist were "false connections"; he realized that they belonged to the primary figures in the patient's early life. From this grew the concept of transference--the idea that the impulses and feelings



directed toward the analyst were "transferred" from the significant parental figure (Racker, 1968). As Freud (1905) states: "To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the physician at the present moment" (Sandler et al., 1973, p. 38).

Although transference came to be regarded as a useful tool in psychoanalytical work, Freud never explored the idea that countertransference too could be an equally useful tool. He saw it as an impediment. Countertransference, according to Freud, was the resistance of the analyst due to the arousal of unconscious conflicts by what the patient says, does or represents to the analyst's unconscious (Sandler, Dare, & Holder, 1973). Coining the term, "counter-transference," in 1910, Freud warned how it limited analysis:

We have begun to consider the counter-transference that arises in the physician as a result of the patient's influence on his unconscious feelings . . . we have noticed that every analyst's achievement is limited by what his own complexes and resistances permit. (Gitelson, 1952, 33, 11)

Countertransference was therefore looked upon as a disturbing factor, inasmuch as it interfered with the physician's neutrality (Racker, 1968, p. 26).

There was limited mention by Freud and few publications exploring and defining the concept of countertransference in the psychoanalytic literature until the 1940s, approximately

thirty years after its conception. In a letter to Jung on December 31, 1911, Freud wrote:

Frau C. told me all sorts of things about you and Pfister, if you can call the hints she drops "telling." I gather that neither of you has yet acquired the necessary objectivity in your practice that you still get involved giving a good deal of yourselves and expecting the patient to give something in return. Permit me, speaking as a worthy old master, to say that this technique is invariably ill-advised and that it is best to remain reserved and purely receptive. We must never let our poor neurotics drive us crazy. I believe an article on "counter-transference" is sorely needed; of course we could not publish it, we should circulate copies among ourselves. (McGuire, pp. 75-76)

Enrique Racker (1968), the first psychoanalyst to present a systematic study of the transference/counter-transference paradigm, suggests that the scarcity of research on this subject is partially due to certain preoccupations within psychoanalysis. He observes that in the same way that the Oedipus complex--the unconscious relationship of the child and parent--is considered more from the child's point of view, so too the patient's and analyst's unconscious relationship has been considered more from the patient's point of view. The parents' unconscious relationship with their children and the analyst's unconscious relationship with the analysands are both neglected. Racker interprets the situation as

unresolved struggles with their own primitive anxiety and guilt. These struggles are closely connected with those infantile ideals that survive because of deficiencies in the personal analysis of just those of transference problems that later affect the analyst's

counter-transference. . . . The insufficient dissolution of these idealizations and underlying anxieties and guilt feelings leads to special difficulties when the child becomes an adult and the analyst and an analyst for the analyst's unconscious requires himself fully identified with these ideals. (p. 130)

According to Lambert (1981), a Jungian analyst, what Racker is contending, namely that transference is a function of "the patient's transference and the analyst's countertransference," is similar to what Jung described, in the early 1930s, as the mutual influence of a two-person dialectic procedure--a situation which occurs between physician and patient within the analytical relationship (p. 143).

Jung conceptualizes the analytical relationship as a dynamic process, with the interchange between the analyst's and the patient's conscious and unconscious, verbal and nonverbal levels, normal and pathological elements interrelating in a variety of ways (Machtiger, 1984). In the late 1920s, Jung began to emphasize the "real" personality of the analyst. He believed that in every activity of the analyst--the arranging of the interview, comments and interpretations as well as voice tones, and so forth--some facet of the analyst was expressed which would progressively become more involved as the analysis proceeded (Fordham, 1960, p. 3).

Although Jung agreed with Freud concerning the incestuous, erotic, and infantile characteristics of the transference, he rejected the suggestion that it was beneficial or even possible to attempt to be what Freud termed an "emotionally neutral" analyst (Fordham, 1974, p.

7). In 1968 Jung said of the emotions:

The emotions of the patients are always slightly [my underline] contagious, and they are very [my underline] contagious when the content which the patient projects into the analyst are identical with the analyst's own unconscious content . . . this is the phenomenon which Freud has described as counter-transference. It consists of mutual projecting into each other and being fastened together by mutual unconsciousness. (p. 157)

The concept of countertransference, neglected in the early psychoanalytical literature, is paid more attention to in the late 1940s and early 1950s by authors, such as Lorand (1946), Winnicott (1949), Heinmann (1950), Little (1951), Reich (1951), Gitelson (1952) and Money-Kyrle (1956).

It is suggested that analysts, such as Heinmann, Racker, Searles, and Kernberg who work(ed) with patients in the area of object relations developed a framework to include their own emotional experiences (LaMonica & Robbins, 1980, p. 60). This is a major development in the evolution of the concept of countertransference. This view considers the analyst's response as a phenomenon of importance rather than as an impediment to the therapeutic progress.

Kernberg (1965) identifies some criticisms of the original definition. First, he feels that it is restricted and tends to obscure the emotional response of the analyst implying that there is something "wrong." This in turn creates a phobic attitude towards emotional reactions to the patient. Secondly, Kernberg sees important information getting lost when the focus is on eliminating the analyst's emotional reaction rather than on its sources. Kernberg thinks that it is only when the analyst feels free to accept the positive or the negative emotions that he will be in a position to use them to understand and to help the patient. Finally, Kernberg considers patients who present character disorders, with borderline and psychotic levels of organization. These patients tend to evoke intense countertransference reaction in the analyst which may give significant information about the patient. Racker suggests that all the therapist's emotions must be considered and that there is

no "normal" emotional state for the therapist, but [that] the inner state is continuously, profoundly and in certain precise and definable ways, responsive to the patient and to what the patient is saying or doing. (Hunt & Issachoroff, 1977, p. 97)

Racker provides a definition which takes into account the therapist's emotional reactions, conscious and unconscious, and he classifies the processes into two different categories: neurotic countertransference and

countertransference proper. Lambert (1981, p. 143) describes Racker's concept of neurotic countertransference as the unconscious identification of the analyst with infantile feelings within himself in connection with the patient, and his defence against these feelings. The therapeutic progress is brought to a standstill until the neurotic countertransference has been identified turning it into countertransference proper. Countertransference proper is understood through the inner experience of the therapist's reactions as either a kind of ongoing empathic response or as reactions giving information about the patient's significant early objects. These categories will be explored in depth later.

Though countertransference was not supposed to occur, it clearly did--as the need for the term attests. We have seen that while Freud regarded the analyst's unconscious as an organ of perception, little attention was paid to taking the necessary steps with regards to countertransference. Similarly, Jung's emphasis upon the importance of the analyst's personal influence within the therapeutic interchange was initially neglected. The term ultimately expanded to cover the analyst's intrapsychic state. As a result the analyst's personality, not only his psychopathology, could be brought under review. The analytical interchange therefore came under close

observation, and this development has led to more detailed studies of the therapist-client interaction in psychoanalysis (Racker, 1968; Kernberg, 1965; Searles, 1968).

It thus appears that there are two main approaches to the term countertransference: On one end of the spectrum there are therapists who adhere to Freud's classical definition--that of the unconscious reaction of the therapist to his patient, based on the therapist's early object internalizations; while on the opposite end there are those who see countertransference as being an incorporation of the total emotional reaction of the therapist to the patient--which includes the latter definition--as well as the therapist's conscious and preconscious reactions to the client. Within the totalistic attitude the classical definition remains intact; but it also includes the recognition of the therapist's conscious and preconscious affective experiences. Sandler, Dare and Holder (1973) suggest that it is useful to take into account a definition which incorporates the therapist's reactions as a useful tool. They propose that a valuable view of countertransference may be one that refers to the specific emotional response aroused in the therapist by a specific quality of the patient.

This proposal provides a good starting point for a working practice. For the purpose of this study it will be considered in conjunction with Racker's framework of the neurotic countertransference and countertransference proper.



## CHAPTER 2

## RACKER'S CONCEPT OF COUNTERTRANSFERENCE

While neurotic countertransference is at one end of the spectrum representing the analyst's completely unrecognized identification with the patient, countertransference proper represents degrees along the spectrum of awareness of the therapist's countertransference identifications (Racker, 1968, p. 134). Lambert (1981) clarifies Racker's concept of the neurotic countertransference as "a neurotic transference to a patient who has done nothing to provoke it" compared to a neurotic counter-response which is a response to the patient's transference (p. 147).

Neurotic countertransference is based upon the therapist's identification with his own infantile and child feelings in relationship to the patient, with the result being a disproportionate reaction accompanied by pathological defenses which renders therapeutic intervention ineffective (Lambert, 1981, p. 145).

Concordant and Complementary Countertransference

Racker (1968, p. 134) describes two types of countertransference proper: concordant and complementary. Concordant countertransference is the development of the

predisposition of the analyst to identify with each part of the patient's personality, while with a complementary countertransference reaction there is an identification with the patient's internal objects.

Hunt and Issachoroff (1977) describe Racker's concept of concordant countertransference as that which "give[s] information about the self experience of the patient" and the complementary countertransference "as reactions [which] give information about the significant early objects, as experienced by the patient." (p. 99).

Lambert (1981) delineates Racker's concept of the concordant countertransference as the therapist's process of identification:

a) the unconscious recognition that what belongs to another is one's own [through introjection I feel that this part of you is me]; and b) the unconscious equation of what is my own with what belongs to another [through projection I feel that this part of me is you]. (p. 147)

The concept of empathy has been compared to concordant countertransference. Empathy, according to the American Psychoanalytic Association Glossary (Moore and Fine, 1967) is defined as:

a special mode of perceiving the psychological state or experience of another person. It is an "emotional knowing" of another human being rather than intellectual understanding. To empathize means temporarily to share, to experience the feelings of another person. . . . The essential psychic mechanism is the analyst's temporary identification with the patient. (p.43)

Thus, Hunt and Issachoroff (1977) claim that the process of the concordant countertransference is the same as the empathic response of the therapist, and Lambert (1981) too suggests that it is related to the therapist's ability to go along with the patient's dynamics with empathy and sympathy. Within this process, the therapist has become the subject while the patient is the object of knowledge and concern. This may have the effect of nullifying the object relationship between the patient and the analyst. This relationship has been likened to that of the mother's response to the infant (Lambert, 1981, p. 148). According to Post (1980), this empathic state in its primal form is a "benevolent, integrated and interactive attunement to whatever is the experiential state of the infant" (p. 280). Winnicott (1971) discusses the paradoxical nature of empathy as being fused with the infant and, yet, as being separate from it (p. 63). Beres and Arlow (1974) suggest that the fusion or identification is relinquished intermittently (p. 33), while Mahler (cited in Post, 1980) proposes that the simultaneity of identification and delimitation in the mother's response is both that of the self object and that of a separate supplier of confirmation (p. 279).

Beres and Arlow conclude that the empathic response involves transient identification with as well as remaining separate from the object. It is not only a matter of being

"with" the person but also of thinking "about" the person.

Both the "with" and "about" are essential components of the empathic process (Beres & Arlow, 1974, p. 33). The experience of being "with" the patient and thinking "about" the patient in the concordant countertransference or in empathy is what Lambert (1981) suggests as the basis of the therapist's most effective and creative work (p. 150).

According to Money-Kyrle (1956), this effectiveness depends upon the therapist's rapid operation of the introjective and projective mechanisms, that is, responding affectively rather than intellectually. If this process breaks down the therapist may get stuck in the introjection phase. Money-Kyrle describes this state as "periods of non-understanding": the introjective period when the therapist fails to recognize that a pattern of the client's emotions represent a fantasy in his own unconscious (p. 361).

Beres and Arlow (1974) suggest that a component of the empathic process is the therapist's affective reaction which may serve as a "signal" to the therapist that an unconscious fantasy has been activated in him comparable to an unconscious fantasy within the patient. It is a momentary identification through introspection of what the patient may be feeling and they label this as the "signal affect" (p.35). Beres and Arlow conclude that the "signal affect" may be cues picked up by both verbal and non-verbal

behaviour represented in the words, gestures and behaviors of the patient.

The effectiveness of the therapeutic interchange depends upon the concordant countertransference, according to Lambert (1981), who emphasizes this as a process which "arises, extends and deepens" (p. 150). Beres and Arlow (1974) suggest that the "signal affect" precedes the therapist's introspection and leads to a more conscious perception of the therapeutic interchange. Post (1980) suggests there is a cyclical movement which returns repeatedly to the "signal affect" in a "process of progressive clarification of the state of another--which signal affect may be maintained paradoxically at the edges of awareness during elaborative phase of the empathic activity" (p. 282). Kohut (cited in Post, 1980, p. 282) refers to this as "trial empathy," described as a provisional, repetitive immersion: the searching of regressions within the therapist. Mariq Jacoby (1984), a Jungian analyst, describes his experience with concordant countertransference.

I am probably experiencing concordant countertransference when I can allow myself to be spontaneously with the patient wherever he really needs me to be, and when I can be open and flexible enough to allow him to "use" me to a wide extent, according to his needs within the symbolic framework of the therapeutic situation. It is of course important for the analyst to be at the same time as aware as possible of where this is leading. But I have seen again and again that if I can let myself be "carried" to where

the patient vitally seems to need me, I experience a deep sense of empathy which allows sensitive new insights to appear spontaneously. (p. 38)

Despite the annulment of the object relationship in the concordant countertransference situation, aspects of the object relationship within the therapeutic interchange appear nonetheless. These aspects may be a part of the complementary countertransference.

Racker (1968) describes the complementary countertransference as the therapist's identification with the internalized objects of the patients (p. 135). Hunt and Issachoroff (1977) suggest that it is not primarily an identification; rather, complementary countertransferences are reactions to the patient's behaviour which parallel the behaviour of parents or other childhood figures. Hunt and Issachoroff give an example of complementary countertransference:

Suppose that in the original situation there was an impatient, irritable, and self-centered mother, and her child coped with the mother's behaviour by becoming clinging, reproachful and full of physical complaints. Such an adaptation, for all its discomforts, may have succeeded in maximizing maternal attention. The child grows up, becomes a patient, treats the therapist as she treats her mother, and everyone else, in a dependent, accusing, and complaining way. Soon the doctor feels impatient, irritable, and with a strong inclination to think about his own matters and not the patient. He feels like the mother. (p. 99)

The complementary countertransference has evolved, according to Lambert (1981) because the patient has been treating the therapist as a projected internal object. In

turn the therapist feels treated as such and therefore experiences an emotional reaction to such approaches.

Kernberg (1965, p. 48) describes this position wherein the analyst experiences the emotions that the patient is putting into his transference object while the patient himself is experiencing the emotion which he had in his past with a particular parental image. This occurrence is defined as projective identification in the analyst and marks the development of the complementary countertransference.

At one end of the spectrum is the neurotic countertransference reaction, an unconscious and pathologically defended against response. Along this spectrum is the therapist's growing awareness of the patient's projection and his utilization of the evoked emotional response as a means of gaining information about both the patient's transference and his own state of identity with the patient's internal object as well. Once the introjection has been successfully understood possibly as the complementary countertransference, the concordant countertransference may be re-established. (See table on page 20).

**Table**  
**Countertransference**

	Process of identification	Mechanisms	Therapist's experience	Result of therapist's consciousness
<b>Concordant countertransference</b>	therapist's predisposition to identify with each part of the patient's personality (Lambert, Racker)	rapid oscillation of introjection and projection (Money-Kyrle)	compared to empathic response of the mother and infant (Hunt and Issachoroff) experience of letting oneself be "carried" by where the patient needs the therapist to be (Jacoby)	gives information about the self experience of the patient (Hunt and Issachoroff, Lambert, Racker)
<b>Complementary countertransference</b>	identification with patient's internal objects (Kernberg, Lambert, Racker) not primarily identification but reaction to patient's behaviour (Hunt and Issachoroff)	can either be rapid oscillation of introjection and projection or temporarily stuck in introjective or projective position (Money-Kyrle)	therapist is treated as patient's projected internal object (Lambert) therapist responds to patient like patient's significant childhood figures (Hunt and Issachoroff)	gives information about significant early (part) object as experienced by the patient (Hunt and Issachoroff, Lambert, Racker)
<b>Neurotic countertransference</b>	unrecognized neurotic transference (Lambert, Racker)	stuck in projection position (Money-Kyrle)	unrecognized, disproportionate reaction to patient accompanied by pathological defenses (Lambert, Racker)	gives information about the therapist's neurotic responses
<b>Indirect countertransference</b>	therapist's (conscious or unconscious) identification with third party	any of the above	arises when a third party plays a central role in the therapist's feelings—often someone in the therapist's professional community or patient's life ex. patient's wife, therapist's supervisor (Hunt and Issachoroff, Racker)	gives information about the triangular situation—patient, therapist and third party (Hunt and Issachoroff, Racker)



### CHAPTER 3

#### COUNTERTRANSFERENCE IN ART THERAPY

The therapeutic use of transference and countertransference in art therapy is dependant upon the considered goals of the treatment. Although there exists a general consensus among art therapists that transference and countertransference are ubiquitous, there also exists a wide variety of attitudes concerning the dynamics of the art therapeutic relationship (Agell et al., 1981). These factors therefore influence the therapeutic usefulness and exploration of the countertransferential material.

The role of empathy in the countertransference response was noted in the previous chapter. A common social expression of empathy is the shared aesthetic experience of the artist and the audience. Aestheticians have suggested that empathy takes on two forms, that of active empathy on the part of the artist as he creates his work and passive empathy on the part of the audience as it feel its way into the work. According to Post (1980), while the empathy of the audience is not a mirror image of the artist's, there does exist some congruence of experience as to what is envisaged and sought by both the artist and the audience.

This study addresses the area of congruence of countertransferential material within the triadic relationship: between the client, the art work and the art therapist.

Winnicott's (1971) concept of "potential space" provides a framework for such an interaction. The "potential space" is where the inner and outer realities of the infant interact in play. The mother's mirroring (imitative playing) endows the infant's actions and reactions with meaning. In infancy, in this intermediate area, the initiation of the relationship between the child and the world is made possible by the "good enough" mother at the early critical phase. A process of increased differentiation develops from an original egoless state to that of a personal identity in which the person is both separate and a part of a larger whole. It is a condition of his socialization that he learns to live in a dynamic relationship with others in the world. In doing so he needs to continuously process a reshaping of his self-image to coincide with such changing relationships. This paradoxical relatedness, that is, being both one with another and yet separate is first experienced in early childhood. Milner (1957) suggests that "fusing with" and "separating from" are inherent in the relation of subject to object. She understands that making art heals the split between subject

and object generated when the infant becomes aware that the mother and self are not one. Making art transcends this split and the art becomes a means of creating the object and regaining lost objects. As Winnicott (1971) states, the infant "creates" the mental image of the mother when she is unavailable, as a means of soothing himself (p.17). With inadequate mothering, the infant's inner and outer worlds will be poorly assimilated. The infant has to create his own imagined organizer for the primary experience. Inevitably this substitute organizer will reflect the infant's fragile experience. According to Robbins the only protection against such experiences may be excessive projections, introjections and denial (Agell et al., 1981, p.7).

In art therapy that which was dyadic play between two people becomes a triadic relationship between the art therapist, the client and the art work, where the art work is the focus of the therapy. The art work may be considered the container of the inner and the outer worlds, while the artistic process constitutes a reenactment of the infant's first creative accomplishments and furthers the lifelong process of individuation. The art work becomes a transitional means to cope with the object loss. According to Robbins (1980), in art therapy the client has a safe place in the art process to repair the damage by investing his energies into his creations. Creativity is therefore

connected to the self and object through "symbols and images that become affective codification of our intrapsychic life" (p.26). The art work, states Robbins (1980),

becomes a playground although at time a very frightening one indeed. Here images loaded with enormous libidinal energies of love and hate can be faced and the patient's vague, fluid boundaries become clearer and more comprehensible. (p. 90)

Wood (1984) describes art therapy as a "triangulation around potential space" whereby the creative act of, for example, painting in the presence of the art therapist alters the "intention and dynamic balance," compared to the person doing the art on his own. The art therapist is present throughout the process from the first mark on the page until the formulated image (p. 68).

Rubin (1984) suggests that the conditions within the art therapeutic relationship foster the emergence of personal material in the art as well as within the relationship. She describes the art therapist's behaviors as non-neutral. The art therapist may be considered as a "feeder" of supplies (the supplies may be experienced as good and plentiful or bad and insufficient), a sensitive onlooker or unappreciative audience, a voyeur, an intrusive prober, or, a helpful support. Rubin (1984) says

I do believe however that the presence of the product modifies what occurs and there are pressures toward certain forms of transference in art therapy . . . . Because there is so much gratification, for example, the likelihood of an initial positive transference is great . . . The "feeder" aspect of the art therapist's

role, as well as the admiring "gleam-in-the-eye" mother who approves of controlling one's (anal/art) products and applauds one's (phallic/art) display or performance-combine to produce a high frequency of maternal transferences in art therapy. (pp. 55-56)

Robbins (1980) feels that creative work "must occur within the context of affective transference" between the client and art therapist so that the internal, frightening images can be neutralized "of their primitive terror" (p. 93): He suggests that the art therapist facilitates this transference through the receptivity of preverbal material, and it is within this pre-verbal matrix that a

spatial, temporal or sequential characteristic of a very complex experience is organized within the therapist's image. Thus the undifferentiated or intangible quality of early experiences gain a moment of apprehension as we move in and out of altered perceptual states. The expressive therapist, therefore does not limit himself to the confines of direct linear communication, but travels to the genesis of one's early imprinting experiences. (p. 93)

According to Wood (1984), transference is present in art therapy with its expression and resolution taking place within the art. She points out that painting can only take place where separation has begun and when the client can be alone, if only briefly, in the presence of the art therapist. If this state has not been achieved then this becomes the goal of the therapy. She explains that the client attempts to make his own containing vessel in his art work; however, she adds, the art therapist is subject to the "overspill of unconscious content, at unconscious levels of

interactions" (p. 70). She suggests that the art therapist must deal with countertransferential material related to the client as well as to the art work. Wood explains: "The art therapist is also in a countertransferential relationship with the painting and can feel inexplicably exercised in response to it" (p. 71).

Working within this subtle area of fusion and separateness, the observation and understanding of the art therapist's countertransference response to both the client and the art is necessitated. Furthermore, applying both the working definition of countertransference as the conscious and unconscious emotional responses aroused by the specific qualities of the client as well as Racker's classifications of neurotic countertransference and countertransference proper to the art therapy situation, the responses of the art therapist would not only be aroused by a specific quality of the client but would also include his conscious and unconscious reactions towards specific qualities of the client's art. Countertransference would therefore be explored as specific affective responses to both the patient's transference and/or the patient's art.

Robbins (1980) suggests that the expressive therapist's strength lies in the ability to understand countertransferential reactions and to use them in the service of the treatment process. To the author's knowledge

there has been no research in the area of the potential use of the art therapist's post session production and countertransference. However, Robbins (1980), an art therapist and analyst, and LaMonica, an art therapist, have addressed the topic of post session imagery in a chapter entitled "Creative Exploration of Countertransference Experiences"; Wolf (1985), an art therapist and psychoanalyst, explores a dynamic of countertransference via the art therapist's art production within the session in his article "Image Induction in the Countertransference: A Revision of the Totalistic View"; and Lachman-Chapin (1983), an art therapist, considers issues in relation to art produced in the session by the art therapist and the client in her article "The Artist as Clinician: An Interactive Technique in Art Therapy."

In the field of depth oriented analysis there have been some studies which explore the use of the analyst's visual imagery that is, images produced by the imagination in conjunction with countertransference resolution; however, these are limited. Kern (1978), a psychoanalyst who studied this area, suggests that this lack of inquiry into the subject is probably due to the analyst's use of free association, as well as the use, at times, of their dreams as a means of countertransferential resolution. Kern studied certain of the analyst's imagery which appeared

irregularly during the analysis. While the overall content of the analyst's imagery reflected the situation described by the patient, Kern focused on what he called the "back drop" imagery, which constituted aspects of the analyst's contributions. Through self-analysis these "back drops" yielded information related to unrecognized countertransference and unconscious communication between the analyst and patient.

Ross and Kapp (1962), two psychoanalysts, studied the visual imagery (ie. the mental imagery) of the analyst's in response to the patient's description of dreams and use it as a starting point for the uncovering of unconscious countertransference. They propose that the images which appear in the analyst's mind during the process of responding to the unconscious activity of the patient's mind is essentially a "new version" of the patient's dream. This "new version" is one in which the analyst's contributions of his imagery is recognized and may be indications of countertransference reactions.

Dieckmann's (1976) Berlin research group asked analysts to carefully observe their reactions to their patients, that is, their emotions, fantasies and feelings as well as the psychosomatic effects arising from the unconscious. The results obtained from the research suggested the coordination of the two psyches. The group found that every



fantasy, emotion and so forth arising from the analyst's unconscious was connected with either the patient's association at a specific moment or at a moment shortly following the patient's fantasy. Secondly, they were able to make observations of resistances in the transferences and countertransferences, and these resistances, they found, were related to a mutual matter of shared anxieties of both the analyst and the patient. And finally, their observations suggested an "astonishing increase" in the aspect of synchronicity between the analyst's associations and the patient's recollections as the analysis proceeded.

Samuels (1985) proposes two types of "usable" countertransference, and both can be seen as communication from the patient. He concludes that there exist two types of countertransference reactions which can be distinguished into distinct groups of responses: a) bodily and behavioral responses; b) feelings responses; c) fantasy responses. He concludes that all these responses are in the form of images because they are active in the psyche in the absence of direct stimuli which could be said to have caused their existence. According to Samuels (1985), the image in these cases may be conscious or unconscious but can be regarded as promoting the feelings, behaviours, and fantasies; it is not a secondary coded message about them.

As concerns countertransference in art therapy, Robbins makes the point that art therapists must not "fool

themselves with false notions of professionalism or objectivity" (Agell et al., p.7). He contends that the art therapist is susceptible to primitive, nonverbal messages by the very nature of this profession, and that he may use defenses that would inevitably interfere with therapeutic progress. He states:

In struggling to avoid the subtle invasions of their egos, the art therapist will, from time to time, employ their own particular defenses such as over-idealization, distancing, defensive anger and so on. (p. 7)

However, Lachman-Chapin, discussing the same topic, suggests that the "artist as clinician" has more of a tolerance toward these subtle, primitive messages and understanding of those "whose basic misery is a sense of confusion about the self and other," since it involves the artist's experience with fusion and separateness within his own artistic processing (Lachman-Chapin, 1983, p. 14). So the art therapist's own artistic process may serve to facilitate an exploration of this preverbal experience in response to the therapeutic relationships.

Two of the most prominent art therapists who make use of "totalistic countertransference" are Wolf and Robbins. The totalistic countertransference takes into account Racker's conception of the neurotic countertransference and the countertransference proper. Wolf (1985) suggests that often a limitation of the therapist is "receiving, deciphering, understanding and creatively" using the

countertransference that may hinder therapeutic progress.

Robbins (1980) feels that because the expressive therapist is dealing with self-object relationships with their origin in a preverbal stage of development that he must be receptive to such an experience. He explains:

We must recapture this very early process where the essence of self and object are formed. . . . we must utilize a process within ourselves as therapists that is receptive and available to this early primary experience. (p. 71)

Robbins describes this involvement within the "potential space" as "two minds attempting to make contact at a prelogical symbolic level" expressed within the imagery and the relationship (p. 26). He suggests that the art therapy framework moves the object relationship into new meanings emphasizing the art therapist's active involvement: "most importantly the therapist must himself experience and make contact with this early developmental field in order to reproduce a transitional space for reparation" (p. 29). One way this is achieved is via the art therapist's countertransference drawings.

Wolf (1985) presents one intervention that reflects this receptivity whereby the analyst attempts to maintain an empathic connection with the primitive organization of the patient. He describes this as a process of non-defensive projective identification. He states that this occurs when the patient

externalises the self or parts of the self onto the analyst with hopes that these projections will be

received and experienced by the analyst but that they will not damage, change or otherwise transform the analyst into either a victim or persecutor. (p. 130)

To deal with this the analyst draws spontaneously as the client talks and is in the process of creating his own art work. Wolf suggests that the analyst's drawing in this case results in the rendition of the client's projection.

Another art therapist, Lachman-Chapin (1983), involves herself in drawing during specific art therapy sessions. She considers this a useful technique for patients with early narcissistic damage, and as a way of working through issues of "mutuality and reparation" (p. 23). She creates her art while the client does the same, after which both works are discussed. Lachman-Chapin reflects upon the art therapist's contribution in this interaction:

One must consider the person of the therapist as experienced by the patient, as well as the transference to the therapist. The therapist, in turn, considers the countertransference as well as how he feels he is contributing by his person, to the patient's reactions. [The dynamics] are more explicit because the results are in a concrete product, products that embody what is going on between two people and can be examined. (p. 24)

Both Wolf and Lachman-Chapin emphasize that this type of intervention in art therapy must be used with careful consideration and that it is not for the inexperienced.

Wolf (1985) states:

Like any good clinical intervention, it must be woven with a solid treatment structure which reflects both the analyst's personal and professional skills, along

with a healthy regard for and understanding where the patient is and what he/she can use. (132)

Lachman-Chapin (1983) delineates the following prerequisites for art therapists involved in the interactive technique:

1. Intensive personal analysis so that the therapist can recognize and manage the subtle messages in his spontaneous imagery.
2. Long clinical experience.
3. Being an artist with an understanding of one's own artistic vocabulary (p. 25).

Finley (1975), a Jungian analyst, contends, on the other hand, that the analyst's participation in the analysand's process exists throughout whether it is acknowledged or not. She uses dialogue drawing, a technique whereby the client and the analyst each make a graphic statement by alternately drawing on the same sheet of paper. By drawing together in the session she suggests that it has a "grounding effect" and that "the patient has tangible evidence of the hooks on which he hangs his projections and then can separate from them more easily" (p. 87).

One method suggested by Robbins and LaMonica (1980) for the art therapist to evolve a better understanding of the transference and countertransference interaction is to draw an artistic representation of the patient in absentia. They conclude that the difference between the art therapist's

intentions and the actual results indicates something about the patient's reality, the transference, the therapist and/or the relationship (p. 67).

They stress that, as artists and as clinicians, the art therapist must move with the patient to experience the early pre-verbal introjects and object representations and must still retain sufficient ego organization in order to gain insight. They explain that "he/she is neither captured nor fused by his identification but indeed finds knowledge, insight and some answers that will move the therapeutic dialogue forward" (p. 71). While Robbins (Agell et al., 1981) acknowledges that at times, art therapists use defensive measures as a means to protect "the subtle invasions of their egos," he suggests that by objectifying the experience through artistic creations the countertransference can be understood rendering the art therapist more effective. Wolf (1985) poses the following question: "We wonder if without this vehicle of externalization (i.e., drawing) the analyst might eventually act out his affective reaction to the (patient's) projection in some way?" (p. 132). Although this question is framed within Wolf's situation of doing art work within the session, it may be relevant for doing art work with the patient in absentia.

Robbins (1980) views the relationship between the art therapist and the client in art therapy as an evolving field of "mutual perceptual differentiation" (p. 23). As the art therapist experiences the patient's self and object representations, he must be able not only to empathize with this position but also may need, at times, to reconcile his own self and object representations.

Countertransference reactions must be clarified and understood in order to achieve progress. The therapist walks a fine and paradoxical line: going "with and against nature" in order to help the client connect up to his transforming images. The process of creating art following the session may be one way in which the art therapist could facilitate his understanding of the countertransference reactions within the art therapy framework.

## CHAPTER 4

### THE POTENTIAL OF THE ART THERAPISTS' POST SESSION ART

#### Aim of the Study

The aim of this study is to evaluate the potential of post session image making by the art therapist as a means of facilitating the therapeutic process.

The inquiry is based on the propositions that:

1) the limitation of therapy is contingent upon the therapist's personal capacity to respond in such a way as to further an expansive relationship, and 2) that if in art therapy the "making of the image" is an integral part of the client's growth, what then is the potential of image making, by the art therapist for:

a) exploring the art therapist's personal capacity to respond to the therapeutic relationship

b) clarifying conscious and unconscious communication

c) monitoring the art therapist's countertransference responses?



### The Approach

The study is designed to investigate the art therapists' experiences with their own post session artistic imagery. The examination of this material in relationship to the art therapeutic dynamic cannot be easily isolated from the multiple levels of interchange of conscious and unconscious, real and imaginal, healthy or pathological material with which they work. This investigation, therefore, is an attempt to describe my own experiences of the art therapeutic process through self observation facilitated by post session art, as they compare with other art therapists' experiences with their post session productions.

The first phase of this exploratory study includes open ended interviews with professional art therapists, examining their experience with art and the art therapy situation. The number of interviews do not represent a sample group and therefore the study is not intended to render conclusive evidence of the art therapists' relationship with their productions and their therapeutic effectiveness.

There are inherent difficulties in open-ended interviews, particularly with such a complex topic as art, art therapy and countertransference. While the field of observation is vast, the fact that some art therapists use their post session productions is significant. The

delineation of themes in this study is viewed as a helpful tool with which to examine the art therapists experiences and not as a means to quantify the experience.

The second phase refers to some of my experiences with post session art work, as it relates to my practicum with adolescents. Watkins (1976), in speaking about the beginner who engages in active imagination (a process of entering consciously to engage the unconscious in a dialogue with the ego) suggests that he may be faced with too much imagery. This was my experience. Responding intermittently with post session imagery would be one solution in this area, and, in fact, is the way in which the majority of the art therapists who were interviewed stated that they worked.

Another factor to consider is what Racker (cited in Hunt & Issachoroff, 1977) calls indirect countertransference which arises when someone outside the consulting room plays a central role in the therapist's feelings and considerations at that time; often this third party is someone in the professional community. Thus, creating post session art work in the knowledge that some of it would ultimately be shared with my supervisor and also be a part of this thesis was significant. Coupled with the fact that I am an art therapist in training, I recognize issues such as my need to be the "good student," as well as the fear of

exposure of personal material and its fantasized rejection and criticism (see below, p. 84).

A final factor to consider is that I was in the process of my own analytic psychotherapy for the first time. When working with such personal material as countertransference, there can be little doubt that material has been censored, left on the sidelines until a later date, and/or has yet to be recognized as important data.

#### Phase One--The Interviews

The first phase of the study consists of interviews with art therapists from a variety of clinical backgrounds and who had at least two years' experience in the field. The rationale for "Phase One" is based on the marginal amount of literature and research in art therapy to support and/or challenge my experiences with post session art. The purpose of these interviews was not only to see if there were other art therapists who were actively involved with using their art in relationship to their therapeutic work, but also to further explore how they used it to facilitate therapeutic progress and to find out if it bore any resemblance to my experiences.

Interviews with fourteen art therapists were conducted privately, on an informal basis, lasting between 20-35 minutes. An open-ended question was presented to the

interviewee: "How do you as an art therapist use your art in relationship to the art therapeutic process?" This question was used to begin the interview after which more directed questioning was made, depending upon the path the interview was taking. Each interview was transcribed and returned to the interviewee to be edited (see Appendix 5).

To provide a procedure of analysis, some of the guidelines described by Polet and Heingler (1983) were followed. They say that the analysis of the qualitative material generally begins with a search for themes which is essentially a search for commonalities. In this study the themes and subthemes were delineated when at least two art therapists described similar experiences. In an attempt to validate this procedure I follow Polet and Heingler's suggestion of the iterative approach whereby the researcher reviews the themes to see if the material reflects the subject and then refines the themes if necessary.

#### Phase Two--My Experience

I undertook this inquiry into the aspects of the therapeutic interchange within the art therapeutic framework as a second year master's student in art therapy. I worked on the premise that the therapeutic relationship is a highly subjective and complex undertaking between two personalities involved in an ongoing interaction on multiple levels.

Following the art therapy session, while reflecting upon the interchange, I created images spontaneously, using the available materials. Notes were kept on each session. I attended case conferences on the clients and individual and group supervision as part of my educational training.

My practicum was in a special school setting for adolescents (see p. 67). Each client had individual art therapy once a week for fifty minutes.

At the completion of the study there were thirty-six art responses, and notes on each of the sessions. These sessions were reviewed. Those holding relevant evidence of the post session art experience which parallel and at times contrast with the professional art therapists' experiences are presented in this study.

#### Importance of the Study

This study provides some insights into the conscious and unconscious phenomena derived from art therapists who consider their post session art in relationship to the therapeutic encounter. In an attempt to address some ways in which the art therapist may use his creativity as a means of further effecting art therapeutic intervention, he may expedite an understanding of the countertransference by objectifying the experience in art work. The study provides some suggestions for future research in this area. For

example, one such suggestion is that successive interviews would be useful in order to build a relationship that would foster trust about sharing personal material and the post session art work. Another example would be a quantifiable approach using a questionnaire designed to evaluate a larger number of art therapists and their experiences specifically with regard to post session imagery and countertransference. As well, the process of doing post session art work may be a consideration as a training method to sensitize the student art therapist to the dialectic process and the variety of countertransference responses.

#### Thematic Search

Of the fourteen art therapists who were interviewed twelve returned their edited version copies. Eleven interviews are included in this study because one was returned too late for review.

The major themes which were delineated derived from the art therapists' concept of their art and how they related it to the art therapeutic experience (see Appendix 1). These were:

1. art for art's sake
2. art as a personal therapy
3. the art therapists' art during the session
4. the art therapists' art prior to the session
5. the art therapists' art post session

Subthemes emerged from the art therapists' experience with their post session art work which were identified (see Appendix 2) as:

1. art used to clarify feelings
2. art used to help differentiate the affect
3. art used to explore the relationship
4. art used to explore the preconscious and unconscious
5. art used to develop empathy through replication of client's imagery

Countertransference experiences promoted through the imagery, which supported a growing empathic response and were derived from the above subthemes, were considered under Racker's concept of countertransference (see Appendix 3). A description of the imagery and the art therapeutic relationship, which suggests that the client's projections of early significant objects onto (into) the art therapist and which were clarified within the post session imagery, were considered as countertransference proper (complementary and concordant). Neurotic countertransference was identified when the art therapists' reactions towards the clients' art work or the client was not recognized and in some way made the art therapist less effective.

Although the focus of the study is with post session imagery, the experiences of the art therapists while doing the art within the session are useful. These are correlated with Racker's conceptual framework (see Appendix 3).

### Art and the Art Therapists' Experience

Although it is not within the scope of this study to do a thorough study of the matter, the term "art" was represented by at least two if not three, different definitions for each of the interviewees (see Appendix 1). On the one hand, there was art which was created separately and considered separately from the art therapeutic situation. Terms such as "academic art" (p. 115), "social art" (p. 123), "art art" (p. 144), "proper fine art" (p. 115), and "authentic art" (p. 135) were used to describe one approach. The general consensus of such a variety of definitions seems to be that this art is created for its own sake.

Along the same spectrum is "art work for a (personal) therapeutic reason." This art was described by some as "self restoration art" and as a "support system" (p. 155), "art therapy art" (p. 144), "non-art" (p. 124), "clean the slate art" (p. 122), "spontaneous art" (p. 115) and so on. The main purpose for doing this art is as a "therapeutic" experience, whether for catharsis or self-exploration.



At the other end of the spectrum is the art work done in relationship to the art therapeutic experience. This is divided into two categories: 1) the art work done inside the session; and 2) the art work done outside the session but related to the session.

The art work done in the session by the art therapist was identified by the majority as art done "at the service" (p. 142) of the client as a "technique." As C. describes one of her experiences of doing art in the session:

I have used parallel drawings with adolescents. It wasn't my first choice. I tried to not do what he was doing. I felt he wanted his sense of identity. I felt he needed to experience our separateness so I did, in terms of the art, what I wanted to do. His images were mostly castle-like fortresses while mine were light, pastel imagery.

Q. How did you process this work?

I did not process mine too much. I looked at his work and at what he was saying. I did not work with the countertransference and transference in a conscious way. (p. 121)

There are questions as to why C. did not reflect upon her own art work particularly since it was created during the session. Lachman-Chapin (1983) describes interactive techniques in art therapy. She suggests that the client's and the art therapist's art work embodies what is going on between them. Robbins (1980) describes the art therapy experience as offering the patient many ingredients of the early mother/child dyad. He suggests that as the therapy proceeds "both patient and therapist work toward perceiving,

feeling, and sensing their experiences which in turn facilitates the creation of mutual imagery. These communications now become a part of a transitional space that permits the process of discovery, recognition and understanding to continue." (p. 88). C.'s inattention to her imagery suggests the omission of an important aspect of this interchange. Her reflection upon both the client's "castle-like fortress" imagery and her "light, pastel imagery" responses may have provided her with some insight into the transitional field of interaction.

When framed within the concept of "technique" the art therapists' suggested that their imagery seem to be needed to be "managed" and kept "conscious." For example,

Q. Do you draw in the art therapy session?

Yes, but you have to be very careful and conscious of what you put on the paper. We are artists. We can facilitate an image with skill, avoiding some possible misinterpretations. We can move a pencil more slowly while we think about why or what we are putting down. It is a conscious therapeutic strategy. (L., p. 156)

If I draw in the session, it is with conscious intervention. (G., p. 135)

I always do this (draw in the session) with a great deal of trepidation personally because I want to be therapeutic in the gesture I make. (H., p. 141)

The implications for the "mismanagement" of the imagery suggested by some of the art therapists were described as either "Freudian slips on the paper" (p. 135), or a

distortion of the therapeutic frame which may destroy the therapeutic alliance (p. 157), or over-identification with the client (p. 112), or the narcissistic nature of art-making rendering the art therapist less available for the client (pp. 135, 141, 152).

The majority of respondents (ten of the eleven) expressed hesitancy about, if not opposition to, using their art in the art therapy session. As A., an art therapist who also teaches responds:

Q. Do you suggest that your students do art work with clients?

No. I refuse to allow that approach until their experience has given them sufficient maturity and objectivity and there is no danger of over-identification with the client. (A., p. 112)

However, the attitude that the imagery may lead to identifying the transference and countertransference relationships (p. 117), reveal other psychological states of the art therapist (p. 156), and reflect the therapeutic relationship (pp. 117, 124, 132, 136, 157) is also prevalent. L. relates a facet of using the imagery in the session:

It [drawing in the session] is a conscious therapeutic strategy but the amazing potential of art to release and concretize unconscious feelings often can reveal countertransference factors, or the psychological states of the therapists. (L., p. 156)

So, while acknowledging the technical aspect of drawing in the session as an effort to be "conscious" of the imagery

that is created, art therapist L. also points to the "amazing potential" of the unconscious material within the art therapist imagery which can be uncovered.

Two art therapists who mentioned the strategic aspects of drawing in the session also mentioned an approach which by their explanation appears not to be "technical" per se.

Previously I had used my art for my own issues, the therapeutic context, countertransference implications, to empathically know what the other person was going through. . . . I used the art, actually working in a therapeutic situation in an art context, not a psychological context per se, although what I would work through is my psychological knowledge of it. It was more art base. (G., p. 134)

While the second art therapist seems to be implying a similar approach.

If this requires I do a drawing with them, trading strokes with different pens, I'm willing to do that. . . . Being an art therapist draws upon one's creativity. And if you're in touch with your clients and you have an empathic connection, I think you can take certain intuitive moves. Sometimes they are wrong, but you trust your gut instinct and based on real empathy as a result the alliance is improved, the child (the client) feels there is something authentic and of value going on. (L., p. 156)

Finally, after having explored the art therapist's use of art in the session, there is the second category which is the art work done outside of the session but related to the session (see Appendix 2). Subthemes which emerged from the art therapists' descriptions focus upon this process as a way to clarify and differentiate feelings, explore the

therapeutic relationship, uncover unconscious reactions and aid in the development of empathy.

### Countertransference, Art Therapy and Post Session Art

Of the eleven art therapists interviewed, two art therapists maintain that they never use post session art as a means to help clarify the art therapeutic relationship (see Appendix 1). E. considers her art work with reference to making her "sensitive to the [art therapy] experience" but doesn't believe that the unconscious is always revealed within her imagery (p. 127). When questioned about her relationship with her own art she describes one process she uses: "The process of doing spontaneous art is getting in touch with what is going on internally" (p. 128). However when she was asked how she might identify countertransference she explained that she did so in terms of self-analysis via questioning:

When I know where I am, when I know what's happening, I'm always reflective, asking myself questions. When I'm uncomfortable with my reactions I know I have to look at this. It's an awareness of my own state. Is this totally me? Is it evoked by Johnny [client]? (E., p. 129)

E. later adds that she processes countertransference reactions in her mind, by using mental imagery (p. 129).

Both E. and A., when asked whether they use art to help clarify the therapeutic interchange, responded in the negative, saying it was due to time limitations.

A. concludes that doing art after the session "would be a luxury that time does not permit. My days are so condensed that it would be very difficult to fit the art in" (p. 110). A. states, on more than one occasion, that she considers her art from an aesthetic point of view only (p. 110). She does mention that during her art therapy training she utilized her art work in conjunction with her therapy to promote self awareness (p. 112).

In terms of countertransference, A. examines her feelings and body responses and goes for supervision (p. 114). Although both A. and E. explicitly state that they do not use their art in relation to the therapeutic situation, they did not deny its potential usefulness. Rather, in response to the question that was put directly to both of them, "Do you ever do art to help clarify the therapeutic session?", both responded by reflecting on the limitation of time. As B., another art therapist, who has used art but does so infrequently, states:

If there is any resistance to doing the art work it is a resistance to doing more work. The work I have done with images has served me well. (B., p. 118)

Moreover both art therapists, A. and E., seem to acknowledge the benefits for insight within their own art experiences. E. spoke of her spontaneous art work in terms of "getting in touch" with internal processes and in the terms of "psychological" approach (p. 128). A. acknowledges its usefulness while training to be an art therapist.

However, in contradiction to her stated position, that she creates and views her art from an "aesthetic perspective only," she seems to describe her relationship with her art work from more than merely an aesthetic point of view.

Whereas before it (her art) used to be: "Does it appeal (to me, to others) or not?" now it is: "what does it mean to me?" Not as an indication of "my space" but generally from an aesthetic position. There is always a curiosity to see whether or not it corresponds to how I feel about myself, but not much more than that . . . My drawings are usually more sensitive, more how I experience myself. They have a searching quality that the pure use of colour does not. My art focuses on curiosity: Who am I in the world? (A., p. 110)

In the following discussion attention to the relevant subthemes derived from the interviews of art therapists' who do use their post session art is given and correlated with Racker's concepts of evolving countertransference reactions.

Lachman-Chapin (1979) states that art therapists are particularly drawn to the empathic way of relating to the world because of the nature of their artistic pursuits. The artist projects his state of mind onto the art work, while the work objectifies and presents the artist's introspections in another form outside of himself which others can understand through vicarious introspection.

We [art therapists] . . . grasp empathically the art work produced by others. Thus we, as artists, are attuned to the empathic response as a therapeutic element, especially as we help clients to produce expressive works of art and as we respond to their creations. (p. 80)

Lachman-Chapin's description is idealistic; unfortunately the therapist is not omniscient. There exists

recognition that such an ideal state of relating to the imagery and the client breaks down. Robbins (1980) suggests that because of the preverbal nature of the unconscious interchange between the art therapist and the client, the art therapist will occasionally contribute to the recreation of past traumas.

H. and G. describe their experiences towards the clients' imagery:

Another example was when I was depressed and the client was depressed. The [client's] art symbols made me feel my depression. I was so overwhelmed by the depression in the art work that I had a sense of futility, uncertainty and I was not able to respond adequately to the client. The client's symbols corresponded so closely to my own inner state. The therapist in me folded up her suitcase and went home because the part of me which was depressed had taken over. (H., p. 142)

During my first internship experiences I was literally boxed in with a joint drawing rendering me ineffective as the therapist. I was quickly able to feel what the client was feeling through a few lines but needed to learn the skill of not being manipulated. My own issues of aggression and release of expression of anger needed to be analyzed, a fine tuning. (G., p. 134)

These two examples represent situations where the clients' art activates unconscious identifications in the art therapists. G's unconscious identification was temporary while in H.'s situation the identification is prolonged, rendering her ineffective as a therapist within the described session.

As well, other circumstances arise in the art therapeutic situation such that the therapist's reactions are not solely motivated by the art. B. describes:



I knew I was feeling anxious and sometimes getting angry at the client, not during the drawings but in situations where she would refuse to leave at the end of a session. (B., p. 116)

Robbins (1987) points out that the skill of the art therapist is to be able to maintain a positive supportive relationship to ensure effective art therapeutic intervention (p. 67). Edwards (1987) suggests that the art therapy process is best served when the art therapist "is able to channel countertransference feelings into caring about and bringing ideas to the image" (p. 104). This ability and skill to maintain a positive relationship towards both the client and the client's imagery depends upon the art therapist's concordant countertransference. That is, the art therapist must feel comfortable in being able "to go along with the patient's dynamics with empathy and sympathy" (Lambert, 1981, p. 147). In the case of the art therapy situation this becomes "to go along with the patient's dynamics and [imagery] with empathy and sympathy" (my emphasis).

Concordant countertransference is not always achieved within the immediacy of the art therapy session. From some of the descriptive experiences of the art therapists, it would seem that their post session art served to help them develop an empathic way of relating to their client and the client's imagery (see Appendices 2 and 3). One aspect of an evolving concordant countertransference is an identification

with the client and his object, a matter of being "with" the client (Beres & Arlow, 1974).

Three art therapists made specific reference to the idea of replication of the client's art productions<sup>1</sup> (see Appendix 2) as a means of developing their empathy. As L. describes:

Occasionally if there is some client's art work I'm having particular difficulty understanding or empathizing with, I will try to replicate this work myself and thereby hope to 'get inside' it.  
(L., p.161)

Although this is not within the scope of this study<sup>2</sup> there may be some correlation with that of mimicry and dance. It has been suggested by some (Feinichel, 1926; Jacobs, 1973) that emotion can be transmitted through an identification by way of the emotion we see in action.

On one hand the replication of imagery as an attempt to be "with" the client can be described as a technical approach to develop empathy. On the other hand, it may indicate aspects of the neurotic countertransference. An example of this is an unconscious wish to merge. Or it may indicate a complementary countertransference: the therapist's inability to be "with" the client may represent

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<sup>1</sup> G. makes reference to the idea of replicating students art work.

<sup>2</sup> To the author's knowledge the idea of replication of imagery as a means of developing empathy is unexplored in the art therapy literature.

the client's relationship with an object who was not able to be "with" the client.

The replication of art productions may hold some parallels to what Kohut (cited in Post, 1980) calls "trial empathy." H.'s description provides an example of the empathic process involving the aspect of copying the client's productions.

In art therapy I have drawn with the client in mind independent of the sessions and I have copied the work of clients (dynamic of the art process experiences). It made me observe more closely the person and the work and because of that observation, that attention, that "living with the image" I would be more empathic. (H., p. 140).

Being "with" is one aspect of the concordant countertransference but as important is the capacity to separate and think "about" the client (Beres & Arlow, 1974). "Living with the image" suggests the "trial empathy" with the patient's imagery, while the differentiated state is suggested by H's observations "about" the imagery.

For some, post session art serves the art therapist as a way to clarify feelings (see Appendix 2) by means of identifying with the client's symbols and experiences. G. describes an evolving concordant countertransference situation:

I often made countertransference drawings after my sessions when I was working with a client who was working through incest issues. She used the metaphor of broken glass. The image of being cut by glass is extremely painful. Although I hadn't been sexually abused, but analytically had dealt with the fantasized elements in my personal therapy, I had been recently mugged. In a separate but perhaps parallel way, I was

responding to what it felt like to be violated or intruded upon. My drawings reflected the "fear of life leaving you." Psychodynamically, once you have been sexually abused your damaged body often is felt as it is never being truly yours again. (G., p. 137)

The paradox of being "with" and thinking "about" the patient is exemplified in G.'s experience of her concordant countertransference. Her "countertransference drawings" seem to provide G. with the opportunities to identify with a shared affective experience--through introjection I feel that this part (metaphor of the broken glass) of you is me and through projection I feel this part (fear of life leaving you) of me is you--and to clarify her affective reactions and those of the clients through observation and associations.

A similar processing of introjection and projection is remarked upon in the following example preceded by the "signal affect" of anxiety and anger:

I produced four pictures with the client in mind, with minimal intellectual processing. They seemed entirely spontaneous. At least, the first one was. The first painting showed the persecutory aspects of the transference, the constellation of the mother complex. I knew I was feeling anxious and sometimes getting angry at the client, not during the drawings but in situations where she would refuse to leave at the end of a session. It wasn't until I produced the four drawings that I realized these feelings were persecutory. I don't know how much it helped me with the processing but the drawing refined what the feelings were and enabled me to pinpoint the hypothetical age to which she had regressed. It was possible to gain access to this information by the feelings she was evoking in me and presumably the feelings I was evoking in her. I have a feeling that sometimes when one does spontaneous art work that sort of thing does come out, if one but knew it. I

probably have other pictures that came about as a result of something that happened with a client. (B., p. 117).

It may be assumed from B.'s description that prior to doing her drawings she was stuck in the introjective phase, rendering her anxious and angry. Money-Kyrle (1956) describes these states as "periods of non-understanding" (see above, p. 16). According to him these periods, if not clarified, can lead to conscious or unconscious anxiety which in turn continues to diminish the possibilities of understanding. He also suggests that this anxiety is likely to affect the patient. B.'s imagery provided her with an opportunity to refine her feelings, become conscious of the shared experience of "persecution" and to lessen her anxiety. The feelings were clarified with the result of a better understanding of the client's object relations within the transference and countertransference matrix..

J.'s experience with post session imagery represents an example of clarification of feelings; however, in this case these feelings were unconscious:

it [the post session imagery] shows me a little bit and sometimes it's no surprise, nothing much happened. Or sometimes I think I've been supportive and I find out from my art work that I really was quite angry at what was happening or I was frustrated because . . . of whatever. It [post session art] is very helpful. (J., p. 151)

According to Robbins and LaMonica (1980), the process of creating provides a relaxed atmosphere where free association is possible. They suggest that the art

therapist who uses his own imagery is involved in an experiential interplay of the art process, the art product and a free associational response to the patient in absentia. Robbins implies that while involved in the act of creating, the art therapist is in a "fully enmeshed" state where he becomes aware of early impressions. These impressions can be experienced through the art making process and sensations providing the therapist with an access to pre-verbal material. On the other hand, the process provides a distance between what is experienced (the "fully enmeshed" state of doing the art) and what is observed (the looking at the art).

What had been experienced as a "fully enmeshed" state during the art therapy session seemed to be differentiated for some through the post session imagery. The following descriptions suggest such experiences:

Yes [the after session drawings help to evaluate and clarify the countertransference]. Anyway you can you help yourself to clarify what went on in the session. You have to realize you are one half of the human element in the session. It is important to clarify and separate what has been happening in the session. The more we clarify what was happening with us, the more we can separate it from what was happening with the client and the more we can see how the interrelationship leads to a healthier functioning for the client. (J., p. 153)

I used response drawings to sort out a separation between my feelings and those of my clients.  
(G., p. 133)

As I reviewed the process I would ask the question: Was I furious or was it the kid's [the client] fury I was picking up on? (C., p. 120)

The clarification of boundaries can result in the subsequent clarification first of the complementary countertransference and second, of a renewed concordant countertransference. As H. describes:

Drawing with the client in mind probably doesn't help me so much with the understanding of the client as much as an understanding of my own dynamics and what's going on with my relationship with that client. It helps me clarify things because I can then figure out what's "me" and what's "them" a little better. For example, I had a client who every week did something that related to me or some work of art I had done, and it was a little eerie. I spent a lot of time thinking this through because it was so close. I sat down and drew specifically. The drawing helped to clarify the relationship or the role I played to that client in what ways I was replaying for the client what the role that his mother had in relationship to him and what aspects of my personality played into this. (H., p. 140)<sup>3</sup>

Through her art H. differentiated her affect from that of the client's. This differentiation led her to a more profound understanding of her unconscious identification with the patient's projected internalized object--the complementary countertransference. Ultimately, she was able to renew her concordant countertransference.

Another of B.'s experiences serves to exemplify a developing awareness of the complementary countertransference.

In my own art work it moved me to be more self-aware, so that I didn't become debilitated and therefore ineffectual to the client. One of the fears at that particular stage of development (or regression) is that

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<sup>3</sup> Without further clarification--i.e., Had the art therapist been drawing in the session?--no comments can be made on significance of the client's imagery.

she would destroy the nurturing figure. In some ways that can be done, the energy can be sapped. What helped me was the acknowledgement of that, and therefore I became a little clearer with my boundaries so that she couldn't scoop me out any more. This was clarified for me through my art work. (B., p. 118)

The imagery helped B. recognize her unconscious identification with the patient's internalized part object and clarify the boundaries within the complementary countertransference. Concordant countertransference resulted, making the interchange more effective.

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Creating post session art is not always necessary to clarify the countertransference response (Robbins, 1980, p. 70). None of the art therapists who were interviewed suggested that they relied on this method on a continual basis. Some, in fact, never used the post session art; nonetheless, the experiences of several of the art therapists demonstrate that post session art has been useful as a means to develop empathic capacity, to clarify confused feelings or render acknowledged feelings into form, and to evaluate the countertransference reactions within the dynamic triad of art therapy.



## CHAPTER 5

### MY EXPERIENCE WITH POST SESSION ART WORK

The interviews with art therapists provided an objective means to delineate themes and thus clarify the variety of countertransference responses explored with the use of post session imagery. Moving from this objective methodological position to a subjective account, I review some of my experiences with post session art work as it relates to my student practicum with adolescents.

#### Countertransference, Adolescence and Art Therapy

Marshall (1978), a child psychoanalyst, states that there is a lack of attention in the literature on the topic of countertransference with children and adolescents due to the variety and strength of the affective response evoked in the therapist coupled with a defensive reaction towards these affects. He delineates the influences of this attitude and suggests that one aspect is the pedagogical-helper background of early child analysts, their main perspective being that the child's growth took place through learning, sheltering, protecting and communicating cultural values. The relationship was based on "giving" and forming a positive transference. A second influence was Anna

Freud's belief that a transference neurosis could not be established with children. Forty years after this conception, in 1955, she recognized that the transference neurosis could occur. The third influence is the inattention to the topic by both Anna Freud and Melanie Klein, which Marshall feels deterred other therapists from exploring their countertransferential feelings. Finally, he suggests the client-centered approach to children, with its emphasis on unconditional positive regard of the child and its advocacy that the child was "free" to do what he wanted, created an attitude whereby any limit setting and feelings evoked in the therapist that were anything but a "positive regard" were considered indicators of an unsuccessful therapist.

Masterson (1972) focuses on aspects of the neurotic countertransference and suggests that the young therapist in training who has recently emerged from his own adolescent conflicts is more likely to be frightened by the intense and mercurial emotions of the adolescent. He describes one of the most common countertransferential issues as the therapist's inability to tolerate the intense affect of the adolescent. When working with the adolescent whose disturbance rests within the symbiotic unity of the mother and child dyad, Masterson suggests that the therapist is likely to encounter feelings such as:

homicidal anger, incestuous wishes, dependency, helplessness, fears of abandonment, suicidal depression, despair and hopelessness, all of which are unveiled with all their naked elemental force. (p. 233)

Malmquist (1978), a child psychiatrist, identifies two aspects of treating the adolescent, as compared to treating the adult, which may lead to countertransference reactions. These are 1) the lack of positive feedback from the adolescent client, and 2) the degree of aggression displayed by the adolescent (p. 823). As Winnicott (1965) aptly describes one of the questions of adolescence:

How shall the adolescent boy or girl deal with the new power to destroy and even to kill, a power that did not complicate feelings of hatred at the toddler age? It is like putting new wine into old bottles. (p. 42)

Erikson (1951)<sup>a</sup> has described adolescence as a period to "re-fight many of the battles of earlier years" (p. 235). He considers that the boy or girl comes to adolescence with a past personal history, including patterns in organization of defenses against a variety of anxieties. They approach this period of change with predetermined patterns because of their infant and early childhood experiences.

Blos (1979), an expert in the field of adolescent psychology suggests that all adolescents go through a second separation-individuation phase. He compares the first phase to the second separation individuation phase of adolescence:

What is in infancy a "hatching from the symbiotic membrane to become an individuated toddler" becomes in

adolescence the shedding of family dependencies, the loosening of infantile ties in order to become a member of society at large, or simply, of the adult world. (p. 141)

He concludes that the root of disturbance in adolescents who manifest chronic forms of acting out, negativism, moodiness, lack of purpose, and learning disorders lies within the first separation-individuation phase. He adds that these disturbances ultimately infringe upon the process of the second separation-individuation (p. 146).

Therapeutic intervention, therefore, takes into account the arrests of the first separation-individuation phase. Mahler (1965), through her extensive observation of mothers and their children, identified the beginning of this phase in the infant at about 18 months. She describes the process as the infant's intrapsychic separation and the beginning of self-perception as separate from the mother. She identifies a sub-phase of the process as rapprochement which occurs at around 15 - 22 months when the child begins to move away from the mother yet maintains a connection, returning to her for "re-fueling." The "black and white" thinking of adolescents is described by Blos (1979) as having its roots in the symbiotic stage of infancy when the child derives a sense of omnipotence by sharing with the mother and psychically perceiving himself as all powerful although he is concurrently in constant danger of losing this vital source. This state is maintained by the infant by the

processes of splitting and idealization. Splitting takes the form of the all "good" and the all "bad" mother. The infant needs the mother's affection and approval to build a sufficient sense of self. Deprivation of these supplies results in a rage-reaction which the child fears may destroy the mother. To deal with this the child splits the introjected image of the mother into all "good" and all "bad." This dichotomy becomes synthesized into the "whole object," that is both "good and bad" during the process of separation. Blos says that eventually, in normal adolescent development, the "black" and "white" thinking is integrated through reason and judgement.

According to Masterson (1972), in the adolescents who have not successfully completed the first separation-individuation phase, the primitive defense of object splitting persists as a defense against the rage and the fear of separateness. The adolescent relates to the world as either totally gratifying or totally frustrating rather than as a whole, that is, as both gratifying and frustrating. A therapeutic goal, therefore, is to support the adolescent who has not achieved a successful sense of himself within the first separation-individuation phase. Art therapy offers the adolescent a "holding" environment where he can feel that someone is present who can give support to the more mature part of his personality, enabling him to

work towards separation and integration and who can share and survive his experiences. Wood (1984) suggests that the art therapy situation makes a "distinctive contribution in allowing for the privacy of self-discovery, and in holding the paradox of being found and yet not found," which is particularly important in adolescence (p. 71). Robbins (1987) says that each developmental problem requires a different "holding" in order to transform the "pathological space" into "therapeutic space." For the client who is developmentally arrested in the rapprochement phase, Robbins suggests that he may need active holding or quiet mirroring, with the goal of supporting the adolescent's integration of the good and bad split (p. 72).

Literature on countertransference as it relates to the borderline aspects of adolescence in art therapy is scarce. Mottai (1983) addresses specific countertransference reactions to the behaviour of adolescents in art therapy. In her work with adolescents diagnosed as borderline, she suggests that the patient's defense of splitting, that is his inability to integrate both the "good" and "bad" aspects into the same internal image, can have an intense effect on the art therapist. She describes these adolescents as inordinately sensitive to minor frustrations; they characteristically respond to these frustrations by withdrawing all positive perceptions of the art therapist.

She goes on to say that the art therapist is vulnerable to feelings of anxiety and guilt evoked by this withdrawal.

Lachman-Chapin (1979) suggests that the art therapist acting as self-object is in an area "fraught with danger."

She suggests:

We [art therapists] must through training, supervision and scrupulous attempts at honest self examination see our counter-transference and not be caught up and invested in our own grandiose design for the patient, our own omnipotent fantasies of cure. At all costs we must know that we are not as powerful as the patient believes us to be. We have the power and magic of being artists. Beyond that we must deal with our psychic structure as do all other psychotherapists, that is, with constant self-examination. (p. 6)

Therapeutic work with adolescents can be "fraught with danger" when there is a lack of self-examination and understanding of the primitive reactions which can be reactivated within the therapeutic interchange. In the following case examples, my post session imagery provides me with one tool for learning and developing my capacity to respond therapeutically to adolescents who were struggling to adjust to this period of their lives.

#### The Setting

The following examples represent my experience with post session art, focusing upon the countertransferential relationship with three adolescents: David, Sarah and Jason.

As student art therapist I worked in a special school setting. The adolescents who attended this school were from

a variety of backgrounds and exhibited behaviors that the regular school system was not equipped to handle. This environment offered more individual attention by teachers trained in special education as well as an after school activity program with child care counsellors. Social work intervention was provided for the adolescents' families whether the adolescent was living at home, in an emergency shelter or in a group home. Psychiatric intervention was provided by community hospital out-patient clinics which were not directly affiliated with the school. I developed and implemented a part-time art therapy program which provided some of the students with the opportunity for individual art therapy on a weekly basis.

#### My Experience with Post Session Art

Responding after the session by drawing or painting is presented as a personal approach. As an art therapist in training, this process helps me to examine my developing capacity for empathic responsiveness and gain insight into the countertransference responses.

Understanding the process of art therapy as a means to revisit the early, preverbal matrix of the mother and child dyad, Robbins (Agell et al., 1981) contends that countertransference reactions are not only unavoidable but can provide important information about the transitional



field of the self/object relationship. He suggests that the patient and the therapist both "struggle with their respective ghosts and demons" and that the struggle on the part of the art therapist provides the basis for therapeutic empathy. Paradoxically he concludes:

the therapists' effectiveness will be partially determined by their ability to untangle themselves from the countertransference reactions so that they can listen and respond effectively to the patient. Both therapist and patient are in treatment within any given art therapy relationship, each struggling with his or her particular attachment to the past and emotional responses to the other. (p. 7)

Wood (1984) describes the art therapist's role as a containing vessel.

the therapist becomes a pliable vessel with a good-enough fit around most of the yet unknown contents put into it, until the time comes for the recognition through reflection. But the vessel also has to tolerate unknown contents which distort it, and the therapist realizes a burden of feelings and ideas, not personal belongings, and not necessarily evoked by the overt situation but existing concurrently with it. (p. 70)

Robbins (1980) suggests that it is through the use of "personal belongings" that the art therapist comes to a better understanding of the therapeutic interchange. He says that art therapists work:

as a filter [and that] we are not an empty sieve, but filled with our own substance, and it is through this substance, specifically our emotions and thoughts that the other is filtered and discovered. (p. 58)

In the following example, the post session art making experience helps me to filter my feelings and associated

thoughts after an initial session with David, a fifteen-year-old adolescent. The result of this experience is the discovery of a parallel experience with that of the client, providing a basis for the concordant countertransference.

#### An Evolving Concordant Countertransference

I began working with David six months after he was placed in a group home and started in this program. His oppositionality and stealing at home and ~~in~~ his community school precipitated this placement. Prior to this, he lived with his mother. The mother did not want David to return home because he was "difficult to live with." His father left the family and remarried when David was twelve years old. The father had minimal contact with David during this period. He also had a history of being physically abusive toward his son.

David had learning disabilities as well as a history of hyperactivity which had been controlled by ritalin for eight years. The school report indicated that he was in need of structure to help him concentrate and complete academic tasks. He was described as having a "black and white" thinking and a tendency to constantly complain about being bored. David was referred to art therapy to help him express his feelings which the intake report stated he "hides, avoids and represses."

David's defensive object splitting and acting out typical of the borderline aspects of adolescence was evident during the first session in art therapy. After having explained the art therapy framework to David, I inquired if he would like to use some of the art materials. David's immediate response was to say that the materials were "stupid," "no good" and that there weren't enough of them. He was reluctant to use the art supplies, however, in the remaining few minutes of the first session he drew (Fig. D:1). His sketch was done tentatively with a thin black marker. He hesitated, stopped and began again after some encouragement. He created a profile of a male with two protruding eyes coming from the crown of the head. He titled this work "E.T.". "E.T." (extra-terrestrial) is the title of a contemporary film which David had recently seen, and in which a gentle and determined alien-being is on Earth attempting to find his way back to his home planet. As David was leaving this first session he turned at the door and in his gruff manner "warned" me that he might not be coming to the next art therapy session and exited quickly without any explanation.

My attention is drawn to the contrast between David's hesitant and timid drawing, on the one hand, and his aggressive, impulsive manner on the other--both elicit vague feelings of uneasiness in me.

Money-Kyrle (1956) states that if the therapist is disturbed the patient is likely to be contributing to it. He suggests that there are three factors to consider: 1) the therapist's emotional disturbance, with which he must himself deal before he can disengage sufficiently to understand the other; 2) the patient's part in bringing it out; and 3) its effect on the therapist (p. 361).

Beres and Arlow (1974), as I had mentioned in Chapter 2, suggest that the therapist's affective response may be used as a "signal" that an unconscious fantasy has been activated in him comparable to the unconscious fantasy of the client.

Immediately following the session with David, aware of my uneasy feelings, I created an oil pastel drawing of a portrait which is surrounded by blue diagonal lines and covers all the face except the eyes. The head seems to float in the expansive white space of the page (Fig. RD:1). As I looked at my drawing I was reminded of a painting I had done years ago when I was experiencing a deep personal loss of a family member. It is similar to this drawing. I had painted a portrait of myself outdoors in winter. In the portrait I wear a large wool hat that is pulled down to my eyes and a scarf which is wrapped around the neck, covering the lower part of the face. The similar features of both

art works are the covered portrait and the expansive white background space.

I associate the "covered" portraits of both these works as a kind of protection against the vulnerable feelings of loss and isolation (cut-off body floating in space). Gradually I recognized that the blue lines in my post session art do not only "cover and protect" but simultaneously appear to "obliterate" the face.

Masterson (1972) describes the fantasy related to abandonment: when the infant's dependency and need for affection and approval from the mother are so absolute, and when his rage and frustration at the deprivation of these supplies is so great, the infant fantasizes that these feelings may destroy both the mother as well as himself (p. 24). In my relationship with David, by responding to the signal affect of uneasiness and also by the process of reflecting upon my drawings and associations, I was able to clarify the feeling as vulnerability, and the fantasy as abandonment which evoked feelings of isolation, loss and rage.

Robbins (1980) states that within the context of post session art "the creative process taps the resource of early internalizations . . . and makes a bridge between the dyad of the therapist's mother-child with that of the patient's" (p. 70). Through the countertransference David was playing

out my object representation of the mother who threatens "not to come back" (not to return to the next art therapy session).

My reaction was gradually perceived as the complementary countertransference. David continued to issue his unwarranted "warnings" in the next three sessions, evoking transient feelings of vulnerability in me. Having identified the parallel experience and the associated feelings I was able to empathize, that is, to be "with" and think "about" David's deep sense of loss and the primitive feelings associated with the abandonment. My partial identification sensitized me to David's primary need for object constancy. I felt particularly aware of the need to maintain the therapeutic stance of being "ever-present" in the face of David's expression of anger and rage which then surfaced both in his behaviour and his art work.

Racker (1968) suggests that the concordant countertransference is closely connected with the destiny of the complementary countertransference. He explains that to the degree that the therapist fails in the concordant countertransference, the complementary countertransference becomes intensified (p. 135). David returned to art therapy on a regular basis, his "warnings" ceased and his underlying feelings of rage and depression surfaced in his art works, all of which suggests an evolving concordant countertransference.

### Neurotic and Complementary Countertransference

Wilson (Agell et al., 1981) addresses the issue of the art therapist who uses countertransference feelings as a source of information about the clients although the art therapist has not been fully analyzed himself. She suggests that

observing one's own inclination toward such acting-out can yield valuable information about the meaning of a patient's behaviour. Providing the therapist has attained profound self-knowledge through psychoanalysis or intensive psychotherapy so that he knows his typical countertransference responses well, it is possible to draw inferences about the situation which brought them on. (p. 20)

Wilson recommends that if art therapists draw they should draw the patient's images.

we must draw our patient's images, not our own, and if we speak about our patient's work we should describe what we see and not our associations to it. And if we speak of fantasy and feeling we should be sure that we are talking about our patients' not our own. (p. 20)

Robbins (Agell et al., 1981) suggests that no matter how well-analyzed the art therapist is, because of the nature of art therapy, the therapist is confronted with his self/object experience as it surfaces in relationship to a particular client. He states that the art therapist's emotional receptivity and ability to call upon personal imagery ultimately helps the patient to examine and develop his own images (p. 7). It seems to be that the crucial point is not the therapist's reactions to the patient from out of his own self/object relationship and personal imagery because these aspects are bound to be a part of the

therapist's total response to the patient. Rather it rests upon whether the therapist identifies with these reactions and develops a disproportionate response in connection with the client and defends against these feelings. Watkins (1981) supports the art therapist in

stay[ing] close to the images that form the structure of our own psychological experience. We must write out our dreams, illustrate them, speak to their characters, paint spontaneously, seek for the images that determine our responses to others, to ourselves, our patients and our life. (p.125)

My spontaneous response is not always to draw the client's images as Wilson suggests; rather, I attempt to explore the affect and fantasies I am experiencing within a particular relationship.

In the following case vignette I present two consecutive post session art experiences. The first encounter involves a dawning recognition of my neurotic countertransference and the second experience helps to clarify the complementary countertransference.

Sarah, age fourteen, is referred to this setting because of a school phobia. She had seen a psychiatrist the previous year for short-term intervention to help her return to her community school; however, she was unwilling to return there the following year. At the age of thirteen she had been admitted overnight to an emergency clinic for taking an overdose of aspirin. She suffers from chronic eye and ankle problems which, it is suggested, are




psychosomatic. Sarah will occasionally cut her skin superficially with a knife until it bleeds. She is obese.

Sarah's family had been in family therapy for one year but it was reported that there was slow progress due to "irregular attendance and resistance." The family, seen by the school's social worker, is described as "in turmoil." The father is noted as emotionally removed, physically distancing himself from the household as much as possible. He often returns home intoxicated with alcohol. The mother remains in the home and is said to withdraw into depressive states. Intensive family therapy was recommended; however, there was doubt expressed as to whether the family would follow through and attend on a regular basis. Sarah was therefore placed in this setting on probation. A commitment was never secured from the family, and Sarah left the program.

Sarah was referred to art therapy by the school staff because of her poor peer relationships. She claimed that most of her peers did not understand her. In school, she isolated herself and would become physically aggressive on occasions.

Sarah's transference, typical of the borderline, is of the kind described by Modell (cited in Shapiro, 1978) as similar to the infant's response to the transitional object. He suggests that the patient recognizes the therapist as



existing outside of himself, but that the quality of this perception is determined by the processes arising from the patient. In a sense, the patient "uses" the therapist as a protective shield against the perceived dangers of the outside world and simultaneously projects both loving and destructive aspects into the object i.e., the therapist (p. 1306). This accounts for Sarah's consistent investment in the art making process and her fluctuation in idealizing and devaluing her art work and also the art therapist.

My post session art work and my associations with the work suggests that I was reacting within a primitive transference situation with unconscious infantile feelings. I clarified feelings such as rage (Fig. RS:1), intrusion (Fig. RS:2), confusion (Fig. RS:3), and anger (Fig. RS:4) and defended against some of these feelings by not drawing (Fig. RS:5). Were these feelings projections or perceptions?

Jacoby (1984) addresses the difficulty in identifying the difference between the neurotic countertransference and the complementary countertransference. He poses the question: "Is he [the therapist] projecting upon the patient or is he perceiving something in the patient via his countertransference feelings?" (p. 41). He concludes that very often countertransference feelings are a mixture of the neurotic countertransference and the countertransference

proper; both unconscious projection and genuine perception.

Kernberg (1965) states that one of the dangers in dealing with the reactivation of the therapist's early identification when working with the borderline patient is the strong temptation to control the patient in consonance with an identification of her with an object of the therapist's own past (p. 45). In the seventh session this became evident when I was uncharacteristically more directive with Sarah. At the beginning of the session she explored her feelings of isolation and destruction. Sarah drew a picture of a barren tree in the centre of the page describing this as her self. On either side of the tree she drew black lines stating that they were "seeping in and harming the tree" (Fig. S:7.1). To explore these feelings further I suggested that she may like to respond to her first drawing by drawing a second one. She then drew a tree in the centre of the page with the black lines encircling it. Sarah stated that the lines were "strangling the tree" (Fig. S:7.2). "Strangling the tree" I echoed, and quickly gave Sarah a third piece of paper and suggested she do another response drawing. I questioned this intervention to myself at the time; however, I did not arrive at any conclusions until I was in the process of doing my post session art work.

In Sarah's initial drawing of session seven, she represented, for the first time, a quality of separateness in her art. The tree is unattached to the two forms on either side of the page. In her second drawing, the tree is connected and "strangled" by the black line. These two works suggest the dilemma Sarah confronts. To be separate represents object loss and feelings of depression and deprivation (the barren tree). In her second drawing Sarah may be confronting feelings associated with engulfment within the symbiotic unity as reflected in the lines surrounding "strangling" the tree. It is at this point that I unconsciously identify with my own fears of re-engulfment and destruction.

Responding after the session I spontaneously drew a portrait. The mouth is opened and as I drew I fantasized that the figure was swallowing poison (Fig. RS:7). To prevent the poison from getting into the body I drew brisk perpendicular lines across the neck. I was experiencing intense feelings of being "strangled" and recognized that I had unconsciously identified with Sarah's drawing of the isolated tree; my fears associated with the destructive fantasies and engulfment led me to interrupt her processing of these feelings.

The thematic current of the following session may be the result of the previous misintervention. There is a

recapitulation of the fusion state, and issues of dependence versus independence are raised. In session eight, Sarah expressed her ambivalence about leaving her mother to go on a trip. She addressed this issue while she was painting. Sarah commented on her discomfort about how the colours she has painted "blur" together. She then outlined the amorphous form with a black painted line (Fig. S:8). Is Sarah symbolically questioning whether she can separate from the art therapist (leave the mother)? Is her discomfort with her fused imagery not only suggestive of her rudimentary sense of self within the symbiotic unity but reflective of the discomfort she experiences within this relationship, while I experience a certain loss of ego boundaries and become identified with her imagery?

In my post session painting I began my work with the same colour Sarah has used. I decided to incorporate her colours, "blur" them and define the form with a black line the way she did in her painting (Fig. RS:8). I compared the two paintings and considered how Sarah's form rests bordered by the paper's edge while the form I have painted is "in flight."

Giovacchini (1978) suggests that during adolescence and adulthood the feelings of getting too close is an elaboration of the fantasy of being "swallowed up, annihilated and reduced to an amorphous mass" (p. 322).

It became clearer to me through the process of my art productions that I have been unconsciously reacting to Sarah out of my early self representation of a needy infant and I had been perceiving Sarah's neediness as devouring.

I considered my painting of the amorphous shape "in flight" reflecting the paradox of a merger/separation bound/unbound, formed/and yet to be formed. This painting seems to objectify the rudimentary differentiation of the self/object relationship as well as the object relationship. It reflects my neurotic response to Sarah as I unconsciously perceive her as devouring, and I defend against these feelings and "take flight." The painting may also reflect the complementary countertransference--the therapist's response to the patient like the patient's significant childhood figures (Hunt and Issachoroff, 1977). My "in flight" reaction may be a recapitulation of Sarah's parental withdrawal.

Dosamentes-Alperson (1987), a movement therapist, describes her complementary countertransference while working with the borderline patient which parallels my experience:

Complementary identification I have experienced with the borderline patient include feelings of being swallowed up whole or spit out entirely and not being seen as a separate person but treated as an extension of these patients. At such times I may become claustrophobic and long for a greater distance from them. (p. 212)

The process of doing art work following the session helped me to differentiate my feelings and to clarify unconscious reactions effecting the way in which I related to Sarah. Temptations to "control" Sarah's processing were more easily recognized and my intense feeling responses were more readily available for conscious exploration. Within the evolving concordant countertransference I was in a position which encouraged Sarah's psychological quest for separation. Her art work in the following sessions began to convey a sense of integration in the face of separation. The tree, as a symbol of her self, resurfaced in her final drawing (Fig. S:12). Compared to the tree she had drawn in session seven (Fig. S:7.1) there was less evidence of the split in the branches. Rather than a barren, isolated tree this rendition has tiny, green buds and flowers on the branches with a sun in the sky. She uses strong values and vibrant colours as compared to the sketchily rendered and muted coloured drawing of a tree in session seven.

I question Wilson's suggestion to "draw our patient's images, not our own." I speculate that working within this framework, the deviations from the replication may indicate the countertransference reactions within the transitional field of interaction. Although I hadn't intended to replicate Sarah's work, the differences between her imagery and mine (session eight) provides a valuable basis for

comparison which ultimately helped, in this case, to clarify the transitional space.

### Direct and Indirect Countertransference

In the following example, my post session art work serves as a means to identify my defensiveness as it relates to direct countertransference, in my relationship with Jason, and to indirect countertransference, in my relationship to my supervisor.

As I worked with Jason I found myself wondering about my ability to "contain" and provide a "good-enough" holding environment. Jason is a twelve-year-old boy at the threshold of adolescence. He had been referred to art therapy because of an escalation of stealing from staff and peers, temper tantrums, and running away from the group home where he had recently moved. His first few months of life were spent in hospital because of fetal malnutrition. His natural parents were separated and Jason remained with his mother for two years until she placed him for adoption. It was suspected that she neglected and physically abused the child. He lived first with his aunt but at the age of three and a half was placed in a foster family. At that point Jason was not yet speaking and appeared fearful. After this placement rapid progression in his development was noted. At eight years old this family adopted a female



infant at which point Jason's behaviour deteriorated and he was referred to a residential centre. At the age of twelve Jason was transferred to a multi-age group home. Jason had been involved in art therapy at the residential home. Jason presents borderline symptomology. Masterson (1972) suggests that the earlier the developmental arrest occurs the more likely the patient's clinical picture will resemble the psychotic and the later this occurs the more likely the clinical picture will resemble the neurotic. In either situation however there is a persistence of the ego defenses of object splitting, a failure to achieve object constancy and the development of a negative self-image (p. 23).

Working with Jason was challenging. Through supervision it was confirmed that I was providing a "good-enough" holding environment. In the first three months of art therapy Jason chose to use paper which he would "stab" (perforating the surface), "kill" (using markers to "attack" the paper) and x-out what he had drawn or painted. Occasionally his aggression would be "playfully" directed at me. Later on, Jason chose to use clay, which was an ideal medium for his expression of his destructive and reparative impulses.

Gradually it became apparent to me that the "containing" I had been wondering about was not related to what I thought of as a lack of capability, but, rather it

related to my own unconscious fantasies and reactions which became reactivated as I worked with Jason. The metaphor of "containing" was recognized as my need to defend against the feelings I was experiencing. Following a supervision session where I had been challenged to consider this issue I reviewed my post session art work (Fig. RJ:9-14).<sup>1</sup> I realized that I had been working in pencil or felt marker, which, because of the structured nature of these mediums, effectively helped me to defend against my unconscious reactions.

Following session sixteen I used a marker and drew a picture incorporating Jason's drawing which he described as "Two Faces" and what appears as a female figure without arms or feet (Fig. J:16). I used the marker and carefully cartooned a female figure whose arms are unattached and reach out to embrace. Off to the side are smaller figures which are outside of this embrace (Fig. RJ:16.1). The cartoon was somewhat humorous in nature and confirmed what I experienced as my incapacity to "contain" effectively. I then decided to do a painting. I was completely absorbed in the process. After finishing the work I stepped back and was surprised to see the reappearance of the dismembered body (Fig. RJ:16.2). The legs and arms are missing and

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<sup>1</sup> The fact that I began this study three months after meeting with Jason accounts for the lack of post session art work prior to this period.

within the womb is an embryo. This painting holds the paradox of my feelings of incapacity (dismembered body) and potential or capacity (the embryo).

After reflecting upon this work I recognized the possibility of the complementary countertransference. Marshall (1979) describes the countertransference reactions when working with a child who has characterological problems and a history of neglect and exposure to trauma, particularly to violence: "the usual induced countertransference is one of frustration, failure, incompetence, anger, 'floating' and impotence" (p. 421). This post session experience provided me with a basis for understanding Jason's self/object relationship.

Why was there such a prolonged period before I was able to confront the feelings of helplessness? One of the factors, as mentioned above, is that this was a supervisory case, within which there appears to be evidence of indirect countertransference. Hunt and Issachoroff (1977) describe Racker's concept of indirect countertransference:

The indirect countertransference arises when it is a third party, someone outside the consulting room, who plays the central role in the therapist's feelings at the moment. Very often this third party is someone in the psychiatrist's professional community, such as the colleague who referred the patient, a supervisor, or some senior figure. As the treatment goes well or badly, the therapist's mood is determined by his fantasies of praise or censure by some person important to him. (p. 98)

My pencil drawings, which had been designated for supervision, may well reflect my need to defend against certain unconscious feelings about my supervisor--the indirect countertransference. This becomes evident because the paintings which I did following these pencil drawings were not brought to supervision. In retrospect, I realize that the dismembered figure which I painted appears to be male, as evidenced by the broad shoulders and wide neck. I question my feelings about the male-mother/male-supervisor figure and my own infantile needs for a "good-enough" holding environment. Alternatively I question my association with capacity and potentiality of the male/mothering figure.

This retrospection may have been lost to reflection if I had not had my post session art works. Milner (1957), speaking about the process of art making suggests that the nature of the feeling experience is fleeting and because "Life goes on at such a pace that unless these (feeling) experiences can be incarnated in some external form, they are inevitably lost to the reflective life" (p. 159). Naumberg (cited in Rubin, 1987) describes one of the advantages of the art produced in art therapy: "the productions are durable and unchanging; their contents cannot be erased by forgetting and their ownership is hard to deny" (p. 280). This unique opportunity for tangible

evidence in art therapy has also been the result of this study. The many post session art productions I created become a means for re-examination and further reflection.

## CHAPTER 6

### CONCLUSION

#### Post Session Art in Identifying Countertransference

One of the problems encountered in discussing countertransference is that the term is used in a variety of ways, slipping from one meaning to the next. There are therapists who consider countertransference as meaning the therapist's unconscious resistance based on early object internalizations and viewing it as an interference in the therapeutic process. At the other end of the spectrum there are those therapists who regard the term countertransference from a broader perspective. This includes the sum total of the therapist's reaction and is referred to as totalistic countertransference. Within this definition, neurotic countertransference is considered as obstructive, while the countertransference proper is viewed as a helpful tool with which to explore the patient's projections and the analyst's perceptions (Racker, 1968).

The exercise of creating my own imagery following each session provided me with an opportunity to explore my countertransference reactions and to examine the subtleties of my conscious and unconscious responses via my post

session art experience. Several art therapists, in this study, used their post session art work to facilitate an understanding of their countertransference (see above, chapter 4). Although the process by which the art therapists arrived at the countertransference interpretation remains unclear, a majority suggested that their art work and reflection upon their imagery helped to bring to the surface and to clarify unconscious and preconscious, as well as conscious reactions within the art therapeutic relationship. The framework which became invaluable in examining these experiences was Racker's model of countertransference (see table, p. 20). In retrospect if I had used this model as a means to direct my questioning, not only about my own post session imagery, but also during the interviews, the results may have rendered more substantial evidence as to how and under what circumstances art therapists find their post session imagery helpful. For example, is the art therapist, who is particularly drawn to this method, using his post session imagery as a means to clarify the neurotic countertransference or as a means to primarily examine the complementary countertransference?

Certain art therapists (Lachman-Chapin, 1983; Robbins & LaMonica, 1980; Wolf, 1985) emphasize the recognition of all feelings and all imagery which arise in the therapist as being important in the treatment process. Wolf (1985) and

Robbins and LaMonica (1980) explore the concept of totalistic countertransference within the art therapeutic situation. They propose that through the process of creating a representation of the client in absentia the art therapist's conscious and unconscious reactions to the patient can be explored. They imply that the neurotic as well as the complementary countertransference may be clarified by using this method (p. 67). Wolf (1985) suggests that when the therapist spontaneously draws in the session, the complementary countertransference may become apparent in the therapist's imagery (p. 130).

What has not been explored either in the art therapy literature or in this study, but which may ultimately make a significant contribution to art therapy, is the imagery per se which surfaces in the post session art work. The art therapist's imagery, as well as the materials he uses to create the imagery, may be indicators of the type of countertransference response. For example, was the imagery which I spontaneously created and which I neither incorporated the client's symbols nor used the same art mediums as the client, indicative of a neurotic countertransference response, while those works which I did incorporate more of the client's symbols and used the same mediums as the client, reflective of a complementary countertransference response? Are art therapists



incorporating the client's symbols in their post session work as a means of exploring the complementary countertransference? and so forth.

In the fields of depth oriented psychotherapy and psychoanalysis, some analysts are beginning to examine their mental imagery, elicited during the session, for countertransference. Ross and Kapp's (1962) approach in examining the analyst's mental imagery as a "new version" of the patient's dream, in order to examine countertransference reactions, is of particular interest (see above, chapter 3). This, in some ways, parallels those experiences when I incorporated the client's imagery in my own post session art responses. These post session art works helped in the clarification of the transitional field of interaction and the complementary countertransference (see above, chapter 5).

In the second phase of this study although countertransference interpretations were made, these were not brought into supervision on a regular basis. In retrospect, I can see that Ross and Kapp's (1962) proposed criteria for the study of mental imagery and countertransference interpretation within the psychoanalytic framework may have been worth considering for the study of post session art work in the context of art therapy. To validate their data, Ross and Kapp propose a comparative

study of countertransference interpretation with the training-analyst's supervisor. They suggest that during the course of supervision there are periods when the supervisor is aware of possible unconscious countertransference issues in the training-analyst. Before communicating this, the supervisor would write down his impressions. At the same time, the training-analyst would take a new dream of the patient's and write down his impressions of the countertransference derived from a self-analysis via the mental imagery. The two written reports would then be compared. In the context of art therapy, the supervisor could write his impressions of the countertransference, and these could be compared with the conclusions drawn by the student art therapist from his post session art experience. While other variables would need to be considered, this method may be a valuable starting point from which to

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confirm the use of the art therapist's post session art as a means for self-analysis in identifying countertransference issues. Using Racker's framework of countertransference the supervisor and the student art therapist could then identify the type of countertransference that the post session art experience clarified.

A final step of this research could involve studying the student art therapist's post session art work. The art

work could be reviewed retrospectively using Racker's framework to see if there is any emerging patterns in the imaginal response, ie. the subject matter, the medium used and so on, as it relates to the different types of countertransference responses.

### The Post Session Art Process

The primary intention of a few art therapists who did art following a session was to cathect their feelings.

Occasionally, they reflected upon their imagery and arrived at an understanding of the countertransference (see Appendices 1 and 2). For example, I had been questioning D. about her post session art experience. I wondered if she made any connections between her imagery and her relationship with the client. She replied:

After session drawings tend to be more of an outlet. Sometimes I feel overwhelmed. I've taken so much in and I need to get some of it out.

Q. Has the results of this spontaneous imagery benefitted you in other ways?

. . . it's mainly been an outlet for feelings that I didn't know where to put . . . When I have looked at the work for meaning it has had to do mainly with countertransference issues. How do I perceive that person? (p. 124)

D.'s post session experience of using the expressive art process to cathect and to occasionally interpret countertransference reactions parallels, in some ways, my on-going experience. During this study, drawing or painting

following the session became a way in which to cathect my feelings, and, on some occasions, my reflections served as a means for countertransference clarification. Wolf (1985) suggests that through the process of spontaneous art expression the therapist can neutralize the projections he is receiving from the client. He states:

It is interesting to speculate whether ongoing reception of such projection would eventually cause the analyst to mobilize some defence mechanism, if he were not able to neutralize the projections through his own process of creative externalization, in this case drawing. (p. 132)

The process of neutralizing the projections may be an important outcome of doing post session art work with certain clients. In the literature on the borderline syndrome, it has been expressed by many authors that one of the difficulties in working with these patients is their ability to create intense, rapid and chaotic countertransference reactions in the therapist (Shapiro, 1978, p. 1308). Kernberg (1965) suggests that, when dealing with the borderline, the therapist tends to experience emotional reactions having more to do with the patient's primitive state than the therapist's past. He states that "the therapist's capacity to withstand psychological stress and anxiety" is paramount in the treatment of the borderline personality (p. 43). The act of creating after the session, therefore, may be one method of neutralizing the incurred stress reactions while, at the

same time, creating a forum for these feelings within the art work. This may be particularly valuable for the art therapist who works with the adolescent or adult who presents borderline symptomology.

### Living with the Image: The Art Work

None of the art therapists who did post session art work relied on this method on a continuous basis. Rather their spontaneous art responses were intermittent. Several art therapists suggested that these intermittent art responses were helpful in clarifying the countertransference. Some of the art therapists indicated that their insights were not immediate. Rather, their understanding evolved over time as they "lived with the image."

My experience was based on upon doing art work following each session. As I mentioned, at times my art work served as a means to identify countertransference responses while at other times I found it a useful tool with which to cathect my feelings. In the latter instance, although I would attempt to reflect upon my creations, the meaning seemed incomplete. The experience helped me, as a student art therapist, to "live with the image" and to explore further possibilities in understanding the dynamics of the therapeutic relationship. Robbins and Eigen (1980)

address the client's relationship to the evolving process of the art experience in art therapy. Although they present their views from the client's perspective these views are also relevant to my experience:

As the individual's sensitivity to moment to moment nuances and possibilities of his work quickens, he becomes more committed to a lifestyle aware of dangers inherent in premature closure operations. He learns not only to expect the unexpected but to rely on what the unforeseen must teach him. This leads to better use of one's incessant stream of silent questioning. . . . Through repeated contact with one's expressive work the very sense of what an object is or can be enters new dimensions. One's attitude toward what an object is, what is possible for an object, itself becomes a source and means of wonder.

In addition to my art therapy training, this process enriched my experience with my own imagery, particularly concerning the preconscious and unconscious images. In the training program, opportunities to explore the artistic process, transference and countertransference, and so on, were within a group workshop environment, and group and individual supervision. The process of doing my art, and of reflecting upon it following each session, introduced the factor of successive imaginal responsiveness in a concrete form to a particular therapeutic relationship.

One of the limitations of this study becomes a strength in retrospect. Although drawing following each session became overwhelming at times because of the abundance of imagery; on the other hand, the art work serves as a continuous record of my on-going responses. What is

distinctly unique about doing post session art work is that the art becomes a concrete product available for reflection by the art therapist at any time as opposed to using one's mental imagery--a process which produces fleeting images at best. As H. eloquently states:

It [the post session art work] made me observe more closely the person and the work and because of that observation, that attention, that "living with the image," I would be more empathic. (p. 140)

The art work therefore becomes one way to explore conscious and preconscious material by the art therapist at and around the time it is created. It also facilitates a means to re-examine responses that could affect future therapeutic work. The imagery created and consolidated in the past as post session art becomes a living record in the present.

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Appendix 1Thematic Search of Interviews

Art for art's sake	Art as personal therapy	experience' of art in session	yes, pre session art	yes, post session art
A (110, 112)	A (112)	A (110, 112)		
B (115- 116)	B (115, 116)	B (116, 117, 118)		B (117- 118, 119)
C (123)	C (120, 122)	C (121, 122)	C (120, 123)	C (120, 121)
D (124, 126)	D (124, 125)	D (125)	D (124)	D (124- 125)
E (128)	E (128)	E (127)		
F (132)		F (131- 132)		
G (134, 135)		G (133- 136)		G (133, 137)
H (144)	H (140, 144)	H (141- 142)		H (140)
I (146)	I (147)	I (146- 147)		I (148)
J (152)		J (151- 152)		J (151- 153)
L (155, 160)	L (155)	L (155- 157)		L (155, 161)

Appendix 2SubthemePost Session Art as an Effective Tool.Clarification  
of feelingsDifferentiate  
affect from  
clientClarify/Investi-  
gate relationship  
(disturbances)

A

B (117,  
118)

B (118)

B (117)

C (120)

C (120,  
121)

C (120)

D (124)

E

F

G (137)

G (133)

G (133)

H (140)

H (140)

H (140)

I

I (147)

J (151,  
153)

J (153)

J (151)

L

L (161)

. . . 2/

Appendix 2, page 2.SubthemePost Session Art as an Effective Tool.Explore  
pre/unconsciousDevelop empathic responses  
(replication)

Assessment

A

B (117,  
118)

B (117)

C (120)

C (121)

D (124),

E

F

G (137) .

G (133)

G (133)

H (140-  
141)

H (140)

I (148)

J (151)

L

I (161)

Appendix 3SubthemePost Session Art Experience and Countertransference

Neurotic	Concordant	Complementary
A		
B	B (117, 118)	B (117-119)
C	C (120-121)	C (120-121)
D (126)		
E		
F		
G	G (133, 137)	G (133)
H	H (140-141)	H (140-141)
I (147)		
J (153)		J (153)
L		



Appendix 4SubthemeThe Session Art Experience and Countertransference

Neurotic	Concordant	Complementary
A (112)		
B (117)	B (116, 118)	B (116, 119)
C		
D		
E		
F (132)	F (130, 131)	F (131, 132)
G (136)	G (133-134)	G (133-134)
H (142-143)		
I	I (146)	
J		
L (157)	L (156)	

Appendix 5: Interviews

A.

How do you, as an art therapist, use your own art work in relationship to the art therapeutic process?

I have done very little art work recently but when I do a very different type of art appears compared to my early works, particularly those in art school. I also experience more interest in my own work. Whereas before it used to be "Does it appeal (to me, to others) or not?" now it is "what does it mean to me?" Not as an indication of "my space" but generally from an aesthetic position. There is always a curiosity to see whether or not it corresponds to how I feel about myself, but not much more than that. I find more balance in my work generally, particularly in doing interpretations of objects or people around me. My drawings are usually more sensitive, more how I experience myself. They have a searching quality that the pure use of colour does not. My art focuses on curiosity: "Who am I in the world?" and probably confusion.

Do you ever do art to help clarify the therapeutic session?

No. That would be a luxury that time does not permit. My days are so condensed that it would be very difficult to fit the art in. I never, never do art work with patients.

Why not?

It dilutes my attention and can profoundly influence what they do. I feel that my time is for them, not for me. However, if part of the therapeutic process involves a decision to actively intervene then that could be one way of doing it.

A.

Do you ever do joint drawings?

Strictly for graphic communications. I do not do this often, only if people are stuck and it is necessary to make some exchange.

How do you understand your art work?

Only from an artistic or creative point of view. I look at it as an art object or a work of art. As an artist and an art collector does it interest me? It is more from an aesthetic position.

Do you interpret your work?

Never. I don't know how, and further, I don't really think I'm interested. I look at my work from an artistic angle only.

How do you look at clients' work?

It's hard to say. We look at consistencies and inconsistencies in the art work together and try to verbalize the client's experiences with the process of painting and in understanding the result. I work from the client's framework. My response is intuitive but based on my learning and experience in a variety of approaches to therapy, e.g. Gestalt, Transactional Analysis, Psychoanalysis, Existential. I often surprise myself at my intuitive capacity, and have difficulty explaining what happens. Ethically, of course, what right do I have to 'reveal' what I see to my clients? My decision to work deeply within the imagery or the information in the painting would be based on my knowledge of pathology and in relation to the client's needs.

How do you work with your intuition?

I go with the client by looking at the art work metaphorically or symbolically, and becoming aware of changes or developments in style, type of imagery, use of form and colour, etc. This is done with them. For example: A coloured drawing is presented to me that depicts a box underground. Inside of the box there is someone buried. On top of the box there are rocks, and

A.

on the earth surface is a distant mountain and a few faceless people. This is a change from the usual raw abstract expression produced by this person. I may ask questions such as "Can the little person come out? What would it mean to come out?" If the information illustrated in the painting concerns me I may suggest putting a little survival magic in the little person in the box, or placing a jewel with them, or if not too threatening indicate a path or a way out of the box. So much depends on the disorder and the client's awareness of the meaning of their visual statement. It is difficult to work with this method if you are presented with an impassioned and coloured painting of an abstract nature. How I work with a person really depends on the nature of the disorder and other factors in that person's life.

Do you take any of this "way of looking" and use it with your own art?

Absolutely not. I don't recall doing so, other than training. When I leave I disassociate from my job. I never look at my work in a psychological way. Early on in my training I took my art work for therapeutic reasons and I took my art to a therapist because I couldn't understand it myself. I needed the therapist to help me see what I was doing.

Do you ever ask your students to do drawings and use them to clarify and understand themselves better?

I don't do individual counselling. That is done by another therapist. However in training students in group work or group techniques I work this way, but it is placed in the context of the training experience.

Do you suggest that your students do art work with clients?

No. I refuse to allow that approach until their experience has given them sufficient maturity and objectivity, and there is no danger of over-identification with the clients. There must also be a specific therapeutic goal in doing so. Children can be the exception, of course, but I work primarily with adults. The difficulty is that students are struggling with their own identity as therapists.

Often they don't know who they are, or who they are in relation to the client. The boundaries between student-therapist and client can become very fuzzy. The client's welfare is primary. Transference/countertransference issues are dealt with in practicum supervision through subjective self-reporting.

Does the transference/counter-transference appear in the drawing?

Always. If it is there it can generally be detected.

How do you recognize transference?

It is always there as part of the therapeutic alliance.

How do you recognize countertransference?

The way in which the student looks at the client's art work and how they describe the session. There are many ways, through observing the session, client reactions, etc. The question is difficult to answer in this particular context.

Some supervisors ask their students to bring in their art work to clarify countertransference issues. I don't want to know or become involved in their art work.

Why?

I don't think it's relevant to that particular situation unless they are doing art work with their client in a session. I encourage more of the relationship with the person through the art produced by the client. Student art work belongs to and should be dealt with in their own personal studio sessions or art therapy sessions, otherwise the whole situation becomes incestuous, and practicum supervision becomes clouded with student art therapy sessions. I don't have the time. I agree that countertransference issues must be known and dealt with. What I do is have each student submit in written form a description of the session in three parts.

1. A brief description of the session.
2. An objective clinical summary.
3. A subjective and interpretive analysis of the

A.

session and the client as they experienced it.  
No hold barred.

What are the subjective comments like?

Comments like: "I don't like this person" or "I feel uneasy and I don't know why" or "I really think this person is terrific." It is hard to remember and often very difficult for students to relax with their written comments.

Do you call this countertransference?

Not particularly at that point. Countertransference is dependant upon the developing situation. We would have to look over time at the notes and comments on the art work to be able to identify the countertransference. Body language and verbal nuances during debriefing sessions can be indicative.

How do you self analyze?

I'm not sure I do. I look at my feelings. I also have a very good psychiatric supervisor. So I'll talk to my supervisor or the psychiatrist who work with that patient if I find myself uneasy with the patient or my work. Then there are feelings in my body that I become aware of (having trained for years in bioenergetic analysis). I don't seem to carry much in my mind, generally I just seem to react and then consider what I am doing and what it is all about.

How do you approach your own art work?

I nearly always paint from reality, from the objective world around me. Unless I am immersed in colour and form for its own sake. I like to paint objects and people, and I work aesthetically (whatever that means). I can also become deeply involved in purely expressive work with nothing coming in from outside. That's really powerful. I would like to see a development in how I see the world, objectively and subjectively. I always tend to like what I do, but I would like to do much more one day just to see what develops, and to make it the best I can.

B.

How do you, as an art therapist use your own art work in relationship to the art therapeutic process?

It was late in my personal development when I began looking at my art work as being revealing of something I didn't know about myself. I was doing art therapeutic type of work about a year before I started art therapy studies. In my art therapy training I found the workshops absolutely phenomenal and couldn't believe I could get as much out of my art work as I did but it was definitely a bit of a mind trip as well. I enjoyed very much searching out the literature for possible explanations for what I had done. It was a definite balance and it was not totally related to the image. Ideas would be triggered and I would search that out somewhere else so there was a constant flow between the verbal and the visual.

Did your art work change when you began to see it as a reflection of your psychological self?

It, my spontaneous art, didn't change. I have a particular way of doing that sort of spontaneous art work. It probably has changed somewhat but it feels very much that there is something there that is my style.

Before, in my "academic" art that really belonged to my fine art training I was deliberately striving after technique.

I used spontaneous works as well to express my personal perspective. As time goes on there is less of a visible distinction between the two. I have become less obsessional about my art work.

Do you look at all your art work from the personal point of view?

No. It had never occurred to me to look at my "proper fine art" in that personal way. I maintain a distinction that I had in those days. In the spontaneous work that I do in my journal I don't try and convert it into a verbal process. I feel it may not do it justice. For example, a couple of years ago I did a series of paintings that I didn't know what they were about. I simply kept on painting. The journal work got me to a point where I was able to say "These paintings have been about energy fields". And

B.

that tied in very specifically with something that was going on in my life. In my journal work I am more trusting of the image. I like its honesty. I get "hung up" when doing fine art (the kind of stuff you could conceivably frame) and I worked "too hard" and tried too consciously to be the "best one" which inhibited my spontaneity. The journal work works because it is not public and therefore won't be evaluated. The images have integrity and spontaneity.

Do you look at your work in a similar way in which you look at your clients' work?

My first response is to say, not at all. However, if I look at their work in terms of the elements, such as the pictorial integration etc. then I do look at them in the same way. I suppose I do put some of the "fine art criteria" onto them.

I may change that depending on the client. The form and content seems to be intimately related to my relationship with the client, to some message I am getting from the person. I "psychologize" all the time. I can scan a picture and find myself a little later writing up my notes and realizing I have subliminally done something with the image.

What framework do you work within?

I find this a hard question. If I look at the content I may look at it from a archetypal perspective (i.e. I use analytical psychology). When it come to breaking down the components, let me give you an example. Archetypally the picture may represent the mother complex so we are talking about analytical psychology. To refine that I sometimes use Kleinian concepts, sometimes Mahler for the later stages of the mother complex, but mostly Klein.

Have you ever used your art work in art therapy?

My first experience was actually in a session when the client asked me to do a drawing with her. I was taken aback by it. I knew there were reservations on the part of art therapy about drawing with the client. I found myself doing it against my will. It made me feel guilty in that I felt I was doing something I ought not to be doing as an art therapist. There was something I was giving in to on the client's part. As it turned out it appears to have worked out all right. One of



B.

the important differences between verbal therapy and art therapy is the actual physical setting in that, and I am not sure that this is everyone else's experience, but it's my feeling that one tends to sit closer in art therapy. If I think of my own therapy, I am much farther away than I am with my own clients. There is that plus the joint drawing promotes an intimacy. Not just an intimacy on the paper but a physical intimacy as well. In the case I am referring to, the client used this to be close to me. Again, I feared my peers' judgement. I ultimately developed strategies to wean her away. The joint drawing brought home to me the way in which I respond to certain situations. It was very much a maternal response, so there was the countertransference aspect. The picture "clarified" this for me. It is interesting that I frequently refer back to that experience but I have found that I have not got myself into that situation again. I think that's because I am conscious of introducing another variable that influences the transference situation. In a class workshop I produced four pictures with the client in mind, with minimal intellectual processing. They seemed entirely spontaneous. At least, the first one was. The first painting showed the persecutory aspects of the transference, the constellation of the mother complex. I knew I was feeling anxious and sometimes getting angry at the client, not during the drawings but in situations where she would refuse to leave at the end of a session. It wasn't until I produced the four drawings that I realized these feelings were persecutory. I don't know how much it helped me with the processing but the drawing refined what the feelings were and enabled me to pinpoint the hypothetical age to which she had regressed. It was possible to gain access to this information by the feelings she was evoking in me and presumably the feelings I was evoking in her. I have a feeling that sometimes when one does spontaneous art work that sort of thing does come out, if one but knew it. I probably have other pictures that came about as a result of something that happened with a client. On occasion I used the art work deliberately to identify my position in the therapeutic relationship. I used a time when a client did not show up and came up with two different pictures. I used her therapy time to draw, holding the client in my mind. One of the pictures showed how I was conducting the therapy. The image suggested that I was "bending over backwards" although I am still not sure I was doing this. However, I did pay attention to this. The second one was of a

B.

maternal configuration. It looked very much like a negative mother constellation. I tend to be able to clue in somewhere on the maternal continuum. I am sort of expecting this now and I see which phase gets activated.

Why don't you use art more?

I don't have the time. When I do it and get very involved, it takes a long time. If there is any resistance to doing the art work it is a resistance to doing more work. The work that I have done with images has served me well. Maybe I do not do a lot of it now because it is self-regulating!

Do you think that the therapy was expedited when you drew?

In the joint drawings, for the client, it put more of a structure on the client's issues. It concretized what in other terms was flying all over the place, so in that sense it may have made the therapy move more rapidly.

In my own art work it moved me to be more self-aware, so that I didn't become debilitated and therefore ineffectual to the client. One of the fears at that particular stage of development (or regression) is that she would destroy the nurturing figure. In some ways that can be done, the energy can be sapped. What helped me was the acknowledgement of that and therefore I became a little clearer with my boundaries so that she couldn't scoop me out any more. This was clarified for me through my art work.

Do you think that creating gives you energy?

Yes, I remember I was excited about these images. As far as the client was concerned, there was a pick up in the tempo of the therapy. I don't know if it was those drawings that did it though.

Would you say then, that you use drawings to help you clarify the countertransference?

In the two most recent drawings I described I wanted to clarify the countertransference. In the "bending over backwards" image I was introduced to a new element that I had to think about.

B.

Do you take these images to someone else to look at?

I took them to my supervision (not an art therapist) but she did not do very much with the images. However, associations were made revealing the dynamics in one of the drawings I did. This had not been conscious and with the supervision helped clarify this for me.

How do you self analyze?

One of the ways is when I do my journal drawings and notes. I also tend, when I am relaxed, to mull over events.

How do you analyze a therapeutic situation?

At the end of the session I take notes. I have a fairly good recall. I cast a net using all the four functions and come up with something I can understand.

Afterthought:

My own particular interest in the use of my own art work in relation to clients has to do with the idea of how the latter exert control through the use of projective identification, a forerunner of empathy, transference and countertransference.

C.

How do you, as an art therapist, use your own art work in relationship to the art therapeutic process?

I haven't had much time to do as much art work as I should. I tend to do pre-session drawing, which is looking more as how I am feeling rather than looking at art as self-expression without a purpose. The purpose of the pre-session work is to find out what I'm feeling, to get out the feelings I am having. I find it helpful and as a good way of 'clearing myself' for the session. After session art work I would find out how I was feeling. A lot of times I reflected in my work as to how the kids were feeling in my art work so if the session was upset, then the art therapy was picking up the kids feelings.

How would you compare the quality of these two types of work?

I found the ones done pre session were usually the ones that were more jumbled, more chaotic. This reflected the way I was usually feeling. The after session works was more representative, as if I had attained more attention to specifics with the client.

Could you say that these drawings enriched your experience in the art therapy?

I think so but sometimes it was quite a few weeks after because I didn't really take the time to look at them. As I reviewed the material I would see the process. I could ask the question: "Was I furious or was it the kid's fury I was picking up on?" They became more valuable as the time went on.

Would you show these works to anyone?

I used them as a supervisor. I did not have an art therapy supervisor.

Was this your main way of self analysis during this period?

Yes. I really relied on this quite a bit. We were taught to use this. It probably would have been more helpful if I had a supervisor to show it to.

C.

Did the drawings help you clarify countertransference?

Yes, primarily I use this for that purpose. For me, countertransference is one, bringing my material into the session and two, the feelings I am picking up from the clients. Probably even more countertransference than transference. Although a bit, very often I was feeling the way the child wanted me to feel like the way they wanted to make their parents feel so I was aware of that. Sometimes the other stuff, the way I was responding related to my own kids.

Did you ever find yourself making symbols that your clients would make in following sessions?

That's an interesting question but one I didn't look for as I did my drawings so I would have to say no. The children I work with are relatively healthy kids experiencing a current trauma, working through the transference therefore is less prone to 'pick up' these subtleties. I also do my present work with groups and in general this situation is less prone towards the transference/countertransference dynamic. With psychotic children, however, I could see this may happen. When I would work with this type of population I had a threatening feeling, symbols didn't feel strange and then suddenly I would get sucked in. My drawings seem to start out normal and then change. I found this scary as if one could feel how it was to "lose your sanity". I would imagine that the imagery could have provoked these feelings.

I think there's always an empathy for the symbol, for example I worked with a child who is abused by the mother and being kept in an overturned crib as a child. This child's symbol was the cage. For some reason I picked up on this symbol. A lot of kids, I still can feel for their symbols. I think that's inherent in art therapy.

Have you used joint drawings?

I have used parallel drawings with adolescents. It wasn't my first choice. I tried to not do what he was doing. I felt he wanted his sense of identity. I felt he needed to experience our separateness so I did, in terms of the art, what I wanted to do. His images were mostly castle-like fortresses while mine were light, pastel imagery.

C.

How did you process this work?

I did not process mine too much. I looked at his work and what he was saying. I did not work with the countertransference and transference in a conscious way. I tried to look at as many different things as I can. I think it is "that what hits me first", for example an outstanding colour, a line. . .

So, you are looking at the aesthetics?

In terms of feelings. I ask what is the line feeling..is it depressed? Angry? I look at the symbols later on, but I am much more comfortable looking at the elements in the picture, and what is said about it. As time goes by I look to see what symbols reappear, how they change etc.

I was trained to diagnose. I still feel more comfortable when the person has made it clear about what the symbol means to him. I am very careful. I do keep it in the 'back of my mind' ie. what Hammer might interpret etc. I would never use it in a report unless it had really been validated.

What psychological framework do you work from?

I've been trying to answer that one for a long time. It is definitely psychoanalytic. Oral, anal and phallic can be identified through the symbols. However, that comes later on. I am more analytic than I think. I like to have a lot of data. I find Piaget, Anna Freud, Kellogg's and Klein's work helpful. I do not like having to say I have a specific theory. I try to get a rounded perspective.

I guess basically I am pretty Freudian. I change how I work too. With the group I am more "here and now", and with individuals you get quicker into the material.

Do you process your own work in the same way as the clients?

I do art work for two different reasons. I work in two different ways. If I'm upset and I want to know what the heck I'm feeling I do a picture specifically to find this out. There are other times, I try not to analyze because it seems to ruin it and I just do it. Then afterwards if it says something to me, that's fine. I find it very hard to create art as I did in art school. After doing art therapy training, I find it hard to do art work. It speaks to me so much. Just like I do with countertransference, I try to "clean

C.

the slate" so I try to let myself "be" without being analytical, but it's hard which is why I don't think I do that much art work.

In the second type of art work, the framework is more social, so I don't tend to do ugly art work or upset art work. That's not my style. I tend to do something I would like people to look at. There are artists who do display personal feelings in their work (that is, it may be what I call ugly art work) but I wonder if they would do this if they were an art therapist? If they had really looked at what their symbols are revealing about them? I think they are doing what I describe in the second process, to allow the feeling and whatever just to come out. For me, I wouldn't do that. I couldn't let other art therapist's see all those types of feelings out there.

D.

How do you, as an art therapist, use your own art work in relationship to the art therapeutic process?

I am not doing a lot of art work like a lot of art therapists I know but when I do, I do "non-art" which is very spontaneous art. I'm not taking it further into more secondary processing and turning it into art. When I do "art" which is rarely, I need to process it. The inspiration may come from the spontaneous art work but then I step back and look at it and rework it, etc.

Is your spontaneous work related to your work with clients?

Yes, in many ways sometimes it is a reaction to sessions. Very often I paint before or after a session. When I paint before a session I find it seems to deal more with myself and less with what's in the session. On occasion some of my expectations of the session come out. After session drawings tend to be more of an outlet. Sometimes I feel overwhelmed. I've taken so much in and I need to get some of it out.

Has the result of this spontaneous imagery benefitted you in other ways?

It's difficult to answer. From what I remember, it's mainly been an outlet for feelings that I didn't know where to put. In terms of looking at those drawings and looking at their meaning I haven't done that much of it because I do it so much with the client I don't feel like doing it with my own work. When I have looked at the work for meaning it has had to do mainly with countertransference issues. How do I perceive that person?

Do you do this art work ever to simply clarify the countertransference issues?

No, that is not why I do it. It happens afterwards. It helps clarify the countertransference.



D.

When do you think the countertransference issues would arise in your art work?

I think more after a session, but sometimes before.

Do you do any other kind of art work?

I do, but most of the time its spontaneous art and I don't call it art. I have an easel and crayons at home and I play with them. It's bit much different from the post session work except for the issues that are involved. It's basically the same style.

How do you know when your art is countertransference?

Simply, somehow it deals with certain feelings in relating to my relationship to particular clients.

Sometimes I've even done portraits of clients.

Sometimes they were striking. They were expressive in certain ways I hadn't thought of before.

What theory do you find yourself attracted to?

I don't work with transference/countertransference too much. I know they are there. I tend to emphasize with the relationship of the client and his/her art. My basic approach, in a few words is I believe, very much like Winnicott's theory of the transitional phenomenon, and the act of creation that my patient and I are involved in. Art is the element that has the emphasis because it receives a lot of attention from me and the client. I don't put that as much emphasis on the therapeutic relationship. It's there but I don't emphasize it that much.

Do you do joint drawings or your own work in a session?

I do my own work only very rarely and this is when children need stimulation. I do joint drawings when the therapeutic relationship needs to be worked on. I want to balance the relationship within three elements: the art and the two people. The joint drawings explores this relationship. It seems natural if the therapeutic relationship is not formed I may do some joint drawings to explore from both points of view how the relationship can be formed.

D.

Do you ever find yourself surprised about your own art work?

I don't think I have revolutionary discoveries every day. I look at the process, and I keep a check on myself and browse through the work and I look at the work as I would at the clients work. In essence it helps clarify my own issues.

I find it harder now to do 'real art' for aesthetic purposes. Harder now, ie. after my art therapy training. It seems more natural for me to do spontaneous art. It has enough meaning. The rest doesn't seem necessary.

What form does your "real art" take?

Sculpture, painting . . . and they are slightly figurative. I am focused so much on the art therapy that it seems that the art is in another drawer and it's closed right now. Art has become self art therapy.

How do you work in art therapy?

Even if I say the art is the emphasis I am very verbal. We look at the art and work through the metaphor. It depends on the patient however. Certainly with psychotics its the only thing to do.

E.

How do you, as an art therapist, use your own art work in relationship to the art therapeutic process?

I think my art is not directly related, but it makes me sensitive to the experience. I don't believe that the unconscious always comes onto the paper.

Do you ever do art work inside the session with your clients?

No. I think that it has a way of becoming a potential for distraction particularly in my situation. It's difficult for deaf children to pick up all the nuances of what is going on. The total visual quality of their understanding of what is going on. If I do something they are always looking at me in a different way than a hearing person would. I primarily interact in sign language with a focus on the relationship. The art is an extension of them.

Have there been times you've used the art?

I draw pictures to illustrate an idea, as a way of substitution for the sign language or speech, and for direction.

Have you ever used art work before or after to help clarify anything in the session?

No, there is no time for that. Within a school day the time is short.

What psychological framework would you say you work from?

I don't consciously use a framework. My own Jungian analysis gives me a perspective, that of Jungian psychology and I'm sure this spills over into my perception. If I have any system at all, it's to be very careful to see as much as I can see, style, image and to keep looking and to put all those things together in a constant flow. There is always a potential for change. I focus on the client and the art work.

E.

Do you look at your own art work in the same way as your clients' work?

The subjective experience I'm thinking of is quite different for me. The process of doing spontaneous art is getting in touch with what is going on internally. There is some similarity because of this connection. There is a great deal of difference in my processes in doing art work when I set out to be an artist compared to when I set out to be a person with a psychological approach. Rarely do I start with the subject as therapeutic when I am focusing on art as a product. As an artist I choose a subject. As my own therapy I am spontaneous. This affects the contents. When I look at my work it is like two different people when I use the two different approaches. The styles are entirely different.

Have you ever done art work which related to the work you do with your clients?

In my training we were asked to do something like that and because I was asked to do something in particular there was rarely the same spontaneity then when I worked solely on my own in an expressive way. The relationship between what was going on and my response drawing lacked spontaneity. It is "always interesting" to see what I chose to do but it was "too tight" and I wasn't comfortable with this. I understand using art but I don't feel drawn to this approach.

In terms of doing this as a response in the session there are too many variables that I'm not really comfortable with. The subjectivity mixes up the process of art therapy. I am not comfortable with Winnicott. I think of the paper as an extension of the person's self who is revealing him/herself to me. I reflect back in some way my acceptance of that person and that is the essence of my work.

My process is my process. Your process is your process. If I am going to be the container for you, I can't get involved in my own process. It's too easy to mix your own process on the paper and not easy to separate it.

E.

Sometimes therapists do mix their stuff, and this is referred at times as countertransference. How do you identify this?

When I know where I am, when I know what's happening, I'm always reflective, asking myself questions. When I'm uncomfortable with my reactions I know I have to look at this.

It's an awareness of my own state. Is this totally me? Is it evoked by Johnny?

How about "Was it evoked by the drawing Johnny was doing?"

Yes, but I don't call that countertransference. It is probably a projection. A projection is a common experience especially with images so I might have some projections of my own psyche which may come from the countertransference.

What is the difference between projection and transference?

Projection is towards the image. Actually I'm not sure that there is a whole lot of difference. There is however a great deal of difference between the psychoanalytic process and art therapy process. I process countertransference in my mind, by using the imagery which is not always on paper.

Afterthought:

As explained in the interview, I do not do art work during session or after session. My art work is either in response to dreams, spontaneous or a particular exercise in art per se.

F.

How do you as an art therapist use your own art work in relationship to the art therapeutic process?

I do use my art work with my clients. I started out working with very seriously emotionally disturbed children. I found there that working the best way was to bring in my own work to the school. I made my art along with the groups and individuals I worked with. I found this useful for the severely disturbed; it was good to have the work between us, it acted as a sort of "buffer" for the feelings that were coming from the child. Working together on a piece of art is also an interesting way of doing therapy but that depends on the personality of the children and people involved. In my work with adults I do something different, for example, I worked with a woman who was fairly regressed and in need of early experiences, in need of a mothering approach. The best way to deal with her was to work together on the same piece of art. We worked for six months in this way. I had very strong countertransference, very strong feelings.

How did you recognize this as countertransference?

I had no personal need to work with her. I tested it out and suggested that we work independent of each other. At the end of the session she said that it didn't feel right and that gave me the reassurance that I was doing the right thing. I gradually sensed her distancing and then we separated and she worked on a separate sheet of paper. I always worked with her either in conversation or on a separate piece of paper. I never let her work alone.

How did you identify your countertransference?

In the kind of work I do with this particular person. (She's a commercial artist.) She came to me and wanted art therapy and wanted to do something that she couldn't edit. I gave her goob. (It's an amorphous material.) The imagery that evolved was more abstract. You could see the difference in the colours. It's subtle. It's much more the relationship between us. I said very little to her and there was occasional interpretation.

F.

I would like to find out about you in this process. You mentioned countertransference. I wonder how this was significant to you?

I have a client I'm working with now who I would classify as chronically hostile. This woman works on her art work and I work on mine. I saw her for quite a while and I didn't work on anything. I was just there. It wasn't until I saw the work developing in a certain way. I started to do my own work. I work from feeling and intuition. I got a sort of euphoric feeling and felt "okay, now it's time for me to work". You see, with this woman what I am aiming for is to be able to work together. We may never be able to work on the same page, but even if she accepts the working on the same table will be a gain.

What happens to your images? How do they relate to what is going on?

When I worked in the school with the emotionally disturbed children I simply worked on my own art work and the children on theirs. I never had any trouble with the children wanting to work like me. Of course, some would pick up my ideas but in fact, if I wanted the child to work in a certain direction I started doing something that the child would pick up on. With the adults I try with the feelings I'm getting. It's still mine. It's very much my own but I try to work on something that sort of relates to the feelings I'm getting. Very interesting images comes especially when I work with the client in a joint drawing, particularly the commercial artist. Although with this material I work with there is no real imagery. I mean, there is no figurative imagery.

What psychological framework do you work from?

I do have a theory. I use the psychology of Melanie Klein. I do believe that these works are an externalization of an internal object and I feel that anything that a person make is this. But what's more important than the actual imagery is what the person does with it. The object they have created and how they feel about it.

F.

How do you recognize the transference/countertransference?

I guess I recognize it in small subtleties. For example, a client of mine brings her own brushes into the session and lately she has inadvertently left them behind. Now she consciously leaves them behind. I feel this is transference. I see it more in her than in her work. Although if I did examine the work I'm sure I'd find it there. The paintings are beginning to get depth.

I recognize the countertransference by the way I feel.

Were you ever surprised by your art work?

That's a good question. Yes, sometimes my work surprises me. Things I thought I was working on change. I realize it after the session. For example, a client and myself were both doing independent imagery in sculpture. To my surprise, I was making what was I thought would be a "closed" sculpture and it actually turned out to be "open". I realized later that the client was experiencing the "openness" of this situation and somehow I was picking up on this. We were not looking at each other's work. We conversed as we worked.

How would you compare your personal art work with that which arrives in the sessions?

It varies. The ceramics in the school was my work. In the second examples (with adult clients) the art work is different. You are using your self when you are working with your art work. Working with the psychotic children you would go into their psychotic images and work with them. It was very frightening. As a Kleinian, I act as container for the feelings.

In joint drawings, did the countertransference ever obliterate a session?

Oh, yes these things happen. I had a piece that was partially done. It was an abstract done in coloured ink and I suggested that my client complete it. That was really a mistake, she didn't want to touch it. She was not ready to interact with my object or to get that close with another person.



G.

How do you, as an art therapist, use your own art work in relationship to the art therapeutic process?

The time of my pregnancy was the most artistic and authentic time for me to integrate my own art work in relationship to the therapeutic process. I came from an art background and with a great investment in the "experience" followed by a rigorous clinical experience whereby there was limited art production. At this time I reviewed the question "who am I?" My roles now had grown into a teacher, clinician, artist and mother/wife that interrelate. I feel I achieved a balance with the artist in me, a self-reflective understanding of my involvement in the academic milieu, my active engagement as a therapist and in my development of my family life. In part my art became response drawings that dealt with a host of emotions, of unsettled feelings. I used these response drawings to sort out a separation between my feelings and those of the clients.

I often use them (response drawings) as a tool in supervision with students. I would take on the students' artistic style (like a chameleon) to understand what they were processing and ultimately what their clients were processing. This would serve as an exploration into their defenses. The full range of reactions to the pregnant state I viewed analogously to psychological birthing processes that get stirred by those who are in close proximity to the "pregnant therapist" or educator. I feel pregnancy is one of the most potent times where unconscious issues resurface. It is a lost opportunity not to explore the psyche in an artistic way or a psychological way. In the art world, people talk of art as creation. Remembering back when I was in Germany (as an invited guest speaker for art therapy) I engaged in response drawings with a psychologist, when we had difficulty communicating through verbal language (i.e. English and German). His drawings were new to me, as with every new interaction. He drew a wild horse, flowers and helmets. Because he was also a football coach, he showed me his green machine that symbolized money for his team. (I'm choosing not to go into depth of a psychoanalytical interpretation for the purpose of this interview). His own art was externally defensive. For one of the first times in my life I was called upon to not do "perfect" art, rather the situation called upon

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the instinctual, feminine side of art in my response as an artist. I started to use his symbols and incorporate the flower. (The flower was a gift that had been given to me on one of the city tours, in between the conference schedule.) I took that theme to counteract the instinctual side of the wild horses that were out of control in him; to balance the elements. These drawings uncovered unresolved areas for me that had been packaged away. Rather than running away from it, I took the opportunity to explore my "male spirit". The flower that was given for me, was the same one that a close girlfriend has previously given to me, as her symbol of my personality (reflective of early adolescent developmental phases). It is a phallic flower, white with the stem popping out. She had given me that flower surrounded by black saying "That's you". The recurrence of this metaphor asked me to look at life in a kind of existential way, in a new and different language, from a sensation function. Part of this invitation to Germany was also to participate as an artist. I did this through a performance piece. I took an unfinished kitchen, that was part of a studio space that local artists were using, and turned it into a dinner feast. The "flower and wild horse" feasted on energy in a pictorial way. A few days later, local artists came in and saw the playful exhibition and said, "Ah, she is an artist, not just an art therapist!" Narcissistically it was invigorating to be acknowledged as an "artist" since my professional life had been clinically oriented for many years (putting aside my former experiences as a professional artist). Through the response drawings, a few days later, the psychologist commented that he had to make big changes in his life. He realized through his animal form that he tended to bulldoze through things without thinking. His new symbol became a lion, a king of the forest, who was very much in control. His lion was wild too, but showed a defensive response to experiences where he felt too vulnerable. Previously I had used my art for my own issues, the therapeutic context, countertransference implications, to emphatically know what the other person was going through. This was a much more trying creative process. Why did I need that lion? Everything was kind of cross-looking at.

I used the art, actually working in a therapeutic situation in an art context, not in a psychological context per se, although what I would work through is

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my psychological knowledge of it. It was more art base. Freeing some very tight concepts. The shift was to differentiate feelings. I would already know the area of concern, or the theme that was emerging.

Do you use your art work in a session?

In my professional training, there was an implication that your art was private. The model was to keep art and verbal separate. I feel few people in art therapy who intermingle their art within the therapeutic environment, have ease in maintaining control and professionalism. The unconscious issues often bring up a strength or vulnerability that can be theoretically or clinically criticized. A straight verbal psychotherapist can hide behind the persona, which has both positive and negative effects. An art therapist has overt creative tools to be authentic with, to avoid burnout, of maintaining a certain image. The skill and timing of when and where to use this additional access must be closely investigated. It is very powerful. The director's hidden agenda (where I studied), was that she was an artist. I now understand why she kept undercover. In the early phase of training, at least 50% of the students couldn't handle the depth of the exposure of art work due to transference issues. They tend to be searching for a role model in their professional identity, and need room to expand their integration of art therapy to not end up as a carbon copy of their educator. If I draw in the session, it is with conscious intervention. I am critical of Mildred Lachman-Chapin because she often appears to be unconscious of the images she is emitting. Our psyches tend to respond to each other spontaneously. The possibilities of "Freudian slips on the paper" is high. The care, intuition, and the sensitivity is extremely necessary. The narcissistic elements of authentic art making tend to make the therapist less available to the client's involvement during the art making process. I am not convinced that drawing with the client is always helpful and beneficial to the client's own process. Parallel drawings require supervision. I usually use them as "good-bye" drawings once the client is reaching towards autonomy and hopefully individuation. This is when the therapist becomes more human, normal, less myth-like for the client within the termination phase.

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I often remember the images that the client has produced and selectively re-visualize them to the client for insight and integration. My clients have appeared moved by my investment in their symbol making. It's a very non-verbal way of sharing humanity. It often helps me to personally separate by delineating and reviewing the client's issues. This process synthesizes together parts of the process into a gestalt for closure.

Sometimes I have had clients (especially children) demand that I draw. I would try to draw exactly what they desired as an auxiliary ego. The image would serve as a concretization of their image. The danger is on the dependency and projection to solve the issue for the client which is inappropriate. During my first internship experience I was literally boxed in with a joint drawing rendering me ineffective as the therapist. I was quickly able to feel what the client was feeling through a few lines, but needed to learn the skill of not being manipulated. My own issues of aggression and release of expression of anger needed to be analyzed, a fine tuning.

How do you work as a therapist?

I always felt myself as a "creative therapist". (The notion that there is an art in doing therapy.) I try to understand the person in terms of the media responses as well as the psychological responses. I use a change of media after having explored the full psychological implications in counter-transference and transferential phenomena. I believe this is a creative response that is flexible. I presently feel I am experiencing a move from the more rigid Freudian framework to a more eclectic art therapy framework. This has been possible through my growing confidence as a psychotherapist. The professional growth I feel is a "knowing" flexibility.

Why do you think that some therapists use their art work to explore their reactions while others do not?

Depends upon your training and family background. The way in which the therapists' personal experience of coping and surviving through their family crises, makes

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the art therapist responsive or not to the transference relationship issues. Perhaps, specific to the nature of art therapist, how the family used art (broadly termed) and the aesthetics as a way of solving problems, e.g. during conflicts did family members escape watching T.V. or playing piano. (Sublimation, ventilation and exploration are patterns that are early set.) What mechanism did the person draw upon to provide effective changes?

There seems to be a socialized bias in North America that it is more advantageous not to be a "crazy" artist. Since culture is more integrated in Europe, the artist tends to have a high status from my experience with hospitals and mental health communities in North America. Here it tends to be more financially viable to present yourself as a psychotherapist primarily before the art. I look forward to a period when the treatment community at large is more enlightened.

How do you see the transference/countertransference relating to the imagery?

For example, I often made countertransference drawings after my sessions when I was working with a client who was working through incest issues. She used the metaphor of broken glass. The image of being cut by glass is extremely painful. Although I hadn't been sexually abused, but analytically had dealt with the fantasized elements in my personal therapy, I had been recently mugged. In a separate but perhaps parallel way, I was responding to what it felt like to be violated or intruded upon. My drawings reflected the "fear of life leaving you". Psychodynamically, once you have been sexually abused your damaged body often is felt as it is never being truly yours again. Through drawing I was able to distinguish the therapeutic issues. Symbolically this is not unlike my recent artist/therapist experience in Germany.

\* Have your drawings ever surprised you?

They always do. Once I befriended the process, it first became a playful process with the image, followed by analysis and then at the end reflection. I would often gaze at the art work for one or two hours and journey through it. I chose to let the symbols "pop

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up" in the act of feeling free and not worrying myself about restrictions. It is now a delightful experience. Even the pain of tears become delightful because of the befriended nature.

Do you share your art work?

I draw on a weekly basis. I share art work with one or another person because they are a communication tool as well. As my artistic confidence matures I would like to one day exhibit.

Is this the way you self analyze?

Fundamentally I initially needed one person to share the work with, but slowly have been able now to share it with different people. I feel we can hide behind doing the art work alone, or hide behind doing the practicing verbal skills alone. There must be a marriage.

Is there a difference between personal and public art?

Yes, some would say the exhibiting ratio is one painting in five or ten that becomes public. What are the works in progress: They may not be used psychologically but they are in a process. Similarly in a roll of film you don't get 36 good pictures. If I were exhibiting, I'd probably do a microcosm of what I'd be doing as an artist. Being an "artist" is not a dominant character in my lifestyle at present. It's one quarter of my being, unless I am being philosophical.

Kurelek, a professional artist, is a good example of art work that he was produced for therapeutic necessity (personal) or economic sustenance (public). The expectation of a clinician is not to be poetic. The artist in me helps to appreciate and respect the unknown. Art holds the meeting grounds for me.

What psychological framework do you end up looking at your art with?

I see the clients' works and mine both from a psychodynamic analytic perspective, being flexible to the needs and the personality of each client in the basic chemistry between the client and therapist that

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establishes a solid rapport and trust. I am curious about the 'language of life', metaphorically of how people exist and create meaning in their lives. My approach has evolved to be eclectic in the full sense of the word.

It is based on the investigation of psychic life and reality. I enjoy each and every fresh image and I want to explore the implicit and explicit parameters. My most meaningful experiences in the therapeutic process has been when the client connects to the images and to the significant relationship. Various theoretical orientation can describe the process, but I feel the most important development is a sense of effective change and growth for each particular person. This is such a pioneering profession. Unfortunately there are preoccupations with security, jobs, etc. that seem to temporarily take away the freedom to invest in art. I hope this will not always be the syndrome.

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How do you, as an art therapist, use your own art work in relationship to the art therapeutic process?

In the past I used art in personal therapy, then I went to art school. I was sensitive to how art work related personally in that I used it to relieve stress and to work through stress.

I looked at the content to see how it spoke back to me as to what was going on inside of me. My own art work is very important to me. That is why I am an art therapist.

In art therapy I have drawn with the client in mind independent of the sessions and I have copied the work of clients (dynamic of the art process experiences). It made me observe more closely the person and the work and because of that observation, that attention, that "living with the image" I would be more empathic. Drawing with the client in mind probably doesn't help me so much with the understanding of the client as much as an understanding of my own dynamics and what's going on with my relationship with that client. It helps me clarify things because I can then figure out what's "me" and what's "them" a little better. For example, I had a client who every week did something that related to me or some work of art I had done, and it was a little eerie. I spent a lot of time thinking this through because it was so close. I sat down and drew specifically. The drawing helped to clarify the relationship or the role I played to that client in what ways I was replaying for the client what the role that his mother had in relationship to him and what aspects of my personality played into this.

Is this countertransference?

I could call it countertransference for want of a better word. I avoid the term because it is so imprecise and used in so many different ways by so many different people. I'd rather struggle to define it in terms of the relationship then put that blanket word over it.

Do you follow a certain format, in reference to doing these drawings, that clarify your feelings?

I do it once and a while when I need clarifying. I thought about doing a series.



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Do you show these drawings to others?

The pictures helps me analyze a situation and help me be aware of what feelings I was having vis-a-vis the situation. Sometimes I keep them on the wall and look at them for a period of time but I can't remember that I would bring them to my supervisor.

Do you draw inside the session?

Here are some ways I've worked with art in art therapy.

- a. Line conversations which is the constructing of a picture in a cooperative effort. It was in vogue when I was in school and I did a fair number of these.
- b. Drawing with the client on the same paper but I did not do this that often.
- c. Portrait of the client while the client did a portrait of me or the client does this at another time.
- d. Drawing independent of the client but in the session. I had a client who demanded I do this and it was important to her that she be able to "call the shots". For her it was not being in the one-down position. She was rebelling against that role.
- e. Being the hand and tool of someone who cannot draw.
- f. The client would draw for 30 minutes or so and my intervention may be to do one gesture on the page.
- g. Comic strips where the client does one box followed by my box and so on.

Do you recall your art work from these interactions?

In all these examples I try to be aware of the person's needs, capabilities and style. I always do this with a great deal of trepidation personally because I want to be therapeutic in the gesture I make. I think it is very important that you are not there as an artist in the sense that you are there to show your style, your stuff and to get affirmation but to be there for the person you are with. You put the artist in you at the service of the client.

When I draw in the session I take the time to settle myself and hope to give the most therapeutic response I can. I like Kramer's recent article referring to the

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"third hand". She describes how the therapist has been referred to in the past as the third ear, the listener, listening to what is going on an unconscious level, to the undercurrent of the messages. The third eye, is the art therapist as observer looking at the art work. Kramer's article talks of the third hand. The art therapist using his/her art background at the service of the client in the session. How to unblock the process. For example, when the client gets blocked and how the art therapist can make that one intervention on the paper that enables them to continue their work. The third hand is what she calls the art therapist using his/her art skills in the session.

We cannot control all the images that come up in our work. Have you had an experience that has surprised you?

Well, sure, that happens to everyone.

Do you think it's more possible to "slip" in the visual image rather than verbally?

It's hard to compare. More often I respond verbally then through art work and more often I analyze my verbal responses. Yes, there was an occasion I wasn't feeling empathic and my anxiety came through on the paper.

Could you say you have had experiences of counter-transference in reference to the clients' art work rather than the client per se?

Becoming so involved with the aesthetic experience that I don't see the work? Yes, I think so. For example I was working with a group of latency age boys who were building clay penises. I was surrounded by a forest of penises and it was a very violence prone group. That was not a situation where I was doing art work with the kids but I did have a countertransference reaction vis-a-vis the art work. Another example was when I was depressed and the client was depressed. The art symbols made me feel my depression. I was so overwhelmed by the depression in the art work that I had a sense of futility,

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uncertainty and I was not able to respond adequately to the client. That client's symbol corresponded so closely to my own inner state. The therapist in me folded up her suitcase and went home because the part of me which was depressed had taken over.

The wounded healer?

The wounded healer is not just a wounded person but is a wounded healer. That situation describes an example of two wounded persons. A case of the blind leading the blind.

What psychological framework do you from?

I hate to say this but if I have to I'd say Jungian. That is secondary to my experience of the art work itself. The experience of bringing art work to supervision and therapy (Jungian) made me realize how much of the artist I am as an art therapist.

Do you look at your own art work in the same way you look at your clients' work?

Before I went to art school, I used art in a therapeutic sense. I did not look for pathology but I was concerned about aesthetic criteria. There were times I felt I had conveyed a message. I had said something. I had communicated to someone. At art school I let my own art work communicate to me, seeing sometimes the pathology, for example, with the photography I did I had done a series of walls. I had 20-30 photographs of walls in front of me. I became very depressed and wondered why I had chosen the theme of the wall and it was then I realized seeing all these walls how blocked I had felt in this course. The big issue for me in art therapy training was how much pathology would appear in my art work. There was a period of time being deliberately pathological. In my first art therapy workshop, I used colours deliberately such as red = anger etc. Now I look at my work differently from how I look at my clients in that I look more deliberately at aesthetic criteria. I look at it the same way as my clients work in that I look for what there is in the work emotionally and how I respond to it.

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What about the Jungian perspective?

I think that "being Jungian", looking at archetypes, etc. can be very reductive. Identifying the archetype may be where you begin but there are many more sides to this.

Is there a difference between your personal art work and the work you do as a response to the session?

The art work I do when I go out to work as an artist looks a lot different from the art work I do for my own personal therapy or in response to the client. There doesn't seem to be much of a difference between my own personal therapy art work and my response drawings. I am not sure why this is so. I spend a lot longer doing "art art". Art therapy art tends to be the "expression" of something that is inner. Art therapy art is more of a sketch, then a finished work of art.

What about the content?

In art art, I never tried to draw a dream.

Afterthought:

In broad lines, the correlation between my own art work and my work as an art therapist or student art therapist fascinates me. My stimulus to enter the field of art therapy were primarily my own art work and my interest in the psychological processes which relate to my own personal therapy experiences.

Subsequently I noted an increased resistance, fear of judgement/diagnosis of my art work, stemming from my studies in art therapy. This fear influenced a decrease in my own art work as an artist, as well as strong negative-positive conflicting urges re. doing my art work as part of my own therapy and eventually a decrease in art work in the context of my therapy as we.. (a new twist to the infamous "medical students" disease').

At the present, while I miss working as an art therapist, I miss even more the involvement in my own art work that I had before entry into the field of art therapy. I ask myself whether it is possible to have a deep involvement in both my work as an artist and my

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work as an art therapist, considering questions of time, energy, orientation, etc.

I find your question exceedingly interesting. My own personal preoccupation at the moment is probably the other side of the same coin: the effect of my art therapy training and experience on myself as an artist, instead of vice versa.

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How do you, as an art therapist, use your own art work in relationship to the art therapeutic process?

In my training as an art therapist ones own art product was never emphasized. My original training was in O.T. I was interested in a great variety of art forms. I don't think I can say I have an art form now. It may be coming more and more evident as writing, rather than painting, drawing or sculpting. One of the art forms I felt great comfort and creativity with was the use of clay in sculpting. That came long after O.T. I spent several years doing sculpture. I would think that if there was a medium I felt most comfortable with it would be with clay, rather than wood and carving. I have used painting and collage. My secondary interest would be dance because I have a sense I will come back as a dancer rather than using the visual arts!

Do you ever use art in the sessions with your clients?

The only time that my art is visible is when, and this is very infrequently, I would do a painting along with a client. Recently there was a dramatic session when insight was gained and the transference began to be resolved. I had not painted previously with this client. The transference came alive in this woman's mind and I think we made great progress from then on. The woman started drawing herself in the garden in England where she grew up and she was on a swing. I decided (I knew that image from her verbal work, and other art therapy) I wouldn't touch it, because it came from a time when I knew she was very strong. So I decided I would represent myself with my blues and greens which I know well are my colours and they were placed to one side, running down the side of her paper, slightly away from her image and she came and immediately "x"ed them out. Everything I did I was dotted out with jabs or "x"ed out. Then she made two scallops that looked remarkably like breasts and I underlined them very gently and she knew she couldn't touch those and that was the moment of transformation in the process. She then went back to her swing and put flowers in the tree, the father leaning against the tree. I put a basket near the swing to see what she would put in it and she put fruit in it. Then I thought there are flowers in the garden she may like a

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vase so I made a vase shape and she "x"ed it out. I'm not clear about the other steps. In the end however there were two visible sides to the work. We had her mother . . . I still am her mother but less frequently now in the transference and in the therapy. This was the moment we began to dissolve the potency of the transference, which had been very demanding. She had given me the withholding quality of her mother. There are very rare times I use art with the client. The only other time I am perhaps more visible with the art is if a client is having a hard time starting, I will say: "Let's stand in front of the table, let's look at the colours. Are there any colours that attract you? Here are a variety of brushes. Which one is speaking to you? Do put a gesture on the page. Is there something else you'd like to add? Is it complete?"

Do you use this approach with yourself?

It's so long since I've painted or sculpted. I only use my spontaneous painting if I want to investigate some feelings of a personal nature that may well be interfering with the therapeutic situation. Last year I did go back to work with a woman therapist and I found I really needed my art to explore my therapeutic issues.

Have you used that process to help clarify your feelings with a client?

No, you see my art doesn't come into the situation at all unless it is a joint drawing and that is very infrequent.

How do you identify your countertransference?

I sense that I am overreacting to the situation. It feels so comfortable to me to deal with the transference. For me to have gone into my training when I had graying hair meant I experienced transference from the moment I began my training and I learned very early how to question what was happening and felt comfortable with it from the beginning. I've been pretty diligent about my therapy. This last year was to work out my relationship with my mother with a woman therapist, whereas before I worked with male

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therapists and felt I had identified the neuroses most associated with my father. It feels to me as if I'm fairly clear and clean in the therapeutic situation. I must add this component. I do have a supervisor, who is a psychiatrist and I see him on a regular basis. He is not that interested in the art, although he is very interested in art therapy. He really questions me and asks me about countertransference.

My own therapy and that emphasis in our training was so good for the transference/countertransference dynamic.

How were you trained to identify the countertransference?

I think only in my own supervision as a student. In reference to the students I worked with I would pick up transference and countertransference through our discussion. I would ask students to draw how they felt about their client. I encouraged them to look at it (the countertransference) through an art medium.

You seem to have a clear differentiation between yourself as an artist and an art therapist.

I didn't come into art therapy through fine art. I never saw myself as an artist until recently. I'm looking forward to using writing as an art form. I have never seen myself as a visual artist.

In your art forms, have your clients ever shown up?

No, I belong to the psychoanalytic school where I leave most of myself outside. I try to be as anonymous as possible. I realize I cannot be and I realize in my postures and in my clothes I am making a statement but I do come from that school of thought that I be as unobtrusive as possible, warmly present, warmly supportive and to use or not use the art. My art work has nothing to do with my practice.

Do you have anything to add?

Movement comes into the session with the dancers in my practice. When a client is struggling with their neuroses I can sometimes physically show them what they are doing, with gestures, movements. For example when I see them carrying a very heavy emotional load, that is holding them back, I will ask them to stand up to



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show me what it feels like to be holding that emotional load. How much movement do you have with that load? This is what we are dealing with in therapy. We are dealing with the load that is preventing the free gestures, the reaching out and a sense of balance

Again, you are guiding the creative work?

I stand up with them and move. I love to move and so it's easy for me. "You're standing as if you are feeling unbalanced. Stand on one foot. How easy is it to make a decision standing on one foot?" I do a kind of translation through body movement occasionally but not in every session.

Back to the first client and the joint drawing. What were your feelings when she was "x"ing out your work.?

Strange, I didn't feel uncomfortable. Perhaps when you get to be older and feel comfortable with oneself it benefits the therapeutic situation. I've had lots of angry people, I know this anger doesn't belong to me and I'm able to make that distinction. It belongs to the client's childhood. I have never worked alongside a client. I have been beside them as they work. I don't touch anything. I might create an environment where clients might get a message from me. In the past I had seen children copying each others' imagery and from that thought that as being anonymous as possible was important. The investigation is all theirs and I really feel they move faster if I don't clutter up the environment with my perceptions. To me it's the time to concentrate on their needs. My needs are being looked after. If I need therapy and supervision, I go for it. I don't experience burnout. I take great exception to this idea that therapists experience burnout. We don't need to have it.

Why do others experience burnout and you don't?

I think countertransference doesn't run away with my emotions. This is the reason for not experiencing the burnout. Countertransference doesn't distort my perception of the reality. I'm not trying to be helpful, helpful. I'm very present for the needs of the client but I do not live their needs. I'm hearing how Freudian and Kleinian I really am.

I.

**Afterthought:**

The best things for me was my appearance during my training education. Right from the first days I had transferential issues thrust on me in my group art therapy and group psychotherapy. I also experienced transference in my practicum which was with groups. Transference and countertransference was everywhere! In group situations in my training the transference issues are always visible and there is a pressure to find a way to deal with those issues and feelings. In group therapies the group members experience transference and countertransference and the therapist creates an experiential as well as a didactic situation that facilitates the immediate working through. In all my training this working through process was repeated over and over until there was a natural response and appropriate methods of questioning oneself and the client became part of the students' repertoire. Group therapy, group practicum experience are essential components in art therapy training. Groups provide the appropriate initial milieu for the understanding and working through of transference and countertransference. Because of the extensive experience in my own therapy and practicum transference and countertransference were resolved with considerable insight and ease.

J.

How do you as an art therapist, use your art in relationship to the art therapeutic process?

There are two different ways. One, I do art after the session for myself. I think it is very directly related to the relationship.

When you say after session, what do you mean?

Sometimes it is immediately after, sometimes it is at the end of the day and sometimes it's days later but very much my own processing of the session. I often understand a lot more of what has gone on in the session especially if there's something a little bit perplexing. Then I say very explicitly, "I must get some time to do a sketch so I can work this out." And this I can look at and often times I can see thing that are happening between the client and myself when I look at what I've done.

That's a way of clarifying what's going on.

Yes.

Is it to your surprise?

Sometimes, and sometimes its subtle, and sometimes it's a longer process. It shows me a little bit and sometimes it's no surprise, nothing much happened. Or sometimes I think I've been supportive and I find out from my art work that I really was quite angry at what was happening or I was frustrated because...of whatever. It is very helpful.

The other way is actually using art in the session with the client and I don't do it that way very often. There are a few techniques with certain groups, say for instance, adolescents, that I will use. One is the conversation drawing, the response drawing but that's not very often. I use it when they are having a difficult time getting engaged and need an amount of support.

Why don't you use art more in the sessions?

When you do your own you're absorbed in your own. You can't possibly be engaged with a client at the same level. Your intensity is not with the client, whether your response is a reflection of the session or whether

J.

you are actively engaged in observation, you can't do that.

At least I don't feel I can when I'm doing my own art work. I am too absorbed in whatever it is that's going on between me and my own art work so that it is very rare for me to work that way.

Very occasionally I do something on a piece of paper alongside a client. For instance someone who is exceedingly paranoid and needs to think I am not observing, but I don't even call that doing my own art because that's a technique. It's a diversionary tactic. It is really not art.

Do you do other art work not associated with art therapy?

Some.

Is it different from that which you do related to art therapy?

Yes. It feels far more spontaneous. The doing of the art work is far more spontaneous. Much less motivated, much less purposeful. It is art for art's sake. I am an art therapist and so I cannot just divorce myself from that knowledge. Obviously it has some relationship to the other work I do. But there is a difference in art work that is motivated to some extent by issues that are going on rather than your personalized and spontaneous artistic expression.

Do you look at your work the same way you examine that of the clients?

It's harder. No, I can't say I do. It's harder to do that about oneself. When you look at someone else's you are more objective. When I look at my own work a while later then I have probably more of a more similar way of looking at it.

Do you ever bring your own art work to a supervisor?

I have done it a couple of times. I bring it to my own therapist especially around countertransference issues.

Was it the art that clarified the countertransference?

It was.

J.

Was this an immediate observation or did it come a few days later?

It was with a little distance. Obviously there was a sense there was a personal thing being worked out. I remember I knew I was frustrated and I knew this didn't come just from the work of the client. I knew when I was working on a certain piece I was working out my frustrations. I had various associations that had very, very little to do with the client. What they were, were not immediately evident to me. About three weeks later I remembered it was a very strong experience, it was a "How come I didn't see it?" I really encourage people to do that, to use their own art work.

The drawings, then, would (1) evaluate the session, and (2) clarify the countertransference?

Yes, yes. Anyway you can help yourself to clarify what went on in the session. You have to realize you are one half of the human element in the session. It is important to clarify and separate what has been happening in the session. The more we clarify what was happening with us, the more we can separate it from what was happening with the client and the more we can see how the interrelationship leads to a healthier functioning for the client.

What psychological framework do you work within?

It's not really psychoanalytic because I am not studying psychoanalysis. I have some understanding but it's much more accurate to say psychodynamic, more in an existential framework, in the sense the place where the bottom is, is also where all the beginnings are, so that when you are touching the deepest and the darkest you are also touching the beginning, the joy, the hope. Where the greatest fear may be is also where the greatest hope may be.

Do you use this to look at the art work?

Yes. It is not a matter of saying, "There, there . . . you've reached the bottom now. . . . The sun will begin to shine" That would be trivial. For instance when we

J.

look at a Goya or Picasso's Guernica which has expressed some of the bleakest and the darkest thoughts of human nature, some of the most destructive elements, we see that as paintings they may work very beautifully. In that there is a kind of joy, despite the fact that the subject is deep and dark. There is that grandeur.

Looking at the client's work?

The patient tells you. Start from him, his associations and have a sense all of this is part of a whole thing. It can involve joy etc, the wealth of associations that can be there. I hope I can help the person see how his symbols are a part of a bigger picture and to help the patient to walk around his symbol, to come to understand how it may fit into his world. Someone may be stuck and see only one way. Existentially, the more the possibility is increased the more the world belongs to him.

Do you look at your own work in this way?

Yes. It's hard at times. In a way you choose the perspective you have. Sometimes it's hard to hold your own hand to walk around your symbol. Sometimes you need someone to push you around a little bit.

Anything else you'd like to add?

The indirect way, the most important thing is the fact you understand from inside of you what this whole process is about because you make art, because it has meaning in your life. I don't know how you can possibly work with someone in art unless it has meaning to you. That is obviously the most important thing. That's the bottom of it. That you have done, you are doing, and that you will do is central to the relationship that you have with the patient through the art. That is what makes you an art therapist, coming from that place. It is what makes you an art therapist in the first place.

L.

How do you, as an art therapist, use your own art work in relationship to the art therapeutic process?

I will try and answer that in two parts. One is to do with the art work I've done in the past, the other is to do with what I am doing now. Right now, the art work is, for me, my way of restoring myself, of maintaining an equilibrium, a way of cleansing myself. Coming newly to T., and not having too many resources, I counted on my art work as a support system and it has helped. It has helped me a lot.

In the past, I have had a career as an artist. That gives me a nice perspective. I've had quite a broad experience from painting to video to performance art. That helps me process a lot of what happens to me in the therapy sessions through my art and perhaps I can appreciate maybe more fully what some of the possibilities are that exist in a client's art work. Elements in their work may imply aesthetic solutions, or possibilities. I won't lead them but it helps me take different perspectives. There's more potential for meaning. It enriches my experiences with the patient's art and it makes the patient's art more exciting for me.

From what I understand, it's your experience of being an artist that sensitizes you to what process the client is going through.

In part but also, it is the excitement I've had from art. Perhaps I am able to communicate that in tacit ways to the client. Sometimes I get the feeling that the patient may not value what s/he does very much. When you look at the surface it may not be a particularly interesting mark or image but I try and look at it from a lot of different perspectives. For example, that maybe this could develop into a comic strip or maybe it could form a film strip of images. That helps me keep well connected to what's going on with the patient and the work. When sometimes I don't find a patient's work interesting I will try and draw in some fresh perspective to help me see the potential.

L.

Have you every used your art work in a session?

I take a client-centered approach. I'm willing to take a few chances. I work in a crisis centre. My first objective is to develop an alliance with some of the kids. If this requires I do a drawing with them, trading strokes with different pens, I'm willing to do that. I'm even willing to do drawings 'for' people in certain contexts. This, according to my own orientation is a questionable procedure. If another art therapist did this I would want to ask them why. I don't see that there's a right and a wrong. It's a therapeutic and creative decision. Being an art therapist draws upon one's creativity. And if you're in touch with your clients and you have an empathic connection, I think you can take certain intuitive moves. Sometimes they are wrong, but you trust your gut instinct, and, based on real empathy as a result the alliance is improved: the child feels there is something authentic and of value going on.

You use the term "creative choice", do you ever make a psychological choice?

Of course and that's usually much more pre-meditated. I have a goal in mind. I may choose a strategy that I hope will work. Other times I may find myself in a quandary, I may make that creative decision and take a chance. If I can give a gift of a drawing to the child (this would definitely not be my first choice), and if this will encourage trust and help put more value into their art work then I think its maybe not wrong. If what I do will make the clinical situation more therapeutically valuable, I will try it.

Do you draw in the art therapy session?

Yes, but you have to be very careful and conscious of what you put on the paper. We are artists. We can facilitate an image with skill, avoiding some possible misinterpretation. We can move a pencil more slowly while we think about why or what we are putting down. It is a conscious therapeutic strategy but the amazing potential of art to release and concretize unconscious feelings often can reveal countertransference factors, or other psychological states of the therapists.



L.

Are you ever surprised by your imagery?

The surprises happen more in a joint drawing. You're thinking very carefully about your strategies and yet sometimes there are surprises. First you have to see if the client is aware of it to the same extent that you are. We, as art therapists, are tuned into nuances in the meaning of the images, even to the line pressure of the pencil and its meaning. They are not, for the most part.

Could you describe what a "surprise" is?

I think we are using quite a powerful and dangerous instrument in art therapy. That art work itself has a very powerful effect on us that is difficult to control. It's a great mechanism for liberation and like the practices of the shaman, this power is potentially destructive and dangerous and can destroy what the healer is trying to do. If that gets unleashed and cannot be controlled you may have problems, you may distort the therapeutic frame. You may destroy the trust in the alliance, and you, as an art therapist are going to have more serious problems.

This destructive symbol may sometimes be referred to as countertransference. Is this how you would identify it?

That would be one way. My own opinion is that you can feel it coming and there is your chance to exercise your control. Can you recognize what it is? Can you alter it? Can you stop it? It's not something I would suggest someone who is in training to do without much care, that is, pick up a pencil and draw, because it is risky. Someone with more experience can observe the psychological forces that may have little or nothing to do with the patient, and guard against communicating them to the patient.

Has your imagery helped you understand more of what is going on in the therapy?

In the joint drawings, sometimes very much so. The relationship is made more tangible. You get real graphic evidence. My own art work that I do at home I think has little to do with the sessions except perhaps

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in as much as my own psychic equilibrium is involved. In the therapy sessions, my work is representational (cartoons) or very minimal (lines, dots) and at home I paint and it's an abstract and visceral experience. I really try to have some kind of separation. One is very much for "me". The other is entirely for the client, ideally.

And the relationship between your art and the art therapy session?

In a broad sense, my way of being as a therapist has effected my paintings. My paintings have a sense of 'Self', that for me seems to reflect a certain orientation that I've gained by becoming a therapist, so in that way it's effected my paintings. To really underline my own art in a session, it is done with the client in mind. I would not want to do something that has 'me' in it. It's a gesture. Again, it is a strategy. In a way it's me giving something to the client s/he needs I'm giving something that they need, I'm not giving something that I need to give them.

How would you describe the psychological model you work from?

The relationship is of prime importance. If there is no trust, there is no therapy. Also if the client doesn't value his own art work, if there is no investment, or identification or engagement with art work then I don't see art therapy happening. Sometimes a model works, sometimes it doesn't. Some models work with some clients, others work with other clients. . . . Relationship and investment or identification are important but as far as let's say Jungian, Freudian, etc. whatever may describe the process with the greatest degree of elegance and have respect for what seems to be occurring in the room with the patient then that's what I would call upon. The more resources I have to call upon the more effective I'll be as a therapist. I don't rely on any one model. I don't have to prove if my model works. That's not my job. My job is to be with the patient. If the model doesn't work I'll throw the model away and find another model. As an occupation under the dominance of

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psychiatry art therapy has not yet found its' own theoretical base. The theories of depth psychology are of course major tools for psychotherapists. For the most part, I take the Rogerian approach of client-centeredness and recently more of a self psychology.

What about the art?

My own research into the anthropology of symbolic healing has focused my attention on identification and importance of the patient's relationship with the art. It's the art therapist's most important tool. We have relationships with our clients. Our clients work with us. They have relationships with their art work. We have relationships with their art work. There is a complex symbolic interaction, a triadic movement between the three. It's absolutely rich with all kinds of meaning and I think a lot of it is entirely non-verbal. I don't often take an active role in encouraging the patient to talk about art work. I'd rather they put their time and effort into their looking at it. I put a lot of store in looking at it and in subtle ways encouraging their relationship with it. In time the moment for verbal interpretation and discussion will reveal itself.

How do you understand the art work and how do you help the client understand it?

That varies. I usually look at three things:  
One: what is in the art work (form, content, colour, imagery or lack of it)  
Two: the process, the way things develop over time within a given picture and through a series of works, and  
Three: what's being said and not said (non-verbal behaviour).

Any interpretations that I want to make about the art I really feel much better about when they are grounded in other patient activities and behaviors as well. I look for the correlation between what is said and what is drawn or painted. I feel I am able to use that in order to get a good understanding as to the usual way the client exists in the world.

Art work will imply certain directions for further movement. For example, if the client does, and tries

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to do controlled "perfect" work with little emotional involvement and their attempts at perfection are constantly doomed for failure, I would feel I made a great gain if at the end of a period of time the patient was working spontaneously and freely in colour. Although they may not be able to talk of the change we would know it was there.

Encouraging them to take creative decisions to change their life is reflected in this, and grows out of their rediscovered sense of self.

This creative energy can be tapped and transformed into another realm. They can get a sense of mastery and autonomous activity in the art work that they may not feel in their lives and they may begin to think "Gee, maybe I can really do something." For example I worked with a boy who had spinal problems and congenital heart problems and therefore had some difficulty moving coupled with the fact that his mother recently died when he was 12. Now he is 15. Michael was withdrawn and depressed and seemed to feel he had absolutely no control over his life. He felt he couldn't make any moves. He felt frozen. In one session he drew a picture of a stadium with a football field and there were no people on the field. I responded to this by saying "There's no one in the field. Nothing is happening. There's no action." I suggested he put a player on the field. He cut out a cardboard player (this way protected the originality of the work) and he used his player on this picture, moving him around running, etc., gaining from the creative play activities. Essentially he got back in touch with the sense that he could do something in his life, his power, his autonomy.

He was a kid who drew in a controlled way and now afterwards we had these water colours where waves were falling across the page. So there was a beginning of a flow of energy. To describe that process, to put it into words is difficult. It is a liberation of that creative energy that can heal and re-vitalize. As art therapists we are trying to liberate this creative energy in our patients because it's the essence of mental health.

How do you self analyze?

I do it in a fairly pre-meditated way. I go to a therapist. I have supervision. I examine rigorously the new situation I am in, new job, new city. I have

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to do my own art work. I do different kinds of art work. My own painting I just feed myself with them. I don't analyze them too much but I can't help it sometimes. My paintings are more abstract and have to do with colour and surfaces and a sense of balance amidst chaos. This nurtures my spirit and restores me so I can go back to work. At the same time my work as an art therapist has enriched and expanded my understanding of art, and clarified the sense I have of myself as a person in art. The activities--artist and therapist--seem to enhance each other.

Afterthought:

Occasionally if there is some client's art work I'm having particular difficulty understanding or empathizing with, I will try to replicate this work myself and thereby hope to "get inside" it.

