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**Intercultural Intervention in Art Therapy**

**Sondra Goldman**

**A Thesis**

**in**

**The Program**

**of**

**Art Therapy**

**Presented in Partial Fulfilment of the Requirements**

**for the Degree of Master of Arts in Art Therapy at**

**Concordia University**

**Montréal, Québec, Canada**

**September 1994**

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## **ABSTRACT**

### **Intercultural Intervention in Art Therapy**

**Sondra Goldman**

**This thesis explores issues of theory and practice relating to intercultural intervention in the field of art therapy. Cultural factors need to be acknowledged in order to render relevant therapeutic services to our culturally diverse clientele. Intercultural intervention in art therapy can no longer be considered just an item of interest, it is now an ethical necessity. The goal of this thesis is to identify and expand upon the issues involved in intercultural intervention. These issues include therapeutic definitions and assumptions, expectations, theoretical orientations, communication styles, and assessment procedures. The research cited in this thesis is derived from many sources including literature on art therapy, art education, intercultural communication and intercultural intervention. Ultimately, the aim of this research is to become aware of the potential cultural gaps and conflicts that exist between art therapists and clients, and then to suggest ways in which they may be overcome.**

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## TABLE OF CONTENTS

<b>Chapter</b>	
<b>1</b>	<b>Introduction . . . . . 1</b>
	<b>Research Goals &amp; Objectives</b>
	<b>Operational Definitions</b>
	<b>Research Methodology</b>
	<b>Data Collection &amp; Analysis</b>
	<b>Organization of the Thesis</b>
<b>2</b>	<b>Intercultural Issues Raised by Art Therapists . . . . . 24</b>
	<b>Key Assumptions</b>
	<b>Theoretical Orientations</b>
	<b>Educational, Institutional &amp; Professional Values</b>
	<b>Assessment Procedures</b>
	<b>Treatment Goals and Strategies</b>
<b>3</b>	<b>Intercultural Issues Expanded . . . . . 49</b>
	<b>Key Assumptions &amp; Definitions</b>
	<b>Theoretical Orientations</b>
	<b>Educational &amp; Professional Values &amp; Standards</b>
	<b>Assessment Procedures</b>
	<b>Treatment Goals &amp; Strategies</b>
	<b>Racial/Cultural Identity Development</b>
<b>4</b>	<b>Strategies for Intercultural Intervention in Art Therapy . . . . . 73</b>
	<b>Introduction</b>
	<b>Awareness</b>
	<b>Knowledge</b>
	<b>Skills</b>
<b>5</b>	<b>Conclusion . . . . . 100</b>
	<b>Summary</b>
	<b>Conclusions</b>
	<b>Results &amp; Contributions</b>
	<b>Limitations &amp; Need for Further Research</b>
<b>References</b>	<b>. . . . . 110</b>

## **Intercultural Intervention in Art Therapy**

### **Chapter 1:**

#### **Introduction**

**Art therapists are just beginning to become aware of the influence of cultural factors upon the theory and practice of our therapeutic interventions. Some of us have realized that without such an awareness we may be intervening inappropriately with our culturally diverse clientele (Campanelli, 1990; Lofgren, 1981; Gardano, 1986; Waller, 1990).**

**The need for professionals in the field of mental health to further understand issues concerning intercultural intervention is no longer considered an item of therapeutic interest but has become recognized as an ethical responsibility (Comas-Diaz, 1988; Sikkema & Niyekawa, 1987). Sue and Sue (1990), who have written extensively on the subject of counselling the culturally different, have emphasized that not understanding the impact of culture upon the therapeutic relationship may have many negative ramifications. One such negative consequence may include the perpetuation of racism itself. "Racism runs deep and dies hard!...To say that we have somehow escaped our racist upbringing, that we are not perpetrators of racism, or that the racial climate is improving is to deny reality" (1990, p. 6).**

**The implications of this statement are profound, affecting the entire therapeutic process from the initial assessment through to the termination, prognosis, and future recommendations for our clients. Although we are generally encouraged to become**

aware of our intense emotional responses to our clients (as in the case of negative countertransference), the analysis of these feelings usually focuses upon the influence of the art therapist's family unit and rarely upon the culture which helped to form that unit itself. Considering that no family unit lives within a cultural vacuum, we cannot deny the impact of culture upon our identity formation. One of the implications for art therapists is that feelings of transference and countertransference that arise in any therapeutic encounter will be influenced by the cultural make-up of both clients and their therapists.

No one, including art therapists, can be exempt from cultural biases (Das, 1990; Morey, 1991). In fact, those art therapists who are unaware of the impact of such biases may be unintentionally supporting racist or ethnocentric ideologies to the detriment of their clients. For instance, as art therapists, we may sometimes make the assumption that art is a universal language of humanity that automatically crosses all cultural barriers (Lofgren, 1981; Malchiodi, 1988). Influenced by this assumption, art therapists, who are often required to provide personality assessments based on an individual's art productions and processes, may wrongly consider characteristics of a client's imagery to reflect pathology instead of normal, culturally-learned expression (Gardano, 1986; Lofgren, 1981). Such misinterpretations may be the result of maintaining too rigid a construct of how pathology manifests itself in visual form.

A number of factors, including the growth in recent research in cross-cultural counselling, the rising number of art therapists studying and working abroad, and an



increasingly diverse client population, have prompted a growing concern in the literature to develop appropriate theoretical and clinical guidelines for intercultural intervention in art therapy (Campanelli, 1990; Simpson, 1990; Lofgren, 1981; Gardano, 1986; Waller, 1990, and Lewin, 1990).

In response, the American Art Therapy Association (AATA) expanded its training policy in 1993 to foster greater cross-cultural understanding. This policy, though it reflects an important step toward clarifying the issues involved in cross-cultural art therapy, has not yet clearly defined the terms *culture* or *cross-cultural*. Moreover, neither this policy nor the art therapy literature provide us with guiding strategies to help us effectively apply this knowledge to intercultural intervention.

### Research Goals & Objectives

The purpose of this thesis project is to develop such strategies. My goal is to clarify and delineate the pertinent issues involved in intercultural intervention and to provide art therapists with a *modus operandi* for intervening interculturally.

Ultimately, the aim of this research is to become aware of the cultural gaps and conflicts that may exist between therapist and client, and then suggest potential ways in which they may be overcome.

Research has revealed that the most profound influence culture has upon our lives is the way in which it shapes our value systems and perceptions of reality (Freilich, 1989). When value systems clash, as may be the case with an art therapist

and client from dissimilar cultural backgrounds, irreconcilable differences may occur within the therapeutic relationship. This rift may prevent the development of basic communication and trust, essential elements needed to establish and maintain a therapeutic alliance. Without such an alliance, therapy often terminates abruptly (Sue & Sue, 1990). For instance, Sue & Sue (1990) describe a scenario in which Sylvia, a Native-American woman is wrongly assessed by a psychologist:

[Sylvia is] low-keyed, restrained in behavior, avoids eye contact, and finds it difficult to verbalize her thoughts and feelings. After several meetings, the psychologist concludes that Sylvia would benefit from assertion training. She is placed in such a group during regular working hours but fails to show up for meetings after attending the first one. (p. 258)

The psychologist did not recognize the difference in communication styles or the values that she was unconsciously placing on her client in regards to her need for assertiveness. To help prevent or reduce such situations from occurring, art therapists need to develop an awareness of how culture, including their own culture, impacts upon therapeutic interventions (Pedersen, 1988; Das, 1991).

Cultural factors need to be acknowledged in order to render relevant therapeutic services to our clients (Pedersen, 1988). Yet is also important to not forget that clients have idiosyncratic and universal needs as well. Without keeping this in mind, we may take what we learn about different cultures and apply it without consideration of the unique individual(s) in front of us. Therefore, we may need to modify our theoretical orientations and practices to respond to our clients' varying needs. Before such modifications can take place, we need to share a common language. Crucial to any discussion of culture is the identification and clarification of

some of the basic terms used in research, for these are the conceptual building blocks upon which this thesis is built.

## Operational Definitions

### Art Therapy

According to the AATA (1990) brochure, art therapy is a profession in the field of human services which provides opportunities for individuals, groups, and families to explore personal difficulties and aspirations through therapeutic art experiences. The process includes verbal and nonverbal expression and the development of, "physical, emotional and/or learning skills....[Art therapy] recognizes art processes, forms, and associations as reflections of an individual's development, abilities, personality, interests, and concerns." One important element that I would add, which is not included in the AATA's definition, is that these art processes, forms, and associations can also be reflections of an individual's cultural background.

### Culture

Culture is a very broad and elusive term. In fact, one study, completed four decades ago, revealed that over 150 different definitions of the word existed (Kroeber

and Kluckhohn, 1952). Even anthropologists, whose primary focus has often been the study of culture, have not been able to agree on a single coherent meaning. Part of the reason for this discrepancy is that *culture* has been used to reflect many meanings.

However, there have been various anthropologists who have agreed upon one central aspect of culture which is relevant to the study and practice of intercultural intervention: Culture includes those characteristics of human groups such as language, customs, and rituals which have been learned through socialization and enculturation (Goodenough, 1989). Pedersen (1988) expands upon this definition by differentiating between *objective* and *subjective* culture. He referred to objective culture as those manifest "artifacts or behaviors that are culturally learned or derived, and that can be objectively identified or pointed at by both persons within and outside a given culture" (p. 4). He continues to describe subjective culture as those "internalized feelings, attitudes, opinions, and assumptions members of a culture hold that, although profoundly important to the culture, are difficult to verify" (p. 4).

Objective symbols of culture tend to be noticed more easily than subjective ones. Physical characteristics, accent, or body odours may be more immediately obvious than the aspects of subjective culture which are less visible and shape the values and behaviours of those whom we perceive as different.

Culture may be defined narrowly or broadly. We tend to think of it ethnographically in terms of nationality, ethnicity, language, or religion (Pedersen, 1988). However, other factors such as demographic, status, and affiliation variables

also help to shape our cultural identity. Demographic variables include age, sex, and geographical location; status variables include social, educational, or economic level; and affiliation variables include membership in professional associations or informal groups (Pedersen, 1988; Gudykunst, 1984).

We may acquire culture by being part of a group that shares values which reinforce certain social practices (Wildavsky, 1989), such as our affiliation with various organizations. The Association des art-thérapeutes du Québec (AATQ), for instance, may then be seen as a culture. To become a professional member of the association, university training is required, as well as acceptance of the values and practices prescribed by the association. Obtaining membership in an association or a degree from a university involves adopting certain rules, standards of conduct, and ideologies.

Subjective culture, as defined above, profoundly influences our lives by playing an integral role in the formation of our perceptual and value systems (Das, 1990; Wildavsky, 1989; Lakin, 1988; Pedersen, 1988). Our membership within any particular cultural group predisposes us to implicit and explicit frame(s) of reference that colour our perception and affect the way in which we interpret and are interpreted by others (Lakin, 1988; Green, 1982). Culture affects the phenomena to which we do and do not attend (Wildavsky, 1989). For instance, as a Jew, I may feel the hair on the back of my neck rise when I see the Nazi swastika appear on a wall or in one of my client's drawings. Whereas another art therapist from a different cultural background may not be so affected.

We need cultural structures to help bring order to the world as we know it, to understand and give meaning to the past, and then to use this information to try to predict the future. Although culture is an existential reality, it may be also understood metaphorically like a theory. "This most comprehensive of all social theories--culture itself--organizes perception of the immense areas of uncertainty that necessarily surround human action" (Wildavsky 1989, p. 62). Wildavsky eloquently elaborated culture's function as follows:

Think of cultures as rival theories; they organize experience. If everything is possible, without constraint, there is no need to choose and no way to think, because no act interferes with any other. If nothing is possible, everything being constrained, there is also no way to choose and no point in thinking. In between total constraint and limitless possibility, theories tell us what to take for granted (the assumptions) and what to test (the consequences). (1989, p. 60)

Communication may be simplified and clarified when we share common cultural assumptions and cues which affect our interactions with one another. For instance, I find that in working at a hospital for elderly Jewish geriatric patients, I understand many of their mannerisms, Yiddish expressions, and attitudes about the world around them. Someone from outside of this culture would have more difficulty connecting to these subtleties.

Yet even when we do learn about these cultural cues, our interpretation of the cues may not always be right. Such misinterpretations can lead to cultural stereotyping, for no theory is immutable. Culture, like a theory, changes via an ongoing, rigorous testing of its assumptions and consequences (Wildavsky, 1989). Experience supports and reinforces certain aspects of a theory, while other variables

are added or subtracted to reduce, modify, or replace moribund conceptions. Culture, therefore, both molds and is molded by us. We reinforce its structure through actions and, therefore, are not merely passive receivers of culture, but active participants in it as well (Gudykunst, 1984).

People who share similar cultural values "use their social filter to develop preferences about what sort of behaviour they think will support their way of life," or what they may consider to be the good life (Wildavsky, 1989, p. 65). Such cultural preferences may, then, shape art therapists' and other mental health professionals' conceptions of the goals of therapy, healthy-versus-pathological behaviour and appropriate-versus-inappropriate thought. As art therapists we have a responsibility to try to avoid imposing our culturally-learned values upon our clients' thoughts, feelings, and behaviours.

One's culture includes the total way of perceiving, experiencing and acting within the world. As human beings, we exist within various cultural contexts from which we derive a major part of our identity. Yet, identity is also connected to one's unique experiences as individual as well as one's universal needs as a member of humankind. It is not possible within the space of this thesis to elaborate upon this complex dynamic, but it is important for us to keep this in mind to avoid making inappropriate generalizations about others.

## Intercultural, Multicultural, Cross-Cultural, and Transcultural Research

The terms *intercultural*, *multicultural*, *cross-cultural* and *transcultural* have often been used interchangeably, creating much confusion and sometimes reducing the relevance of their respective definitions. Nonetheless, there are certain accepted conceptualizations of these terms that have particular pertinence for this thesis.

Pedersen, one of the leaders in the field of cross-cultural training and awareness for mental health professionals, has seemed to prefer the use of the term multicultural for his research and activities in lieu of the other three aforementioned cultural descriptors. He suggested that "multicultural...[implies] a variety of co-equal status without comparing one group to another" (1988, p. viii).

Although Pedersen has found the term "multicultural" useful, in that no one culture is better or worse than another, in Canada its usefulness is considerably decreased. Canadian *multiculturalism* is a term with which we are very familiar, but one which we may have considerable difficulty defining. Although the then Prime Minister of Canada, Pierre Elliot Trudeau, officially declared Canada a bilingual and multicultural country (Canada, 1971), clear definition of this term has not appeared on a nation-wide basis (Smith, 1983). Smith's (1983) excellent article on the nature of multiculturalism in Canada explores the struggle Canada has had in this respect. Multiculturalism policy acknowledges that cultural plurality exists within our country but does not address the specific conflicts or solutions needed to live together harmoniously. Depending upon what community you belong to, in what region of the



country, at any given period of time, the interpretation of multiculturalism will differ. For example, Smith (1983) identified four separate groups of people who perceive the term differently:

the ethnic groups (who for one reason or another embrace the concept and its promise), each of whom has its own views and expectations of multiculturalism. The liberals and humanists embrace the concept as a path to increased tolerance, brotherhood, and an opportunity for all to share in a generally more humane world. The opportunists see it as a path to employment, status, power, or privilege. Finally, there is the remainder of the populace, who ignore the whole topic because it has not touched their lives significantly. (p. 264)

Thus, as a Canadian, it is hard to look at this term without some bias and scepticism.

Transcultural research is another term which has been applied in many different ways. For the purpose of this thesis, transcultural will refer to those universal qualities of human interaction which transcend, or go beyond, cultural differences. These "include the more universal constructs of before birth, after death, and religious philosophical concepts" (Pedersen, 1988, p. ix). Defined in this way, this concept is not particularly germane to the present discussion, since this thesis is primarily concerned with cultural differences and the impact of these differences upon therapeutic interactions.

Cross-cultural research, however, does address cultural differences and is, therefore, very relevant. What cross-cultural research strives for is "a comparison of some phenomena across cultures" (Gudykunst, 1984, p. 8). These phenomena may include therapeutic goals, assumptions, or intervention strategies. Yet, cross-cultural research does not tend to describe the interactional dynamics that occur between two culturally different people within various contexts (Gudykunst, 1984).

Because art therapy is an interactional process, generally involving a minimum of two participants (the art therapist and client), the term "intercultural research" seems most a propos for the purposes of this thesis. Intercultural research is distinguished by its focus upon the "interaction between people from different cultures" (Gudykunst, 1984, p. 8) that occurs within varying contexts.

### Intercultural Intervention

Intercultural intervention in art therapy, as applied to this thesis, will concentrate upon the influence of culture within the therapeutic relationship that joins together client, therapist, artwork, and the context in which the therapy occurs. It necessarily includes cross-cultural and intracultural studies to provide valuable information about the specific cultures involved in the interaction. Any and all aspects of the therapeutic relationship in which cultural differences and similarities contribute to the successful or unsuccessful initiation, process, and outcome of the encounter will be considered.

### Construct

Culturally learned *constructs* shape the way in which we interact with and perceive the world. Kelly believed that there is no absolute truth, and that the meaning of actions or symbols changes depending upon the way in which they are

construed by individuals (Pervin, 1970). A construct, as defined by Kelly (1955), "is a way of perceiving or interpreting events" (Pervin, 1970, p. 215).

Kelly (1955) described three principal types of constructs that each of us possesses to different degrees, namely, *loose*, *tight*, and *permeable* constructs. Tight constructs are those that resist change regardless of the circumstances, even if they are consistently invalidated. For instance, an art therapist who is rigidly attached to a personal, ideological or theoretical orientation such as a psychoanalytic perspective may not be able to empathize with a client who understands the world from a different cultural perspective. Without flexibility, art therapists may have difficulty learning to see and value their clients' unique ways of construing the world.

Tight constructs are also illustrated by a therapist or client who attempts to obsessively take in all information about a phenomenon or, conversely, defensively tries to avoid it all together (Ivey, 1980). Such may be the case with a white therapist who actively anticipates her black client to accuse her of being a racist and remains on the defensive. Or this same therapist might overcompensate by telling her client how many black clients she has worked with before and how much she has enjoyed doing so (without this ever being an issue that the client brings up in therapy).

On the other hand, someone whose constructs are so loose that they lack any form or direction may also experience problems. An unthinking therapist who spontaneously and erratically changes the therapeutic framework can cause confusion and show a lack of commitment to the process of therapy (Ivey, 1980). Without an

ability to make a commitment to particular theories, beliefs, or actions in art therapy, the process can become confusing and disorientating.

Thus a major goal for therapy, according to both Ivey and Kelly, would be to help both the client and the therapist to develop more permeable constructs.

Permeable constructs are those that work effectively for the individual using them within a particular context. Ivey described both clients and counsellors as being competent when they can act with intentionality: "Intentionality requires permeable constructs with adequate flexibility, and the ability to commit oneself to action through use of these constructs" (1980, p. 162). Intentionality involves becoming aware of culture's influence upon the formation of our constructs. Intentionality also encourages therapists and clients to assert their own integrity yet still be flexible enough to adapt to the context in which the constructs are applied. "More than one therapeutic mode may be required to reach any single client in all critical areas" (Ivey, 1980, p. 150).

### Personal Construct System

According to Kelly, each of us will develop a personal construct system over the course of our lives. A personal construct system usually consists of our own theory about the good life, human nature, health, and other value-laden constructs. Each of us carries these values around with us, values that are often culturally learned, yet few are completely conscious of the implicit assumptions contained within

these construct systems. In spite of this ignorance, we use them daily in order to organize reality and to try to predict the future (Kelly, 1955).

This personal construct system provides...[each individual] with both freedom of decision and limitations of action--freedom, because it permits him to deal with the meaning of events rather than forces him to be helplessly pushed about by them, and limitation, because he can never make choices outside the world of alternatives he has erected for himself (Kelly, 1955, p. 58).

No theory can inclusively explain all forms of human motivation, behaviour and affect. We can look at the various theories that have been applied in psychotherapy and see that each consists of a system of organized constructs. Psychological theories are derived from individuals who have had their own idiosyncratic visions of the world, with all of their inherent insights and limitations. The limitations of psychological theories are rarely addressed by the theorists themselves. Therapists who have not critically examined the limitations of these theories may use these frameworks inappropriately with their clients.

Few construct systems will have only tight, loose or permeable constructs. Most will have an array of constructs that in some contexts are effective and at other times are not. Our clients may be able to function very well in certain contexts, but be immobilized in others. Thus, Ivey (1980) suggested that therapists may need to use several modes of intervention to deal effectively with the variety of problems that a client may present at any particular time.

### Minority and Majority Cultures

A group is labelled a cultural minority because its members are somehow oppressed by the larger, more powerful cultural majority. This is a qualitative rather than quantitative designation that "generally refers to a group receiving differential and unequal treatment because of collective discrimination. In this sense women are sometimes classified as a minority" (Pedersen, 1988, p. viii).

### Transference and Countertransference

Transference and countertransference are two widely recognized phenomena that occur within the therapeutic relationship. Transference includes the spectrum of feelings projected by the client upon the therapist or the artwork. Countertransference includes the intense feelings of the therapist projected upon the client or artwork in art therapy (Naumburg, 1966). According to most literature written on the subject, the origins of these responses can be traced to early relations with the family and significant others. The influence of culture upon transferential and countertransferential responses is generally not addressed or is down-played in the literature.

Cultural transference and countertransference, like other forms of transference, may be negative or positive. The type of responses that emerge may be affected by the nature of the socio-cultural status of the individuals within the therapeutic

relationship (Das, 1991), as well as by one's stage of awareness of cultural identity development (Sue & Sue, 1990). Depending upon the particular dynamic, different transference and countertransference feelings may be evoked. "In the majority-minority counseling dyad or group [it is especially complicated] because minority group members bring to the relationship intense emotions derived from experiences with the majority group" (Vontress, 1973, pp. 2-3).

Das (1991) presented three different examples of potential therapeutic helper/client dyads. Each dyad is composed of individuals who share or do not share similar socio-cultural backgrounds. (For instance, one may come from a minority culture while the other may be from a majority culture, or they may both be from the same socio-cultural background.) The examples provided in the following table, derived from Das' research, illustrate some of the potential transference and countertransference responses that could occur in each of the possible scenarios:

<b>DYAD (client/ therapist)</b>	<b>TRANSFERENCE (client)</b>	<b>COUNTER- TRANSFERENCE (therapist)</b>
<b>Minority/ Majority</b>	<ul style="list-style-type: none"> <li>• cultural distrust</li> <li>• touchiness</li> <li>• resistance</li> <li>• too accommodating</li> <li>• loss of identity</li> <li>• aggressiveness</li> </ul>	<ul style="list-style-type: none"> <li>• does not acknowledge cultural difference</li> <li>• pity</li> <li>• guilt</li> <li>• fear</li> </ul>
<b>Minority/ Minority</b>	<ul style="list-style-type: none"> <li>• perception of therapist as omniscient &amp; omnipotent</li> <li>• therapist becomes a saviour, a traitor, or a hero (someone who has succeeded)</li> </ul>	<ul style="list-style-type: none"> <li>• distant from cultural origins</li> <li>• over-identification</li> <li>• ambivalence</li> <li>• guilt because of success</li> <li>• contempt</li> </ul>
<b>Majority/ Minority</b>	<ul style="list-style-type: none"> <li>• scepticism re: professional competence</li> <li>• fear of abandonment</li> <li>• perception of other as foreigner</li> </ul>	<ul style="list-style-type: none"> <li>• resentment</li> <li>• need to prove competence</li> <li>• cultural inadequacy</li> </ul>

Transference becomes a very important issue in various intercultural interventions involving problems such as psychological trauma of refugees, or the culture shock experienced by new immigrants. Indeed, "immersion into a new and different culture powerfully stimulates experiences of ambiguity, dependence, and helplessness" (Draguns, 1981, p. 12). Transference, positive or negative, may create an unconscious resistance to the goals of therapy if left unchecked (Harrison & Carek, 1966).

Negative cultural countertransference is difficult to acknowledge. To admit, as a member of the helping profession, that we dislike, feel hatred towards, or do not



accept our clients' values or behaviors (Cantle, 1983), can threaten our perception of ourselves as benevolent givers who accept our clients with unconditional positive regard. It can become even more painful to acknowledge that we ourselves harbour ethnocentric or racist constructs. Yet we cannot divorce ourselves from the cultural upbringing that implants these racist and ethnocentric inclinations within us. Unless we become aware of these inclinations, we may perpetuate the very values that we abhor. Thus, it becomes important for us to take responsibility for these biases, which if left unchecked, "may lead to persistently inappropriate behaviour towards the counselee, resulting in untold strains in the counseling relationship" (Vontress, 1973, p. 3).

Cultural countertransference is not necessarily negative. Indeed, when brought to consciousness, like any form of countertransference, it can provide tools to better understand the client (Agell et al, 1982). Once we become conscious of such feelings, we can use them to identify "specific characteristics (specific contents, anxieties, and mechanisms) from which we may draw conclusions about the specific character of the psychological happenings in the patient" (Racker, 1968, p. 129). The more we become used to recognizing these issues, the more adequately we can learn to effectively address the needs of our clients (Searles, 1979, p. 182).

### **Ethnocentrism**

Our personal construct system affects the way in which we see and interpret the world and the way in which we order reality. Many people feel that their world view is superior to those of others. This attitude has been termed 'ethnocentric'. Such ethnocentric biases are shaped through our own ethnic/cultural/racial backgrounds (Das, 1990). When not recognized, ethnocentric attitudes on the part of the art therapist, may, like any other form of unchecked countertransference, decrease the effectiveness of the therapeutic services offered (Pedersen, 1981).

### **Racism**

Race, in relation to racism, refers to a group of humans, "that defines itself or is defined by others as culturally different by virtue of innate and immutable physical characteristics" (The New Encyclopædia Britannica, 1991, p. 336). Racism is a tendency to categorize people within a race on the basis of an inherent notion of superiority and inferiority (Das, 1990). Racism, like ethnocentrism, may take the form of transference or countertransference in the therapeutic relationship.

## **Research Methodology**

The strategies developed in this thesis have evolved through a thorough review of the literature written on the subject. It is a type of applied research, "conducted for the purpose of practical application, usually in response to a specific problem and the need for decision making" (Sproull, 1988, p. 7). Since no one within the field of art therapy has yet proposed a cohesive theory for intercultural art therapy intervention, the choice of this particular research methodology seemed most appropriate. The suggestions presented are based upon a critical analysis of the published literature gathered in my literature search and discussed in chapters 2 and 3.

The actual construction of this thesis has been influenced by both Kelly's (1955) personal construct system and Ivey's (1980) general theory for psychotherapy. General theory is a meta-theory, or a "theory about theory" (Ivey, 1980, p. 170), which looks for those common elements that exist in all forms of psychotherapy. The basic elements of psychotherapy theories provide the foundation for building a theory for intercultural intervention in art therapy. These building blocks are modified by the particular demands of intercultural communication.

## **Data Collection & Analysis**

The data for this research have been collected, for the most part, from bibliographic sources gathered at the Concordia and McGill University libraries.

These sources were found through manual searches (card catalogues, indexes, and bibliographies) and computer searches (ERIC, PsychLit, and SocLit.) The suggestions integrated into this thesis were gathered from readings that were critically evaluated for their relevance to art therapy, as well as their parsimony, comprehensiveness, efficacy and validity. In particular, I have searched for information that helps us to clarify how culture influences our visual perception, exposure to and/or valuation of art materials and the art-making process, art form and content, and our responses to and interpretations of artwork.

### Organization of the Thesis

The remainder of this thesis is organized into four chapters. Chapter 2 includes an art therapy literature review that addresses the issues involved in an intercultural approach to art therapy intervention. The strategies which the authors suggest for intercultural intervention in art therapy have been analyzed for their strengths and weaknesses.

Chapter 3 broadens the discussion by moving to the more general field of intercultural research. The way in which the issues have been identified, and the potential suggestions which are presented to address the issues, are then analyzed for their relevance to the field of art therapy. Those suggestions identified as relevant to art therapy are then examined in terms of their efficacy for practical application.

**Chapter 4 synthesizes the information gathered in chapters 2 and 3 to propose strategies for intercultural art therapy intervention.**

**Chapter 5 draws conclusions from the construction of this thesis. Limitations of this thesis as well as suggestions for continuing research in the realm of intercultural intervention in art therapy are also discussed.**

## **Intercultural Intervention in Art Therapy**

### **Chapter 2:**

#### **Intercultural Issues Raised By Art Therapists**

**This chapter focuses on identifying and further developing the theoretical and practical issues raised in recently published art therapy literature concerning intercultural intervention. Additional research from related disciplines, such as art education and studies in visual perception, has also been included when it helps to clarify or expand the issues. Further research from outside of the field of art therapy will be explored later, in chapter 3.**

**Based upon a thorough review of the art therapy literature, it seems that most of the intercultural intervention issues identified fall within one of the following categories: key assumptions; theoretical orientations; educational, institutional and professional values; assessment procedures; treatment goals and strategies.**

#### **Key Assumptions**

**Many therapists unconsciously use language which conveys implicit biases. Lewin (1990) has challenged art therapists to become more aware of this tendency by suggesting that they examine the words that they use in their practice. Without carefully exploring the meaning of these terms, art therapists may be using constructs that perpetuate racist and oppressive assumptions. Basic terms such as pathology,**

health, healing, normality, appropriateness, or phrases like "the good life," contain explicit and implicit assumptions that influence how we address the needs of clients. They should not be taken for granted. These key assumptions create the foundation for our therapeutic interventions. Before therapy even begins, the strengths and limitations of these assumptions need to be carefully examined. Certain assumptions of special pertinence are that the client is the only member of the therapeutic relationship with a cultural identity, that just belonging to a minority culture calls for change, and that a therapist may, by mistake, place too much emphasis upon a client's cultural identity and ignore the real reasons why he or she sought therapy in the first place.

One assumption that is often made is that the client is the only person with a cultural background that influences the therapeutic relationship. However, in intercultural intervention, the impact of culture affects all parties involved. Consequently, it is not feasible to create a discipline that addresses the issues of minority clients without also acknowledging the issues related to the majority therapists who tend to administer the treatment (Lewin, 1990). Canadian art therapists, who tend to be white, middle-class and female, are typically part of the dominant or "majority" group in society, and members of a society's dominant culture generally do not have to question their cultural identity because the cultural values of the society are taken for granted. As a result, they may forget that they too have a culture of their own, and that their cultural background influences their role in the therapy process. To give just one example, North American culture stresses the need

to be goal-oriented and productive to enjoy a fulfilling life. This has traditionally resulted in a focus on the need for individuation away from the family unit, contrary to the we-oriented values of many eastern cultures. Thus, an uncareful therapist may assume that a client's source of depression is the result of an unhealthy symbiotic link with the parents rather than the real cause which, for example, may be related to a lack of employment and not being able to support the family.

Unfortunately, minority cultures are often seen as needing change, leading to attempts such as the early missionaries' conversion of the native North American "heathens". This is an ethnocentric attitude that categorizes "others" into tight or stereotypical constructs, and places us "in danger of reproducing racist assumptions by defining cultures as either static or fixed, or conversely in need or [sic] transformation and alteration" (Lewin, 1990, p. 13). Therefore, we need to remind ourselves that both therapist and client are individuals whose cultural characteristics may or may not be relevant at any given time in the course of therapy. Depending upon the impact of the client's cultural background upon their lives, culture may be a relatively minor factor in their present reason(s) for coming to therapy--in fact, it may not be a source of stress at all.

To focus too much on cultural issues may take away from the fact that we are never just cultural beings; each of us also has universal and idiosyncratic qualities. For instance, I may be Jewish but I am also a human being who has need of shelter and security. I also have particular likes and dislikes which are dissimilar to other Jews whom I know.



Nevertheless, cultural factors may still play a greater role than we sometimes realize. Parker & Deręowski (1990) completed research which indicated that though human beings may be born with similar or universal perceptual capabilities, their responsiveness to particular stimuli will be based upon cultural and personal determinants. Thus, we are most likely to focus upon those aspects of our clients' behaviours, artistic styles or affective expressions that fit into our own culturally determined perceptual frameworks. The ability of our senses to fine-tune our responses to certain stimuli and ignore others is what G. Kelly (1955) referred to as our personal construct system at work. Our selective perception focuses upon those salient aspects of an event or object which fit into and reinforce our current constructs about the world around and within. We develop symbolic antennae to seek out, measure and describe various phenomena based upon our preconceptions of what these will be before we even see them.

Individuals whose construct systems are permeable tend to be able to absorb large quantities of symbols which can be interpreted personally, differently by others, or whose meaning can change with time (Kelly, 1955). Therapists who have this kind of flexibility recognize that visual symbols which might seem to be universally understood are often culture-specific. For instance, very basic body gestures that some people may consider as being universal are not always so. One example can be seen by comparing North Americans with some people from India. Most North Americans would recognize the side to side movement of a person's head as a gesture

indicating "no." In some parts of India, however, this very same gesture may be interpreted as "yes" (Morey, 1991).

Similar misinterpretations may occur when we attempt to interpret or assess the symbolic meanings in clients' artwork. Their use of symbols often derives from their cultural backgrounds and their appropriation of the symbolic meanings common to their respective cultures. In North American culture, for instance, the colour black is often associated with death or depression. In contrast, China and some other Eastern countries traditionally use white at funerals; in their cultures, this colour has been symbolic of death. To interpret a Chinese client's frequent use of the colour black as an indicator of death imagery or personal depression might therefore be a serious mistake. Such differences reinforce the need to confirm our interpretations with our clients before assessing the meaning of any apparently symbolic expressions. Furthermore, the above example suggests how potentially important it is for art therapists to expand their knowledge of the meanings associated with various colours in different cultures.

It is not just colours, but forms, composition and movement which also need to be carefully interpreted to ensure the appropriate interpretation of meaning. When a symbol, a colour, or a gesture is rigidly interpreted, the symbol loses its magic, reifies and becomes resistant to change or differential interpretation. In this circumstance a symbol could be easily misinterpreted or narrowly conceived, if it is viewed as having only one meaning. This type of misinterpretation may form the

basis of a stereotype which could then be used to generalize particular experiences or perceptions into fixed, universal expressions.

Of course, stereotypes are not necessarily bad; in fact, they often perform the necessary function of easing our ability to categorize and sift through vast amounts of incoming information. It is also important to realize that stereotypes are not in-born; we learn about them through a process of social learning. From a young age we absorb a range of stereotypical views through our exposure to subtle and not-so-subtle influences, including family, friends and media. Unfortunately, some of these views have racist overtones.

Knowing that we learn racist ideas helps us to cope with the pain and guilt often associated with becoming aware of how each of us can perpetuate them. However, knowing that racism is learned also makes us aware that it can be unlearned. Knowledge helps us to realize the extent to which our different cultural backgrounds affect one another (Lewin, 1990). As long as racism is perpetuated, it is very difficult to feel safe in expressing our differences, whether those differences be racial, social, political or intellectual. Racism limits everyone. Fortunately, as we better understand the impact of racism, we are able to "regain our common heritage of humanitarian spirit....We are without blame and yet we have responsibility" (Lewin, 1990, p. 14).

Pointing our finger at others as the perpetrators of racism and not taking responsibility for our own internalized racism only sustains "the oppressive mechanism which cultivates stereotypes and keeps groups divided" (Lewin, 1990, p.

14). There is another route which therapists can take, however, as Lewin's prescription for healthier white/black therapist-client relationships suggests. Lewin argues that those members of the typically "white" dominant culture who challenge their "internalized racism" move closer to becoming "effective allies in the struggle for freedom and equality. Black liberation is our own liberation" (1990, p. 14). We free ourselves through sharing our power and knowledge with one another. This shared learning opens up new ways of seeing and experiencing the world. Developing awareness of our biases and assumptions help to provide a firm basis upon which the theory and practice for intercultural intervention can grow.

### Theoretical Orientations

Most interventions made by art therapists will be guided by theoretical orientations, founded upon particular assumptions. Theoretical orientations are types of construct systems that help clarify our understanding of the complex human dynamics that affect our clients. Theory is generally influenced by the Zeitgeist or 'spirit of the times.' This means that theories are intimately tied to the cultural context in which they are construed. Due to this contextual nature, some psychotherapeutic theories may be relevant to only a small proportion of people who are dealing with specific issues. Without understanding the limitations and strengths of such theories, we may be unintentionally imposing certain values that do not genuinely address our clients' real needs. Understanding these limitations can help us

to realize that no therapy or therapist will be equally effective for all people under all circumstances.

Most art therapy theories are founded upon predominantly white, middle-class value systems. These frameworks shape the way in which we interact with our clients and their artwork. We naturally tend to gravitate toward those theories that confirm and support our own world views. For instance, I have on a few occasions heard art therapists boast about how psychoanalytic art therapy intervention is the best type of treatment available. They are so immersed in this perspective that they cannot see how a behavioural or cognitive approach may, in certain contexts, be much more helpful. This seemingly innocent attitude is ethnocentric and illustrates how no one is free from personal biases (Das, 1990; Morey, 1991).

One way to address this issue, according to Campanelli (1990), is to become aware of our "ethnocultural influences and biases while also incorporating a knowledge and respect for the client's ethnocultural system" (p. 02). Unfortunately, he does not elaborate upon how this awareness and knowledge could be developed. There are, however, many ways in which art therapists can do this. Participating in cultural exchange programs and role playing in peer supervision represents a few of our options. These and other options will be further developed in chapter 4.

## **Educational, Institutional & Professional Values**

Values and biases come not only from our family experiences but also from our lifelong education. Through studies in public schools, colleges, and universities, individuals learn how society perceives not only illness and appropriate forms of therapy, but also the processes and products of art. In North America, for instance, art that is representational and entertaining tends to be most valued. These biases potentially influence our work as art therapists.

Formal art therapy education and clinical training influence our world views by modifying, expanding or radically changing our theoretical orientations. Our training gives us a language to interpret the phenomena which we observe. That language points us toward certain methods of intervention. Indeed, the training we receive gives us entry into a separate culture--the professional culture of art therapy.

After we leave the university or college in which we studied, we then enter another institution, our work place, which will again emphasize certain theoretical orientations, policies, and objectives that ultimately may influence the way in which we practice art therapy. If we were to study in Bulgaria, for instance, we would find Pavlovian psychology (behaviourism) being used as the predominant theoretical orientation; other forms of therapy are relatively unknown (Waller, 1990). In contrast, the art therapy department at Concordia University, where I obtained my formal art therapy education, focused upon psychoanalytic theory and practice while the behavioural application of art therapy was rarely discussed. In the United States,

where health care is costly and insurance policies tend to cover only short-term interventions, a more problem-oriented approach is required. Thus, psychoanalytically oriented art therapy, which tends to involve pricey, long-term intervention, is often precluded. This latter example suggests how the resources available within any given educational setting, as well as the resources available in the community itself, will influence the type of education offered to its students. This education will not be unbiased.

Besides our place of work we are also subject to the rules and values of the professional associations in which we take membership. Their bylaws, standards of conduct and codes of ethics provide a framework within which our professional culture evolves. In the AATQ, for instance, art therapists who are not Canadian citizens may not hold positions on the board. Thus, although perhaps equally qualified, they are denied a higher position within the association's hierarchy in which they would potentially influence the direction of the association. This limitation is likely due to the association's desire to maintain a strong Canadian identity. As a young profession in Canada, we are still in the process of establishing our cultural identity and, therefore, may feel threatened by the potential influence of other cultures.

As professional standards become increasingly rigorous, through necessity we become more and more selective of the individuals who can become professionally registered art therapists. The AATQ has in recent years reformulated its requirements for professional membership and has plans to develop registration standards

commensurate with those already developed in the U.S.A., Britain and other Canadian art therapy associations. Unfortunately, since accredited Master's programs are nearly nonexistent in Canada and can be very expensive in the United States, the high standards set by these institutions may inadvertently exclude or restrict admittance into the profession for those individuals who do not have the resources or language ability to attain such a training. The limited number of approved art therapy programs and the often prohibitive costs of education prevent many individuals from minority groups from furthering their education, although this problem is not restricted to the profession of art therapy.

Even though the Canadian government subsidizes our post-secondary training, economic stressors and the number of required prerequisites needed to enter the program make the art therapy profession relatively inaccessible to anyone not coming from a middle- or upper-class background. The result, as Campanelli (1990) observes, is that there is not enough representation in the AATA of art therapists from cultural minority backgrounds. This is probably true of Canadian institutions as well.

The solution to the problem of minority group under-representation will likely be found in removing some of the obstacles which currently make it difficult for members of these groups to obtain the necessary training and enter the profession. It may be necessary, in fact, to change the way art therapy is taught. Beyond the economic obstacles, it could be that the theoretical orientations themselves are too restrictive and do not represent diverse values.



One obstacle preventing minorities from forming a larger percentage of our profession may be that the majority of art therapy research is written and published in English, thus limiting the access to this information to English-speaking persons. (This problem is also true of psychology and many other fields.) To expand our degree of minority group representation we may need to translate our research into other languages as well as translate into English research completed abroad. This would be one way to connect with other art therapists internationally.

The International Networking Group (I.N.G.) of art therapists has been one solution that the international art therapy community has formed to create links between art therapists from different cultures. However, the future cultivation of these links may depend upon how we go about learning from art therapists from different cultures and countries whose art therapy training or professional standards differ from our own. In spite of the validity and reliability of our theories and practices, we need to be careful not to unconditionally impose these professional standards upon others. Although what we already know about art therapy may work very well, we still need to be careful not to deny the relevance of healers within various communities who may be able to provide or teach us about other potentially useful practises which integrate art and healing.

It has been suggested that art therapists who travel to teach or practice art therapy abroad need to be careful not to go as evangelists or colonizers hoping to transform so-called 'primitive' mental health practices. We cannot assume that other approaches to healing are wrong, primitive or in need of our intervention--or that our

approach would necessarily be better. Instead, our work needs to be directed toward becoming personally sensitized to their particular needs, values and practices before any interventions are made. Acknowledging the differences of others does not necessarily negate our own practice. We can remain committed to our own way of working, be critical of their methodologies and concurrently remain open to their ancient and present wisdom.

Waller (1990) was aware of some of these issues when she helped to set up an art therapy service and training program in Bulgaria. To be sensitive to their needs, Waller established a "close collaboration between the British and Bulgarian workers" (p. 27). Waller (1990) wrote that while in Bulgaria, she had to train doctors in art therapy who had had no previous art education (doctors were the individuals providing psychotherapy.) In order for them to be more sensitive to the art therapy process and to build confidence in their own creative abilities, she provided the doctors with an opportunity to work with a variety of art media to enlarge their visual perception. Without such awareness, Waller realized, institutions would neither offer the support needed to develop art therapy programs nor take the profession seriously.

In order to understand what other art therapy institutions are doing abroad, McNiff (1985) suggested we develop a publication of international art therapy program descriptions. This could be one way to improve our knowledge of the symbolic expression of various cultures and the use of art therapy in these contexts.

Malchiodi (1988) tried to sensitize herself to Chinese art activities and traditional values before being invited to travel and teach art therapy in China. In her

article she clearly explained how she had completed a considerable amount of preparatory research before her arrival there. Her intention was to become sensitive to the possible differences in art expression that she would encounter there. Through this research she discovered that the Chinese culture stressed 'collective' or family values that often conflict with our Western emphasis on 'individual' achievement and values. Indeed, the concept of self-actualization, a common goal of humanistically oriented therapy, would generally be frowned upon by the traditional Chinese culture. This potentially represents a problem for Western therapists working with persons in individual therapy who come from a traditional Chinese background. Since personal matters are usually not discussed outside of the family, it would be difficult for such individuals to talk about them without a "loss of face" in their own cultural group. Indeed it would be quite understandable if such individuals were reticent to open up to "outsiders," or to view their psychological well-being in terms of self-growth and personal achievement. This example clearly illustrates the need for art therapists to be sensitive to the cultural backgrounds of clients from other parts of the world. This preparation can help art therapists to stand a better chance of intervening effectively in cases of intercultural intervention.

When implementing art therapy programs in countries foreign to our own, Malchiodi described the importance of being sensitive to the culture's current views and practices vis-à-vis art education (p. 54). This knowledge can help art therapists to understand the values and uses of art in various cultural contexts. However, it is important to avoid using that knowledge to create stereotypes about cultural imagery

that could inhibit individual expression. For example, Malchiodi (1988) expected the Chinese people she would work with to make stereotypical Chinese paintings, but then discovered that very few people in China receive the requisite art education to make such paintings. Only those who are wealthy, have the time, and come from the right social class have the opportunity to study art. For the most part, the educational emphasis in China is placed upon academic excellence and not artistic expression. The result, she noted, is that there are far fewer Chinese having the opportunity to express themselves artistically than one might expect.

As well as the influence of institutions and associations upon art therapy, the expression of art itself can be potentially influenced by the political milieu of a society. Individuals who have lived or are living within oppressive regimes will probably not have had the liberty to express themselves symbolically without considerable constraint. Such is the case under dictatorships where artistic expression is severely censored. For instance, Vomberger (1986) looked at the differences in content that existed in the imagery of children from the extermination camp of Terezin and children from a refugee camp in El Salvador. The content of the drawings from the refugee camp was much more explicit and reflected more of the hardships that the children were enduring. Whereas the drawings from children living within the confines of the concentration camp did not reveal as much: This would have been too dangerous for them.

## Assessment Procedures

Our perceptual filters influence how we interpret and assess our clients' attitudes, expressions (verbal and non-verbal), gestures, moods, art processes and products (Campanelli, 1990). Our world views, influenced by our cultural backgrounds, create selective frames of reference through which perceptions, representations, and then interpretations are made (Das, 1990). The interpretations we make often form the basis for the assessments of and interventions with our clients.

Culture helps shape our appreciation and "preferences" for art. From our culture we learn about the value, meaning, and function of artwork and art-making. These teachings then influence the way in which we use line, colour, form, space and composition. Our cultural heritage also influences the types of media with which we are most familiar and skilled as well as the symbolic content contained in our imagery. To accurately assess a client's problems we need to factor in these cultural variables.

Most symbols have a range of culturally based meanings (e.g. the sun can indicate summer, light, warmth or heat). Most symbols also have a subjective meaning, which can vary from person to person, usually within the range of accepted meanings, but sometimes completely outside it, according to that person's experience. (Liebmann, 1986, p. 34)

When assessing the elements of an image, it is sometimes difficult for art therapists to differentiate those elements which are culture-specific, idiosyncratic or common to all cultures. Art therapists who work with children from other cultures

need to be especially sensitive to this distinction; research reveals that both universal and cultural patterns can be found within the developmental stages of children's drawings (Ives & Gardner, 1984).

As Ives and Gardner demonstrate, children's art development can be divided into roughly three stages: 1- to 5-year-olds; 5- to 7-year-olds; and 7- to 12-year-olds. During the first stage of development, universal qualities appear to dominate the children's drawings. Near the beginning of the second year they begin to scribble and place marks together; by the age of 2 they try to imitate marks that others make and start to draw basic forms; 3-year-olds join their forms together; and 4-year-olds make basic forms that begin to be recognizable. However, culture still influences their images during this first stage, as the next paragraph will illustrate.

Those children who have not had access to drawing materials or who have been discouraged to use them, will not pass through this supposed "universal" stage. Ives and Gardner (1984) discovered that the types of materials to which children from different cultures have been exposed greatly influenced both the content and style of their expressions. For example, a child who had never used a pencil for drawing would find it very difficult to copy geometric shapes on paper. Certain media, in short, elicit certain "kinds of referents which the child is likely to depict" (p. 18). Therefore, paint tends to be used to represent "fire, rain, or grass," whereas clay elicits three-dimensional shapes that suggest "food, snakes, and balls"; and wooden blocks suggest the construction of tunnels, architecture, etc. As Ives and Gardner point out, "The kinds of referents available in the culture and the attitudes of adults

toward those referents constitute another area in which the culture exerts an early influence on children's drawings" (p. 18).

During the second stage of development (ages 5 to 7), children tend to become more active in their communities. "This transitional stage seems to produce drawings that are recognizable and clear without being clichés or stereotypes" (Ives & Gardner, 1984, pp. 20-21). There are several factors that determine the extent to which drawings completed during this stage will reflect more universal or cultural characteristics. Firstly, children who begin school at an early age or who spend a lot of time with their peers are more likely to have their drawings influenced by the surrounding culture. Also, cultural referents in their images may be more prolific if they develop rapidly through this stage. Another cultural factor influencing drawing composition is learning how to write. Children coming from cultures whose written language is transcribed from right to left tend to draw pictures in a similar fashion on paper. This can be observed in drawings from children who have learned Arabic or Hebrew scripts (Ives & Gardner, 1984).

Of the three early stages of drawing development, the third is most intensely influenced by culture. Children aged 8 to 9 are usually "well socialized and enculturated individuals. Secure in the knowledge of their physical world, fluent in symbolic capacities, they now confront head-on a major challenge: to come to know in detail the practices, rules, customs, and mores of their society" (Ives & Gardner, 1984, p. 22). They incorporate this knowledge by attentively observing and imitating the actions of others. They learn to follow rules of action which dictate what is and

is not considered acceptable. The need for social approval may help us to understand why pre-adolescents tend to draw more literally and lose much of their earlier spontaneity.

Although North America has been witness to a vast array of art movements, it may be safe to say that our society tends to reward most highly those individuals who can render visual realism with accurate perspective. Those children who cannot fulfil these expectations, and therefore do not receive the social admiration that they seek, often stop drawing all together. Thus, a rapid decline in drawing activity occurs during this stage (Ives & Gardner, 1984).

Not as much is known about latency aged children from non-Occidental cultures during the fourth stage of drawing development. Nonetheless, Ives and Gardner (1984) speculate that those cultures which value certain things over others will probably see a more prolific development of the more valued type of expression. Dennis' (1966) research would seem to lend support to this contention. He showed that

the kinds of persons, clothing, and life styles admired in a given culture proliferate in the drawings of children of that culture. Particularly striking is the fact that members of minorities, especially abused minorities, rarely draw themselves or their own customs but instead choose to render representations of the "dominant culture" [because these representations are valued]. (Hraba and Grant, 1970, p. 398)

By the same token, cultures that value particular types of artistic expression can influence the drawings that young people produce. For example, "the high performance of Japanese students on a visual version of an intelligence test (a mean



**IQ of 138) has been attributed to the overall emphasis within that culture on visual expression" (Hilger, Klett, & Watson, 1976, p. 438).**

**Ives' and Gardner's (1984) research has helped us to recognize how culture influences the standards for making and judging artwork, but as they suggest, we still do not know much about the extent to which culture influences the "command of the medium; exhibition of aesthetic properties; the ability to use lines, forms, and colors in certain ways" (p. 26). Nonetheless, this research points to the need for art therapists to become aware of cultural influences upon the choice of content, style, and media used by our clients before we make assumptions about what that content, style and media represent.**

**In terms of how we judge artwork, Congdon (1989) provided a useful analysis in his article entitled, "Multi-cultural approaches to art criticism." Congdon's definition of art criticism as "communication about art objects" (p. 176) directly relates to the way in which we (art therapists and our clients) view and discuss art process and products. According to Congdon, people use their personal construct systems to communicate about art in a structured manner. This structure "helps them focus on what they feel the function of art is, or should be, in their lives, and what they want to learn from talking about art...in a way that is comfortable with their world view" (Congdon, 1989, p. 176). Thus, as art therapists, we may search for easily explainable constructs to help us to feel more comfortable and in control but which may also prevent us from appropriately assessing and treating our clients' more difficult problems. A client who does not share feelings with anyone outside of her**

immediate family, may feel threatened by a therapist who feels this expression is a necessary part of healing.

Of course, every construct we use to describe or analyze a person's process or art product will have its limitations. Our limitations are bound by the quantity and quality of constructs contained within our personal construct systems. Any framework that we choose to use to interpret imagery both "allows access to particular types of knowledge and denies or obscures access to other types" (Hamblen, 1986, p. 4). Fortunately, as we expand our symbolic repertoire we are able to develop a broader range of constructs to interpret our clients' art therapy expressions. As part of this process, we need to work towards understanding the role, meaning, and value of art within the client's culture. McNiff (1985) argued, in fact, that art therapy programs need to "grow from indigenous culture and art forms" (p. 25) for art therapists to learn alternative healing practices and art processes.

Lofgren's (1981) experience with a Navajo client provides one example of how therapists can benefit from broadening their understanding of the use of symbols in other cultures. Lofgren described working with a woman of Navajo decent who had previously been referred to a psychiatrist by a doctor who misinterpreted her lengthy silence during a regular physical exam as pathology. The psychiatrist had diagnosed her as having schizophrenia, which according to Lofgren, is "the most common diagnosis given women of color in psychiatric setting in the United States...twice as often as any other group" (p. 25). The woman was referred to art therapy, where the therapist's receptivity to alternative cultural practices proved crucial in helping her to

avoid the same mistaken diagnoses made by the psychiatrist and doctor. First of all, the woman's lengthy silence, mistakenly diagnosed as "pathology," became quite understandable in the context of her cultural background. As the woman explained during the first art therapy session, "I'm a quiet person by nature. My people don't believe in saying anything unless it's important" (p. 25).

Lofgren also benefitted from her understanding of Navajo sand painting.

Noting the role of sand painting in healing among the Navajo, Lofgren described how she eventually made the correct interpretation of a drawing that her client made within the context of art therapy. She said that without the knowledge of sand painting, she too may have interpreted this image as having been drawn in an "impoverished manner [with a]...failure to integrate mind and body". Fortunately, Lofgren later came to understand that the image represented a "guardian" that, for her client, was intimately connected to Navajo mythology. Rather than a sign of an unhealthy mind, the image was a cultural artifact reflecting her own cultural heritage.

Like Lofgren's example of the Navajo woman, Gardano's (1986) discussion of responses specific to different cultures makes us aware of how problematic diagnosis can be when working with clients from different cultures. As part of a study comparing the emotional reactions to colour of non-hispanics and hispanics in the United States, Lofgren asked her subjects to fill out a

Profile of Mood States or POMS for each of the colors. The POMS, which was designed to identify and assess transient mood states, consists of 65 words or phrases relating to mood....For each color, subjects indicated the degree to which they felt each of the 65 emotions. (p. 120)

Her study confirmed research originally conducted by B. I. Levy (1980) which suggested that emotional reactions to colour vary culturally and subculturally. Gardano accomplished her objectives by firstly rewriting Levy's original text into Spanish so that the test participants "could most accurately reflect their feelings in their native language" (p. 120). The test was then administered by individuals whose cultural identity and language were similar to those of the subjects. The results of this research indicated that hispanics and non-hispanics had similar reaction patterns to the many colours that were used in the test. However, the hispanic level of reaction was more intense. This higher level of intensity was most apparent in recent immigrants who had been in the country for five years or less. Gardano assessed this differential as being due to either problems of acculturation or the influence of strong cultural factors. One of her conclusions was that there is a need to do further cross-cultural research into the influence of culture upon emotional response to colour.

### Treatment Goals and Strategies

Once we have appropriately assessed the needs of our clients, treatment goals and strategies are formed. Lofgren (1981) listed three of many obstacles that can undermine communication, preventing therapeutic goals from being achieved in an intercultural context: "(1) The language barrier that often exists between client and therapist, (2) class-bound values whereby therapists tend to conduct treatment within

the value system of the middle class, and (3) culture-bound values that are used to judge normality and abnormality of clients" (p. 29).

These obstacles may create a variety of negative countertransferential or transferential responses. As mentioned in the first chapter, these feelings, when not integrated into the therapeutic process, can inhibit progress. Art therapists, clients, and supervisors alike use their cultural filters to monitor the progress of any intervention in order to evaluate its efficacy, to determine the appropriate time for the termination of therapy, and to make recommendations for future or alternative treatment(s). If they are not sensitive to the obstacles outlined by Lofgren, they may not be able to truly empathize, interpret or guide the client for their interventions will not correspond to the way that client views the world.

One way to enter the world of the client might be to combine traditional/folk medicine with our present art therapy practices, as Malchiodi (1988) suggests. This could be achieved through developing a greater understanding of the healing work practised by laymen, shamans and fortune-tellers from different cultures. If we, ourselves, are not prepared to incorporate these practices into our own, then we can at least become knowledgeable about their function and where these services are offered if so needed. In this way we broaden our knowledge and ability to address the needs of a multicultural clientele.

One thing we can say for sure is that our field has only minimally addressed the impact of ethno-cultural factors upon our profession and that the few articles that do exist have not addressed this topic's vastness (Campanelli, 1990). An

understanding of this vastness occurs when we look at how researchers and clinicians from outside the field of art therapy have identified issues that art therapists have not yet tackled but still need to address. The goal of the next chapter is to examine and develop on some of these issues as they have been addressed by theorists outside of the field of art therapy who specialize in intercultural intervention.

## **Intercultural Intervention in Art Therapy**

### **Chapter 3:**

#### **Intercultural Issues Expanded**

**Chapter 2 outlined various intercultural issues identified in art therapy and the related literature which are relevant to intercultural intervention in art therapy. Considering that research into intercultural intervention in art therapy has been limited, and that a larger base of knowledge exists outside of the sphere of art therapy, it was important to explore the broader spectrum of mental health and intercultural communication. The issues touched upon in this chapter include those that have not yet been addressed by art therapists or that need further clarification. This chapter also describes some practical approaches through which the above mentioned intercultural issues may be addressed. All research included within this chapter has been analyzed for its depth, clarity, efficacy, and direct relevance to art therapy.**

#### **Key Assumptions & Definitions**

**Most psychological orientations used in Canada and the United States have been constructed by individuals from "white, middle-class culture" (Ivey, 1980, p. 11). Each orientation contains implicit or explicit definitions for key terms in mental health such as health, normality, and pathology. These constructs are often presented**

as universal definitions, and as such fail to delineate the implicit value systems contained within them. One result, as Sue and Sue (1990) have noted, is

the exclusion of culture-specific...[results in] fostering *cultural encapsulation*....[which] refers specifically to (a) the substitution of model stereotypes for the real world, (b) the disregarding of cultural variations in a dogmatic adherence to some universal notion of truth, and (c) the use of a technique-oriented definition of the counseling process. The results are that counselor roles are rigidly defined, implanting an implicit belief in a universal concept of "healthy" and "normal." (Sue & Sue, 1990, pp. 8-9)

Clear definitions for psychological terms are necessary to determine the "problems" or issues our clients are dealing with and what is needed to "help" them move toward a state of "health". However, rigidity in defining these issues or treatment strategies limits the scope through which problems are identified and resolved. Each selected definition blocks out other potential perceptions. The assumptions contained within these definitions provide the foundation for many art therapy interventions. Insurmountable conflicts may arise in therapy when these implicit assumptions are not acknowledged. To illustrate how supposed universal truths are contained within our definitions, the following examples are provided for the terms *mental health*, *deviance*, *abnormality* and *pathology*.

### Mental Health

Mental health has been defined in many ways. One such definition includes characteristics "such as competence, autonomy, and resistance to stress [which] are related to White middle-class notions of individual maturity" (Sue & Sue, 1990, p.



11). This definition places the full responsibility for mental health upon the individual and little or none upon society. A "person-focused definition of maturity...[nullifies the fact that] minorities...subjected to higher stress factors in society...[are] placed in a one-down position by virtue of racism...the definition will tend to portray the lifestyle of minorities as inferior, underdeveloped, and deficient" (Sue & Sue, 1990, p. 11).

Ivey's (1980) research revealed that each psychotherapeutic theory contains implicit or explicit definitions for 'ideal' healthy living or the 'good life'. It is towards this goal that both therapists and clients strive. How the theorist, therapist, institution and client define this ideal will reflect the biases and expectations of the parties involved. Sue & Sue (1990) suggest that many psychologists, such as Rogers and Maslow, have used discriminatory constructs in their definitions of normality or the good life. These constructs describe "ideal mental health...as one of the criteria of normality...stress[ing] the importance of attaining some positive goal" (p. 10). However, attainment of a 'positive goal', though it appears reasonable enough, is problematic. Consider, for instance, one positive goal that has often been stressed, personal achievement. This has sometimes been identified as a universal ideal necessary for mental health. This is an Occidental or *anthropocentric* world view in which humans are at the centre of the universe (Sterlin, 1992). In order to maintain their mental health, clients would have to be exerting their will. In contrast, a West African attitude may be more cosmocentric in which humans are but one element in the universal whole. This includes the spiritual dimension of the person. Thus,

mental health occurs when individuals are in balance with the universal energy inside and outside of themselves (Sterlin, 1992). Ideals, such as mental health, are constructs that denote the "theoretical frame of reference and values held by the practitioner" (Sue & Sue, 1990, p. 10). Neither Rogers nor Maslow, according to Sue & Sue, clarified or mentioned the ethnocentric bias contained within their theories.

### Deviance, Abnormality, and Pathology

Definitions of deviance, abnormality, or pathology are also influenced and limited by the values of the practitioner. One way in which deviance has been determined is through statistics: Anything that deviates from the norm is considered abnormal. The norm is generally represented and determined by the majority (Sue & Sue, 1990). Because deviations from the norm can be constituted as abnormal, minority racial or ethnic populations may consider this definition highly derogatory. Using this description, individuals or groups of people who practice distinctive intracultural customs or behaviours not used by the majority could be labelled deviant.

Many supposedly universal definitions are learned through our formal education as therapists. Indiscriminately applying these assumptions to our work may be harmful to the well-being of our clients:

The culturally encapsulated counselor may become a tool of his/her own dominant political, social, or economic values. Ethnocentric notions of adjustment tend to ignore inherent cultural-class values, allowing the encapsulated person to be blind to his/her own cultural baggage. The net

result has been that mental health services have demanded a type of racial and cultural conformity in client behaviour that has been demeaning and that has denied different ethnic minorities the right to their cultural heritage. (Sue & Sue, 1990, p. 13)

Fortunately, as we develop awareness of the normative values contained within psychotherapeutic definitions, art therapists can better understand the assumptions that they are using, and then use them only when appropriate.

### Theoretical Orientations

Those theories and values about which clinicians feel most strongly inevitably influence the therapeutic interventions made with their clients. Unfortunately, the myth that psychotherapists can be neutral or unbiased in their observations of and responses to their clients has not been sufficiently challenged. Given that graduate education requires therapists to devote a substantial portion of their time and energy to master a particular school of thought and methodology, it is unlikely that professionals can be truly unbiased (Yalom, 1975). As Wachtel argues,

Psychotherapy is not just a technical activity performed by a practitioner. Psychotherapies have existed throughout history, and they have always been rooted in philosophical views of human nature and man's place in the universe. The theories that guide psychotherapeutic efforts both reflect and shape the culture's view of human potential and the good life. (Wachtel, 1977, p. 3)

Ivey (1980) warned therapists and clients of the dangers of becoming too attached to a single set of constructs. He noted that this stance "can lead to an inability to hear the client, difficulty in appreciating her or his unique construction of

the world, and forcing the client consciously or unconsciously into what you believe the world should be" (Ivey, 1980, p. 158). A client who comes from a culture where discussions about family matters are taboo, may be offended when asked to do so. The therapist, in turn, may see this as resistance to the therapeutic process in the form of avoidance or denial and not respect the client's needs.

Understanding the strengths and limitations of any particular theory helps the clinician to incorporate theories when relevant; this develops with knowledge and skill. Ivey (1980) suggested that each therapist generate a bank of theories and interventions to deal with the diverse needs of our clients, including those from other cultural backgrounds. This would require each therapist to construct a general theory for psychotherapy in order to determine the right theory for the right person at the right time. Moreover, therapists need to be aware that the client's problems may or may not involve cultural issues, and that focusing upon such topics may not address the specific needs of our client (Ivey, 1980).

Most psychotherapeutic orientations outline certain patterns of skills required in intervention. Ivey (1980) suggested that the more "skills, qualities, dimensions, and theories of helping" (p. 27) one has, the more one is able to address the multiple issues that arise in intercultural intervention. Each theory provides different insights into and strategies to address client issues that could not be obtained through one theory alone.

Both Ivey and Kelly have supported the use of an eclectic, intentional approach to theory. "The primary approach should be to help the therapist develop a

professional construction system which is printable, psychologically informed, systematically intact, scientifically supported, amenable to searching inquiry, and in process of continuing revision" (Kelly, 1955, p. 1180). The goal of a general theory is "to use what you think and feel are the most accurate ideas from each theory and to build your own theory about the world" (Ivey, 1980, p. 7).

There is a sense in which personal-construct psychology, in accepting a wide variety of psychotherapeutic procedures, is eclectic. The theoretical grounds upon which the varying procedures are accepted do not, however, represent eclecticism. There is no particular objection to eclecticism implied by this. It is interesting to note, in passing, that when eclecticism is itself systematically formulated it loses its eclectic flavor. (Kelly, 1955, pp. 810-811)

Art therapists can form an eclectic approach to art therapy which, when used intentionally with intelligence, sensitivity and experience, may prove to be the most appropriate foundation for intercultural intervention.

#### Educational & Professional Values & Standards

Both formal and informal educational experiences confirm, modify, expand or radically transform our world views. Our education has an impact upon how we and others, including our clients and the institutions in which we work, perceive and value psychotherapy, art processes and products. The language we learn contains constructs we use to describe how we perceive these processes and products and, ultimately, how we are likely to interact within that world (Ivey, 1980.)

The value-laden constructs we learn both within and outside of the classroom are rarely examined critically. Students are encouraged to fit clinical experiences into

the construct systems which are taught without generally being encouraged to challenge the basic premises and assumptions upon which these theories are based. It is in this manner that therapeutic practices can reify "the societal status quo" (Ivey, 1980, p. 154) and promote cultural insensitivity.

Sue & Sue (1990) challenged this status quo by criticizing mental health training programs for not including more culturally sensitive substance in their curricula. They cite this lack of material as the main cause of "ineffectiveness in working with culturally different populations....It has been ethnocentrically assumed that the material taught in traditional mental health programs is equally applicable to all groups" (p. 14). They and other professionals have implied that the gathering and distribution of knowledge concerning "cross cultural counseling and the training of culturally skilled counselors" have been hampered due to an "obvious pervasive bias and racism inherent in such programs" (Sue & Sue, 1990, p. 14). They based this claim on several studies, of which one they cite by Parham and Moreland (1981), surveyed more than 30 "doctoral programs in counseling psychology and found that potential minority applicants did not apply because course offerings appeared to lack a non-White perspective and that the academic environment was nonsupportive of minority concerns, needs, and issues" (Sue & Sue, 1990, p. 14).

Sue and Sue (1990) also identified several other general shortcomings in present educational programs. Firstly, there have been many suggestions made for curriculum improvement, but its implementation in the education system has been slow due to lack of motivation and commitment on the part of the faculty. Secondly,

many cross-cultural counselling programs have been successful in raising cognitive and affective awareness about the issues, yet, there still is "strong need to relate these components to specific skills in working with the culturally different" (p. 14).

Finally, even if all of the above components are in place, if the program lacks a "self-exploration of one's own racism....trainees (especially Whites) will continue to deny responsibility for the racist system that oppresses their minority clients" (Sue & Sue, 1990, p. 15).

To reduce cultural encapsulation and to increase cultural competency, several psychology conferences have recommended that:

- (a) professional psychology training programs at all levels provide information on the political nature of the practice of psychology,
- (b) professionals need to "own" their value positions,
- (c) client populations ought to be involved in helping determine what is "done to them",
- (d) evaluation of training programs include not only the content, but also an evaluation of the graduates, and
- (e) continuing professional development occur beyond the receipt of any advanced degree. (Sue & Sue, 1990, p. 16)

Also stressed was the need for training programs to provide learning experiences "that generate sensitivity and appreciation of the history, current needs, strengths, and resources of minority communities" (Sue & Sue, 1990, p. 16). Rather than seeing minority individuals as somehow deficient, deviant or disadvantaged, we need to "recognize the legitimacy of alternative lifestyles, the advantages of being bicultural

(capable of functioning in two different cultural environments), and the value of differences" (p. 21). Such knowledge can enrich student therapists on both personal and professional levels by changing the way in which they perceive differences.

### **Assessment Procedures**

As art therapists equip themselves with the skills, knowledge and affective awareness needed to work interculturally, they acquire the tools to help them make effective decisions within the context of therapy. Decision-making is an important facet in any intervention and begins in the assessment process (Ivey, 1980).

Although art therapists may not primarily focus upon making personality assessments or diagnoses, they are generally required to assess whether or not therapeutic interventions may be effective. Some supposedly "objective" tests used in assessment can have drawbacks for certain individuals from minority backgrounds. For instance, the following case illustrates how the results from certain intelligence tests could potentially injure clients.

In the State of California (Larry P. v. California, 1986), Judge Peckham ruled in favor of the Association of Black Psychologists' claim that individual intelligence tests such as the WISC-R, WAIS-R, and Stanford Binet could not be used in the public schools on Black students. The improper use of such instruments can lead to an exclusion of minorities in jobs and promotion, to discriminatory educational decisions, and to biased determination of what constitutes pathology and cure in counseling/therapy. (Sue & Sue, 1990, p. 12)

As we recognize both the applications and limitations of any given test, we can better use the data gathered to make assessments.



Before we can form a test to measure or identify a problem, we first need to define what we mean by "problem". For instance, Ivey (1980) described psychological problems as "incongruities" that take the shape of "repetitious, often blocked or immobilized constructs" (p. 149). Kelly (1955) similarly identified them as "any personal construction which is used repeatedly in spite of consistent invalidation" (p. 831). Based on their personal construct systems, therapists will be looking for a certain types of problems within their clients. Therapists, themselves, may have problems if they rigidly stick to a single theoretical orientation containing preconceived notions about how their clients' problems will manifest themselves. They, thus, may not be able to actually identify their client's problems in a way that will be beneficial to the client.

If, for example, the source of the client's problem lies outside of their construct system, some therapists may still attempt to fit their client into this framework, even if the fit is not good (Ivey, 1980). Although we need to both believe in and be committed to what we do, "a single-minded commitment to a sole theoretical school can represent a rigidity which makes it impossible to reach and help many people who might respond to another point of view" (Ivey, 1980, p. 7). Thus, a Haitian client who genuinely feels possessed by evil spirits, coming from a culture where possessions frequently occur, may refuse or not benefit from a psychodynamically-oriented assessment. On the other hand, this same person may respond well to a cosmologically-oriented approach in which the circulation of energy around that person's body is evaluated. This is done through creating balance

between spirits, humans and the environment and is very connected to Haitian vodun beliefs (Sterlin, 1992).

To fully understand the nature of another person's problems, a person who may view the world very differently from ourselves, art therapists need to enter into the client's personal construct system in a manner such that "language and meaning barriers are removed" (Ivey, 1980, p. 149). Without a shared language, we clearly may not understand the client's unique world view. Such an understanding is necessary before intervening and attempting to create change within that world. The "interpretations which are most meaningful to the client must agree with the client's construct system or way of thinking" (Ivey, 1980, p. 83).

Problems exist contextually; cultural, social, economic and other environmental factors deserve careful consideration when assessing mental functioning.

It is a mistake to assume that a psychologically healthy person can immediately adjust himself happily to any kind of situation. Adjustment can only be achieved in relation to something. It makes a difference what one has to adjust to. Diagnosis is not complete until the clinician has some understanding of the milieu in which adjustment is to be sought. This position represents a departure from the common notion that diagnosis involves an analysis of the client only....Therefore, both the client and his milieu must be understood. (Kelly, 1955, p. 804)

Some contexts exist in which adjustment is not healthy. In such situations people may be asked to assimilate normative majority values and devalue or give up their own distinctive cultural characteristics, values and traditions. To avoid antisemitism, for instance, many Jews have converted to Christianity throughout history. Many others refusing to do so were persecuted. Jews have struggled to maintain their values and

traditions, in spite of being dispersed throughout the world and living in nations that were not their own. Their fear of cultural assimilation is a real one and has been substantiated through many historical events. Thus, in light of the events of Nazi Germany, a therapist should be careful to not interpret a Jewish person's fear of being persecuted as a paranoid reaction.

Therapists may need to develop a sensitivity to minority clients' reasonable--and often adaptive--mistrust of Whites, including White therapists. This mistrust may be misinterpreted as a general paranoia not based in reality. As Sue and Sue (1990) note:

Minority groups who have consistently been victims of discrimination and oppression in a culture that is full of racism have good reason to be suspicious and mistrustful of White society. In their book *Black Rage*, Grier and Cobbs (1968) point out how Blacks, in order to survive in a White racist society, have developed a highly functional survival mechanism to protect them against possible physical and psychological harm....this "cultural paranoia" ...[is] adaptive and healthy rather than dysfunctional and pathological. (p. 10)

Clients who have this "cultural paranoia" may be overly fatalistic about the chances of therapy producing a positive outcome. Research has elaborated the fact that if clients do not have an expectation that therapy can help, it will probably not succeed. Nonetheless, absolute faith in the therapist is not a precondition for success in therapy. In fact, some sense of suspicion or wariness about therapy is healthy, and does not breed an over-dependence upon the therapist (Sue & Sue, 1990).

## Treatment Goals & Strategies

If the assessment indicates that discrimination is a major cause of the client's problems, it may be the environment that needs changing and not the client.

Unfortunately, even if environmental changes would resolve the problem, such changes generally do not occur without resistance. In the case of institutionalized racism, for instance, "changing a massive system of institutionalized attitudes and behaviours is arduous work. Small wonder that most counselors prefer to work with individuals and ignore the surrounding environmental influences!" (Ivey, 1980, p. 40).

Even art therapists who want to change the system may be resistant to do so if such changes would reduce their opportunities for work. For instance, at present, art therapy is still a young profession in Canada. Art therapy jobs are scarce, especially full-time positions. How many art therapists from the majority culture would thus be willing to give up their place in line to provide more opportunities for art therapists from minority backgrounds?

In any human organization, there are those who lead and those who follow. In Canada, those who lead have always been of the mainstream culture; minority cultures have usually been among those who followed. It is not necessarily in the interest of those who lead to have change occur that will reduce their status, control, and power. (Smith, 1983, p. 267)

As a result, few may fight for institutional changes in policies that could potentially reduce their own employment prospects.

In spite of the risks involved with finding environmental solutions, not moving in this direction reinforces the status quo and potentially contributes to the problem--complacency and passivity are political positions in and of themselves. "Therapists can easily fall into symbolic violence through encouraging their clients to adapt to societal demands, thus maintaining social class status quo" (Ivey, 1980, p. 157). Ivey (1980) also suggested that therapists become social activists, though he admitted that few would be willing to take this path. Political activism may involve getting "out of the office and into the streets, homes of clients, and offices of state and federal agencies. A comfortable and well-appointed office is no longer sufficient for the relevant practice of helping" (Ivey, 1980, p. 41). Although many psychotherapists may begin with "strong social concerns...when faced with the difficulty of changing large dehumanizing systems, they retreat to individually oriented definitions of client problems as more workable and safe" (Ivey, 1980, p. 41).

If we accept that the problems and issues brought to art therapy revolve around life's incongruities, then, according to Ivey (1980), a central goal of therapy is to address, resolve or integrate these disparities. As mentioned above, incongruities may result from social discrimination based upon one's culture, gender, age, or social status as well as struggles with one's past. Therapeutic goals cannot ignore such inequities, yet, realistically we may not be able to resolve them.

In any event, before therapeutic goals and plans can be established, they need to be developed with our clients to avoid imposing our own values upon them (Sue & Sue, 1990). Once the client's problem(s) are clearly understood, then the therapeutic

goals and strategies can be developed. Depending upon what the client is dealing with, strategies "may range from traditional middle-class helping techniques to culture-specific techniques or referral to a Hispanic counseling group" (Ivey, 1980, p. 10). This is where understanding a broad variety of interventions is useful.

When the interventions we use do not bring us closer to our goals and we are thus faced with our limitations, we may need to connect with someone from the client's cultural community who may help us better become aware of some of the alternative or traditional ways of dealing with mental health and illness. This can be achieved through establishing a network of people working in the community who understand the specific needs of various cultures. These cultural liaisons can become valuable resource persons to us and our clients.

The cultural liaisons may make us more aware of indigenous healing practices. McNiff (1985), a well-respected art therapist, has studied shamanistic practices and incorporates them into his clinical and educational work in art therapy. He has found that these practices have expanded his vision of the world and provided him with other frames of reference through which his clinical work, teaching, and research have grown. Unfortunately, because many forms of traditional therapy are relatively unknown to us in Canada, and have not been studied empirically, their worth has often been devalued or ignored. For instance, Zen therapy has been significantly successful in treating psychosomatic disorders since the mid 1900's (Singh, 1984) but I had heard little or no mention of this therapy before beginning my research.

Art therapists who were trained in universities and are members of professional associations may be further deterred by the fact that indigenous treatments are often administered in ways that appear informal by people who seem to be untrained. For instance:

The Iroquois of New York State used to carve masks on a living tree. When they removed the mask, the spirit of the tree would remain in the mask. These were the masks of the False Face Society. They were carved in very grotesque shapes. From behind these masks, the Iroquois would work to cure their sick. (Sun Bear, 1970, p. 23)

These interventions fall outside of the sphere of professional health care in North America, and thus appear unconventional (Ivey, 1980). In the past, if the Iroquois were caught performing this ritual it is likely that the majority culture would have forcibly stopped them from continuing such practices, and perhaps, even punished them as well. It was not until the 1950's "that the religious ceremonies of many tribes such as ritual dancing, sweat bath purification, peyotism, and vision quests were done openly after many decades of suppression" (Dufrene, 1990, p. 126). It is because these traditions have been useful for healing ceremonies that they have survived. Perhaps these ceremonies may prove to be healing for people outside of the Native communities as well. We as therapists may benefit from learning more about these treatments if they were more accessible to us.

It may be that art therapists would be reluctant to try treatments which do not fall within our construct of what heals. If a particular practice does not fit into our construct system, it would be difficult for us to accept it as helpful. As a result, Wildavsky (1989) saw cultural conflict as inevitable: "cultural theory may be

distinguished by a necessity theorem: conflict among cultures is a precondition of cultural identity. It is the differences and distances from others that define one's own cultural identity" (p. 65). Our encounters with others, though they may provoke intense feelings, essentially help us to define ourselves as unique.

Likewise, Das (1993) has said that once this *culture shock* passes, we can become enriched through understanding that differences teach us additional ways of viewing and acting in the world that otherwise we may not have experienced. This is what I learned through my travels in Latin America. Although it was difficult for me the first few weeks, when I could speak only a few words of Spanish, joy gradually replaced my fear. Words slowly strung into sentences until I was able to describe complete thoughts in Spanish. This new language opened up a whole new world to me. As an art therapist, I find that the Spanish I learned before helps me now to create links between myself and the elderly Moroccan Jews with whom I work.

While verbal communication with our clients is clearly important, it is with the non-verbal language, or meta-communication that many misinterpretations can occur. Often the meaning conveyed in language is expressed more through how the idea is expressed rather than the content alone. Non-verbal exchange is very important. If our words are incongruent with our behaviour, confusion and mistrust can result. Even intonation of one's voice can change the meaning of the words we use. If other people do not understand this intonation, conflict or confusion is likely to occur.



## Racial/Cultural Identity Development

Becoming aware of our own cultural identity helps us to recognize the impact of this identity upon others as well as ourselves. Each stage brings a different level of awareness. Understanding the transformation that may occur in each stage may help us to anticipate possible countertransference reactions elicited by encounters with clients who are culturally different from us. Likewise, it may also help us to understand the stages of cultural identity development through which our clients may be passing, and thus help us to expect and appropriately deal with the possible transference issues that may arise (Sue & Sue, 1990).

Sue & Sue (1990) described five stages in their description of racial/cultural identity development: conformity, dissonance, resistance and immersion, introspection, and integrative awareness. This description refers predominantly to understanding the dynamics occurring between a minority client and a majority therapist, though they are not limited to that dyad alone. Sue & Sue also referred to white cultural identity development which in many ways is similar. However, due to space limitations, it will not be elaborated here.

Stage one of Sue & Sue's description of identity development, is characterized by conformity. In this stage, one works very hard to be like everyone in the dominant culture, denying that one is a part of any culture other than the dominant one. Not "fitting in" can be very upsetting, as I can attest to because of my own experiences as an invisible minority. As a child, I remember watching other children

decorate their Christmas trees with zeal. I felt excluded from this supposedly global celebration. I wanted to be just like them and felt that something was wrong with me and my family that we were so different. In short, I struggled very hard to conform, as do many others in similar situations.

The need to be a part of the dominant culture may be so great that some individuals attempt to break all ties to their culture of origin in order to avoid victimization. Again I can identify with these feelings, having believed all of the stereotypes I learned about Jews during my childhood. We were not very religious and my family seemed okay--we were the exception, or so I thought. I hoped that if I avoided other Jews, no one would know I was one of them, and I would never be discriminated against like my older brother, father, mother, grandparents, and great grandparents before them. I would not be a victim or a scapegoat.

Thus, I rejected my cultural roots and pursued a secular life with almost exclusively non-Jewish friends and lovers. Most of my friends were Christian. Yet even mentioning the name of Christ made me feel sinful and guilty, that somehow I was betraying my cultural roots. I stood tenuously on a fence between these two cultures, feeling at home in neither.

This is a common feeling that occurs during the next stage, dissonance. Something happens to shake up our ideal vision of the dominant culture. One may begin to see beyond the negative stereotypes internalized about one's own culture and start to see some of the things that are not so great in the dominant culture. A "growing suspiciousness and some distrust of certain members of the dominant group

develops" (Sue & Sue, 1990, p. 102). As well, rather than focusing on negative stereotypes, we may begin to positively identify with some of the members or positive qualities of our own cultural group.

I started to read about Jewish women in history and found several whom I quite admired. Golda Meir, Gloria Steinem, Letty Cottin Pogrebin and many others who helped me see that there were positive female role models who were Jews and not just slaving at home over the stove. As well, I learned more about Jewish history and realized that denial could not help me to escape my past. Increasing tensions, incessant denial of the holocaust, synagogue desecrations, bombing of Jewish institutions, and bouts of anti-semitism and xenophobia throughout the world illustrate that the discrimination of the past continues to repeat itself in the present. In denying my cultural roots, I was denying the values I learned in the process. I was also forgetting about the beauty shared in family gatherings, the meals, the songs and the traditional celebrations. My biases originate in these roots. To honour the cultural identity of my clients, I have had to first honour my own. In honouring my own identity, I am less envious of others and less ashamed of my past.

The third stage, resistance and immersion, is one through which I have not passed. In some ways it is like wearing blinders or seeing tunnel vision. This stage is distinguished by a full endorsement of "minority-held views" and rejection of "the dominant values of society and culture" (Sue & Sue, 1990, p. 103). The person in this stage will open themselves to learning about their own history and culture and

probably identify strongly with other members within the group. During this stage, the following occurs:

First, a resolution of the conflicts and confusions of the previous stage allows greater understanding of social forces (racism, oppression, and discrimination) and his/her role as a victim. Second, a personal questioning of why people should feel ashamed of themselves is asked. The answer to this question evokes feelings of guilt, shame, and anger. (Sue & Sue, 1990, p. 103)

This anger will likely be directed towards members of the majority and, thus, if a minority client is in therapy with a majority therapist, a lot of negative transference may be felt.

This is a stage that I may still need to experience. I have never deeply identified myself religiously with Judaism, though I am proud of our rich cultural and intellectual heritage. Judaism is not comprised of a homogenous group of people: Religion alone separates Jews into reformed, reconstructionist, conservative and hasidic categories--the latter of which I know almost nothing. I find little solace in the religious teachings, which I continue to perceive as predominantly patriarchal. This is not to say that there is not much to learn, it is just that at this point, I am not that interested.

By stage 4, introspection, some of the intense feelings of anger directed toward the majority are let go so that more energy can be directed inwards toward greater self-knowledge or knowledge of one's culture. There is no longer a need to be reactive. In fact one may begin to notice aspects of one's own culture that are oppressive or rigid and preventing aspects of the person's individuality from

surfacing. There is also a desire to relate with members of other cultural groups (Sue & Sue, 1990).

The final integrative awareness stage is one in which people have developed:

an inner sense of security as to self-identity. They have pride in their racial/cultural heritage yet can exercise a desired level of personal freedom and autonomy. Other cultures and races are appreciated, and there is a development toward becoming more multicultural in perspective. (Sue & Sue, 1990, p. 112)

The process by which an art therapist or client arrives at this stage of integrative awareness is not an easy one. Nor is it a place which one occupies without ongoing reflection. It is easy to fall back into past, habitual ways of responding.

Nonetheless, as we have learned from Freudian psychology, denial and avoidance can consume a tremendous amount of our energy. Without understanding our history, we may be unprepared to deal with the present and future conflicts that this history provokes.

I know that as a Jew and as an art therapist, I am not alone in this search to understand my past. We are all trying to understand where we belong, why we are here, what should we strive towards, and what is really important. I think the problem that occurs, or at least part of the problem, is when that group of "others," or people from outside of our group, begin to tell us where we will find these answers without realizing that we already have many answers of our own. It is through the on-going development of my awareness, knowledge and skills that I increase my effectiveness as an art therapist working in a multicultural milieu. But beyond increasing my effectiveness in my intercultural work, understanding where I

have come from, what my biases are, and what I value, has helped to me to clarify and be more proud of my own cultural heritage.

## Intercultural intervention in Art Therapy

### Chapter 4:

#### Strategies for Intercultural Intervention in Art Therapy

##### Introduction

The research discussed earlier suggests the ethical and practical need to develop a model for intercultural intervention in art therapy. However, creating a single *modus operandi* for intervening interculturally no longer seems appropriate after having reviewed the literature. It seems clear that no one framework will work for all individuals, with all problems, under all situations. As a result, Ivey (1980) suggests we each make our own general theory--a systematic, eclectic approach to therapy to meet the diverse needs of our clients.

Systematic eclecticism is not simple. In fact it presents a great challenge to art therapists, given the complexity of pulling together a model made from the parts of several other models. It would appear to be much easier to choose one theoretical framework into which we would attempt to fit all of our clients' issues. Yet, based on the research cited thus far, it is clear that such a methodology will eventually fail unless one can somehow work with a homogenous clientele experiencing similar conflicts in similar situations.

In order to help art therapists form their own general theory for intercultural intervention in art therapy, this thesis presents the rudimentaries of a *meta-model*. A

meta-model is not a definitive psychological paradigm, but rather a structure through which other theories may be examined. Ivey's meta-examination of various psychological theories sets a precedent for us to do the same (1980). This is necessary in order to determine "which treatment for which individual, under what conditions" (Ivey, 1980, p. 170). A meta-model allows us to look at a variety of theoretical and practical approaches and then choose one or more aspects of several approaches that best respond to the clients' needs.

This thesis borrows from Ivey's general theory mainly because its central goal, intentionality, is an important goal to any intercultural intervention. "Intentional living occurs in a cultural context" (Ivey, 1980, p. 9). Thus, any development and application of our intercultural awareness, knowledge and skills will happen within a cultural context. Intentionality is the "creative generation of new responses to life and living" (Ivey, 1980, p. 1). Intentionality is achieved when an individual has the freedom to generate the maximum amount of possible constructs before taking action.

Intentionality involves permeable thinking which helps us to be conscious of and sometimes go beyond our typical ways of perceiving, interpreting and responding to others. Intentionality is required to develop the meta-components that both art therapists and other researchers have identified as relevant to intercultural competence, namely, awareness, knowledge, skills, and a strong antiracist component (Sue & Sue, 1990; Pedersen, 1981; Das, 1991; and Lewin, 1990). While developing these areas of competence, we need to remember that intercultural competence is not



a final stage that we arrive at; rather, it is dynamic and grows and changes as our awareness, knowledge and skills expand.

### Awareness

Implicit within each and every art therapy theory, assessment, goal and treatment strategy are assumptions and values. Many of these values may be so close to our own personal values that we never need to look at them. Yet, as suggested earlier in this thesis, whether we are aware of them or not, they play a big role in the therapeutic decisions that are made. Without being aware of the impact that such values have on others, we may be unconsciously directing our clients in ways that do not meet their needs.

Intercultural relations can be very rewarding. Exposure to difference allows us to expand our personal construct system and become aware of the world in ways that we may not have imagined. It teaches us greater perspective. Rather than just working with black and white, we have a whole range of tones, hues, and shades to chose from. These filters can greatly increase our perception and appreciation of things that we may have otherwise taken for granted.

Awareness helps us to examine our assumptions about how other people are different or similar to us in terms of their actions and beliefs (Sue & Sue, 1990). These assumptions, biases, preconceptions, values, or stereotypes are often deeply ingrained personal beliefs. They are internalized feelings and thoughts about our own

culture and the culture of others as well. Whether or not they are grounded in reality, they remain our truths, even if these truths are not shared by all. Thus we need to identify the assumptions with which we work, including the assumptions of our clients. How our clients perceive their problems, and what they feel needs to be done to resolve them, shapes their expectations from art therapy.

Becoming aware of our assumptions is especially important in intercultural intervention, where our prejudices may surface without our awareness. One of the dangers of unconscious preconceptions is that clients may be alienated inadvertently even before the therapy begins. This is what happened to Ms. S. who sought the services of an art therapist. During the first few minutes of the beginning session, the art therapist mentioned that she had previously worked with another Chinese client who had also been very quiet, much like her. She then asked Ms. S. if this was a common Chinese characteristic. This affected Ms. S., making her feel uncomfortable and overly conscious about her Chinese identity, something of which she had not really come to terms with. Although the art therapist's intentions may have been to better understand the client, Ms. S. felt uncomfortable with the immediate reference to her ethnicity, rather than the emotional needs that she had hoped to address in art therapy.

Ms. S. continued sitting in the session to try to understand why the art therapist had brought up this issue, but it did not seem to make sense to her and she left before the session was over. Had the art therapist been aware of the early phase of cultural identity development, she may have been less likely to share her

interpretation with the client. Nonetheless, even if the art therapist's generalization had been true for Ms. S., psychoanalytic art therapy training often emphasizes the importance of limiting one's interpretations to the client until after a basic level of trust has been established. It is important to remember, however, that allowing our stereotypes to surface is not a bad thing. In fact, it is the only way in which we can be aware of their presence. We need to be sensitive to the fact that clients may not want or be able to teach us about their cultural identity. Thus, art therapists may have to tap other resources to confirm, expand or negate our cultural assumptions.

Cultural stereotypes are not just projected upon others; they are also internalized and influence our own cultural identities. As a result, therapists need to become aware of these stereotypes because of their potential impact on our relationships with our clients. In my own case, I continue to struggle with the many stereotypes I have internalized, including stereotypes about people from other cultures and members of my own culture(s). As a multicultural person, I see myself as Jewish, female, Canadian, white, artist, and art therapist (though not necessarily in that order). All of these cultures, except for artist and art therapist (cultures which I have acquired), were given to me without choice. Yet, the one with which I have had to struggle the most is my Jewish identity. As a Jew, there are many cultural stereotypes that have been placed upon me. In some cases, these stereotypes have had the effect of limiting me in terms of who I am, or who I want to be. Indeed, I had internalized the idea that Jews were either victims or aggressors.

This very limited dichotomy is the result of centuries of prejudice which has often taken the form of a deep hatred towards Jews. Jews have been labelled as Christ killers. They have been characterized as greedy, stingy, cheating and manipulative pariahs--people who are not to be trusted. They have been depicted in literature as *Shylock* or *Fagin* types, or presented in other similarly dubious forms (Deutscher, 1968). Caricatures depict them as having big, hook-shaped noses (Appel & Appel, 1986). They are seen as arrogant, associating only with their own kind, and believing that they are the "chosen" ones. Worse, they have frequently been accused of conspiring to take over the world.

These are only a few of the stereotypes which potentially affect my cultural identity and, by extension, my dealings with clients. In this respect, I am like other Jewish therapists who have faced the difficult task of coming to terms with negative views of their culture so that they are in a better position to help others. If we do not do so, we may project the same negative associations that have so adversely affected ourselves onto our Jewish clients. Or for that matter, react defensively to clients who perpetuate the negative Jewish myth in the form of transference. For instance, for a few years I worked as a animator and art instructor at a alternative mental health community centre. One member deduced from my last name that I was Jewish. On several occasions, thereafter, he brought in his Bible and insisted I read various chapters about the supposed wrong doings of Jews in the past. He provoked a lot of anger and discomfort in me that I was not able to deal with at the time. I had to deal

with the countertransference it triggered within me before continuing to work with him.

Understanding the roots of discrimination and the energy that continues to fuel it is a complex process. Moreover, even if we were able to understand all the causes of prejudice, it is unlikely that we could completely eliminate it. Nonetheless, we can certainly attempt to reduce its presence in art therapy theory and practice. To do this we need to create a safe atmosphere in which such deeply ingrained feelings may surface, without fear of judgment or retaliation. We need to share these feelings with others--not to perpetuate them, but to understand them better. Without this awareness, we risk perpetuating them inside and outside of our art therapy practice. How can we deal with the psychological ramifications of racism upon our clients if we have never looked at these issues within ourselves? If a client accused you of being a racist, how would you respond? Would you respond defensively and say, "I'm not a racist"? It is likely that such a move would not enhance the therapeutic relationship. Greater awareness may need to be developed before the art therapist may know how to adequately respond.

The origins of the cultural baggage that we carry around with us may extend many lifetimes before our own. How members of our culture have related with members of other cultures throughout history carries into our present relations with others. Knowing about the tumultuous relations between Jews and Arabs, I was concerned before working with my first Arabic client. He was referred to art therapy in the psychiatric hospital where I was doing an internship. I wondered if he knew I

was Jewish and if this would make a difference to him? I knew little or nothing about Arabic culture and when he refused to draw with me, it was really I who felt uncomfortable. He later told me that in the Islamic religion, he was forbidden to draw any images that could potentially desecrate the image of God--so he chose not to draw at all. Instead, he spent our sessions completing calligraphic expressions of prayers from which he found much solace. These sessions helped him deal with his anxiety. Learning to recognize our own prejudices and fears helps us deal with situations like the above.

We may begin to become more aware as we remember and recount stories of our encounters with discrimination. This may take place in the classroom, in peer supervision, in workshops, at conferences, or other settings. This sharing of stories helps us to get in touch with the associated feelings provoked by prejudice such as fear, guilt, "anger, desperation, hopelessness, as well as confusion" (Lewin, 1990, p. 14). Sometimes these feelings may make us feel very alone, thus sharing these responses may help people to have their feelings validated and normalized.

It is the internalising of these kinds of feeling which contributes to holding the oppression in place and externalising them is a process of self and group emancipation....Internalised racism will also result in mistrustful and attacking behaviour towards whites. As white allies, we need to become able to hear and listen to the experience of discrimination without taking it as an attack, and to value the person as a human being....to show interest, respect and willingness to learn about the experiences and customs of people who have different lifestyles and cultural heritages. (Lewin, 1990, p. 14)

Some people fear that becoming aware will open up a Pandora's box which contains many potentially explosive issues. Thus in whatever way art therapists chose to expand their awareness, there needs to be a structure in place in which participants

can feel free to explore some of these feelings. The following section of this thesis looks at how this can be done.

### Knowledge

Affective awareness alone is not enough. We can become aware of our feelings of prejudice and our assumptions, and may wrongly accept these assumptions as truths unless they are confirmed, expanded or challenged by concrete, factual information from various sources. Without this knowledge, we may unknowingly reinforce existing stereotypes (Sue & Sue, 1990). Being aware of our prejudices without seeking information to confirm or refute them could be considered irresponsible. Indeed, it is not enough for a therapist to simply say, "My own belief is that most Mexicans wear big *sombreros* and take frequent *siestas* under trees," and leave it at that. Instead, the art therapist would have a responsibility to evaluate his or her beliefs by seeing Mexico in person or by consulting reliable sources-- translations of indigenous literature might be one source--which could provide an accurate picture of Mexican life.

In short, we gain knowledge through actual interaction with, and research about, various cultures, including our own. Our intercultural knowledge can be expanded through cross-cultural, intracultural or intercultural research. For example, through comparative research we could learn more about the different applications of

art in healing or education throughout the world. This may help us to better understand the cross-cultural differences in drawing styles and use of media.

There is much information written in the anthropology literature concerning customs, traditions, rituals, and behaviours of most cultures. Increasing our knowledge through these resources may reduce the myths and misconceptions contained in our assumptions and help us to further expand our understanding of alternative value systems, communication styles, uses of art, and therapeutic practices.

Although reading about different cultures may expand our horizons, it is the actual contact with them that leaves a lasting impression. The secondary research we do from literature searches, conferences, and lectures, for instance, is what Sikkema & Niyekawa (1987) refer to as *passive* cultural learning. Yet a deeper learning occurs when multiple levels of our lives are touched: cognitive, emotional, physical and perhaps even spiritual aspects. Those encounters which are most helpful are those that generate sensitivity and appreciation of the history (oppression, domination, victimization, etc.), current needs, strengths, and resources of minority cultural communities (Sue & Sue, 1990).

Learning about different communication styles is also important in intercultural intervention. Learning about the subtle and obvious forms of verbal and non-verbal cues used in a culture can reduce misunderstandings. If, for instance, an Islamic client walked into your office while your feet were up on the desk, he or she would consider this a grave insult. Showing the soles of your feet, the part of your body



which walks on the dirt, is considered an offensive act. In effect, it is like saying to a person "you are like the dirt beneath my feet." Seemingly innocent non-verbal gestures can be greatly misinterpreted cross-culturally.

Since art expression is intimately tied to art therapy, information about cross-cultural uses of art in healing can also increase our knowledge base. McNiff (1985) suggested we develop a greater interest in understanding how art therapy is being used internationally through the publication of art therapy program descriptions from other parts of the world. Through this we could learn more about the development of the art therapy profession cross-culturally. At the same time, we could also examine the lay use of art in healing practices, or healing practices that may not even incorporate art. The following example illustrates a traditional Native practice that could potentially be adapted to our own therapeutic interventions:

War paint was used by many tribes. Each man had special markings and sometimes he would paint a red hand on his horse--a symbol that he was out to revenge the death of a friend or relative. Sometimes the man would paint his bare chest as well, maybe hand marks or dots. Perhaps in a vision he had received a message telling him how to paint. The Apache would use black and yellow. Other tribes used red, black, white, and even blue...The Indian decorated his war shield with symbols to protect him in battle. This was made of tough buffalo bull hide and had special medicine on it. (Sun Bear, 1982, p. 34)

In some situations in which clients are struggling with their own personal demons, painting symbols on their bodies may help them to feel strong enough to confront those shadows. In effect, our clients' opponents may be their psychological distress rather than an actual person. War paint and protective shields helped the Natives to feel strong and willing to face their fears and to provide protection for themselves

while they were doing it. Learning about the cross-cultural functions and applications of visual expression could greatly enhance our practices.

We also need to learn more about cross-cultural communication styles. Such knowledge can be found in books, but the more subtle forms of verbal and non-verbal expressions can only be learned through experience. Furthermore, culture is not static and meanings may change. It is necessary, therefore, to periodically confirm that our previously gathered knowledge is still correct through the contacts we make with cultural liaisons, perhaps through periodic trips abroad, and more importantly, through trying to confirm our interpretations with our clients themselves.

One way to insure adequate interpretations of foreign gestures and expressions is to consult a cultural representative, expert, or liaison in the community. This is a form of networking that helps us to connect with people who either can answer our questions themselves, or who can point us toward someone else who knows. This liaison is someone who can help us to become more aware of the resources of the community and perhaps even teach us about traditional forms of therapeutic intervention which may be better suited to our clients than those with which we are more familiar. Native tradition, for instance, has often relied on the wisdom and experience of tribal elders who would recall a story in which an animal or another person, similar to the one seeking help, had dealt effectively with the problem. This approach presents the client with potential solutions without telling the client what to do. The use of storytelling is a technique used frequently in drama therapy, something of which we could apply to our own practice. On the other hand, if art

therapists who work with a Native population became more familiar with the members of Native communities, then they could seek the knowledge of the elders themselves and refer their clients to them as well.

Actual experience in working with clients who are culturally different from ourselves can give us opportunity to become aware of our unique ways of seeing and acting in the world. Art therapy students should be encouraged to have internships in settings which provide such opportunities. Lofgren (1981) suggested we involve ourselves in

long-term therapeutic group activities, practicums and internships in culturally different communities, living in subcultural environments...[guided by] concerned educators and supervisors [who] must themselves have achieved considerable personal insight and knowledge of different cultures. (pp. 29-30)

An example of a possible internship would be one in which students are specifically assigned to a community centre which caters to a large ethnic clientele. Experiences such as this one would likely produce at least a few incidents in which intercultural conflict occurs. These could then be discussed or acted out in a role play in the context of group supervision at school. Ideally, the instructors of such courses would have to have gained a considerable amount of intercultural competence themselves to help the students deal with such problems.

Peer supervision is needed not only in the school but also in the workplace and our professional associations as well. The value of group work is gained through art therapists participating in groups of their own. Group workshops for practising arttherapists provide a forum in which cultural difference will inevitably manifest itself. Even in a supposedly homogenous group, differences will surface. As

suggested earlier, role playing can help us connect with the hidden victim, aggressor, racist or bigot within. Without judgement, such an environment can help us to get in touch with our affective responses to prejudice. With this affective awareness in mind we can then better understand the emotional ramifications of racism upon both victims and aggressors and, perhaps, anticipate some of these reactions within our culturally different clientele.

As we describe critical incidents, act them out, draw them or perhaps even videotape one another, our peers can help us to identify patterns we may not have recognized otherwise. They may note certain preferences we have, certain physical gestures or art materials which we tend to make most available to the client. As well, they can help us to identify the verbal and non-verbal cues we send to our clients. Such gestures may reinforce particular behaviours in our clients. Used consciously, this reinforcement is the role of the therapist. However, used unconsciously, we may be swaying our clients in directions which do not meet their needs.

Critical incidents, as suggested earlier, are situations in which an intercultural dilemma is presented. Video-taping these role plays allows for a content analysis to identify the repeated constructs and behaviours used in dealing with such conflicts. However, some people may feel uncomfortable being videotaped for various individual or cultural reasons. This, too, may be something that we need to be sensitive to. Nonetheless, video can help us to identify the typical constructs we use so that the assumptions underlying these responses can be addressed. It is in these assumptions that we may find some of the unconscious values and beliefs that we

uphold. In role play, group members take on the different roles of being the art therapist, client, or perhaps administrator of an institution where the conflict is occurring.

As part of this questioning process, the group may want to collectively look at commonly held assumptions underlying such terms as mental health, pathology, and normality. They may explore what culture means to them and how they feel it influences their lives. In undertaking this activity, group members will likely find themselves engaging in a certain amount of solidarity building. As Lewin explains,

workshops and conferences designed for experience sharing, debating and dialoguing on themes of Black-White relationships, Racism and Oppression...[can help to] create a basis for meaningful and genuine communication and exchange of information. Within these settings are sown the seeds which flower into fresh insights, and new initiatives which further our anti-racist cause. Here, through listening to people's experiences with respect and without interruption, as well as sharing time equally, we begin to build up trust in the others' capacity to be an ally and provide support in each other's struggle. (1990, p. 14)

The learning which occurs during group workshops can be both painful and humiliating--participants may not want to express their deeper prejudices for fear of reproach. Thus, disclosure of this nature needs to occur within a safe, non-judgemental environment that encourages people to openly express both the pleasures, prejudices and pains associated with intercultural relations. Open expressions of this nature could be particularly problematic during a time in our history in which being 'politically correct' holds such importance. To openly explore one's prejudices may be narcissistically injurious.

The individual group members' openness to this process may be reflected in their respective stages of cultural identity development. Those in the earlier stages of development may be less aware of their cultural identities and, thus, be more reactive to such expressions. Again, it is important for a group facilitator who is aware of the potential conflicts arising from such interactions to be present. As intercultural awareness expands throughout the field of mental health, and especially in the field of art therapy, there will be more of these facilitators in the community to sensitively guide art therapists in dealing with these feelings. In fact, the 1993 AATA revised training requirements include cross-cultural content in the curriculum.

Art therapists, art therapy associations and training institutes may also want to consider inviting cultural representatives to come to their classes, meetings and workshops to teach participants about some of the traditions, beliefs, and practices of particular ethnic communities. These representatives could lead discussions revolving around identifying and challenging basic assumptions about members belonging to that culture. Cultural liaisons may also inform participants of frequent mental health issues that arise in the context of therapy, as well as potential obstacles that occur, and how they may be addressed. As well, some liaisons may be aware of the traditional use(s) of art and healing in their respective communities.

One of the most powerful and lasting ways to gain both awareness and knowledge about other cultures is through structured cultural sojourns. This is what Sikkema & Niyekawa (1987) refer to as *active learning*. These are periods of study in which students are completely immersed into a culture different from their own.

**Sikkema and Niyekawa advocate sending students on cultural sojourns to radically different cultural environments. The greater the cultural distance, the more our assumptions, values, and traditions will be put to the test--the more potential for culture shock as well.**

**To provide structure to this experience so that it becomes a constructive experience of how to deal with difference, it needs to be guided by a teacher with intercultural expertise (Sikkema & Niyekawa, 1987). Otherwise, there is a potential for the student to become overwhelmed. The leader(s) frame the experience through both introductory and de-briefing courses. Competent instructors are required in order to help the participants extend the awareness, knowledge and skills that they learn from these particular experiences to other intercultural encounters.**

**Unfortunately it is not feasible, nor perhaps necessary, for all art therapy students and professionals to travel to different parts of the world to truly understand cultural difference. We may be able to extrapolate from less intense, though equally provocative experiences, that most of us have encountered at some point in our lives. Such experiences are what many intercultural communication experts refer to as *critical incidents*, moments in which an encounter with a person from a different culture provoked fear, anxiety, fascination, or another intense emotion (Sue & Sue, 1990). As mentioned before, critical incidents may be role-played, videotaped and then viewed and analyzed for repeated effective and ineffective verbal and non-verbal responses.**

Sue & Sue (1990) have provided some excellent examples of critical incidents that can be used when training therapists and prospective therapists. One such example illustrates a "White female high school counselor [who] has just undergone some group-dynamics training in conducting group counseling" (p. 270). She ran several successful study skills, career planning and personal-problem groups. She noted that the White and Black students tended to be very verbal and actively participated in their groups whereas the Asian-American students remained relatively silent. She wanted them to become more verbally involved and as a result, decided to "force participation...[to] help them get over their shyness and inhibitions...she devised several role-playing situations in the group" (p. 271).

Sue & Sue (1990) presented this critical incident without commentary and then followed it with several questions to stimulate group discussion. One such question is, "Can you identify 'group-counseling values' or characteristics that may clash with the traditional cultural upbringing of Asian-Americans?" Discussion of questions such as these can help art therapists to become aware of the values inherent in the situation, realize where we may need to learn more about Asian-American culture, as well as to identify the skills that could have been used to best deal with this situation.

Critical incidents such as the one mentioned above may trigger cultural transference and countertransference responses. Reactions may be mild or intense and include feelings such as fear, anger, alienation, frustration and confusion. The intensity of these reactions increases depending upon the perceived cultural differences



or *cultural distance* (Das, 1993). The larger the cultural distance, the greater the potential for conflict.

Countertransference and transference may be triggered by any number of stimuli including differing values, expectations, physical characteristics, clothing, body odour, customs, behaviour, drawing style, body gestures, or eye contact. Something as seemingly inconsequential as a brightly coloured sari, for instance, may be all that is required to reawaken past, unresolved conflicts which emerged out of earlier contacts with cultural difference. Fortunately, participants involved in re-creating these critical incidents are often able to examine and work through their fears and prejudices with the help of their instructors and peers. This is one of the main advantages of using a critical incidents approach to training.

Knowledge of intercultural issues in art therapy will also expand as more art therapists and art therapy training programs make this a priority. Some of these needs can be met simply by encouraging a greater representation of ethnic minorities within our profession. The AATA Mosaic Committee is dedicated to this goal. Moreover, committee members are presently in the process of gathering cross-cultural information about potential conflicts and issues that may arise in intercultural art therapy sessions. They continue to share this knowledge through workshops and presentations (Anderson, 1994).

While it has done some good, however, the Committee has also acted in a way which may hurt the cause of intercultural therapy. Motivated by the desire to "maintain self preservation" (Anderson, 1994, p. 8) the Committee has been

concerned with limiting discussion of racial or ethnic clients to art therapists of that same race or ethnicity. The committee's rationale is that

many conflicts that occur in a clinical setting have been reproduced in presentation. This occurs with transference, historical mistrust, or when credibility issues surface and when repressed feelings become evident. This is particularly true when the presenter is of a different racial or ethnic group. (Anderson, 1994, p. 8)

I agree with Anderson's perception that misrepresentation and ignorance can perpetuate damaging stereotypes; however, when such stereotypes are not allowed to surface, like any other form of countertransference, they cannot be addressed and potentially dealt with; they may remain unconscious. Repressing or avoiding cultural ignorance within our profession does not take it away, and it may even make the problem worse. Indeed, stopping a Jewish art therapist from making a case presentation of her work with an Arabic client can only lead to further fear and ignorance. Such presentations may prove to be an opportunity to challenge and rectify our assumptions if we can feel safe to acknowledge our own ignorance and use the exchanges as forums to further develop our knowledge, awareness and skills. However, I do agree that if art therapists attempt to present themselves as experts about cultures other than their own, without defining the limitations of their understanding then, yes, stereotypes and misconceptions unfortunately may be reinforced.

An equally important strategy for fostering intercultural awareness is to make greater use of practising art therapists in other parts of the world who could share their experiences and knowledge with us. Again, this knowledge could be shared

with us through articles in our journals, presentations at our conferences, and perhaps even cross-cultural exchange programs. While they may not share the same education or training, art therapists around the world are doing work that is helping others to heal. Learning about their experiences could greatly expand our own knowledge.

### **Skills**

Skills are required when we put our awareness and knowledge about intercultural intervention into practice. When conflict arises, specific skills are needed to establish effective communication between individuals who differ in their goals, expectations, or ways of seeing the world. Our skills develop as access to them becomes more spontaneous and natural. Sue & Sue (1990) suggested that there are certain ways of working with different cultural groups which have proven to be more effective.

Art therapists who have such skills may be better equipped to negotiate and potentially resolve conflicts with their clients. When working at a native community centre, I, quickly discovered that the psychoanalytic approach was a real "turn-off" for many clients. They wanted a more practical opportunity to make artwork, share their experiences and have these experiences validated by members of the centre. I began participating in social activities at the centre as well as being a participant/facilitator in the group. Changing my role and approach helped me to better identify their needs and to create a safe space in which their expressions could

surface. In short, the ability to be flexible is one of the most important skills that therapist working in an intercultural context must possess.

Unfortunately, it is not always easy to know what to do when working interculturally. As well as developing our knowledge and awareness through role play and videotape, Lofgren (1981) also suggested that this is a method for us to further develop our intercultural skills. Conflictual intercultural situations can be examined through this media. Video acts like a mirror that reflects the typical verbal and non-verbal communication patterns that both we and our clients use. Subtle non-verbal cues like eye contact, voice intonation, moments of silence and other gestures can be identified through this process. These patterns reflect our biases, biases which affect how and what we perceive (Ivey, 1981). The skill that we acquire by using role play and videotape is the power to increase our own level of self-awareness, a necessary ability if we are to guard against unconscious prejudices which may jeopardize our therapeutic interventions.

However, some people would not find the use of video or role play acceptable either due to their reluctance to share intimate thoughts or feelings in group situations or due to their beliefs based on their religious or cultural traditions. Nonetheless, the underlying principle--the capacity for reflection, for seeing ourselves though the eyes of another--might be achieved through other means, too. For example, drama therapy actively incorporates the audience as well as the actors. As observers, the audience can write notes which they can later compare with one another. Those aspects of the

scenario to which they attended the most will often reflect the biases of the viewers and help them to recognize these biases within themselves.

Unfortunately, even once we do gain skills from exercises similar to the above, we may still find it difficult to establish the initial cultural links with clients from a different ethnic group. One reason for this is that some groups may be (justifiably) hesitant to open up, as I discovered while working as an art therapy intern at a native community centre. At first, the members mistrusted me. According to Sue & Sue (1990) this is a healthy, adaptive response referred to as the *paranorm*, a state in which members of a minority group learn to be suspicious of the majority members' intentions as an adaptive means to defend oneself from potential threat. One of the reasons for their mistrust eventually became clear: The members of the centre later shared stories with me of having been "studied to death". They described lots of money going to researchers who studied them and few, if any, benefits ultimately going back to the communities studied. They cited one study in which close to a million dollars was spent assessing the condition of day care facilities for children within the Canadian Native communities. Dozens of recommendations were made and yet neither follow-up services nor funding was provided. In order to spare themselves from further disillusionment and disappointment, my clients adopted a reserved and sceptical attitude towards people like myself who wanted to learn more about them.

Their lack of trust could have been a serious impediment to successful therapy if I had allowed myself to become overly discouraged or defensive in the face of their

scepticism. What I did instead was to take a more relaxed approach which fostered a greater degree of trust between us. In particular, I played pool and participated in other social activities at the centre as a way of interacting with them on their own turf, in a context which was familiar and safe to them. In addition to demonstrating my willingness to reach out to them, this also allowed them to see me in a different light. In a short time, attendance at the more structured "therapy" sessions increased dramatically as they began to see me more as a person, offering something of value, and less as a representative of a majority culture which had betrayed them in the past.

Other art therapists can also benefit from taking a similar approach when working with clients from different cultural backgrounds. Simply understanding a bit about the parnorm helps prevent art therapists from becoming defensive when they encounter resistance. Skill is needed to work with it rather than pretending it is not there. In addition, art therapists can also help clients go beyond the parnorm state by making it clear how the therapy will benefit them; the client must feel that there is something ultimately to be gained from art therapy for it to work.

An additional skill that therapists may need to develop is the ability to see beyond the immediate client-therapist relationship when a broader perspective is required. Indeed, one aspect of pathology that we sometimes tend to ignore is that an important source of psychological problems may be rooted in the social system in which our clients are raised. To more clearly see this, art therapists may need to move outside of the art therapy space and into the larger social context of the client (Lofgren, 1991; Campanelli, 1990). We may find that a child's behavioural problems

are rooted less in the dysfunctional environment of the family and more in the racial slurs and isolation they experience in the school yard. We may then discover that institutional policies and practices need reform and that our lobbying efforts may become an aspect of the therapeutic intervention needed. Therefore, intercultural sensitivity programs may be needed to be integrated into the school curriculum for both teachers and students. If we are not prepared to be implicated in such lobbying, then at least we can learn to team up with those who do and provide our support and experience to help them create change where necessary.

Lewin (1990) is at least one example of an art therapist who has successfully worked toward reducing institutionalized racism. She described her own cultural roots and her commitment to creating change. She wrote that she viewed herself as

a white Zimbabwean woman who is committed to anti-racist work, [who] has participated in, and led 'liberation' workshops, here and in Zimbabwe, with white groups working on white racism and with mixed groups working on alliance building. Undeniably, such a forum for the sharing of experiences provides a solid ground for the building of personal relationships as well as for political activity and strategizing at a more public level. (p. 13)

Another example of therapists going beyond the immediate therapist/client intervention in intercultural therapy is provided by those practitioners who also act as resource people for their clients. For instance, an immigrant mother on welfare who speaks little English and is a victim of wife-abuse may benefit from belonging to a support group of other women in her situation. There she can get legal advice on what her rights are, and help to look within herself to find the strength to end future abuse. Involvement in such a group would allow her to receive support from people in similar situations, and to connect her to the community at large. In short, art

therapy may be a means to help her identify outside resources beyond her own therapist.

Again, it cannot be overemphasized that intercultural competency is a life-long process that does not end upon the completion of one's studies. Moreover, understanding the influence of one's culture upon one's life is not easily accomplished; the search is a struggle filled with many mysteries and obstacles--not all of this understanding is available to us in our immediate consciousness. In addition, some of that awareness may not be a source of pride for us. For instance, most participants at the "In-house conference on cross-cultural intervention: Clinical issues for art therapy" frequently expressed their ambivalence about identifying themselves with their cultural backgrounds (Bouquillard et al., 1991). Although many recognized the positive characteristics associated with belonging to a cultural group, the majority seemed to have difficulty integrating the negative aspects of their cultural heritage into their identity of who they were. One woman described feeling ashamed of her French elitist and colonialist ancestry, while another felt isolated as a Jew growing up among Christians, but also privileged (and guilty about these privileges) to enjoy both the Jewish and Christian holidays. Having the opportunity to express these feelings in a non-judgmental atmosphere will almost certainly help such therapists to come to terms with their own cultural backgrounds. Providing such opportunities is one of the biggest contributions that conferences on cross-cultural issues can make.



**In summary, as art therapists intentionally direct their energies toward becoming aware, knowledgeable and skilful in intercultural intervention, our intercultural competence will develop. It is important to remember that intercultural competence is not a summit to which we finally rise but, rather, a path which weaves up and down, in circles and perhaps even backwards at times. We stay on this path through our conscious intention to do so.**

## **Intercultural Intervention in Art Therapy**

### **Chapter 5:**

### **Conclusion**

#### **Summary**

**This thesis has explored issues of theory and practice relating to intercultural intervention in art therapy. Chapter 1 clarified the importance of considering the influence of culture upon the theory and practice of art therapy. It described the ethical responsibility that art therapists have in becoming aware of these issues as well as the potential negative consequences that could occur if such issues are not considered. The chapter illustrated why no one is exempt from cultural biases and suggested that the most profound impact that culture has upon our lives is the way in which it shapes our communication styles, value systems and perceptions of reality.**

**Operational definitions relevant to intercultural intervention in art therapy were clarified including concepts such as art therapy, culture, intercultural, multicultural, cross-cultural and transcultural, intercultural intervention, construct and personal construct system (Kelly, 1955), minority and majority culture, transference and countertransference, ethnocentrism and racism.**

**Chapter 2 included an art therapy literature review identifying and further developing potential theoretical and practical issues involved in an intercultural approach to art therapy intervention. There was no one principal author from whom**

the majority of this information was gathered. Rather, research was gathered from a diverse group of authors writing about various subjects. Some of the authors included in this section were Lewin (1990), Parker & Deręowski (1990), Campanelli (1990), Waller (1990), Malchiodi (1988), McNiff (1985), Liebmann (1986), Lofgren (1981), Gardano (1986), Congdon (1989), and Ives & Gardner (1984).

Chapter 2 also described basic terms, assumptions, theories, values, treatment goals and assessment procedures, often deemed as universal, such as mental health and pathology, were challenged. Personal anecdotes and examples from the art therapy literature were provided to show how the art therapeutic process and product are potentially influenced by cultural and idiosyncratic variables.

The influence of culture upon our perception and the resulting impact of this perception upon art therapy theory and practice were discussed. Our perception, being selective, both structures and limits our work as art therapists. Conscious awareness of these limitations as well as some means to working with these limitations were briefly discussed.

Chapter 3 broadened the discussion of intercultural intervention through incorporating research from outside of the field of art therapy. Authors such as Ivey (1980), Kelly (1955), Smith (1983), Sue & Sue (1990), Wildavsky (1989), and Das (1993) greatly contributed to this discussion. The issues touched upon in this chapter included those that had not yet been addressed by chapter 2 or that had required further clarification. All information included was analyzed for its relevance to the

field of art therapy. The chapter also described some practical approaches through which the intercultural issues may be addressed.

This chapter highlighted the need for art therapists to carefully examine the key assumptions and definitions they use in their theory and practise, including how they define a problem or help. The potential danger of using supposedly universal terms such as mental health, deviance, abnormality and pathology were also examined. Underlying these terms are assumptions which challenge the supposed neutrality of psychotherapists.

The value of using an eclectic and intentional approach to intercultural intervention was emphasized. This approach is generally not encouraged by mental health training programs. Training programs were criticized for not training their students to work effectively with culturally different populations. Several suggestions were presented to increase intercultural competency and overcome these problems.

It was also suggested that learning more about traditional modes of healing in various cultures and how to effectively deal with differences can ultimately lead us to value and see more clearly our own uniqueness as well as helping us work with our clients. Sue & Sue's (1990) description of racial/cultural identity development helps us to understand the possible issues that may arise when working with a client from a minority background.

Chapter 4 synthesized the issues presented in chapters 2 and 3 to discuss ways in which intercultural art therapy intervention could be improved. A single *modus operandi* for intervening interculturally was not deemed appropriate, given that no one

framework will work for all individuals, with all problems, under all situations. Instead, an intentional, systematic and eclectic approach to intercultural intervention in art therapy was suggested to meet the diverse needs of our clients.

Intercultural competence was deemed to be a dynamic rather than static process that grows and changes as our awareness, knowledge and skills expand. The majority of the chapter was dedicated to how we can become aware of, learn more about, and become more skilful in our intercultural interventions as art therapists. Although this process can be difficult at times, given that it requires us to look at our own prejudices and experiences of discrimination, the results of such explorations can be very rewarding, expanding our way of perceiving and being in our world and increasing our effectiveness as art therapists.

Our intercultural knowledge may be expanded through passive or active cross-cultural, intracultural, international or intercultural research (Sikkema & Niyekawa, 1987). Art therapy programs need instructors who have intercultural expertise in order to help both students and professionals deal with critical incidents as they arise. Suggestions were presented in regards to how such critical incidents could be processed to develop our intercultural awareness, knowledge and skills.

### Conclusions

The foundation for our beliefs, goals, wishes and desires is culture--a powerful force in our lives. In art therapy, it affects the interaction of client, art therapist, art

materials and forms, and the institutions containing them. Culture shapes how we perceive the world and how others in the world perceive us. We cannot separate ourselves from the environment in which we are shaped. Moreover, we must attempt to be sensitive to the cultural backgrounds of others. As a result, this thesis has suggested that the field of art therapy needs to put more emphasis on intercultural intervention.

Intercultural intervention is concerned with the dynamics that occur between people from different cultural backgrounds. It involves a multi-dimensional approach to therapy which is premised on the fact that we no longer can assume that one theoretical framework will work with all people under all circumstances. If we take our personal construct systems (Kelly, 1955) for granted, we may become confused, disoriented or perhaps even angered when others do not see the world as we do.

Since we can expect to encounter others whose world views differ from our own, it seems important to take steps to be better prepared to deal with these differences and help to make positive and appropriate changes in our clients' lives. As members of a culturally heterogenous society, we are likely to encounter cultural differences throughout our careers as art therapists. Thus, it has become an ethical responsibility for art therapists to become aware, knowledgeable and skilful in the theory and practice of intercultural intervention.

Although a great deal has been written by others on the subject of intercultural communication and intervention, a minimal amount of this knowledge seems to have been incorporated into art therapy theory and practice. This is one reason why art

therapists have tended to focus on the idiosyncratic and universal, rather than cultural, qualities of the imagery when they look at the art work produced by their clients. Very few references in the art therapy literature have noted the impact of culture upon such art products. Thus, there is a great need to identify the way in which culture influences the making and interpretation of art. This is especially important for the assessment process, which involves the analysis of art therapy products and processes. The use of space, media, composition, content and other elements are all potentially influenced by culture.

### **Results & Contributions**

By pointing to the need for art therapists to look at the impact of culture upon the therapeutic process, this thesis addresses an issue which has not been sufficiently addressed in the past. Particularly important is the need to look not only at the client's culture, but also at the culture of the art therapist and the institutions in which they interact.

There has been very little research that has looked at the impact of culture upon the values, education, and practice of art therapy. That which has been conducted has predominantly focused upon expanding our knowledge about particular cultural groups, rather than the dynamics occurring between groups. Introduction of the term intercultural into art therapy language helps us to focus upon these dynamics.

In addition, the concepts of both G. E. Kelly (1955) and A. Ivey (1980) have rarely been addressed in the art therapy literature. Their theories both enrich and expand the present theoretical foundations commonly accepted by most art therapists. Moreover, they direct us to look at the assumptions beneath the ideas and methods that we use in our day-to-day work with clients. Ivey's (1981) concept of intentionality encourages us to be committed to our psychotherapeutic theories and interventions without becoming rigid. Both he and Kelly have illustrated the importance of permeability in order to be flexible in our work as professional in the field of mental health. Permeability gives us the necessary perspective when we are confronted with difference which at first may appear odd or even threatening. A permeable approach gives us the required flexibility to deal with ambiguity, which, though difficult to contend with initially, can enrich and expand our way of seeing the world.

#### Limitations & Need for Further Research

When tackling a field as broad as intercultural intervention in art therapy, it is impossible to cover all of the issues in one thesis alone. Intercultural intervention can be very complex; there are many specific variables which I have not looked at which may need to be examined in future studies. Each of the sub-sections I have outlined in my thesis, such as assumptions, theoretical orientations, therapeutic strategies, could be developed into a thesis of its own.



Also, the impact of gender, class, and status differences within each culture, will each have a different cultural significance in different societies. In order to be adequately prepared to help their clients, art therapists working with people from different cultural backgrounds may need to familiarize themselves with the potential significance of all of these variables, especially the way in which they can influence the therapeutic intervention. In the case of a male therapist counselling a female client, for instance, the therapist's gender may be an underlying factor which negatively (or positively) affects their interaction together because of the client's (or therapist's) unconscious adoption of culture-specific behaviour related to gender. By being aware of this possibility, therapists are in a better position to avoid potential problems.

This thesis has called us to challenge our commonly held assumptions and the definitions which we use in our practice. Terms such as deviance, abnormality, pathology, minority, ethnocentrism, racism, and professional identity need to be discussed more in depth cross-culturally to bring out the issues. Each of these terms will reveal commonly held values and norms acquired through our educational and the cultures in which we live. Clarifying our biases helps us to take a position so that we may become more intentional in our intercultural interventions as art therapists.

Another issue not fully explored in the context of this thesis includes the needs of newly arrived immigrants. These needs will likely be very different from those of third or fourth generation Canadians sharing the same cultural roots. Furthermore, the concerns of refugees seeking political asylum are likely to differ from those of

immigrants arriving from politically stable, democratic countries. These are important considerations for art therapists who work with clients from other cultures. Additional research focusing on the needs of different cultural sub-groups, such as first-generation Canadians as compared to second-generation Canadians, would also be of potential benefit to many art therapists, especially if it is research which is done from an art therapy perspective.

Much more cross-cultural research is needed in areas such as cultural attitudes, values, beliefs, verbal and non-verbal communication styles, as well as healing practices within which art is an intrinsic part. The few examples that I did provide in this thesis only hint at the vast amount of information available in regards to the role, philosophy and practice of art in healing in non-Western cultures. There are many philosophical and anthropological works available to help us within this search. Expanding our knowledge and vision of the power of art in healing could only enrich our present knowledge of therapeutic interventions.

Intercultural training, as well, is only in its infancy. Attempts to convey the full impact of sociocultural variables upon the psychological well-being of our clients have only recently been incorporated into our training policies. As part of this training, art therapists may need to become more familiar with the wealth of literature written outside of the field of art therapy concerning intercultural, cross-cultural and intracultural research. As well, white cultural identity development and racism are important areas to consider including in art therapy training programs. I have taken some initial steps in this direction, but much more work is required.

Finally, empirical research is required to determine if the suggestions contained in chapter 4 of this thesis actually make a positive difference in our interventions. After all, the goal of this thesis was to suggest a direction toward a *modus operandi* for intercultural interventions. Practice makes learning active. By testing out our developing intercultural knowledge, awareness and skills, we can assess their value and efficacy. Otherwise they remain merely speculative. Learning more about our cultural identities, how they develop, and how they influence our relationships teach us much about who we are. There is still much work to be done in the field of intercultural art therapy intervention.

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