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Sara R. Schieffelin
Using Art Making in Cross-
Cultural Clinical Therapy

ABSTRACT

Literature in the field of multicultural counseling and therapy supports the need to develop effective theories and practical models for working cross-culturally. Literature in the field of art therapy provides strong evidence that art-making can be a successful tool for therapeutic use with a wide range of clients. Yet there is little research linking these two fields. This theoretical study aims to extend the limited research on this topic by looking at the literature from these two fields, and examining how art-making in therapy can be used as a tool to alleviate some of the problems that can occur when traditional verbal psychotherapy is applied to cross-cultural and cross-linguistic therapeutic situations. The findings in the study point to the conclusions that art-making can be used in cross-cultural and cross-linguistic therapeutic settings to enhance communication by bridging language and cultural barriers, to strengthen the therapeutic relationship, and to increase engagement and understanding between practitioner and client.

USING ART MAKING IN CROSS-CULTURAL CLINICAL THERAPY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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2008

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CHAPTER I

INTRODUCTION

Psychotherapy, first developed and practiced by Sigmund Freud in Vienna during the late 1800s, is used in clinical social work settings to help individuals, families and groups gain insight into their mental, emotional and relational problems, and address these problems in ways that, ideally, lead to healthy and positive change. Over the past hundred or so years many theorists and practitioners—mostly of European and North American descent—have added to, developed, critiqued and changed Freud’s original ideas, theories, and practice modalities. This body of knowledge comprises contemporary psychodynamic clinical theory, and is used by social work practitioners throughout the United States to address a wide range of client groups.

Scholars such as Perez-Foster, Moskowitz & Javier (1996) point out that every thinker and practitioner in the field, from Freud until now, has been the product of their cultural environment and thus their theories are reflective of their respective cultures. Since most psychotherapeutic theorists and practitioners have been of Western descent, Western concepts and ideals have inherently been built into psychotherapeutic thought and practice (Dyche & Zayas, 2001; Ivey, D'Andrea, Ivey & Simek-Morgan, 2007; Lo & Fung, 2003; Nelson-Jones, 2002; Roland, 1996; Seeley, 2000; Sue & Sue, 2003).

In his book *Therapeutic Communication*, Paul Watchtel (1993) states "psychotherapy is the talking cure" (p. 1). According to Watchtel (1993), verbal

communication that occurs between client and practitioner can make a crucial difference as to whether effective therapy has taken place. The aim of Wachtel's book is to help social work practitioners hone their therapeutic techniques by illustrating how to use words and verbal response most effectively. Thus for Wachtel, effective verbal communication is considered the basis of successful psychotherapeutic interventions.

Yet what happens when therapist and client do not share the same cultural background and proficiency in the same language? Can Western psychotherapeutic theories and interventions apply to non-Western clients? Can practitioner and client successfully engage in verbal psychotherapy across a linguistic divide?

As our world becomes a "global village," social work practitioners often find themselves working with an increasingly diverse client population—clients from different cultural backgrounds who speak an assortment of languages. As stated above, it is widely acknowledged that the various psychodynamic theories that make up psychotherapy developed from specific Western cultural contexts and historical times, cannot necessarily be universally applied, and are not necessarily translatable across the linguistic or the cultural divide (Ivey, et al., 2007; Lo & Fung, 2003; Seeley, 2000; Sue & Sue, 2003). Many scholars, such as Ivey, et al. (2007), Lo & Fung (2003), Seeley (2000) and Sue & Sue (2003) argue that traditional verbal psychotherapy as practiced in the United States is not necessarily an effective or appropriate means of treating the mental health needs of clients from non-Western backgrounds, due to both the inherent cultural biases of the theoretical and practical models, and due to the traditional mode of delivery of psychotherapy that is generally Standard English. How, then, can client and clinician,

working cross-culturally, engage together in a way that can make effective therapeutic communication possible?

Because linguistic and cultural barriers between practitioners and clients are sometimes too vast to make traditional talk psychotherapy particularly useful or relevant, there is an increasing demand for alternative, culturally appropriate mental health services (Ivey et al., 2007; Lo & Fung, 2003; Seeley, 2000; Sue & Sue, 2003). The literature stresses that social work practitioners be culturally competent, and offers various theories and practice modalities regarding how to most effectively work cross-culturally (American Psychiatric Association, 2000; Dyche & Zayas, 1995, 2001; Freeman, 1993; Hamilton-Mason, 2004; Hall, 2002 ; Healy, 2001; Lo & Fung, 2003; Nelson-Jones, 2002; Seeley, 2000; Sue & Sue, 2003; Wessells, 2001). While most of the literature does not call for discarding traditional psychotherapy completely, it does call for alternative theoretical and practical models that will enhance communication and understanding between clinician and client, and lead to more productive therapy and more successful outcomes.

Psychotherapeutic theory and practice needs to be modified, expanded and built on in order for it to be more applicable to non-Western cultural contexts. Cooper and Lesser (2005) note that there are various recommendations about which psychotherapies are effective in cross-cultural clinical practice, and that considerable disagreement within the field exist. They assert that:

In general, it appears that therapists' training experiences, as well as their racial and cultural perspectives, shape their thinking about what approaches work best with different racial and cultural groups. Our [Cooper & Lesser's] thinking is that most of the time, *all* of the major theoretical orientations on which clinical practice is based can be adapted to work with clients of various racial and cultural groups. It is not the therapist's theoretical orientation, per se, but instead the cultural and racial sensitivity, ability to set goals commensurate with the client's

level of acculturation, and selection of a modality that is tailored to the client's needs that makes for effective cross-cultural practice. (p. 65)

I agree with Cooper & Lesser's (2005) and other scholars' claim that psychotherapy does not need to be completely discarded when working across cultures. I assert that aspects of psychotherapy and all of the theoretical orientations on which clinical practice is based have aspects that can be useful when treating clients from different cultures. I also assert that psychotherapy needs to be expanded, modified, and adapted to fit clients from various cultural backgrounds: a therapist cannot stick to traditional verbal psychotherapy if it does not suit the clinical situation. Thus therapists need to have a large repertoire of theories and practice modalities from which to draw, and these may include some non-traditional or alternative models.

There is an increasing body of literature that asserts the effectiveness of art-making in therapy as an alternative mode to working with a broad spectrum of populations with whom traditional verbal psychotherapy may not be the best option (Malchiodi, 1998; Rubin, 2005). Making art in therapy can serve as an alternate way for clients and clinicians to communicate, as well as a non-threatening way to build rapport and strengthen the therapeutic relationship (Malchiodi, 1998; Rubin, 2005). Further, the act of producing art can itself be therapeutic, and has been associated with enhancing physical health and well being, releasing traumatic experiences, increasing emotional and mental flexibility, and alleviating stress, physical pain, and depression (Malchiodi, 1998; Rubin, 2005).

It is my contention that using art-making as a therapeutic modality can serve as one way of easing some of the difficulties that are encountered in cross-cultural therapy.

In this study, which is theoretical in nature, I will discuss some of the critiques and difficulties of using traditional verbal psychotherapy in cross-cultural and cross-linguistic therapy, and will examine how art can be used as a therapeutic tool to ease some of these difficulties.

Ivey and colleagues (2007), for instance, urge social workers—and other professionals in the mental health field who work with persons from diverse backgrounds—to be creative, flexible and open-minded in their use of theories and methods associated with different helping models. They believe therapists need to expand their communication repertoire, and use creativity and flexibility in their attempts to effectively communicate with their culturally different client (Ivey, et al, 2007), and they promote an "eclectic" approach to therapy that uses a wide range of theoretical perspectives, and practice methods (Rigazio-DiGilio, 2001, as cited in Ivey et al., 2007, p. 5). I support Ivey, et al.'s (2007) position that a diversity of theories and methods should be used when working with clients from diverse cultural backgrounds, and assert that art and art therapy could be considered as one of these methods for practice.

Literature

Cross-cultural therapy

According to current literature on this subject, there are many problems that can arise in cross-cultural and cross-linguistic therapy when it is based on traditional psychotherapeutic theory and practice (Dyche & Zayas, 2001; Lo & Fung, 2003; Nelson-Jones, 2002; Seeley, 2000; Sue & Sue, 2003). First, talk therapy is monolingual and places a high value on verbal expressiveness. This can be a problem for clients whose

first language is not English as they may not be able to convey complex thoughts and emotions in English, and as a result, lose a lot of their ability for verbal expression in therapy (Lo & Fung, 2003; Seeley, 2000; Sue & Sue, 2003). Second, when client and therapist do not share proficiency in a common tongue, there is a great deal of room for misunderstanding, and consequently for frustration, to emerge (Seeley, 2000). This can be detrimental to the building of a solid therapeutic relationship or working alliance, which is essential if effective therapy is to take place. Third, when clients do not have sophisticated verbal capacities in the language of therapy—generally Standard English—they can be misinterpreted by their therapist as difficult or resistant on the basis of their lack of linguistic abilities. This can lead to over-pathologizing and misdiagnosing of these clients, as well as culturally insensitive or inappropriate interventions (Seeley, 2000). All of the above mentioned issues can lead to premature termination of the therapeutic relationship, which is a very common outcome in cross-cultural and cross-linguistic therapeutic encounters (Lo & Fung, 2003; Seeley, 2000; Sue & Sue, 2003).

Art-making in Therapy

Art and symbols cut through linguistic divides, and "since our earliest recorded history, art has . . . served as a means of reparation, rehabilitation, and transformation, and has been used to restore physical, psychological, and spiritual well being" (Malchiodi, 1998, p XIII). Art therapy as an established discipline is relatively new, though art-making in therapy has occurred since at least the time of Anna Freud, and both Sigmund Freud and Carl Jung were interested in art and symbols as they relate to the unconscious and emotions. Freud (as cited in Malchiodi, 1998) acknowledged that art is closer to the unconscious than words because our visual perceptions precede our capacity

for verbal expression. Jung (as cited in Malchiodi, 1998) was interested in the visual images and symbols of dreams and art, and how they can lead to a deeper understanding of emotional experiences that are contained within them. Thus, art-making in therapy and ideas about the connection between art symbols and the unconscious, have been present in psychotherapeutic thought and practice since the beginnings of the discipline.

There is growing empirical research indicating the usefulness of art-making in therapy for a broad spectrum of populations such as children, the elderly, the chronically mentally and physically ill, persons with PTSD or histories of trauma, persons with developmental delays, persons with communication problems including mutism and deafness, people who are shy or verbally inhibited, and people with eating disorders and substance abuse problems, just to name a few (Bruck, 1996; Hanes, 2001; Keeling & Bermudez, 2006; Korlin, Nyback, & Goldberg, 2000; Malchiodi, 1998; Rousseau, Singh, Lacroix, Bagilishya & Measham, 2004; Rubin, 2005). Often, clients from these groups are unable to engage in traditional verbal psychotherapy: art-making presents an alternative to working with them in a therapeutic context. While there is an abundance of literature surrounding the use of art-making in therapy as an effective mode of working with the above mentioned client groups (Bruck, 1996; Hanes, 2001; Keeling & Bermudez, 2006; Korlin, Nyback, & Goldberg, 2000; Malchiodi, 1998; Rousseau, Singh, Lacroix, Bagilishya & Measham, 2004; Rubin, 2005), there is a dearth of literature surrounding the use of art-making in cross-cultural and cross-linguistic therapy.

Methodology

Literature in the field of multicultural counseling and therapy supports the need to develop effective theories and practical methods for working cross-culturally. Literature in the field of art therapy provides strong evidence that art-making can be a successful tool for therapeutic use with a wide range of clients. Yet there is little research linking these two fields. In this theoretical study I aim to extend the limited research on this topic by looking at the literature from these two fields, and examining how art-making in therapy can be used to alleviate some of the problems that can occur when traditional psychotherapy is applied to cross-cultural and cross-linguistic therapeutic situations.

Cross-cultural therapy

In Chapter II I will provide a review of the literature from the field of cross-cultural therapy, with emphasis on the inherent Western cultural bias of traditional talk psychotherapy. I will begin this chapter with a brief discussion of the history of psychotherapeutic thought, with emphasis on the inherent culture-bound nature of psychodynamic theory. I will then consider globalization and the impact that it has made on social work practice in terms of increasing the diversity of client populations. Next, I will present an overview of some of the original and current writers and thinkers who have looked at the issues of intercultural therapy, and discuss their contributions to this topic. I will introduce the Code of Ethics of the National Association of Social Workers (1996), specifically the section on cultural competency; the Surgeon General's 2001 report on Mental Health: Culture, Race, Ethnicity; and the cultural formulation section of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSMIV-TR) (2000), as all these texts highlight the need for mental health practitioners to consider the cultural contexts of their clients. I will end this chapter with a discussion

of some of the barriers to intercultural therapy that I will address later, including issues of language, issues in trust and relationship building, and issues of drop-out and early termination in intercultural therapy.

Art therapy and art-making in therapy

In Chapter III I will provide a review of the literature on the field of art therapy. I will begin this chapter with a brief history of art therapy by introducing some of the major contributors to the field and reviewing some of the important literature. Next, I will discuss the benefits of using art therapy as they are presented in the literature, then I will address the question of which clients groups would benefit from art therapy according to the literature. In this chapter I will also point out the lack of existing literature surrounding the use of art therapy in cross-cultural and cross-linguistic therapeutic work, thus highlighting the need for this study and further research on this topic. Finally, I will offer a discussion of the much-debated definition of art therapy, and will outline how the term will be used in this paper.

Discussion and conclusion

In the final chapter of this study, Chapter IV, I will offer a synthesis of these two bodies of social work knowledge—multi-cultural counseling/therapy and art therapy—and illustrate, through the use of a case example, how art-making can be used as a tool to enhance cross-cultural and cross-linguistic therapy. In this section I will offer a recap of the issues that can occur in cross-cultural therapy, then point out the ways that using art-making in therapy would help to alleviate these issues. I will identify the strengths and weaknesses of the theoretical methodology for conducting research on this topic, and highlight some of the study's limitations and biases. Finally I will discuss the

implications that this research has for social work practice and offer suggestions for further research on this and related subjects.

Terms and definitions

Before going on to the next chapter, it is important to identify and clarify some key terms and definitions that appear in this study.

Culture is a complex and elusive term. According to the New Webster's Dictionary and Thesaurus of the English Language, culture is "the social and religious structures and intellectual and artistic manifestations etc. that characterize a society" (p. 235). Nelson-Jones (2002) offers a few definitions of culture that illustrate some of the variety of meanings associated with the term:

Herkovits (1948) views culture as that part of the environment that is shaped or created by humans. Spindler . . . defines culture as 'a patterned system of tradition-derived norms influencing behavior' (Spindler, 1963, p. 7) . . . Another definition of culture is that it refers to 'an integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social group' (Cross et al., 1989, p. iv). A colloquial definition of culture is 'the way we do things here.' (p. 134)

The term *multicultural therapy*, which will be used interchangeably with the terms *cross-cultural therapy* and *intercultural therapy*, will refer to clinical situations where client and therapist do not share the same cultural background.

The term *Western culture* or *Western*, which will be used interchangeably with the term *dominant culture*, will refer to the culture and background of people from Western European and North American descent who live in, and currently make up, the majority of the population of the United States.

According to the Carnegie Endowment for International Peace, *globalization* is a process of interaction and integration among the people, companies and governments of different nations, and is driven by economics, information technology and increased facility of transportation. Globalization produces effects on the environment, culture, political systems, economic development and prosperity, and human physical well being in societies around the world (Carnegie Endowment for International Peace, www.globalization101.org. Visited on 11/7/07). Due to the process of globalization, global interdependence has grown so enormously over the past few decades that its influence on nearly every sphere of life across the globe is virtually undeniable (Healy, 2001). President Clinton (1993) noted in his first inaugural address that is difficult to separate national from international problems because "there is no longer a clear division between what is foreign and what is domestic. The world economy, the world environment, the world AIDS crisis, the world arms race—they affect us all" (p. A15, as cited in Healy, 2001, p. 3). Thus, due to globalization, the action of one country—politically, economically, and socially—can directly and indirectly influence other countries around the world (Healy, 2001).

The term *art therapy*, which will be used interchangeable with the term *art-making in therapy* and which will be explained more completely in Chapter III, will refer to art-making in therapy by social workers and other mental health professional as part of their practice repertoire. This is in contrast to the profession of art therapy, which requires training and licensure, and has its own set of standards and ethics for practice. Art therapy's recognition as an independent field has meant that there are limits to the scope of practice as defined by its professional association, the American Art Therapy

Association (AATA), yet art-making in clinical settings is still used by many practitioners in the mental health field, such as social workers, who do not have specific degrees or qualifications in art therapy. This thesis is aimed at practitioners such as these.

Importance to the Field of Social Work

According to the first sentence of the preamble of the National Association of Social Workers (NASW) Code of Ethics (1996), "the primary mission of the social work profession is to enhance human well-being . . . with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty." In the United States many of the groups that are vulnerable, oppressed and poor are from non-dominant cultural groups, and are often in need of mental health services (U.S. Department of Health and Human Services, 2001, *Mental Health: culture, race, and ethnicity—a supplement to mental health: a report of the Surgeon General*). As I have written above, there are many issues—such as a lack of therapeutic engagement and early termination—that emerge when clients from non-dominant cultural groups present for therapy (Lo & Fung, 2003; Seeley, 2000; Sue & Sue 2003). Therefore, developing effective therapeutic modalities that will enhance engagement of and communication with these populations is critical for clinical social work. Further, research on using art-making in cross-cultural and cross-linguistic therapeutic encounters is useful at this time because it attempts to fill a gap in the social work literature and may encourage future exploration of this topic. This study will seek to demonstrate that art-making in the cross-cultural therapeutic encounter may be one method for clinicians to use to facilitate

effective communication, improve engagement, and increase positive outcomes in cross-cultural and cross-linguistic therapy.

CHAPTER II

MULTICULTURAL COUNSELING

Freud's legacy continues to compromise the psychotherapeutic treatment of patients from other cultures and ethnic groups. Given the newly global character of the psychological clinic, it is a legacy with profound implication for contemporary psychotherapy. (Seeley, 2000, p. 7)

Traditional verbal psychodynamic clinical theory and practice as developed in the West is not necessarily applicable or useful to clients from other cultures and ethnic groups. Over the past fifty years, as global interdependence has increased and Western mental health workers have become more likely to work with clients who are culturally different from themselves, there has been a great deal of work in the social work and related fields to critique traditional psychotherapeutic theory and techniques, and to broaden perspectives and approaches to include those that are more appropriate for non-Western clients.

This chapter is important because it will offer a brief history of psychodynamic theory as it relates to cross-cultural therapeutic work, and it will set the stage for Chapter IV in which I present the ways that art and art therapy may be used to alleviate some issues that can arise in cross-cultural therapy. It is important to acknowledge that there is a great deal of literature on the topic of intercultural therapy (Ponterotto, Casas, Suzuki & Alexander, 2001) and critiques of traditional psychodynamic theory and practice as they relate to cross-cultural therapy. This chapter is not an exhaustive discussion of these

topics, but rather provides a background that will help to frame the issues that can occur in cross-cultural therapy.

History of the problem

Freud and his theories

Psychodynamic clinical theory began in Vienna in the late 19th and early 20th century with Sigmund Freud and his drive and structural theories. In drive theory, the human psyche is understood as being a "seething cauldron" (Berzoff, Flanagan & Hertz, 2002) of sexual and aggressive impulses or drives, and is composed of three structures—the ID, EGO and Superego—which mediate human behavior. Briefly, the ID's function is to discharge the sexual and aggressive drives in an individual. The superego is the moral conscience of the mind, and dictates what one should and should not do, based on societal norms and personal beliefs about right and wrong. The Ego is the mediator between the ID and the Superego, and serves as the decision maker that collects data from these two apparatuses, and then acts based on that data. Freud's theories were based on the Western conception of the individual as the basic social unit, and thus for Freud the aim of psychotherapy was to cure the individual from his conflicting sexual and aggressive drives, arising in the ID, which prevent him from successful functioning in society according to the Superego.

Freud, and his collaborator Joseph Breuer, discovered that an effective mode to cure patients of unwanted symptoms due to their conflicting drives was through suggestions

and questions relating to the patients past experiences, and allowing the client to verbally respond, "[Freud] and Breuer discovered that this *talk* and the emotional discharge it produced when the memory of the original disturbing incident emerged had a curative effect. Through this process . . . the symptoms disappeared" (Mitchell & Black, 1995, p. 3, italics added). Thus psychotherapy became "the talking cure" in which client and clinician used verbal communication in order to help the client resolve psychological and emotional difficulties.

It has been well documented in the literature by such authors as Ivey, et al. (2007), Mitchell & Black (1995), Perez Foster (1996), Perez Foster, Moskowitz & Javier (1996), Seeley (2000), and Berzoff, Flanagan & Hertz (2002), that the theories of Sigmund Freud were greatly influenced by his particular historical and cultural context. Perez Foster (1996) writes:

Born out of the intellectual momentum of the European Enlightenment, Freud's theory of human behavior also reflected the social mores of nineteenth century Vienna. He lived in a Victorian world that placed particular emphasis on social class distinction, appropriate behavioral comportment, and affective restraint. His instinct metapsychology reflected this sociocultural story. He saw the control of impulsive life as the primary imperative of the human condition at that moment in time. Herein, he concluded, lay the source of psychic conflict and psychic pathology. (p. 6)

Psychoanalytic theory continued to develop in Europe in the early 20th century and was elaborated on by analysts who immigrated to the United States after World War II (Berzoff, et al., 2002). Since that time, many theorists and practitioners, mostly Western descent, have expanded on, offered critiques of, and made changes to Freud's original ideas of how the mind is structured, and how human problems are understood. This body of knowledge comprises contemporary psychodynamic clinical theory, and it

is complex, intricate and detailed. Various scholars, including Berzoff, et al. (2002), and Perez Foster, et al. (1996) assert that Freud and every psychoanalytic theorist after him were the products of their particular cultural surrounding, and thus their theories are reflective of their respective cultures. Perez Foster, et al. (1996) note that psychoanalysis in the United States mirrors the dominant culture of the country itself:

The analytic movement in the United States elaborated a view of the individual and his or her functions that essentially described the ideal of the American cultural ethic: self-sufficiency, self-actualization, forward mobility, and conflict-free action in the world. Thusly informed is our psychodynamically oriented work in the United States and thusly defined are the criteria by which we assess our patients. As American psychotherapists, we are part and parcel of the society that views assertion and independent self-direction as the veritable *essence* of good life. And these are the treatment goals that we either explicitly or implicitly establish for our patients. (pp. 6-7)

Many other scholars, as well, have pointed out that Western ideals, which generally hold a universalistic understanding of the human condition, have inherently been built into psychodynamic thought and practice (Dyche & Zayas, 2001; Ivey, et al., 2007; Lo & Fung, 2003; Nelson-Jones, 2002; Ponterotto, et al., 2001; Roland, 1996; Seeley, 2000; Sue & Sue, 2003; Swenson, 1998). These assumptions place a high value on such traits as verbal self-expression, rational thinking, secular and scientific views of the world and the ideal of the autonomous individual. Yet these characteristics are not necessarily emphasized or prioritized in the same ways in other cultures. Swenson (1998) points out that "[Western] universalistic approaches [to therapy] . . . unwittingly impose cultural norms and values of the dominant culture while claiming to be culture-free" (p. 531). Thus these approaches can potentially clash with ideals that clients from other cultures hold.

The beginnings of social work in the United States and the current "global clinic"

The first social work organizations in the United States—the charity organizations and the settlement houses—were developed to meet the needs of the urban poor who were generally new immigrants from Europe who had come in search of a better life in America. Some scholars argue that the workers in these organizations, who were generally middle- to upper-class, college educated men and women, often imposed their values on the poor immigrants, and thus seemed to be making “an attempt to strip these people of their native culture and thereby ensure the stability of the existing American middle class values of the settlement workers” (Barbuto, 1999, p. ix). Due to the effects of globalization, social workers in the United States are still working with diverse client populations, but there is no longer an emphasis in the profession on "assimilating" culturally diverse clients.

The contemporary social work profession has been impacted by globalization (Dyche & Zayas, 2001; Healy, 2001; Ivey et al., 2007; Lo & Fung, 2003; Perez Foster et al., 1996; Sue & Sue, 2000; Seeley, 2003). Social work practice and policies are now, more than ever, influenced by global phenomenon such as immigration and migration, war, civil strife, ethnic cleansing, natural disasters, and the worldwide spread of AIDS (Healy, 2001). Due to the facility of transportation, which has increased the ability of humans to move around the world, social work practitioners are now increasingly likely to treat clients who come from cultural backgrounds different from themselves either domestically in the United States (Lo & Fung, 2003; Seeley, 2003; Sue & Sue, 2000), or in the international arena (Healy, 2001). Walter Lorenz (1997, p. 2), as cited in Healy (2001), eloquently makes the case for the need of social work practitioners to think on an intercultural level:

'Going beyond the national level' in social work cannot be the personal hobby of a few specialists who are dealing with migrant and refugee groups or with ethnic minorities . . . or of the few idealists who want to promote international exchanges to widen their horizons and to learn more about methods and practices in other countries. On the contrary, all social work is enmeshed in global processes of change. (p. 2)

Thus, in this modern, global world, social work as a profession needs to expand its theories and practices to address the needs of multicultural clients (Dyche & Zayas, 2001; Healy, 2001; Ivey, et al., 2007; Lo & Fung, 2003; Perez Foster, et al., 1996; Sue & Sue, 2000; Seeley, 2003).

Multicultural awareness in the mental health profession

In the United States in late 1960's and the 70's, it began to be considered in the mental health field that traditional verbal psychotherapy as conceived of in the West was not necessarily applicable to diverse client populations. Ivey, et al. (2007) identify the "genesis" (p. 31) of multicultural counseling in the United States as occurring in conjunction with the civil rights movement of the late 60's. According to Reed (1964), and Vontress (1969, 1971) as cited in Ivey, et al. (2007), it was during this time that various practitioners and theorists, who were mostly women and people of color, began to critique traditional psychotherapeutic models, and present alternative ways of envisioning mental health and disorder that took gender and culture into account, and offered helping strategies that were more responsive to client diversity. Other authors point to the late 1970s as the time when these critiques of traditional psychotherapy emerged, as it was during this time that the mental health field began to see an increasing number of clients from poor and ethnically diverse backgrounds (Abramovitz & Murray, 1983; Atkinson, 1985; Sue, 1988, as cited in Perez Foster, et al., 1996). Regardless of

when the actual genesis was, it became apparent to some scholars and practitioners in the field, that traditional psychoanalytic theory was not necessarily applicable to or effective for diverse groups of people.

In 1974 the first edition of *Culture and Psychotherapy*, by Theodora Able and Rhoda Metraux, was published. This book acknowledged the need for the consideration of culture in the disciplines that have to do with human behavior, and the goal of the book was "to demonstrate the relevance of cultural patterning to the many kinds of situations with which mental health professionals from different disciplines—psychoanalysis, psychology, social work, psychiatry, psychiatric nursing, guidance and so on—are concerned" (Able, Metraux & Roll, 1986, p. 7). This book acknowledged that mental health practitioners, in their treatment of culturally diverse clients, may be bound by particular theoretical orientation and by culturally determined conceptions of "normality and good mental health" (Able, Metraux & Roll, 1986, p. 7), and suggested that practitioners need to expand their theories and practices to become more culturally relevant and sensitive. While research and literature continued on this topic throughout the 80s, in the mid-1990s, Perez Foster, et al. (1996) charged that the mental health profession as a whole had not yet adequately considered issues of diversity:

We are well aware that American residents span a unique range of cultural, racial, and socio-economic groups. What we have not been so willing to acknowledge is that this diversity leads to questions about the generalization of psychodynamic theories beyond their original patient population—the educated person of European descent. (Perez Foster, et al., 1996, p. xiii)

Judging by the plethora of sources related to the topic of multicultural theory and practice in the mental health world, it is evident that this is still a relevant and contentious issue today.

Currently there are many thinkers, writers, and practitioners in the mental health field who are considering the myriad issues surrounding mental health treatment of minority, and culturally and ethnically diverse clients (Dyche & Zayas, 2001; Ivey, et al. 2007; Lo & Fung, 2003; Nelson-Jones, 2002; Ponterotto, et al., 2001; Seeley, 2000; Sue & Sue, 2003 for example). For instance, Sue & Sue (2003) describe psychotherapy as a discipline which excludes three-fourths of the World's population. According to Sue & Sue (2003), Western values—including individualism, psychological mindedness, and using rational approaches to problem solve—are implicit in psychotherapy. They note that counseling and psychology in Western culture is linear, analytical, verbal, and focused on left-brain functioning, and they attribute this to attempts of the field to mimic the physical sciences, saying "Western society tends to emphasize the so-called scientific method, which involves objective, rational, linear thinking" (Sue & Sue, 2003, p. 112). The emphasis on and elevation of left-brain functions in psychotherapy is in contrast to the philosophies of many cultures that value a more non-linear, intuitive, holistic, harmonious, and thus "right-brained" approach to the world (Sue & Sue, 2003). Sue's & Sue's (2003) thesis is that the Western or Euro-American perspective of what good mental health is, as promoted in counseling and psychotherapy, has harmed culturally diverse groups by "invalidating their life experiences, by defining their cultural values or differences as deviant and pathological, by denying them culturally appropriate care, and by imposing the values of a dominant culture upon them" (p. 8).

Sue & Sue (2003), Seeley (2000) and others, challenge mental health professional to

(a) reach out and understand the worldviews, cultural values, and life circumstance of their culturally diverse clients; (b) free themselves from the cultural conditioning of what they believe are correct therapeutic practices; (c) develop new but culturally sensitive methods of working with clients; and (d) play new roles outside conventional psychotherapy in the helping process. (Atkinson, Thompson & Grant, 1995; D.W. Sue, et al., 1998, as cited in Sue & Sue, 2003)

Thus scholars in the field of multicultural counseling do not call for the complete disposal of traditional psychotherapeutic thought and practice, but rather ask theorists and practitioners to increase their cultural competency, and to develop theories and methods that will better serve clients from diverse backgrounds.

Cultural competency in Social Work

Founded on working with immigrants, social work in the United States has always been focused on treating clients from other cultures, yet there is now a push for clinician cultural competency that asserts that clinicians need to be culturally "literate" and understand their clients' particular backgrounds, so as not impose the values of the dominant cultural on their culturally different client. The Code of Ethics for the NASW (1996) includes a section on cultural competence and social diversity which states:

- (a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
- (b) Social workers should have a knowledge base of their client's cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.
- (c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, [and] color. (p. 9)

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Many contemporary scholars such as Ivey, et al. (2007), Pedersen, et al. (2008), Perez Foster, et al. (1996), and Sue & Sue (2003) highlight the importance of the NASW

ethical standard for cultural competency, and stress the need of mental health practitioners for "acquiring sufficient cultural literacy and competence to understand and to respect the cultural beliefs of the client" (Falicov, 1998, p. 5), and "understanding the value system of families from other cultures and how those values influence the behaviors of the family members" (Cooper & Lesser, 2005, p. 64). Various authors cite different techniques for developing cultural competency (see, for example, Seeley, 2000 and Sue & Sue, 2003) and there are many works, both in social work and related literature, which offer information to practitioners about particular ethnic, cultural or racial groups (see, for example, Falicov, 1998; and Boyd-Franklin, 2003).

Surgeon General's Report

In 2001 the office of the Surgeon General caught up with social work and the many other voices in the mental health field advocating for changes relating to cultural awareness, and published a report calling for these changes. According to this landmark report entitled "Mental Health: Culture, Race, Ethnicity" (U.S. DHHS, 2001) there is a great need to address the mental health needs of the growing multicultural population of the United States. By the year 2025, four major ethnic groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans—will make up over 40% of the country's population (U.S. Census as cited in Mental Health: Culture, Race, Ethnicity—Supplement to Mental Health: Report of the Surgeon General, 2001). According to the Mental Health Report, these and other culturally and ethnically diverse groups hold a minority or "population at risk" (Swenson, 1998, p. 528) status within the United States, that is, they have limited political power and social resources, as well as unequal access to various opportunities,

social rewards, and social status. Coupled with their minority or "at risk" status, these groups are overrepresented in the nation's vulnerable, high-needs groups, such as homeless and incarcerated persons (Mental Health: Culture, Race, Ethnicity—Supplement to Mental Health: Report of the Surgeon General, 2001). These are often the groups that are most in need of mental health and other supportive services. Yet, as the Surgeon General's report goes on to say, it is precisely these groups that are less likely to use existing mental health services, and when they do, they are more likely to be provided with poorer quality care (Lo & Fung, 2003; Mental Health: Culture, Race, Ethnicity—Supplement to Mental Health: Report of the Surgeon General, 2001; Seeley, 2003; Sue & Sue, 2000). In sum, "lower utilization and poorer quality of care, means that minority communities have a higher proportion of individuals with unmet mental health needs" (Mental Health: Culture, Race, Ethnicity—Supplement to Mental Health: Report of the Surgeon General, 2001, Introduction, p. 1). This report discusses barriers that may deter minority clients from seeking mental health treatment. These barriers include: the cost of care, social stigma, disorganization of services, clinicians' lack of awareness of cultural issues, clinicians' bias, clinician's inability to speak the client's language, and the client's fear or mistrust of treatment or services (Mental Health: Culture, Race, Ethnicity—Supplement to Mental Heal: Report of the Surgeon General, 2001). The conclusion of the Surgeon General's report is that people from a wide range of cultural groups in the United States lack access to, or underutilize, mental health services. When they do enter treatment, they are often misunderstood, misdiagnosed, or given inferior care (Seeley, 2000). Clearly, this is a problem that needs to be addressed by professionals in social work and related fields.

DSMIV-TR

The latest edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (2000)(DSMIV-TR) includes a section on cultural formulation in order to guide mental health professional in systematically assessing clients for cultural influences that may have a bearing on diagnosis and treatment (Mezzich, 1995, as cited in Lo & Fung, 2003). For the practitioner, this process consists of: 1) examining clients' cultural identity; 2) looking for cultural explanation for clients' illness; 3) looking at cultural factors related to the psychosocial environment and level of functioning; 4) examining any cultural elements of the therapist-client relationship that might be relevant; and 5) performing an overall cultural assessment for diagnosis and care (Lo and Fung, 2003). The inclusion of the cultural formulation section into the DSMIV-TR is an important step in the field of multi-cultural counseling and therapy, as it serves as an acknowledgement by the American Psychiatric Association (APA) that culture is indeed a factor which must be taken into account when assessing, diagnosing and treating clients.

Yet even with all the research, literature and practice surrounding issues of culturally competency and multicultural awareness, social work and related fields are still not always providing culturally appropriate therapy to multicultural clients. The next section of this chapter will explore some of the issues as they present in contemporary cross-cultural therapy.

Barriers to Multicultural Counseling

As described in the previous sections of this chapter, psychodynamic clinical theory historically has been insensitive to the diverse needs and worldviews of clients

from non-Western backgrounds. This section will discuss some of the barriers to multicultural counseling as presented by contemporary thinkers and writers. While there are many, these particular barriers are being examined because they will be identified later in this thesis as barriers that can be addressed using art-making as a tool in therapy.

One major barrier that can occur in multicultural counseling is the linguistic barrier. Psychotherapy has historically been referred to as the "talking cure," and the language in which it has been generally conducted is Standard English. Authors such as Sue & Sue (2003) note that ever since Freud developed the *talking cure*, psychotherapy required that clients must be able to verbalize their thoughts and feelings to a practitioner in order to receive the necessary help. This puts clients who do not have a solid command of English at a distinct disadvantage in terms of receiving therapy, because they may not have the ability for verbal expression that is considered necessary in therapy (Lo & Fung, 2003; Seeley, 2000; Sue & Sue, 2003). Further, when a client and therapist have difficulties understanding each other due to language difference, there is a great deal of room for misunderstanding to emerge. Clients are often placed in the position of having to explain themselves and their culture to a therapist from a different culture. As Seeley (2000) writes about clients working cross-culturally with therapists "... as they [the clients] faced psychotherapists who knew neither their native language nor their culture, the problems of translation were primarily theirs, in that it was incumbent upon them to make their difficulties comprehensible to their therapists" (p. 232). This means that the focus of the clinical encounter is diverted away from client issues, and instead becomes focused on issues of translation. This can lead to misunderstanding and frustration on both the therapist's and the client's part, and this, in turn, can be detrimental

to building a successful therapeutic relationship. Sue & Sue (2003) acknowledge that breakdowns in communication often occur in cross-linguistic therapy, and this can lead to the alienation of the client, and the inability of the therapist and client to develop trust and rapport.

Therefore, linguistic or language barriers in therapy can often place culturally diverse clients at a disadvantage.

In addition to being monolingual, psychotherapy has historically taken a Western and universalizing view of human problems, which has diverted attention away from the cultural dimensions of clients' psychologies (Roland, 1996; Seeley, 2000). Many authors note that this Euro-American perspective of the mental health fields, which focuses on the individual, has harmed culturally diverse groups by invalidating their varying life experiences, imposing the values of the dominant culture upon them, and by not offering culturally appropriate care to them (Roland, 1996; Seeley, 2000; Sue & Sue, 2003; U.S. DHHS, 2001). When cultural differences are not taken into account in the therapeutic encounter, and when a universalizing model is applied to non-Western clients, the results can be extremely harmful. Often clients from different cultural backgrounds who are assessed and diagnosed by Western standard become over-pathologized or misdiagnosed; this can lead to inappropriate and culturally insensitive interventions (Roland, 1996; Seeley, 2000). As authors such as Ivey, et al. (2007), Roland (1996), Seeley (2000) and Sue & Sue (2003) note that traditional mental health concepts and practices are often inappropriate and even detrimental to the life experiences of clients from non-Western backgrounds. For example, Roland (1996) asserts that many psychoanalysts, when

taking a Western view of their non-Western clients, do not get a full understanding of their client's lives and psyches. He writes:

Psychoanalysts, coming from the tradition of the self-contained, rational individual, simply do not appreciate that patients outside of the Northern European/North American culture belt have a self that is not only far more enmeshed and embedded in an extended family/group/community context . . . but often also in a world of invisible influences. To assume a denigrating attitude toward these psychological phenomena will be to miss a major portion of these patients' psyches. (p. 88)

Celia Jaes Falicov (1998), in her book *Latino Families in Therapy: a Guide to Multicultural Practice*, discusses "cultural misunderstandings" that can occur when professions in the medical and mental health fields do not understand the cultures from which their clients come. These misunderstandings can often lead to "tension and alienation" between client and practitioner, and can "frankly . . . jeopardize [a client's] treatment" (p. vi).

Conclusion

These barriers to multicultural counseling lead to underutilization of mental health services by diverse client groups. This is a problem for the social work profession, because these are the very groups that social workers aim to help. As Sue & Sue (2003), Seeley (2000) and others contend, it is essential for social workers to develop more creative, culturally sensitive theories and approaches to working with non-Western clients that will enhance communication, relationship building, engagement, and trust between client and practitioner. In the next chapter of this thesis I will introduce art therapy and art-making in therapy as a potential tool to overcome barriers in multicultural clinical contexts.

CHAPTER III

ART THERAPY

I recognize the power of art to expand self-understanding, to offer insight not available through other means, and to extend people's ability to communicate.
(Malchiodi, 1998, p. 20)

In this chapter I will provide a brief introduction to the field of art therapy. Much like the field of cross-cultural therapy, the topic of the previous chapter, art therapy is a diverse and complex discipline and is covered by a wide variety of associated literature, much of which is well beyond the scope of this study. Therefore, in this chapter I will offer a broad overview of the field, with particular focus on the aspects of the field that directly apply to the topic of this research paper, that is, using art-making as a tool to ease some of the difficulties encountered in cross-cultural therapy.

I will begin this chapter with a discussion of the history of art therapy and art-making in therapy by introducing some of the major contributors to the field and reviewing some of the important literature. I will discuss some of the benefits of using art-making in therapy as they are presented in the literature. I will then offer a discussion surrounding the much-debated definition of art therapy, and will outline how the term will be used in this paper. Finally, I will address the question of which clients groups would benefit from art therapy according to the literature. In this section I will point out the lack of existing literature surrounding the use of art-making in therapy in cross-cultural therapeutic encounters, thus highlighting the need for this study and further research on this topic.

History of Art Therapy

While art therapy as an established and recognized discipline is relatively new, humans have been creating art since the dawn of the species and art-making has always been a part of the human experience (Malchiodi, 1998; Rubin, 2005; Wadeson, 1980). Rubin (2005) asserts that throughout history, humans have communicated with each other by means of art-making, and that long before there were alphabets, written communication took the form of pictograms and hieroglyphics. Dissanayake (1992) (as cited in Vick, 2003) contends that art-making is an innate human tendency that has existed throughout the history of humankind, and believes that, like tool making and verbal communication, could be used to define our species. Malchiodi (1998) writes, "The need to make art is a basic human urge, a trait of our species as natural as language, sex, social interaction, and aggression" (p. 21).

Art-making and its relationship to mental health also has a long history. In his book, *The Discovery of the Art of the Insane*, MacGregor (1989) (as cited in Vick, 2003) examines the interplay between art, genius and insanity, and explores the relationship of art and psychology over the last 300 years. In 1922, the German psychiatrist Hans Prinzhorn organized an art exhibit, entitled the Heidelberg Collection, which was made up of artwork produced in, and gathered from, Europe's insane asylums. Instead of focusing on the psychopathology of the artists in this collection, Prinzhorn was more interested in the creative process of the artists, and the images that they created.

According to Malchiodi (1998),

[Prinzhorn] believed that humankind's fundamental drive was toward self-expression and communication and that it included the urge to play, decorate, symbolize, and organize ideas into visual forms. [He] held that the creative

process of art-making is basic to all people, with or without illness, and that art was a natural way to achieve psychological integration and wellness. (pp. 25-26)

Sigmund Freud, the father of psychoanalysis and modern psychiatry, was extremely interested in visual images and symbols. It is noted that Freud identified the relationship between the psyche and visual expression when he developed his theories of the unconscious and images that presented in dreams (Malchiodi, 1998; Wadeson, 1980). Freud asserted that often in psychotherapy people could not describe their dreams in words, but said that they could draw them (Malchiodi, 1998). Thus, Freud believed that artistic expression could be used as a route to understanding the unconscious in a way that words could not necessarily achieve (Malchiodi, 1998).

Like Freud, Carl Jung, another early practitioner in the psychoanalytic world, was interested in art, symbols and images as they relate to the human psyche. Jung believed that humanity shared a universal unconscious, and he based this belief on his identification of common symbols and images that appeared in art work across cultures and throughout history (Malchiodi, 1998; Wadeson, 1980). Jung was also interested in symbols of dreams and art, and how they can lead to deeper levels of psychic and emotional understanding (Malchiodi, 1998).

Anna Freud was also interested in art-making in therapy, and used it as an analytic technique in her work with children (Rubin, 2001). When discussing her methods for analyzing children, A. Freud wrote "a further technical aid, which besides the use of dreams and daydreams comes very much to the fore in many of my analyses of children, is drawing" (A. Freud, 1927, p. 30, as cited in Rubin, 2001, p. 16).

While Freud, Jung, and A. Freud were all interested in how art could be related to and used in psychoanalysis, it is Margaret Naumburg who is hailed as the pioneer in the field art therapy, being the first to delineate art therapy as a distinctive form of psychotherapy (Malchiodi, 1998; Rubin, 2005; Vick, 2003; Wadeson, 1980). Working from a psychoanalytic framework in psychiatric hospitals in the 1940s, Naumburg encouraged her clients to draw spontaneously, then free associate to their pictures (Wadeson, 1980), much like Freud had clients do with their dreams. Naumburg considered art to be a "royal road" to a patient's unconscious and is quoted as saying, "art is a form of symbolic speech emanating from the unconscious like dreams" (Naumburg, 1955, as cited in Rubin, 2005, p. 220). Naumburg believed that art could be used as a means of both diagnosis and therapy in psychoanalysis (Rubin, 2005), and that it is the therapists' role to interpret clients' images to better help them understand subconscious thoughts and wishes. According to Malichodi (1998), Naumburg believed the value of art therapy lay in its ability to promote authentic expression and communication.

Edith Kramer was a second pioneer in the art therapy field (Malchiodi, 1998; Rubin, 2005; Vick, 2003; Wadeson, 1980), and used art in her therapeutic work with children in the 1950s. Rather than focusing on using art as a window into the unconscious as Naumburg did, Kramer emphasized the integrative and healing properties inherent in the activity of creating art (Rubin, 2005; Vick, 2003; Wadeson, 1980), and "she observed that the act of creating an artistic product involves channeling, reduction, and transformation of inner experiences, and can be an act of sublimation, integration, and synthesis" (Malichodi, 1998, p. 36). Kramer considered art-making a form of

sublimation¹, in which a person's conflicting wishes, feelings, and impulses were used to create a visually pleasing form (Rubin, 2005). Vick (2003) writes, "[Kramer's] 'art as therapy' approach emphasizes the intrinsic therapeutic potential in the art-making process and the central role the defense mechanism of sublimation plays in this experience" (p. 9). For Kramer, no interpretation or verbal reflection was needed; the process of a client creating art in therapy was itself therapeutic. Thus, Kramer's view of art therapy was more based on the intrinsic value of the art-making process, in contrast to Naumburg's product-oriented, psychoanalytic philosophy (Malchiodi, 1998).

In the 1950s and '60s there were other scholars and practitioners contributing to the field of art therapy. For instance, Hanna Yaxa Kwiatkowska, working at the National Institute of Mental Health in the '50s and '60s, introduced art therapy into family therapy sessions; Janie Rhyne used art in her therapeutic work to achieve "self-awareness and self-actualization" (Malchiodi, 1998); and Elinor Ulman was the founder and editor of the first journal in the field of art therapy, called *The Bulletin of Art Therapy* (later renamed *The American Journal of Art Therapy*), which was published in 1961 (Malchiodi, 1993; Vick, 2003; Wadeson, 1980). Malchiodi writes, "Thanks to such advocates [as Kwiatkowska, Rhyne, and Ulman], by the 1960s art therapy had become a recognized field" (p. 36).

¹ According to ego psychology, sublimation is a defense mechanism whereby unacceptable or asocial sexual and aggressive drives are transformed into derivative behaviors that are socially acceptable and/or valuable.

In the late 1960, the first program to offer a master's degree in art therapy was created at the Hahnemann Hospital in Philadelphia: within the next seven years, 20 such master's programs had been established (Wadeson, 1980). In 1970, Don Jones and Robert Ault, working out of the world-famous psychiatric facility, the Menninger Clinic in Topeka, Kansas, created the American Art Therapy Association (AATA), a national organization of art therapists, thus making art therapy an officially recognized professional field (Malchiodi, 1998).

The early 1970s through the mid-1980s saw the emergence of an increasing number of publications related to the field of art therapy, including two journals, *Art Psychotherapy* in 1973, and *Art Therapy: Journal of the American Art Therapy Association* in 1983 (Vick, 2003). According to Vick (2003) the 1970s and '80s was a seminal time for the profession of art therapy, and "evolved the professional identity of the art therapist, credentials, and the role of the art therapist vis-à-vis related professionals" (p 10).

In 1996, at their conference entitled "One world, one language," the 10th World Congress of Psychiatry officially recognized art-making by patients in session as a legitimate tool to be used in psychiatry, asserting that art expression when used in therapeutic settings can be an important form of non-verbal communication, can enhance communication between patient and physician, and can be a very useful therapeutic modality when treating pathologies where there is a "logico-verbal deficit" (Pini, 1996). Like other mental health practitioners who use art-making in their work, psychiatrists at this conference agreed that it is not the physician's place to attribute artistic value to

clients' artwork, but rather to use the work in such a way as to increase insight into the patients' condition, and help guide assessment and treatment (Pini, 1996).

In conclusion, art-making has been used in the mental health field since the very beginning of the profession. At the current time, art therapy literature and educational programs continue to grow, and work in the art therapy field is ever expanding.

Benefits of art therapy

In this section I will discuss some of the many benefits of art therapy as they are discussed in the literature. These benefits all point to the conclusion that art-making, when used in the therapeutic encounter, can be a very useful and healing modality.

Art is a natural way for humans to communicate and is preverbal

Art is a natural and innate way for humans to communicate (Rubin, 2005), and visual images precede verbal memory and transcend linguistic boundaries (Malchiodi, 1998; Rubin, 2005; Wadeson, 1980). Thus through art, people can access things that happened to them before they acquired language, but that are still encoded in their bodies (Rubin, 2005). Further, through the medium of art, clients can express complex feelings and situation that may have otherwise been left disavowed: they have the ability to represent visually what has been "rejected" or is considered "unacceptable" (Rubin, 2005, p. 25), and "by adding art [to therapy] you are enhancing the possibility that patients can express ideas and feelings that they may not be able to say in words" (Rubin, 2005, p. 27). Wadeson (1980) asserts that visual imagery can stimulate deeper levels of consciousness and give people more access into their subconscious. This fits with Freud's (1963) oft quoted statement about the visual nature of dreams that escapes verbal representation:

We experience it (a dream) predominantly in visual images; feelings may be present too, and thoughts interwoven in it as well; the other senses may also experience something, but nonetheless it is predominantly a question of images. Part of the difficulty of giving an account of dreams is due to our having to translate these images into words. 'I could draw it,' a dreamer often says to us, 'but I don't know how to say it.' (p. 90, as cited in Wadeson, 1980, p. 9)

Thus, according to Freud, dreams—like other difficult or elusive thoughts and emotions—are often difficult to describe in verbal terms: there are situations where using visual images may be a superior way to communicate these thoughts and feelings.

Relaxing and stress relieving

Some scholars cite the relaxing and stress relieving benefits associated with making art in the therapeutic encounter (Malchiodi, 1998; Rubin, 2005). Since making art is generally a relaxing activity, when used in therapy it can break down barriers between clinician and client by making people feel more at ease in the therapeutic encounter, and "the more comfortable people are, the more easily they can communicate with you" (Rubin, 2005, p. 22). Making art in therapy can relieve some of the pressure to talk, which for some clients can be very stress inducing. Wadeson (1980) notes a change in creative and physical energy that takes place when someone is engaged in an art-making activity, which is similar to energy that is created when people play. This energy frees people from barriers they may have previously held, and according to Wadeson (1980), people can become "more open, revealing, and receptive" to the clinician and to therapy than they initially were (p. 11).

Externalization and objectification

Many writers note that there is a process of externalization and objectification that takes place when a person creates art. This happens when a client takes internalized

thoughts and feelings and turns them into external, physical images (Keeling & Bermudez, 2006; Wadeson, 1980). Externalization is a technique used particularly in narrative therapy and its main purposes are: to separate the person from the problem; to permit the problem to be viewed from a variety of perspectives and contexts; and to foster client agency over the problem (Freeman & Combs, 1996; Parry & Doan, 1994; and White & Epston, 1990, as cited in Keeling & Bermudez, 2006). This process of externalization can be beneficial for clients as they can separate themselves from their thoughts and feelings, while at the same time they can look at them, and thus recognize and acknowledge them. According to Wadeson (1980), if during this process all goes well, "the feelings become owned and integrated as a part of the self" (p. 10). Thus, making art in therapy gives clients a concrete, tangible way to externalize their thoughts and emotions.

Durable and lasting product

Another benefit of using art-making in therapy, which is related to externalization and objectification, is that the client is able to create a permanent, lasting and tangible image or object, that becomes a reminder of each session, and can be revisited at different times during the therapeutic relationship (Hanes, 2001; Liebman, 1986; Malchiodi, 1998; Wadeson, 1980). When a work of art is created in therapy, the client and therapist can later look back and consider the piece of work again and again without the distortion of time: the piece will look the same as it did when it was originally made. Hanes (2001) asserts that many people in the field have identified the aspect of permanence as distinguishing art therapy from other forms of therapy. He writes:

this permanence and tangibility of the art product gave art therapy a dimension that verbal therapies did not possess; for, once completed, the art object existed beyond the session and was not subject to distortion or flawed memory. Rather, it remained intact for days, weeks, months, or if necessary, years. (Byers, 1992, 1998; Case & Dalley, 1992; Malchiodi, 1998b; Schaverine, 1987, 1992; Wadeson, 1980; Wilkes & Byers, 1992, as cited in Hanes, 2001, p. 150)

Hanes's (2001) findings suggest that art-making in therapy records the process of the therapy and thus can provide client and clinician with "tangible and undeniable testimony to their progress" (p. 159).

The spatial matrix: transcending temporal boundaries

Art escapes the boundaries of time. As I noted in the section above, art-making in therapy provides client and therapist with a concrete, tangible, and lasting image: and art transcends the temporal boundary in another important way. Wadeson (1980) points out that verbal communication is inherently linear, as opposed to art images where relationships can be created in space, are not necessarily linear and thus are not bound by time. For example, a client could verbally describe their family, and all the relationship and dynamics that take place within it to a therapist, but they would only be able to describe one thing at time, in a linear way. Yet, if that client was able to draw a genogram or picture of their family and its dynamics, suddenly there is the possibility to create an image that, when completed, depicts all of the members of the family and their relationships simultaneously. Thus, the spatial character of art can describe many aspects of an experience concurrently (Liebman, 1986). Further, Malchiodi (1998) points out that,

ambiguous, confusing, or even contradictory elements can also be put into the same drawing or painting, because art, unlike language, has no rules about structure or organization. This ability of art to contain paradoxical elements helps

people integrate and synthesize conflicting feelings and experiences [in a way that words cannot]. (p. 13)

Wadeson (1980) describes clients' ability to use art to synthesize contradictory elements in their lives as tapping into "primary process material," and creatively coming up with solutions to their problems.

Taps into creativity, increases flexibility, and enhances life

The famous psychologist, Abraham Maslow, suggested that when people's basic needs for food, shelter and safety are met, they show a strong drive toward self-expression, and even when their basic needs are not met, some people are still compelled to make art (Malchiodi, 1998). Art therapist Bruce Moon (as cited in Malchiodi, 1998) identifies the existential purpose that art therapy serves by helping people to make sense of a confusing, chaotic world. Malchiodi (1998) asserts that people can find relief from fear, anxiety and stress, and can find new meaning in their lives through creating art. She writes

making art is believed to help one become more flexible, to self-actualize, and to tap into creative problem solving and intuition. Through art-making one can also experiment with new ideas, new ways of expression, and new ways of seeing. Finding joy, playing, creating, and communicating in a meaningful way are necessary for psychological, physical, and spiritual health, and making art provides these experiences. (p. 16)

Art therapy and the brain: scientific research

There is a growing body of empirical research that looks at the connection between art therapy and neuroscience, and how and why art therapy works (Malchiodi, 2003). While this field is still relatively new, many of the findings are showing the neurological

benefits of using art as a treatment modality in therapy. Some of these benefits, which support the findings that I have discussed in the previous section, include: the reduction of anxiety; increased memory retrieval; increased organization and detail of thoughts; increased comfort between therapist and client; and an overall soothing effect (Malchiodi, 2003). Specifically, scientists are looking at art therapy through the lens of attachment theory, and are exploring it as one tool to help clients reestablish healthy relationships. Scientists believe that using art in therapy can be an effective way to reshape and repair attachments because the "non-verbal dimensions of art activities tap into early relational stages before words are dominant, possibly allowing the brain to establish new, more productive patterns" (Riley, 2001, as cited in Malchiodi, 2003, p. 20). Riley's (2001) research has shown that simple drawing exercises can be used to resolve relational problems and can strengthen parent-child bonds (as cited in Malchiodi, 2003). In addition to strengthening relational bonds, using art in therapy can also strengthen bonds between the two sides of the brain. Rubin (2005) notes that creating art enhances left-brain/right brain interaction, thus increasing the overall functioning of the brain.

In conclusion, while neuroscience and its connection to art therapy is a relatively new field of study, scientists are looking at the neurological benefits of creating art. These findings could lead to further scientific support and validation of the field of art therapy and art-making in therapy.

Assessment

Various authors (i.e. Kaplin, 2003; Malchiodi, 1998; Rubin, 2005) identify the use of art as a helpful tool in assessment. First, using art-making in assessment can be a useful way to get to know someone better, and it does so in a different way than talking

(Rubin, 2005). Further, people reveal important information about themselves through their images, and when therapists give clients the invitation to create images of significance, the choice of what is significant becomes completely up to the client (Malchiodi, 1998; Rubin, 2005). Using art in assessment can also be useful not only because of the images that a client may produce, but also because of the client's reactions to the materials and the task of creating art itself. Rubin (2005) cites the verbal and non-verbal reactions that can be elicited when a client uses art materials. These reactions—including emotional reactions, facial expressions, body movements, shows of anxiety or relaxation, flexibility or rigidity—can provide the therapist with important preliminary information about a client.

Who art therapy is good for according to the literature

Since the days of Anna Freud, art-making has always been used in psychotherapeutic work with children (Rubin, 2001), since much like play, it is a common, innate activity for children to engage in. Besides children, there are other client groups that scholars such as Malchiodi (1998) and Rubin (2001, 2005) have identified as benefiting from art-making in therapy. These groups include: people who cannot speak due to either organic or selective mutism; people who are shy or inhibited; people who are highly verbal, and use intellectualization and rationalizations as defense, thus their words "get in the way"; people who are resistant to and suspicious of therapy; victims of abuse; people with eating disorders; people with substance use/abuse problems; people with dissociative identity disorder; people with mood disorders; people with schizophrenia and other psychotic disorders; Alzheimer's and dementia patients; people with developmental delays; and people with communication problems. According to

Malchiodi (1998) and Rubin (2001), since art is an innate human capacity, it can be used in therapy with almost anyone.

While there are many authors writing about who can benefit from art-making in therapy and why, I only came across two examples in the literature that explicitly suggested the use of art therapy in cross-cultural situations. Rousseau, Singh, Lacroix, Bagilishay & Measham (2004), in their article titled *Creative Expression Workshops for Immigrant and Refugee Children*, assert that using "creative expression activities" (p. 235), including art-making, is a useful and non-invasive way to work with migrant and refugee children to help them construct meaning, structure identity, work through losses, and reestablish social ties (Dokter, 1998; Golub, 1989; Howard, 1991; Miller & Billings, 1994; as cited in Rousseau, et al., 2004). This article notes that some children have an easier time expressing themselves through art work than they do verbally, yet it does not discuss situations in which the newly arrived child does not yet speak the dominant culture's language. Further, Rousseau, et al. do not include a discussion about the effects of using art-making and other forms of "creative expression activities" with immigrants and refugees of other ages.

Rubin (2005) is the only writer I came across who specifically acknowledged, albeit briefly, that art-making can be useful in clinical encounters where client and practitioner do not speak the same language, noting "the universal language of art can be a god-sent [in therapy] with recent immigrants when [the client and practitioner] do not speak the same language" (p. 13). Thus, there appears to be a gap in the literature around the topic of using art-making in cross-cultural and cross-linguistic therapeutic work.

Definition of Art Therapy

In this section I will offer an overview of the debate within the field about the definition art therapy, then discuss how the term will be used in this research.

There has always been controversy within in the field about the definition of art therapy, and this debate is based on a lack of agreement about the scope and parameters of the field (Ulman, 2001; Wadeson, 1980). Many writers on the subject (i.e. Liebman, 1986; Malchiodi, 2003; Rubin, 2005; Ulman, 2001; Vicks, 2005; Wadeson, 1980) have offered various definitions of the term, but there is, as of this writing, no agreed-upon meaning within the field.

Most scholars writing on the subject agree that art therapy, as the name implies, is a "hybrid" (Rubin, 2005; Vicks, 2003, p.5) discipline based on the fields of art and psychology (Malchiodi, 2003; Rubin, 2005; Ulman, 2001; Vicks, 2003), with influences from art history, anthropology and psychiatry (Malchiodi, 1998). Yet the exact definition of art therapy is still debated (Malchiodi, 2003; Ulman, 2001; Wadeson, 1980). Ulman (2001) describes the difficulty in defining art therapy as stemming from the diversity of theories and practices associated with the discipline, and the wide variety of professionals who claim to practice art therapy:

'Art therapy' is currently used to designate widely varying practice in education, rehabilitation, and psychotherapy . . . no similar educational preparation, no set of qualifications, nor even any voluntary association binds these people [practicing art therapy] together. Possibly the only thing common to all their activities is that the material of the visual arts are used in some attempt to assist integration or reintegration of personality . . . yet competing and mutually exclusive definition of art therapy have already been published by art therapists. (p. 16)

Since art therapy's inception as an established discipline, there has been a split in how art therapy is understood and, therefore, defined. As Ulman (2001) and Wadeson (1980) point out, the major divide has been an ideological one, where "some art therapists

put the emphasis on art and some on therapy" (Ulman, 2001, p.17). The divergent theoretical formulations of art therapy, as established by two of the profession's pioneers, Margaret Naumburg and Edith Kramer, exemplify this ideological split.

Margaret Naumburg, as I discussed earlier in the chapter, is considered the mother of art therapy. With Naumburg's psychoanalytic position and assertion that art is a form of "symbolic speech," she put more emphasis on the *therapy* aspect of art therapy. Naumburg was originally trained as a psychoanalyst, and later began to use art-making in her clinical work. She believed that art could be viewed as the "royal road to the unconscious" (Naumburg, 1955, as cited in Malchiodi, 1998, p. 220)—much as Freud believed that dreams were a direct route to the unconscious—and that art could make conscious what was hidden in the unconscious. Naumburg (1958) wrote

[Art therapy] bases its methods on releasing the unconscious by means of spontaneous art expression; it has its roots in the transference relation between patient and therapist, and on the encouragement of free association. It is closely allied to psychoanalytic therapy . . . Treatment depends on the development of the transference and on a continuous effort to obtain the patient's own interpretation of his symbolic designs . . . The images produced are a form of communication between patient and therapist; they constitute symbolic speech. (As cited in Ulman, 2001, p. 17)

For those in Naumburg's camp, art therapy is a modality to help people become able to verbalize their thoughts and feelings and thus can be used as an adjunct to psychotherapy which can reveal issues that have not surfaced in verbal therapy (Malchiodi, 2003). From this point of view, it is the art therapist's job to help the client uncover the meaning, thoughts, emotions and drives that are hidden in the art images, in the same way a traditional psychotherapist would interpret the hidden meanings associated with a client's dreams.

On the other side of the theoretical debate are scholars such as Edith Kramer, another pioneer in the field, who put the emphasis on the *art* aspect of art therapy. Those in this camp see the process of art-making as therapeutic in and of itself. They understand the creative process as having an inherently healing quality (Ulman, 2001) and see art therapy as a primary form of treatment that can provide a way for clients to communicate and establish relationships with their therapists (Malchiodi, 2003). According to Kramer (1958), artistic expression is a form of sublimation, and is thus therapeutic in and of itself:

Art is a means of widening the range of human experiences by creating equivalents for such experiences. It is an area wherein experiences can be chosen, varied, repeated at will. In the creative act, conflict is re-experiences, resolved and integrated . . . The arts throughout history have helped man to reconcile the eternal conflict between the individual's instinctual urges and the demands of society . . . The process of sublimation constitutes the best way to deal with a basic human dilemma, but the conflicting demands of the superego and id cannot be permanently reconciled . . . the art therapist's . . . primary function is to assist the process of sublimation, an act of integration and synthesis which is performed by the ego, wherein the peculiar fusion between reality and fantasy, between the unconscious and the conscious, which we call art is reached. (As cited in Ulman, 2001, p. 19)

Advocates of the "art as therapy" position point out the relaxing and stress relieving nature of creating art, as well as the relationship, communication and trust building potentials of creating art in a therapeutic space, which were discussed earlier on in this chapter. In sum, for those in this camp, creating art in therapy is enough: one does not need to interpret or analyze the art for its unconscious or symbolic meanings.

Elinor Ulman (2001), in article her *Art therapy: problems of definition*, tries to reconcile the two conflicting definitions of art therapy, though she acknowledges this is no easy task as "it is always hard, sometimes impossible, to find the ideal name for any

complex and subtle discipline" (p. 16). According to Ulman, art therapy must combine elements of both *art* and *therapy*. For Ulman (2001) *therapy* must, "assist favorable changes in personality or in living that will outlast the session itself" (p. 25), thus therapy aims at durable change, rather than just temporary adjustment for clients. Ulman (2001) purports that *art therapy* is a creative and personal way for people to manage and relate their inner and outer realities in a productive, healing, and organized way:

[Art therapy's] motive power comes from within the personality; it is a way of bringing order out chaos—chaotic feelings and impulses within, the bewildering mass of impressions from without. It is a means to discover both the self and the world, and to establish a relation between the two. In the complete creative process, inner and outer realities are fused into a new entity. (p. 26)

Ulman concludes her article by asserting that "the proportions of art and of therapy in art therapy may vary within a wide range . . . but anything that is to be called art therapy must genuinely partake of both art and therapy" (p. 26). Thus she leaves the definition open to a wide range of interpretation and debate.

Another scholar, Harriet Wadeson (1980), also defines art therapy as an "umbrella term" (pg. 14) that covers the use of art expression for many purposes in a great variety of therapeutic settings. Wadeson (1980), like other writers in the field, asserts that it is important to differentiate between *art*, in which emphasis is placed on the final product, and *art therapy*, which is focused on the process of creating art, and is geared toward growth, self-exploration and creativity in a therapeutic setting. Wadeson (1980) writes "in varying degrees, all approaches to art therapy require a transfer from the realm of materials to the realms of individual creative processes and interpersonal relationships" (p. xxii).

Malchiodi (2003) asserts that art therapists support the belief that all individuals

have the inherent capacity to express themselves creatively, and that this expression can encourage personal growth, increase self-understanding, assist in emotional reparation, enrich daily life, enhance well-being, and help individuals create meaning, gain insight, resolve conflicts, and find relief from overwhelming emotions or trauma (Malchiodi, 1998, as cited in Malchiodi, 2003). For Malchiodi (2003), as for Wadeson (1980), in art therapy it is a person's *involvement* with the art-making process that is important, not the final product.

According to the American Art Therapy Association (AATA), the definition of art therapy is based on the idea that "the creative process of art-making can be healing and life enhancing and is a form of non-verbal communication of thoughts and feelings" (as cited in Malchiodi, 2003, p.1). In 1997, the AATA published a document entitled *Scope of Practice*, intended to define the nature of professional art therapy services, outline educational and supervision standards, as well as standards of practice and ethical standards. According to the AATA (1997), professional, registered and board-certified art therapists have to have completed a degree from a graduate art therapy program, met requirements for Art Therapist Registered (ATR) as set fourth by the Art Therapy Credentials Board, Inc. (ATCB), and have to have passed a certification examination administered by the ATCB.

In addition to the debate about the definition of art therapy, there is corollary debate in the field about the place that interpretation of clients' artwork holds with regard to art therapy. Practitioners who are more psychoanalytic in orientation and who follow in the vein of Margaret Naumburg, believe that it is part of art therapists' job to offer interpretations and insights into clients' artwork, much as they would offer interpretations

of clients' dreams or fantasies. This assumption has its origin in the use of art therapy as an adjunct to psychoanalysis, where clients produced artwork in therapy in order for it to be used as material for analysis (Liebman, 1986). Liebman (1986) notes "this kind of interpretation always takes place in a particular theoretical framework (or psychoanalytic school), and requires considerable training and experience" (p. 34) as set out by the AATA. Therefore practitioners who make use of interpretation in their work are generally trained specifically as an art therapist according to the guidelines of the AATA, would have all the required degrees and certificates, and are trained in specific art therapy assessment and interpretation methods. In this case, there is an implicit understanding that images and symbols have only one meaning, and that an art therapist trained in this way will have the ability to interpret the symbols of their clients based on their understanding of the universal meanings associated with the symbols (Liebman, 1986).

On the other side of the debate are those that believe that symbols and images have a wide range of culturally-based and subjective meanings, which can vary from culture to culture and from person to person (Kaplin, 2003; Liebman, 1986). For practitioners working from this standpoint, the most important thing is how the *creator* of the art sees and interprets it, and what the symbols mean to him/her: it is not acceptable or appropriate for the therapist to offer an interpretation of the artwork without the input of the client (Kaplin, 2003; Liebman, 1986). Those working from this standpoint do not need to have specific training in art therapy per AATA, but instead, simply need an interest in using art in their clinical work and believe that art-making can serve as an alternate way for clients to express themselves and communicate in the therapeutic setting.

In the above two sections I have outlined some of the various definitions of—and the part that interpretation should play in—art therapy as they are presented in the literature. Clearly there is no agreed upon definition, as every scholar and practitioner has a different idea about the scope and parameters of the field, and therefore the definition of art therapy.

Definition of art therapy and place of interpretation as it is used in this research

While there is a professional field of art therapy with certain education guidelines, it is my belief that practitioners in related fields, such as social work, can nonetheless use art-making and certain concepts from art therapy in their clinical work, without being specifically trained in the field of art therapy. I do not believe that a therapist using art in their clinical work needs to be trained according to the standard set out by the AATA, but rather the clinician needs to have the interest in and ability to incorporate art-making into their clinical work. Just as with other therapeutic modalities, art-making in therapy should only be used in therapeutic encounters where the therapist deems it appropriate and where the client has accepted and could benefit from its use.

For the purpose of this paper, I assert that art-making in therapy is an enhancement or subsidiary to communication, and that good communication can lead to solid therapeutic relationships and working alliances. I will define art-making in therapy as a form of non-verbal communication, which offers information about the client to the clinician, both through the images that a client produces, as well as the client's relationship to the materials and act of making art. I affirm that the act of producing art can itself be therapeutic in that it can create a comfortable situation, in which client feels

relaxed in the therapeutic encounter. It can strengthen the therapeutic relationship by enhancing feelings of safety, comfort and understanding between client and clinician.

Further, I assert that art-making can be used as a tool in therapy, regardless of the theoretical orientation of the clinician. As I discussed in Chapter I, Ivey and colleagues (2007) encourage social workers to be creative, flexible and open-minded in their use of theories and methods, and expand their communication repertoire. I support Ivey and colleagues (2007) call for an "eclectic" approach, and I assert that art-making in therapy can be used in conjunction with a wide range of theoretical and practical models.

In terms of interpretation, I believe that there is more than one possible interpretation of various symbols that are used in art-making, and that the therapist cannot offer an interpretation of a client's artwork without the input of the client herself. This is especially critical when working cross-culturally, due to the ambiguity of art images and their associated meanings across cultures. Therefore interpretation is not part of this kind of therapy.

Conclusion

This chapter served as a preliminary introduction to art therapy, with particular emphasis on the history of the field, the benefits of art therapy as they are presented in the literature, the various definitions of art therapy within the field and, finally, my own interpretation of the definition of art therapy as it will be used in this thesis. In the next chapter of this research, I will discuss the issue that this thesis seeks to address, that is, how art-making can be used as a therapeutic tool to alleviate some of the difficulties that arise in cross-cultural therapy. I will do this by reexamining the issues that arise in cross-

cultural therapy, as discussed in Chapter II, and systematically looking at how art can be applied as a therapeutic tool to ease these difficulties.

CHAPTER IV

DISCUSSION AND CONCLUSION

This theoretical study examines issues as they occur in cross-cultural and cross-linguistic clinical therapy based on traditional verbal psychotherapy, and offers art-making in therapy as a way to overcome some of these issues. In Chapter II I provided a history of traditional verbal psychotherapy, identifying problems that can occur when it is applied to cross-cultural and cross-linguistic therapeutic situations. In Chapter III I offered a brief overview of the history of art therapy, highlighting some of the benefits of using art-making in therapy, and defining art therapy as it will be used in this research. In this final chapter I will recap the major issues as they occur in cross-cultural and cross-linguistic therapy and consider how art-making in therapy can alleviate some of these issues. I will do this through presenting a case study that illustrates problems that can occur working cross-culturally and cross-linguistically, then analyzing, using examples from the case, how art-making in therapy was a successful modality to address the issues. I will demonstrate how, through using art-making in therapy, my client and I were able to create a positive working alliance built on trust and safety, a successful means to communicate as an alternative to talking, and a positive therapeutic out-come.

Cultural competency

Before I introduce the case, it is [necessary to reiterate the](#) importance of cultural competency when working cross-culturally. As I noted in Chapter II, cultural competency is now imperative for all social workers according to the NASW Code of

Ethics (1996), the DSMIV-TR (2000), the U.S. Surgeon General (2001), and a large amount of literature in the social work and related fields. There is a large body of scholarly work regarding how to develop cultural competency skills and how to work most effectively with particular client populations. While it is beyond the scope of this research to discuss this literature in depth, what this body of work stresses is that it is imperative for clinicians working cross-culturally to "do their homework" and learn about the particular cultural contexts from which their clients come. It is important to make the point, because I am not asserting that using art-making in therapy can replace practitioner cultural competency: cultural competency is always essential when working cross-culturally, regardless of the theoretical orientations or practical models that clinicians choose to use.

Case study

Nala² is a 16 year-old girl from the Karen hill tribe who lives in Chiang Mai, Thailand. Like many Karen people currently living in Thailand, Nala was born in Myanmar, formerly Burma. When Nala was two years old her parents fled Burma with her and a number of other relatives due to political unrest and persecution of the Karen people by the Burmese government. Nala's parents died from unknown causes shortly after the family arrived in a refugee camp in Northern Thailand, leaving Nala an orphan.

Nala stayed with various relatives in the refugee camp for a number of years. During this time she sustained sexual, physical and emotional abuse at the hands of one

² All names and identifying information have been changed to protect the confidentiality of the client.

of her uncles. After one particularly severe beating which left her near death, Nala, then twelve years old, was removed from the camp by the Coordination Center for the Protection of Women and Children's Rights—the Thai version of Child Protective Services—and became a ward of the state. For the next two years she lived between orphanages and a series of foster homes. When Nala was 14 years old, she was accepted into the New Hope Center, a residential program in Chiang Mai, Thailand for hill tribe girls who have been victims, of or are considered at risk for, labor and/or sexual exploitation, or have come from particularly abusive or traumatic backgrounds.

In Thai culture, it is not common for people to speak about negative aspects of their lives, especially when it concerns abuse, as there is an element of shame, and thus taboo around public disclosure of this type of issue. While all of the residents at the New Hope Center have histories of trauma in some form or another, the director of the program told me that the residents rarely, if ever, discussed their histories with anyone. Instead, many of the residents suffered from many symptoms of post-traumatic stress disorder, and often acted out in ways that were detrimental to their wellbeing. The director and staff of the program, all of whom were trained in trauma response and counseling, thought that it could be beneficial and healing for the girls if they could share their histories with others, in a way that offered them safety and support.

I met Nala in 2007. At that time she had been at the New Hope Center for 2 years. The director of the program told me that while Nala was generally very sweet and loving, she had an angry and violent side that seemed to erupt without any apparent notice. Nala was years behind her peers in school, and the director of the program had had her assessed for learning disabilities. Cited among Nala's many issues were her lack

of attention span, inability to concentrate and hyper-activity. While Nala suffered from learning difficulties, she also possessed an aspect of creativity that her peers did not: she would put together wild, unique out-fits, paint her nails black with white dots, and make other unconventional fashion statements. Nala had a few good friends at the New Hope Center, yet due to her special needs and "free spirit," many of the residents regarded her as odd, and stayed an arm's length away from her. When I began my internship, the director told me that, of all the girls at the New Hope Center, it was Nala who needed a little extra "love and attention."

At the time I met Nala I was a social work student intern from the Smith College School for Social Work, on an international field-placement to complete the requirements for my Masters of Social Work degree. Due to my interest and background in art and my lack of ability to speak Thai, the director of the program and I decided that my skills would best be utilized engaging in art therapy with the residents. I began to co-lead two weekly art therapy groups and hold individual art therapy sessions with a number of the young women.

The art groups, which were composed of ten regular participants each, met once weekly for two hours. Each session focused on different themes that were related to relevant aspects of the girls' lives. We explored these themes using different art media through different projects. Some of the projects included: creating colorful genograms and ecograms, designing cards then writing a letter to someone important that was now deceased or gone, and illustrating emotions. The goal of the art therapy groups was to give participants an avenue in which to explore important, and sometimes difficult, aspects of their lives in a non-invasive, non-threatening, non-verbal and creative way.

Each session started with an introduction of the theme of the day and to the art materials being used, as many of the participants did not have much experience with different media. At the end of the session the girls were given the option to discuss their work with the rest of the group and/or display their work in the art room for others to see. Some of the participants chose to talk about and display their work while others did not: there was no pressure or expectation to do so either way

Originally, Nala had not been enrolled in either art group because the director of the program did not think that she would be focused enough to participate. But one day Nala sat in on a session, really enjoyed it, then asked if she could join the group. Nala became a member of the Tuesday morning art therapy group.

For one of the first art therapy group sessions in which Nala participated, the theme was "stress." Participants were asked to illustrate, in whatever way they chose, things that caused them stress or how stress made them feel. The art media offered for that day was colored pencils, oil pastels and white paper.

Nala's first picture was of a group of stick figures running from what appeared to be a huge cloud of smoke. There were flames in the picture, as well as a large reptilian looking creature. The sun she had drawn was black, and the picture had a disturbing quality to it. After she was finished, she immediately crumpled it up and threw it in the garbage. It was clear that Nala did not want to share this image she had created with the group.

The second picture that Nala drew was of a woman with flaming red hair, and what looked to be tears streaming down her face. Her mouth was sewn shut, and it appeared that she had stitches up the length of her torso and on her forehead as well. On

both of her shoulders were what looked like bullet wounds: red circular dots, with what appeared to be blood coming out of them. After class, Nala told me, through my group co-leader who spoke fluent Thai and English, that this was a picture of what had happened to her when she did not listen to her uncle. She did not elaborate. Because I knew a bit about Nala's history, I inferred that this was a picture of her after her uncle had beaten her. Nala had responded to the theme of stress with a powerful and personal account of an experience which had caused her stress: Nala was able to express, through making art, the trauma and atrocities that had befallen her at the hands of her uncle.

Of course it is impossible to know if these memories would have surfaced for, and been expressed by, Nala in some other way, without the use of art-making. It is clear, though, that I would not have understood Nala if she had tried to tell me about these experiences verbally; I did not speak enough Thai. Yet she was able to communicate her trauma—which, according to the director of the program, Nala had never done before—through her art-making.

A week later, I saw Nala sitting on the grass making a beautiful paper mandala. Unlike other girls at the New Hope Center who spent their free time sewing, Nala enjoyed making these mandalas, which she sold for three dollars a piece at the local market. I sat down with Nala, and asked her—in basic Thai and through gestures—if she would teach me how to make a mandala. She beamed with pleasure, and began showing me how to make the delicate ornaments.

I had been told that Nala had difficulty focusing and finishing tasks: this did not seem to be the case when she was making her mandalas. Nala worked with fine-tuned attention to create her little masterpieces. As I sat with her, she guided me gently and

confidently. She was a patient and meticulous teacher, and after two hours I too had created a beautiful little work of art. As we worked side by side, Nala would often look over and direct me in my mandala making. Though we were unable to share many words, it was clear that a profound communication was occurring between us, and our relationship was developing: Nala and I were getting to know each other through the act of creating art together.

In the months that followed, Nala and I continued to develop our relationship together, and Nala continued to express herself through art-making in the group therapy sessions. During a session in which we explored dreams and hopes for the future through the media of collage, Nala used images cut from magazines of brides in wedding dress, grooms in their tuxedos, and families spending time together. After this session, Nala told me that she really missed her mother and father, and that she hoped one day to have a family again. Again, through the process of art-making Nala was able to express her thoughts, feelings and wishes in a way that was safe and creative, and I—as a therapist coming from a different cultural background—was able to share that experience with her in a way that transcended our linguistic boundaries.

These examples of my work with Nala illustrate how art can be used in cross-cultural and cross-linguistic therapeutic settings to enhance communication, strengthen the therapeutic relationship, and increase the engagement and understanding between practitioner and client.

Discussion

In Chapter II of this study I looked at traditional verbal psychodynamic theory and practice, and discussed some of the barriers that are created by its use in cross-cultural and cross-linguistic therapeutic encounters. In this section I will reexamine the barriers that I introduced in Chapter II, then apply concepts from Chapter III on art therapy in order to demonstrate—using the case material to illustrate—how these barriers can be overcome by using art-making in therapy.

The first major barrier that I identified in Chapter II, is the linguistic or language barrier. Psychotherapy has historically been thought of as the talking cure, and clients are expected to verbalize their thoughts and feelings in order to receive treatment. Yet many clients receiving treatment in the United States, that do not have a good command of Standard English, may be unable to do this successfully. Thus, these clients are at a disadvantage in therapy due to their lack of proficient verbal communication in the language of therapy. If client and therapist do not share proficiency in the same language, the focus can often be diverted away from therapy and instead be on issues of translation. This can lead to misunderstanding and, consequently, frustration between client and therapist, all of which diverts attention from actual therapy. All of this can be detrimental to the building of a solid working alliance between client and clinician, which is essential if successful therapy is to take place.

Art-making is a non-verbal activity, and therefore transcends linguistic boundaries. As I stated in Chapter III, art-making is an innate human impulse that has existed for as long as human-kind has existed. Frances F. Kaplan, summarizing the research from anthropologists Alexander Alland and John E. Pfeiffer and art historian Ellen Dissanayake, states:

Participating in art and art-related activities satisfies something deep within us. This satisfaction can be attributed to the likelihood that the universal impulse to make art is either a direct or indirect result of our evolutionary history and this is embedded in our genes. (Kaplan, 2000)

Clients who are able to create art in the therapeutic encounter have a mode to communicate with the therapist in a way that is innately human, yet without the pressure of having to verbalize their thoughts and feelings which can often put a great deal of stress on both the client and the therapist as they struggle to understand each other. As Rubin (2005) points out, allowing clients to make art in therapy increases the possibility that clients can express ideas and feelings that they cannot necessarily put into words. Further, art-making can be relaxing and stress relieving, in contrast to the stress that may be induced if a client feels pressured to verbalized when he or she is ill equipped or even unable, to do so. Art-making in the clinical encounter—in contrast to strict verbal therapy—may be more likely to put a client at ease, and this will, in turn, enhance the level of comfort that the client feels in therapy, hopefully improving therapeutic outcomes.

In the case of Nala, there was a near total language barrier between us—Nala did not speak any English and I was just in the beginning stages of learning Thai—thus traditional verbal therapy was not a possibility for us: we needed to find other means by which to communicate. Using art-making in my therapeutic work with Nala opened the door for us to develop a solid working alliance, and established a way for us to communicate without the restraints of language. Through art-making Nala was able, and felt comfortable, to share for the first time some of her darkest memories, and some of

her hopes for the future that were rooted in past losses. I was able to be there for her as a witness and to provide support.

A second barrier that can be encountered when traditional verbal psychotherapy is applied in intercultural therapeutic situations is the universalizing perspective that psychotherapy takes which has historically discredited or ignored the alternative cultural dimensions of clients' lives. If these clients already have difficulty expressing themselves in Standard English, then their therapist can misinterpret their thoughts, beliefs, and actions. This Western, universalizing approach to understanding human problems has led many well-intentioned clinicians to over-pathologize and misdiagnose clients, as well as to offer culturally insensitive or inappropriate interventions. Cultural competency, as I mentioned in the previous section, is imperative for clinicians working cross-culturally. A clinician needs to be open to learning about their client's cultural background, while at the same time being careful to not oversimplify, or stereotype the client based on her background. Art-making in therapy can be a useful way for clients to express aspects of their cultural background, aiding therapists in their understanding of clients.

If I had tried to conduct traditional verbal therapy with Nala—even if we spoke the same language—she would not have been as forthcoming about her history due to the Thai and hill tribe cultural expectation that one does not discuss unpleasant aspects of their life. I, then, could have labeled Nala as pathological or resistant due to her unwillingness to reveal certain facets of her past to me. Because art-making was offered as a vehicle for expression, Nala was instead able to communicate her traumatic past in a culturally appropriate and safe manner. Further, art was a natural mode of expression for Nala—one that she felt comfortable engaging in. I was able to work with Nala in a way

that drew on her strengths for creative artistic expression, and this served as a way for us to develop a solid therapeutic relationship.

Finally, early termination is a very common outcome in cross-cultural therapy, due to client's and clinician's inability to develop a successful working alliance. Clients who feel misunderstood by their therapist are less likely to feel comfortable in therapy, and are less likely to keep returning. Early termination and underutilization of mental health services by non-Western client groups is a huge problem for the mental health profession, therefore developing effective methods to keep these clients engaged is imperative. For clients from diverse cultural backgrounds, art-making in therapy, as demonstrated above, can be a welcome alternative to traditional verbal therapy.

Study biases and limitation

While working as an international social work intern in Northern Thailand, speaking very limited Thai, I found that art-making was a wonderful way to engage and communicate with the hill tribe and dementia clients with which I worked. This experience has certainly influenced my interest in this topic. So, just as one of the strengths of this research is my personal and professional interest in, and experience with, using art-making in cross-cultural therapy, this is also the study's main limitation, due to my personal bias and inclination to work in this way.

I also acknowledge the inevitable influence of my personal and cultural background, values, and assumptions on my thinking and writing about this topic. I am a white, upper middle-class, educated woman. Artistic expression and cross-cultural experiences were always encouraged in my family of origin, and I continue to hold these as important aspects of my life and work. I realize that many clinicians do not have the

same background and interests, and that using art-making in their therapeutic work would not be relevant or appropriate.

The major limitation of this study is that it is being undertaken through an analysis of the literature, rather than through empirical study, and thus remains at some distance from the actual lived experience of cross-cultural and cross-linguistic clinical therapeutic work. An empirical study involving either interviews or surveys of clinicians and/or clients who have used art in cross-cultural and cross-linguistic therapy would be a preferable method for gathering this data, but due to logistical and temporal constraints, this was not a viable option. Despite its limitation, the theoretical approach is nonetheless useful in helping to expand on and deepen the body of work related to cross-cultural therapeutic work, and can hopefully offer clinicians an idea for a new tool to enhance communication and engagement in cross-cultural and cross-linguistic clinical encounters.

Directions for future research

Further research is needed to test the claims that art can be a useful tool to ameliorate some of the issues that arise in cross-cultural therapy. Additional empirical research, both quantitative and qualitative, could address both clients and practitioners who use art in their cross-cultural work together. For example, interviews and surveys could be used to collect data from therapists who use art-making in their practices, regarding their thoughts and opinions on its effectiveness in cross-cultural and cross-linguistic therapeutic situation. Clients in cross-cultural therapeutic dyads who have done art-making in therapy could be interviewed or surveyed as well, though this would be more difficult to conduct due to issues of client confidentiality.

Various cultural and ethnic groups have different relationships to and ideas about art and art-making. Another study, which could be either empirical or theoretical in nature, could examine which cultural groups would be more amenable to using art-making in therapy, and also with which cultural groups it would not be as appropriate or useful.

Clinical implication and importance to the field of Social Work

This theoretical study reveals the potential usefulness of using art-making to increase communication and understanding in cross-cultural and cross-linguistic therapeutic encounters, and to alleviate some of the potential barriers that can occur in these therapeutic situations. As I mentioned in the first chapter, the National Association of Social Workers (NASW) Code of Ethics (1996), charges social workers with the task of enhancing the well-being of the people with which they work, especially those who are vulnerable, oppressed and living in poverty. As I point out in my research, very often the clients who present for therapy are from poor, oppressed, and non-Western backgrounds. It is imperative for clinicians to engage these clients, and to offer culturally appropriate therapeutic treatments that will enhance communication and understanding within the therapeutic unit. Therefore, developing effective modalities to work cross-culturally and cross-linguistically is imperative. Art-making in cross-cultural therapy may be one modality.

Finally, I believe that using art-making as a therapeutic tool in cross-cultural therapy is a topic that has only begun to be considered and explored, and that this theoretical research offers an additional step in the move toward comprehensive research in this field.

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