Diagnostic Thought in Expressive Arts Therapies

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Abstract

'Diagnostic Thought' in expressive therapy is the therapist's ability to move in the artistic medium during the course of therapy from an experiential subjective position to a more objective one, in order to understand, identify and decipher the message, the experience and the artistic product presented by the client. This article deals with the form of diagnostic thought that the therapist creates for himself by means of arts, and comprises an added means of connection with the client throughout the course of the therapy. The author uses Casement's (1985) concepts of "Active Observation" and Projective Identification, and then differentiates between "Diagnostic Thought" vs. "Diagnostic Conclusion", "Primary Diagnostic Thinking" vs. "Diagnostic Thinking in Process". A further differentiation is made to "Available Potential" vs. "Latent Potential". The author presents preliminary requirements for becoming a reliable diagnostic therapist: knowledge, experience and sensitivity. In the discussion the author uses McNiff's (1989) terminology for encouraging arts therapist develop their diagnostic thinking".

Key words

Diagnostic thinning, inner supervision, diagnostic conclusion, primary diagnostic, available potential, latent potential

Highlights

Diagnostic Thinking in Arts Therapy

Diagnostic thought vs. diagnostic conclusion in Arts Therapies

Primary vs. Process Thinking in Creative Arts Therapy

Available vs. Latent Potential in Diagnostic Arts Therapies

Literature review

The professional literature in the area of expressive therapies and in certain specific areas of movement, visual arts and music include many references to diagnostic techniques called "assessment" and "evaluation". In order to present the existing approach in the literature regarding diagnosis by means of art, I will present a number of typical examples.

In the book *Expressive Arts Therapies* by A. and B. Feder (1981), the authors demonstrate a diagnostic subject in each of the chapters on arts: the diagnostic perspective by means of visual art (art therapy) is reviewed there (p.60), the approach of psychodynamic psychologists such as Freud, Yolanda Jacoby, who is Jungian, or the dynamic healer with arts Margaret Nomberg. The principal message deals with the unconscious and visual arts as reflecting a projection of urges and conflicts with diagnostic value. In addition, a "glance" into projective personality tests such as Rorshcach and TAT (p.89). also Furth (1988) book *The Secret World of Drawings, Healing Through Art* presents a systematic approach to drawing analysis in this spirit from the Jungian point of view. In the chapter "Therapy by means of music" in Feder and Feder's (1981) book, there are considerable reservations regarding the diagnosis of mental problems (p.120). The authors raise the issue of generalization in diagnosis, and the tendency to categorize clients into problem categories that are too broad. The authors oppose the use of music as a stimulus for associative content projections for diagnostic purposes: "The major disadvantage of using music for diagnostic purposes is in that all the musical techniques for diagnosis are verbal and indirect. Not like the color stain (in the Rorschach test) in art or movement therapy, the

projective musical approach arouses in the client a response and not a product. These diagnostic techniques empty the client of spontaneity and authenticity (p.123).

In contrast, in Unkefer's (1990) book *Music Therapy in the Treatment of Adults with Mental Disorders,* in the chapter discussing the role of music therapy in diagnosis of psychotic clients, the editor presents a long list of models for diagnosis by means of music, including projective techniques. In a comment explaining the rationale for assessment by means of music therapy, the author asserts: "Diagnosis by means of music therapy or under musical conditions is important. The form of diagnosis actually resembles other diagnoses, but the singular difference is embedded in the observed behavior the client will show in certain musical conditions" (p.129)"…assessment of a client in musical conditions enables richer and fuller understanding of the individual" (p. 141).

In the chapter dealing with diagnosis by means of movement in Feder and Feder's (166:1981) book, the authors point to Gezel's work, who emphasized the role of movement in executing a task, and Reich's work, who emphasized the principle of tension in movement. The authors explain that movement can be observed using the principle of symbolism in direction, position and physical motion. In a detailed chapter in Laban's work recording movement forms, Bernstein (1985) in her book *Theoretical Approaches in Dance Movement Therapy* presents different approaches to movement therapy, and with each approach, she dedicates references to observation and assessment. In diagnosis by movement, the writing and the diagnostic/therapeutic model of Eshkol-Vachman must be emphasized as well as Yonah Shachar-Levi's (1990) "physical-mental paradigm".

The professional literature dealing with diagnosis by means of arts is characterized by a central conflict. Art therapists deal with one side of the conflict in assessment and diagnosis of a client, sometimes adopting psycho-diagnostic methods, and on the other side being aware of the danger and limitation of the diagnostic eye. They try to utilize art therapy that is in fact non-judgmental and accepting of the client, his talents and creativity without placing a label on them.

Feder and Feder (1981) point out that "art therapists are undoubtedly influenced in their work by diagnostic labels that are given to clients by psychiatrists and psychologists. In contrast to verbal therapy, most of the diagnostics in art therapy are received independently from the client's artworks. The diagnostic findings gathered by art therapists actually serve as support for the psychiatric-clinical diagnostic findings. Both the artistic product and the movement product reveal much about the idiosyncratic personality of the client. The client can participate in both without previous artistic training, and if the client has previous training in the medium, the therapist will have to discern between the 'authentic product and the dependent product'" (p.218).

Active observation

It is my desire to present in this article a different point of view regarding the issue of diagnosis. I will not deal with diagnostic techniques or with the ethical dilemma of diagnosis, that are indeed raised and elaborated in the literature shown above.

Here I will attempt to introduce the reader to a specific diagnostic-therapeutic outlook that can be called "active observation" and can be adopted in the therapeutic process by means of art.

Casement (1985) in his book "Learning from the Client" explains the importance of the existence of the "inner supervisor" within every therapist, alongside the ability to perform "projective identification ". In his analysis of the term "inner supervisor" he claims that "at the time the client becomes a stress factor, the therapist has a strong tendency to go back and put on the familiar figure and enlist previously known ways of functioning." (p.42). In the various art therapies, "previously known ways of functioning" are associated with the therapist's esthetic preferences, quick categorization of *deja-vu* sensations and sometimes even reduction to the elementary role of art therapists: the role of "enabler" – facilitator – while relinquishing other important roles, such as reflection and interpretation. Casement speaks of the "spontaneous ability for introspection during the therapy session, alongside the internalized supervisor. Thus therapists look inwardly to themselves, while they simultaneously observe the client, using the island of intellectual inward scrutiny as a mental space in which the inner supervisor can perform" (p.43).

In art therapy the intention is to be able (while the client creates) to observe and understand, not only how the client creates, what the connection is to his creation and what the interpretation of his behavior is at the time of creation, but also how his artwork affects him (the therapist). What do I understand from it? What is acceptable to create at the client's current age and situation? What is renewed in the artwork? What is surprising and what is "incriminating"? What is optimistic and what is perturbing? In addition, what can be deduced when the client doesn't create at all? On the other hand, just as the development of the "inner supervisor" requires a certain withdrawal into oneself, precisely from an intellectual perspective, Casement (1985) also supports the ability to perform "projection identification". In this matter he indicates that "(he) often finds there is benefit in using "projection identification" as part of the idea of the inner supervisor. Projection

identification is the empathy needed in our quest to understanding the client, and we develop empathy as the ability to participate in the experiences of others – not as if they were ours, but in actually being our experience" (p.44). According to Casement's personal version, we are speaking about "the ability to enter the thought or emotion of any experience the client describes" (p.45). In therapy by means of art, we will speak of the capacity to experience the client's creative processes and to be a participant in them: to understand the technique the client selected, the way it is performed and the significance of the choice. Putting these two concepts side by side (the inner supervisor and projective identification), Casement demonstrates the importance of the therapist's double viewpoint: the objective alongside the empathic-subjective. The client is indeed very much in need of this double viewpoint.

The scribble, drawing, statue, collage, movement in its various forms and its tiny secrets, notes, rhythms and melodies – all act upon us with direct immediacy, and spark an experience within us that has a certain extent of projection. Out of empathic responsibility and a desire to experience the message "objectively" transmitted by the client, we are in need of the diagnostic point of view. We must understand what the artistic message presented by the client actually says.

First, we must ask and listen with utmost attentiveness to the client's responses, to receive his/her answers simply and to ascertain that we fully understand him/her and their emotions. However, it is our professional incumbency to be capable of seeing the client's viewpoint as the present existing truth alongside other possibilities outside their awareness. When Casement presents the concepts of the "inner supervisor" and projective identification, he hints, in my opinion, about a diagnostic aspect in the concept of 'empathy' as it is raised by Kohut (1975). Empathy according to Kohut is "the way according to

which the person gathers psychological information about another person. When a person brings forward his opinion or emotion, the listener imagines the inner experience of the teller, even though it is not given to direct observation" (p.450). While in verbal therapy, words are the only creation, in arts therapy the artwork is the subject worthy to be imagined by the therapist. Here is the place where "diagnostic thought" is actually performed, which is the silent dialogue between the therapist and himself in the presence of the client's creative process. The conclusions raised are not necessarily from knowledge that can be presented to the client. Often it is recommended not to share our general thoughts with him at all, and sometimes a shared discussion will be a most significant step in the therapeutic process. Here a stand is presented with a different principle from verbal – psychodynamic therapy, according to which reflection and interpretation are central tools to understanding and change. In expressive therapy, healing power is found in the process of raising content from the unconscious, even though it seems to be done with consciousness and understanding. The experience of releasing primary emotions, experience for its own sake and a virginal experience are the healing strength of the medium. However, precisely in being so, it is important that the art therapist will be able to direct within himself, the inner experience of dialogue in the presence of the artwork being continuously formed by the client. Jacoby (1985) in relating to empathy as perceived by Jung in comparison to Kohut points out, that the "the only way I know to find the appropriate perception with my empathic response of the client's reality is never projection, but getting the client's response. Only together can we reach a real enough agreement regarding the atmosphere in his 'inner home' (p.116).

Diagnostic thought in art

Diagnostic thought is a professional requirement for the art therapist toward the one who has turned to him for help, because it testifies to his "understanding" and not just "enabling". It is a testimony to the professional legitimacy of the therapist to try and build a real process with the client of growth and change within the framework of a certain artistic medium. The difference between diagnostic thought and diagnostic conclusions must be discerned. Diagnostic thought is dynamic, opening up assumptions, enabling the raising of associations, stimulates and receives possibilities and affiliations. It is the creative aspect, the instinctive and unpredictable part of thought.

In contrast, the diagnostic conclusion is reductive, logical and binding. Its principal purpose is to enable structuring a clear strategic therapeutic line. Art therapy has a more qualified approach than diagnostic conclusions, which have a tradition of categorizing and placing labels on the client. These conclusions are by nature pessimistic and can be a determiner of their fate. Diagnostic thought does not obligate closing off options or fastening prejudices to the client. It doesn't block the client's creative – artistic process in any way, rather it strengthens the orientation of the therapist and enriches the client.

We will discern the difference between "primary diagnostic thinking" and "diagnostic thinking in process". In "primary diagnostic thinking" we deal with the initial phase, in which the client is referred for help using the artistic medium. This is the phase of gathering impressions whose main purpose is to take a stand regarding the client's condition in light of the psychological-psychiatric information given about him. It is particularly upon us to determine at this point the extent of the client's suitability to work in the particular artistic medium. Often a significant gap is observed between the psychological and psychiatric opinions the client comes with to our therapeutic workshop, and the client's actual ability and functioning in a specific artistic medium. At this stage, a

deep dynamic connection between the client and therapist is not required. The therapist notes what exists and what is available in the client's repertoire. The impressions issue initially from the client's available potential and only later from the client's latent potential. In the art workshop we can, for example, see on the level of 'available potential', a clear limitation in the client from a technical standpoint or a limitation in the strength of the client's 'creative self' and if on the level of 'latent potential' we might note some small evidence of interesting esthetic taste or a preferred unique ability. In a movement therapy studio, we might observe hypotonic with an impaired posture on the 'available level' in the body, whereas on the 'latent level', the potential for power might be identified. In the musical therapeutic space, we might discern that on the level of 'available potential' there is chaotic sound, for example, but on the 'latent potential' level, we might discern a concealed leaning toward the expression of pain.

Initial diagnostic thought examines the gap between three elements: 1. Available potential - (what emerges and is executed in the first sessions).2. Latent potential - (the resources and optimal possibilities that can be aspired to or can be developed by means of the artistic medium). 3. The norm - (what is usually expected from a normal person of the same age, state of health and level of intelligence).

"Diagnostic process thinking" is very different from the "primary thinking" described above. The "process" occurs within the creative-dynamic process of the therapy: it will occupy the therapists as they are playing, drumming or listening to their clients. It exists as they observe a client's drawing during the course of his creation, after leaving the workshop, at the time we hang his work up on display, to dry or to put it in a file of artworks. It will occur at the time of observation of movement of difficult, boring or moving occurrences in a studio in movement therapy, and it will surely emerge as we

create an artwork inspired by intimacy, when there is supposedly no connection between that and being therapists. The art therapist, being a creative artist himself, will sometimes reach only through spontaneous artistic expression "in his medium" a deep insight and the exposure of a repressed experience, that he experienced in the presence of his client.

Our clients sometime comprise a source of deep inspiration for our creativity and a source of energy for releasing repressed creative and dynamic material during the "relinquishing" we do for the sake of our client in the therapeutic framework.

The Challenge of Implementation

Diagnostic thinking requires a combination of knowledge, experience, sensitivity and a high level of boldness.

Knowledge enables understanding of the normal as against the anomaly. It enables the presentation of different and varied possibilities of the source of the problem before us, the source of the strengths before us and understanding of what is revealed and what is concealed within the client's personality. Knowledge is based on knowing the artistic heritage and history of the artistic medium in which we specialize, on experience and knowing the healing strength of this medium and the capacity for activating ourselves in the specific medium. At the same time, we are required to know the normal and the pathological in the different developmental phases of the human body and mind.

Experience will develop great sensitivity in spotting clues and possibilities, it will add confidence and will enable a quick grasp of what exists and what is comprehended, but also patience in the search for what is puzzling and challenging.

Sensitivity and the high level of boldness issue from the fact that in the course of discerning observation the therapist is fearful and apprehensive in remaining within the unknown. When the artwork, the rhythm and the sound, the organization or product, the

movement and expressions are unclear to the therapist, he is liable to remain on the level of mere experience. The therapist is immersed in a very uncertain place. Diagnostic thinking requires boldness while avoiding formulas, dictionaries and standards. It encourages a new and bold way of seeing. Sensitivity in this sense is a creative aspect and it is very necessary during the course of diagnostic thought. The human mind operates with slight indications, contradictions, with a high level of symbolization, paradoxes, and rules similar to the rules of mythology – in which all is possible. Understanding the products of the unconscious that find expression in the different arts during the course of therapy requires great sensitivity. A standard, banal, familiar or commonplace view will produce limited understanding and loss of the truth. We deal, if so, in the act of sleuthing out that is concealed and generated in the therapist's head. While he experiences the creative process or the contention of the client and the presence of the artistic product before him, the therapist often feels a moving experience. Diagnostic thought adds much significance to the experience. "The understanding therapist" knows to choose suitable therapeutic strategies. He knows how to speak with the client and how to respond. He knows which artistic technique to use; how to be a witness to the therapeutic process. Often he also understands when he must turn to consultation with professionals from other areas.

We have a great intellectual challenge before us that takes place within the creative experience itself. The question is raised as to how this diagnostic ability is acquired.

a. We must combine an element of broadening and deepening knowledge of the human mind, of the different developmental stages and of the qualities of the artistic mediums and their characteristics, by means of which the therapeutic process is done.
b. We must remember that diagnostic thought in the different art therapies is based on a combination of three principles: the principle of experience, the principle of

organization and the principle of content. In the presence of the human-artistic creation in its formation, or afterwards, we must always ask ourselves three questions: first, what do I feel now, and what did the creator (client) experience during the birth of the artistic product (the experiential principle). Second, how was the work done, in what way and in what sequence (organizational principle). And third, what does the artwork say to me? Which messages does it transmit and what is the world of symbols that have been used in it? (principle of content).

c. We must know ourselves as a diagnostic instrument: what influences us? How do we express ourselves in the artistic medium, in which we activate the client? What are our dominant personality characteristics and what is obscured in the elusive aspects of our personality? That is, the therapist must expose himself to diagnostic analysis of his own creations in the medium he uses to treat. In his book *Depth Psychology of Art*, McNiff (1989) analyzes artworks he created himself. McNiff claims that "in our profession not enough attention has been addressed to this matter, not in research and not in the therapist training process. We deal almost entirely with investigating others, but only to a very small extent do we investigate ourselves. I believe that long and focused learning of our artistic expressions will reveal the 'self' and will bring us closer to the life of the authentic artistic object that is within us." (p.121). McNiff also points out that "most artists are not actively involved in the psychological investigation of their work. This is not a prior requirement during the course of their training, but we do place this demand in our expectations from an art therapist" (p.122). According to his claim, "The stereotype of the fearful artist who refuses to investigate the psychological process of his creation, out of fear that he will know too much and will then lose the conflictual chemistry that motivates expression, belongs to the past. I found that the process of psychological interpretation deepens and promotes the artist's motivation and his ability to create. The mystery and the power of the

creative process will never reach the level of simple diagnostic judgment and categorization" (p.123). In addition to McNiff's idea, it is upon us to expose the diagnostic thinking that develops in the supervision process before an experienced supervisor, with whom we will work with a combination of knowledge, experience, sensitivity and boldness in the therapeutic process.

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