

## **TOOLS OF THE TRADE**

#### ABOUT THE AUTHOR

**Stephanie L. Brooke** is a private practitioner and organizational consultant in Rochester, New York. She received training as an art therapist at Hillside Children's Center in Geneseo, New York and her certification in art therapy from Nazareth College in Rochester, New York. Additionally, she is an online instructor for the University of Phoenix, Cayuga Community College, and Jamestown Community College. She teaches face-to-face classes as an adjunct in sociology and psychology for Nazareth College.

Second Edition

# TOOLS OF THE TRADE

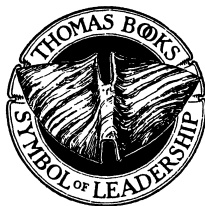
**A Therapist's Guide to  
Art Therapy Assessments**

*By*

**STEPHANIE L. BROOKE, PH.D., NCC**

*With a Foreword by*

**Barry M. Cohen, M.A., A.T.R.**



**CHARLES C THOMAS • PUBLISHER, LTD.**  
*Springfield • Illinois • U.S.A.*

*Published and Distributed Throughout the World by*

CHARLES C THOMAS • PUBLISHER, LTD.  
2600 South First Street  
Springfield, Illinois 62704

This book is protected by copyright. No part of  
it may be reproduced in any manner without  
written permission from the publisher.

© 2004 by CHARLES C THOMAS • PUBLISHER, LTD.

ISBN 0-398-07521-2 (hard)  
ISBN 0-398-07522-0 (paper)

Library of Congress Catalog Card Number: 2004048020

*With THOMAS BOOKS careful attention is given to all details of manufacturing  
and design. It is the Publisher's desire to present books that are satisfactory as to their  
physical qualities and artistic possibilities and appropriate for their particular use.  
THOMAS BOOKS will be true to those laws of quality that assure a good name  
and good will.*

*Printed in the United States of America  
MM-R-3*

**Library of Congress Cataloging-in-Publication Data**

Brooke, Stephanie

Tools of the trade : a therapist's guide to art therapy assessments / by  
Stephanie L. Brooke with a foreword by Barry M. Cohen.—2nd ed.  
p. cm.

Rev. ed. of: A therapist's guide to art therapy assessments. c1996.

Includes bibliographical references and index.

ISBN 0-398-07521-2 – ISBN 0-398-07522-0 (pbk.)

1. Art therapy. 2. Psychodiagnostics. I. Brooke, Stephanie L. Therapist's  
guide to art therapy assessments. II. Title.

RC489.A7B75 2004  
616.89'1656—dc22

2004048020

## FOREWORD

Stephanie Brooke has graciously invited me to write an introductory note to the new edition of her book, reflecting on my experience of creating and shepherding an art therapy assessment over the period of two decades. When I accepted her invitation, I had no idea of the complexity of the issues and feelings that would surface.

In 1981, a couple of years out of graduate school, I moved to metropolitan Washington, D.C. Once settled in our nation's capitol, I set out to create a national slide library of artwork representing the various psychiatric diagnoses. As an ambitious art therapist surrounded by national collections of "this and that," it seemed like a natural project to initiate. But I quickly found that I could not get adequate slide donations from senior practitioners and educators. For the most part, they did not trust the accuracy of diagnoses in samples submitted by others, and were understandably protective of their clients' work. It became clear that I would have to create the collection on my own, from scratch.

Spontaneous works and those made in art therapy sessions cannot be compared for diagnostic research purposes. Differences in materials, formats, and directives make it impossible to compare "apples to apples." So I decided to develop a standardized format for creating a series of pictures that would ultimately allow clinicians around the country to compare artwork by clients along with a standardized research format for studying these pictures. And that is how the Diagnostic Drawing Series (DDS) was born around 1982.

My supervisor, art therapist Barbara Lesowitz and I created a three drawing tool using twelve square chalk pastels and three sheets of large format white paper that could reflect a rich profile of behavioral and psychological information about the artist/patient by using rating criteria that were primarily based on pictorial structure instead of the traditional narrative content. We were encouraged by psychiatrist Thomas Wise to improve the project's potential for publication by obtaining concurring diagnoses from a pair of psychiatrists for each client in the DDS research sample. We began to collect

DDSs within our hospital corporation's several facilities for our first pilot study. Soon after, Lesowitz left town (and subsequently the profession), but fellow art therapists Anna Reyner and Shira Singer joined me in completing that pilot study, which eventually won us the Research Award of the American Art Therapy Association (AATA) in 1983.

From the beginning of this adventure, I have enjoyed receiving inquiries from clinicians in this country and overseas. Mail crossed my desk from the former Soviet Union, Australia, Israel, Italy, Belgium, Great Britain, Norway, and other far-flung places around the globe. In addition to the letters and lovely postage stamps, the idea that people all over the world had heard about the DDS and were interested in using it with their clients was very gratifying. In fact, I met my future colleague/collaborator/wife, Anne Mills, when I was invited to speak at my first international art therapy conference in Canada in 1984.

Training workshops around the country have always been a wonderful way to spread the word, see hundreds of new examples, and to learn more about the DDS from our participants. In particular, a number of trips to the Pacific Northwest were wonderful experiences. A couple of these were organized by our west coast DDS Training Associate, art therapist Kathryn Johnson, who is currently completing a DDS study on bipolar disorder for her doctoral research in psychology.

In recent years, the founding of multiple DDS study groups in the Netherlands has been among my greatest rewards for the often grueling and relatively thankless time spent writing criteria, rating drawings, working with statisticians, shooting slides, responding to inquiries, spraying pictures, preparing presentations, publishing articles, and mailing out packets during those early years.

A few short weeks after 9/11, Anne and I traveled to Utrecht to teach a two-day introductory DDS training session, along with our European DDS Training Associate, Jon Fowler, who is now based in England. It was followed by a special master class with Dutch study group members. This was our second invited training trip to Holland, but the first to be held inside a windmill! The warmth of our hosts and their avid interest in our work stood in sharp contrast to those horrific recent events, and resulted in the most memorable experience of my career as an art therapist.

Looking back at my reaction to the welcome given us—really, to the DDS—in Holland, I am certain my response was somewhat exaggerated by many of the challenges and disappointments that I have faced in raising the DDS to adulthood here in the United States.

Although the last twenty years has been an interesting and pivotal time for the field of art therapy assessment in this country, it is highly unlikely that there will ever be a broad level of interest in art therapy diagnosis and

research here in the United States. Our Dutch colleagues have told us that their interest in the DDS stems from the lack of such information in their training, which is primarily oriented to process issues. But what about American art therapists and their training?

Could it be that American art therapists are so well instructed in this area that they have no need for continuing education? To my knowledge, many of the faculty that teach the DDS to graduate students, or supervise their use of it, have never themselves taken the requisite training (now two days in length, because of the time necessary to convey and integrate the material through practice), yet they feel competent to teach it, write about it, or critique it.

Naturally, the vast majority of American art therapists are less interested in, or comfortable with, assessment or evaluation than clinical work; it stands to reason that art therapists would much rather engage in the activities they are trained to do, such as making art with their clients and otherwise helping them to heal. Moreover, as a general rule, artists tend to shy away from anything that smacks of scientific studies, especially those that involve numbers or statistics.

Now, after twenty years of publications and presentations, there is not a single active DDS study group in North America that I am aware of, but in a small country such as the Netherlands, there are several. In my opinion, this reflects the impact of role modeling by our graduate faculty, coupled with an unproductive form of rebelliousness among American art therapists which manifests in different ways. Here is one that I find particularly destructive:

Rather than turning to established and even validated art therapy assessment tools like the DDS, art therapists seem to prefer creating their own highly idiosyncratic assessments to use with their clients. Stephanie Brooke's *Tools of the Trade II*, is mercifully lacking these creations. However, their annual proliferation points to the naiveté among practitioners who believe that pairing a metaphor with drawing materials is all it takes to make a useful art therapy assessment. And their acceptance annually by the conference program committee may appear to some, I believe, to be a tacit form of approval or endorsement.

So, when art therapists create an ongoing flow of novelty assessments without investing the necessary years of work to render their tools meaningful, who suffers? In my opinion, when they persist in assessing their clients with them and proudly encourage others to use them at our annual conferences, we all do.

I believe that many art therapists simply do not understand or accept the importance of evidence-based work, or explicitly reject standards that the DDS project is based upon, such as objectivity, replicability, and the scien-

tific method. This split in the field is reflected in the American Art Therapy Association's current ethics standards on assessments.

The introduction of the DDS was an important step away from simplistic, psychoanalytically-based symbol analysis in art therapy. In devising rating criteria for the research component of the project that were primarily based on pictorial structure, not narrative content, I was rebelling against what I felt were the "touchy-feely" roots of art therapy which came of age in the late 1960s.

At the time, I noted that I was trying to help art therapists in psychiatric facilities identify and develop essential skills to deal with the arrival of diagnosis-driven short-term treatment. But back in the 1980s, many influential art therapists did not want to "label" their patients nor did they want to deal with numbers or statistics.

They saw the research-associated DDS which was designed to be equally useful to clinicians from all schools of psychotherapy as somehow contrary to the values of humanism, psychodynamic psychotherapy, feminism, spirituality, and intuition.

Once the "hardball" managed care era of the 1990s hit, art therapy positions were seen as luxuries and staffing was cut around the country. Art therapists had little to point to that would show their budget makers why their skills were necessities, especially at higher salaries than recreational therapists, and not reimbursable, either, like occupational therapists. Had the art therapy profession taken a bit of preventive medicine with some outcome studies and the like, perhaps some jobs would have been saved and the field would have moved forward by now.

Just recently, for instance, a young sniper's portfolio of jailhouse drawings was entered into evidence by the defense in a highly notorious murder case, which was tried nearby an art therapy graduate training program. Was a single art therapist called in to look at the pictures and offer a professional opinion? Did the attorneys on either side call for an art evaluation in a case being tried on an insanity plea? Please prove me wrong; this was our profession's best chance to enter the national dialogue on anything, and we clearly missed out because we had not prepared the way. The media and legal professions do not yet realize the unique assessment and diagnostic skills that art therapists have to offer because our profession is still ambivalent about them, and has not promoted itself effectively, if at all, in this regard.

Little did I realize back in the early eighties that the creation of a valid art-based assessment, especially if it is correlated with psychiatric diagnostic nomenclature, is ultimately a lifetime's work. And it is not just one person's lifetime work. Like other things of importance in this world, it definitely takes a communal effort.

But, as Anne Mills has pointed out in one of her conference presentations,



everyone thinks that research, like dirty dishes or other forms of housework, is up to somebody else to do. And once someone comes forward and actually does it, they are roundly criticized, and usually by people who have not read, studied, or even understood their work. In fact, the DDS has taken more than its share of misinformed critiques over the years on this side of the Atlantic and abroad, largely because it is a highly visible target.

The DDS, as I originally conceived it, was a multifaceted project with a number of ambitious but viable goals, most that I believed could be achieved within a matter of years through the support of my fellow art therapists. And I was correct in my assumptions to a certain extent. The resource library of DDSs has grown to over 1000 sets over the years. But the amount of samples submitted over the past decade or more has been minimal, especially when considering the number of students who graduate from training programs annually, and the thousands of registered practitioners in the United States alone.

Still, after twenty years, our achievements as a worldwide network of collaborating clinician-researchers are significant and many. The DDS offers a quick and easy-to-administer art interview, which, through associated research has a large centralized library of carefully collected standardized samples, along with an unparalleled body of multicenter studies by multiple investigators from around the world; add to this its status as the first major scientific study correlating art productions with psychiatric diagnoses. Also, through its handbook of defined structural criteria, the DDS Project provides an objective, common language to describe pictorial communications. It was the first art therapy assessment to norm the art of “healthy” adults, and arguably the first projective drawing tool ever to do so. And, after two decades of use and study, published DDS research has achieved a level of validity unprecedented in the study of art expression and psychiatric diagnosis. As early as 1993, the number of published validity and reliability studies on the DDS effectively doubled the total number of such studies in the entire art therapy literature. Additionally, the DDS has become the best known and most commonly taught art therapy assessment in the United States, and possibly the world.

The DDS, first presented publicly at an AATA conference in 1983, first entered the published literature in 1985, when the handbook was made widely available. Also that year, the test itself was profiled in the American Psychological Association’s *Monitor*, prompting a good deal of interest from psychologists. An overview in a Dutch psychological journal appeared in 1986, and the first DDS research results were presented in the expressive therapies literature in 1988. The DDS was featured on National Public Radio’s “All Things Considered” in 1984, and illustrated in two college psychology textbooks in 1987.

Approximately 35 DDS studies have been completed to date; some are replication studies, but most norm different DSM diagnostic groups. They include: Nonhospitalized controls, children and adolescents (Leavitt, 1988; Neale, 1994; Shlagman, 1996); adults (Cohen, Hammer, & Singer, 1988; Morris, 1995); and seniors (Couch, 1992). Schizophrenia (Cohen, Hammer, & Singer, 1988; Mills & Yamashita, 1996; Morris, 1995; Ricca, 1992). Mood disorders, major depressive disorder, children and adolescents (Leavitt, 1988); adults (Cohen, Hammer, & Singer, 1988; Morris, 1995); Dysthymic Disorder (Cohen, Hammer & Singer, 1988); Bipolar disorder (McHugh, 1997). Dissociative Disorders, Dissociative Identity Disorder (Fowler & Ardon, 2000; Heitmayer & Cohen, 1993; Kress, 1992; Mills & Cohen, 1993; Morris, 1995; Ricca, 1992), Dissociative Disorder Not Otherwise Specified (Fowler & Ardon, 2000). Eating Disorders (Kessler, 1994). Borderline Personality Disorder (Mills, 1988). Posttraumatic Stress Disorder (Des Marais & Barnes, 1993). Dementia (Couch, 1994). Adjustment Disorder, children (Neale, 1994). Conduct Disorder (Neale, 1994).

There are many directions in which the DDS Project and its myriad offshoot studies could be developed in the future. Perhaps some of the present generation of art therapists who have been educated in the importance of reliable and valid art assessment tools, as well as other professionals, will explore ways to expedite the completion of this valuable and still ongoing work. In an aspect of the field almost devoid of scholarly research until relatively recently, we've made a great deal of progress, even if the definitive DDS book is not on your local merchant's shelf . . . yet.

I think the most important goal of Stephanie Brooke's book is its attempt to digest and accurately report on a lot of detailed material for people who would otherwise not take the time to do it for themselves, but who are conscientious, and know that choosing an art assessment must be a well-informed decision, not one simply dictated by training program bias. Keep that in mind as you read on.

BARRY M. COHEN, M.A., A.T.R.

## PREFACE

**T***ools of the Trade* is a volume that provides critical reviews of art therapy tests with some new reviews of assessments and updated research in the field. It is comprehensive in its approach to considering reliability and validity evidence provided by test authors. Additionally, it reviews research on art therapy assessments with a variety of patient populations. The book contains helpful suggestions regarding the application of art therapy assessments.

Specific areas covered include individual, group, family, and multicultural assessment techniques. The desirable and undesirable features of a variety of art therapy assessments are deliberated. This is a valuable resource for practitioners who use art therapy as an adjunct or primary therapy. The book will serve to enhance clinical skills, making therapy more effective for each patient who participates in the assessment process.

This volume critiques a series of art therapy assessments from traditional art therapy approaches to current releases. The goal of this work is to assist mental health professionals in selecting assessments that yield reliable and valid clinical information regarding their clients. Of special interest is the author's approach to writing the results of a series of art therapy assessments in an effort to provide a more complete indication of client dynamics and issues.



## ACKNOWLEDGMENTS

I would like to express my sincere appreciation to Dr. Barry M. Cohen for writing the foreword to this book. I was deeply honored when he accepted this undertaking and shared his experience with developing and refining the DDS. I would also like to thank the following art therapy assessment authors for their communication with me on the writing of the reviews of their chapters: Donna Betts, Linda Gantt, Ellen Horovitz, Myra Levick, and Rawley Silver. I commend them for their endeavors to contribute to the creation of an art therapy assessment and commitment to establishing further reliability and validity to the field of art therapy. To Bodan Petriev, a dear friend, I would like to thank him for the photography of the artwork in this book. I would like to thank my friend, Dr. Michael Hand, who started out with me in my Ph.D. program at Walden University, for his undying support during this work! My deepest appreciation goes to my long-time mentor and friend, Dr. Jack Dilendik, who watched me grow from a novice researcher and writer to a published author.



## CONTENTS

	<i>Page</i>
<i>Forword by Barry M. Cohen</i> .....	v
<i>Preface</i> .....	xi
 <i>Chapter</i>	
1. Introduction .....	.3
2. Human Figure Drawing Test .....	.13
3. Kinetic Family Drawings .....	.29
4. Kinetic School Drawing .....	.47
5. Diagnostic Drawing Series .....	.56
6. House-Tree-Person Test .....	.68
7. Kinetic House-Tree-Person Test .....	.82
8. Family-Centered Circle Drawings .....	.90
9. The Silver Drawing Test of Cognition and Emotion .....	.98
10. Draw a Story Test .....	.112
11. Draw a Person Test .....	.124
12. Magazine Photo Collage .....	.135
13. Belief Art Therapy Assessment .....	.145
14. Art Therapy Dream Assessment .....	.153
15. Face Stimulus Assessment .....	.160
16. Formal Elements Art Therapy Scale (FEATS) .....	.167
17. The Levick Emotional and Cognitive Art Therapy Assessment ..	.179
18. Recommendations .....	.188
19. An Approach to Using Art Therapy Assessments: A Case Study .....	.200
20. Internet Resources .....	.219

*Author Index* .....233  
*Subject Index* .....238



## **TOOLS OF THE TRADE**



## Chapter 1

### INTRODUCTION

**D**ue to the increasing isolation, dehumanization, and overintellectualization of our culture, there is an increasing focus on affect and getting in touch with the inner self (Prinzhorn, 1972; Moreno, 1975; McNiff, 1992; Anthony, 2003). Jung (1958), a novice artist himself, was using art as a method to get in touch with his psyche. Although known as a landscape painter, Jung was focused, the images that emerged from the inner psyche Edwards (2001). Accordingly, therapists are inclined to use creative modalities such as art, music, dance, and drama for psychological healing and growth. Although these methods may be unorthodox to some, people can encounter important self-data by approaching themselves from a new perspective or through a new medium.

Aside from the therapeutic benefit of nonverbal communication of thoughts and feelings, one of the most impressive aspects of the art process is its potential to achieve or restore psychological equilibrium. This use of the art process as intervention is not mysterious or particularly novel; it may have been one of the reasons humankind developed art in the first place—to alleviate or contain feelings of trauma, fear, anxiety, and psychological threats to the self and the community. (Malchiodi, 1990, p. 5)

Art has been used as a means of self-expression for centuries, the evidence of which remains today with pottery, cave drawings, hieroglyphics, masks, and much more. People have used art materials to “make images and connect them to feelings and bodily states [that] bring into the open thoughts that have been only vaguely sensed” (Keyes, 1983, p. 104). Edwards (1986) asserted that drawing exists as a parallel to verbal language and was the simplest of nonverbal languages. Art does not have the restriction of linguistic development in order to convey thoughts or feelings.

## JUNG AND ART

I had to abandon the idea of the superordinate position of the ego. . . . I saw that everything, all paths I had been following, all steps I had taken, were leading back to a single point—namely, to the mid-point. It became increasingly plain to me that the mandala is the centre. It is the exponent of all paths. It is the path to the centre, to individuation. . . . I knew that in finding the mandala as an expression of the self I had attained what was for me the ultimate. (Jung–Mandala Gallery, 2003)

Initially a follower of Freud, Carl Jung, a Swiss psychiatrist, was one of the founding fathers of depth psychology. Jung (2003) inspired the New Age Movement with its interest in spirituality, occultism, Eastern religions, I Ching, and mythology. From *Psychology and Literature* (1930), Jung noted the power of art as a tool to work with the unconscious (cited in Jung, 2003) (<http://www.kirjasto.sci.fi/cjung.htm>).

The artist is not a person endowed with free will who seeks his own ends, but one who allows art to realize its purposes through him. As a human being he may have moods and a will and personal aims, but as an artist he is “man” in a higher sense—he is “collective man,” a vehicle and moulder of the unconscious psychic life of mankind.

Given that art was a natural mode for getting in touch with his own emotions and inner images, Jung used art as a tool to help his patients get in touch with their inner self. According to Stone (2002), Jung’s work prompted Irene Champernowne to set up a center for “Psychotherapy through the Arts.” Irene (a psychotherapist) and her husband, an art teacher, ran the center. Art therapy has also been used in psychiatric institutions. In addition, Freudian psychoanalysts used the drawings as tools for gathering information on the patient’s current mental state (Stone, 2002).

Recently, I attended a presentation by Harriet Wadeson, who wrote the forward to the first edition of this book. She was presenting at Nazareth College (September 26, 2003). Her workshop focused on the use of Jungian principles in relation to art therapy. Specifically, she used art exercises to get in touch with the shadow. Other art therapists have used the concept of the shadow in conjunction with art therapy. For instance, Bouchard (1998) implemented experiential art exercises as a method of transforming the negative elements of the shadow into positive creations. These projective methods designed to explore motivation are not new to the field of psychotherapy.

## **ART THERAPY ASSESSMENTS**

Machover (1949) observed the power of projective methods in discovering unconscious determinants of self-expression that were not apparent in direct, verbal communication. Langer (1953) stressed that “there is an important part of reality that is quite inaccessible to the formative influence of language: that is the realm of the so called ‘inner experience,’ the life of feeling and emotion . . . the primary function of art is to objectify feeling so that we can contemplate and understand it” (pp. 4–5). Art expression offers the opportunity to explore personal problems without dependence on a verbal mode of communication. Naumburg (1966), a renowned art therapist, contended that “by projecting interior images into exteriorized designs art therapy crystallizes and fixes in lasting form the recollections of dreams of phantasies which would otherwise remain evanescent and might quickly be forgotten” (p. 2). According to Knoff and Prout (1985), projective drawings were used for the following purposes:

1. as an icebreaker technique to facilitate child-examiner rapport and the child’s comfort, trust, and motivation.
2. as a sample of behavior that involves a child’s reactions to one-on-one child-examiner interaction with a semi-structured task.
3. as a technique that investigates the interaction between a child’s or adolescent’s personality and his/her perceptions of relationships among peers, family, school, and significant others.
4. as a technique linked to a clinical, diagnostic interview that moves discussion beyond a drawing’s actions and dynamics to more pervasive psychological issues and concerns.

Therapists have found that drawings serve as an indication of the client’s current level of functioning (Wadeson, 1980; Cohen, 1986; Gantt, 2001 a & b). Often, drawings are part of an initial interview with a client. Over the years, these techniques have formed the foundation of art therapy assessment.

What are the nature and objectives of art therapy assessments? “The purpose of the assessment process is to study an individual’s behavior through observation of his/her performance and through a systematic examination of his/her finished product” (Oster & Gould, 1987, p. 13). Further, art therapy assessments may be viewed as tests of personality. Anastasi (1988) defined

personality tests as “measures of such characteristics as emotional states, interpersonal relations, motivations, interests, and attitudes” (p. 17). Generally, there are three types of personality assessments: self-report inventories, performance tests, and projective techniques. Most art therapy assessments may be considered the latter type. Anastasi (1988) defined projective techniques as tests in which “the client is given a relatively unstructured task that permits wide latitude in its solution. The assumption underlying such methods is that the individual will project her or his characteristic modes of response into such a task” (p. 19). These tests are disguised in their purpose, somewhat similar to the performance tests. This reduces the likelihood that the client will “fake” or generate a desired response. The purpose of this book is to discuss the advantages and disadvantages of the various art therapy assessments. As Anastasi (1988) noted:

Research on the measurement of personality has attained impressive proportions since 1950, and many igneous devices and technical improvements are under investigation. It is rather the special difficulties encountered in the measurement of personality that account for the slow advances in this area. (p. 19)

## **SCOPE OF ART THERAPY ASSESSMENTS**

An area of controversy concerning projective assessments centers on validity and reliability. This is often a concern when trying to use art therapy assessments in court proceedings (Brooke, 1997). “The psychologist trained in research design and statistics, sought to demonstrate the validity and reliability of projective drawings, while chief interest of the therapists (who had no training in research) was in how art could contribute to understanding individual patients and therefore, might assist in developing therapeutic technique” (Wadson, 1992, p. 136). Some psychologists stated that projective drawing techniques were not valid indications of personality traits (Swenson, 1957; Chapman & Chapman, 1967; Swenson, 1968; Chapman & Chapman, 1969; Wanderer, 1969; Klopfer & Taulbee, 1976). Despite these findings, researchers still use projective drawings for diagnosis and treatment. Groth-Marant (1990) provided evidence of validity and reliability with respect to projective drawings. The question of validity is still being debated today.

Controversy also focused on structured drawing tasks and spontaneous drawings. Often there is overlap, as Naumburg (1953, p. 124) observed:

The line of demarcation between studies . . . that employ spontaneous art as a

primary means of psychotherapy and those that deal mainly with structured art in diagnosis is not always easy to define. In some cases the therapeutic approach that uses spontaneous art may also include more formal diagnostic art elements; similarly structured art tests may include elements free of art expression as employed in art therapy. An example of this overlapping of areas of therapy and diagnosis is evident in those diagnostic papers which discuss figure and family drawings; in such cases, it can be observed that while the theme for a specific type of figure drawing is set by the therapist, spontaneity is nevertheless encouraged in the execution of this task by the patient.

Neale and Rosal (1993) reviewed some common projective drawing techniques. These authors noted the value of these techniques as instruments of insight and information that can be utilized across professions. Although the projective techniques have great potential in revealing personality characteristics, there were several questions that the authors had (p. 37):

- how accurate is the diagnostic information taken from drawings and paintings?
- should strengths as well as weaknesses be sought in drawings?
- can drawings be used to assess pathology?
- how sensitive are drawings to clinical and therapeutic changes?
- should drawings and paintings be used to assess pathology and to diagnose?

These are questions typically asked by psychologists who use projective techniques. Art therapy assessments are sometimes designed differently from the projective techniques created by psychologists. Neale and Rosal (1993) outlined some concerns that art therapists have regarding assessments (p. 38):

- can objective drawing characteristics be identified without losing the holistic view of the drawing?
- can diagnostic indicators be identified?
- can diagnosis be reached through one drawing?
- how is a scoring manual developed?
- can free drawings as well as set drawing tasks be used in diagnosis and how does one score a free drawing?

These are just a few of the questions that will be considered in this book. Where applicable, I will analyze reliability and validity information. Some of the assessments considered in this book are newly created, thus reliability and validity information is not yet available. If that data is not present for a particular assessment, information that the test purports to yield will be con-

sidered.

Another factor that will be deliberated is the cookbook approach to art therapy assessment:

In the “cookbook” method you look up the meaning of each sign and come up with a ready made diagnosis without regard for the total figure drawn and irrespective of the child’s age, sex, intelligence, and social-cultural background. The circumstance under which the drawing was produced are also ignored. (Koppitz, 1968, p. 55)

There are obvious disadvantages to looking up the meaning of images in a dictionary fashion. Images have various meanings to different individuals. Additionally, observation of the client while completing the assessment provides valuable information about affect and personality. Despite the limitations discussed, art therapy assessments are a valuable source for understanding client issues and dynamics. Although many assessments in this book do not yield quantitative information, they provide a rich source of client information:

Even without this quantification, clinicians are holding firm to the belief that drawings can be considered a unique, personal expression of inner experiences which, when used appropriately, can offer clues that are of value both diagnostically and therapeutically. Even though the value of drawings cannot be measured independently from the accumulated knowledge of the clinician, this does not diminish their intrinsic value as aids in working with both impaired and growth-oriented populations. (Oster & Gould, 1987, p. 8)

In order to gain credibility in the field, to establish validity and reliability, and to use art therapy assessments in court proceedings and continued research, art therapy assessments must be standardized.

So, when art therapists create an ongoing flow of novelty assessments without investing the necessary years of work to render their tools meaningful, who suffers? In my opinion, when they persist in assessing their clients with them and proudly encourage others to use them at our annual conferences, we all do. (Cohen, 2004)

Many creative art therapists are highly resistant to standardizing assessments (Phillips, 1994, Gantt, 2000, Cohen, 2004). Cohen (2004) hits the nail on the head with respect to this problem:

Naturally, the vast majority of American art therapists are less interested in, or comfortable with, assessment or evaluation than clinical work; it stands to reason that art therapists would much rather engage in the activities they are