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THREE HEADS ARE BETTER THAN ONE: THE EXPRESSIVE ARTS GROUP ASSESSMENT

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The physicians from whom we receive referrals are often uncertain about which expressive arts modality to order for their patients or whether any expressive arts modality is appropriate. At West Oaks Hospital, when the information was requested, the Expressive Arts therapists made three individual assessments, one for music, one for art, and a third for movement therapy. The difficulty with this method is that it is neither time nor cost effective because it involves up to six chargeable sessions for the patient, and the therapists have difficulty in adequately comparing the information received in order to present a joint expressive arts therapy recommendation for the patient.

The Expressive Arts Group Assessment was developed by the authors in 1984 to meet three needs: (a) for assessment in our respective modalities of art therapy, movement therapy, and music therapy; (b) for coordinated recommendations for expressive arts therapy treatment for some patients; and (c) for a more time and cost effective means of assessment. It was designed to take place in two sessions and to incorporate all three modalities. As the task of developing this was initiated, the authors did a literature search, seeking documentation of similar assessment methods. Nowhere in the literature did we find any group or individual multimodality method of this type. Thus, we set about the task of choosing those components that included abbreviated versions of our individual assessments. We chose those exercises that could provide the most valuable information in the shortest period of time.

Overview of Assessment

The procedure begins when we receive physicians' referrals. The therapists then form assessment groups based on age of patients and available material concerning their present state of functioning. The groups, each of which consists typically of 3 to 6 members, meet with three therapists (a music therapist, movement therapist, and art therapist) twice for one and one-half hours each session. The challenge of the Expressive Arts Group Assessment is to combine exercises that obtain the maximum diagnostic and experiential data in this period of time.

When the data have been compiled, the three therapists evaluate the diagnostic information and give their assessments of the patients' individual responses to the different modalities. The therapists then report the diagnostic information and the expressive arts therapies recommendations to the treatment team. The format of the written report is divided into sections concerning (a) intrapsychic information, (b) object relations, (c) family dynamics, (d) group

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dynamics, (e) modality responses, and (f) recommendations. Recommendations may take one of the following forms: (a) group and/or individual therapy in one or more modalities, (b) no expressive arts therapies involvement, (c) additional in-depth assessment in one or more modalities, and (d) additional assessment and a later date for future expressive arts therapies involvement.

Although the written report has the form listed above, the order in which the exercises are presented to the patient group is based on the goal of building cohesion and trust among patients in the two group sessions. The assessment begins with introductory movement exercises. These are followed by an art exercise that is a more individualized expression. The music exercise, which ends the first session, is also individual in expression, but it elicits more sharing among group members. On the second day, an art exercise begins the session in as much as some cohesion has already been established. The music exercises that follow involve group interaction, and the movement exercises that end the second session allow for a fairly smooth transition into greater group interaction and closure. The following sections describe the exercises presented by each modality and the kind of information that each one yields.

Movement

The movement therapy portion of the evaluation lends itself to discovering and describing information pertaining to self-image and body image, levels of anxiety, identity, intrapsychic states, developmental arrests, the level of object relations development, as well as strengths and weaknesses in interpersonal relationships, such as intimacy problems and poor ego boundaries in relationships with others. The movement exercises were chosen for their simplicity and their diagnostic potentials.

On the first day of the assessment process, the movement therapy portion introduces the assessment to the patients. The first session includes a group introduction, a spatial boundary exercise, and a body image exercise. In the first exercise, group members and therapists individually introduce themselves by saying their names and making a movement or a gesture that describes themselves. This exercise serves many purposes. It creates a group identity and is relatively nonthreatening, yet it gives the patients an opportunity to reveal something about themselves. We hope that it gives them a sense of control and the assurance that they can modulate their abilities and/or needs either to divulge or to withhold personal information. We do this exercise with them to increase cohesion, to ease anxiety, and to allow the patients to comment to us.

The diagnostic information received tends to be intrapsychic, but sometimes interpersonal material is seen as well. We observe the patients' comfort in using their bodies as a metaphoric creation, their internal sense of what is appropriate to reveal, and whether or not the words match. We also see clues about postural shaping and effort qualities as well as clues about their internal self-concept.

After the basic introduction, we lead the group in an exercise concerning spatial and bodily boundaries. The group members are told to move from the outskirts to the center of the room, and then to choose the spot that, to them, is the most comfortable. This exercise gives us evidence of ego boundaries, comfort or discomfort with interpersonal relationships, posture/gesture shaping, trust, and ego defenses.[1] There are many different responses. Some patients reveal little or no sense of their own kinespheric space or that of others. We see dependency and merger needs as well as fragile ego boundaries.

In the last exercise of the first day, the patients "draw" in the air with their hands the outline of what they perceive as their bodies' appearance. This gives us a sense of their kinesthetic sense of their body image. We are looking for a general sense of body cohesion, the inclusion of body

[1]The assumption that spatial relationships, especially spatial boundaries between human beings, are related to ego boundaries is a basic movement therapy concept. It is also a concept discussed in anthropological research that investigates how culturally determined "body space" between people affects both self-concept and interpersonal relationships. In movement therapy literature the concept of body boundaries/spatial boundaries and ego boundaries has been written about by Elaine Siegel (1984) and Penny Bernstein (1979), among others. In psychological literature the concept of body image and spatial interaction has been addressed by Margaret Mahler (1969), Renee Spitz (1965), and Hilda Bruch (1973).

parts and size, and the patient's ability to communicate this.

On the second day, movement therapy ends the evaluation. The patients are already warmed up interpersonally by the music improvisation. Movement, for many, is the most threatening part of the evaluation, but by the end of the process, the patients for the most part respond to the consolidating elements of group movement. We begin this time with mirroring exercises. We divide the patients into pairs and give them instructions to follow, lead, and "to follow each other." Based on our own observations and the work of other dance therapists, we use the mirroring patterns to raise object relations development from symbiotic type merger to a more autonomous stance, as is demonstrated in Margaret Mahler's work (1969).

Next, we lead the group in a movement experience based on Chace style improvisation (Chaiklin, 1975). We are looking primarily at individual movement preferences and styles. We also look at the ability of patients to function in a movement group, their level of participation and anxiety, and their interpersonal interactions. Changing music tempos gives us a chance to experience the different effort qualities and spatial orientations among the patients. This section is not a detailed effort/shape analysis, but it usually provides more intrapsychic and interpersonal information for our assessment.

Art

In deciding what art exercises to include in the assessment group, it is necessary to focus on the role art is to play in the evaluation process. Drawings as projective techniques have been statistically researched by many authors, notably Buck and Hammer (1969), Burns (1982), Burns and Kaufman (1972), Hammer (1980), Koppitz (1968) and others compiled by D. P. Ogdon (1979).

Therefore, it is important to use the allotted time to gather drawings from the patients in order to obtain diagnostic clues. Approximately 20–25 minutes in each evaluation session are set aside for the patients to draw pictures. To insure that each patient has time to finish the artwork (and to discuss it with the therapist), only one drawing is requested during each day's session.

The patients are given a pencil for one drawing although they are allowed to choose from a variety of media for the other drawing. The pencil drawing is valuable to the assessment because it provides better impressions of a patient's graphomotor responses than other art media (such as markers where it might be difficult to determine variable pressures). The media choices include oil pastels, chalk pastels, colored pencils, and felt tip markers. Although this is a limited selection of art materials, they were chosen for their inherent qualities (low regressive potential and nonthreatening to the patients). Color use may evoke more emotional responses from the patient. The use of color (or lack thereof) also provides information concerning intrapsychic functioning (such as the level of depression). From the media choice, the therapists obtain information about a patient's preferences. At the close of the assessment the patients are encouraged to discuss their media responses.

The two drawings selected for the Expressive Arts Group Assessment are the Tree and the Kinetic Family Drawing (KFD). The tree drawing was chosen for several reasons. In projective techniques, it is considered to be the closest reflection of an individual's personality structure. Wyatt, as quoted in Buck and Hammer (1969, p. 4), states that in projective techniques drawings delve into "deeper, more primary, and less differential levels of experience." Buck and Hammer note that of all the projective drawings, the tree drawing seems to best "tap basic, more enduring and deep intrapsychic feelings and self-attitudes." Tree drawings have been less likely to change in retesting than pictures such as a Draw-A-Person, which focuses more on an individual's functioning on a psychosocial level. Although changes appear in Person drawings after supportive psychotherapy, only deep psychoanalytic therapy seems to bring about major changes in the tree drawings when the patient is retested. This again points to the manner in which the tree reflects an individual's deep intrapsychic structure (Buck & Hammer).

Another reason for choosing the tree drawing for the assessment is that it is less threatening to individuals; it is not as personal as a figure drawing or the house drawing. Thus, an individual is less defended when drawing and discussing it (Buck & Hammer, 1969). The tree was selected

to be the art exercise on the first day so that patients would not come to the drawing portion on the second day feeling already threatened.

Finally, Fudaka, as noted in Ogdon (1979), states that the tree drawing is not affected by developmental factors after the ages of 7 to 9 as much as are other drawings. Thus, it is less influenced by an individual's intellectual abilities. The tree drawing reveals impressions about ego strength and development, stability, security, and reality testing on interpersonal relations.

The KFD ("Draw a picture of your family doing something") is requested of the patients on the second evaluation day. This exercise is important as it is the only one in the group assessment that is directly related to gathering information about family dynamics. It is very threatening to many individuals. As a result, the therapist may need to modulate the patient's level of anxiety. For instance, many patients will ask if they can draw stick figures for their family members. Although full figures are preferable, if it is the only way to get a drawing, the art therapist may permit a patient to use stick figures.

The patients are specifically requested to draw the KFD (rather than just a family drawing) as the action emphasis helps to reveal more about dynamics in the family. This picture elicits material about how the patients perceive their family, their role in the family, and the people they consider to be the members of the family. Upon completion of the drawing, the art therapist, assisted by the other therapists, questions all the patients about their picture. The data gathered help to determine if anyone was omitted from the picture, consciously or unconsciously, as this factor is significant. The KFD further reveals bonds in the family (such as helping to determine if there is a strong parental bond) and conflicts between the members. The amount of warmth, caring, and nurturance that takes place in the family is also reflected in this drawing. Other aspects of the KFD that are considered are the following:

1. Are there symbols of nurturance within the drawing (if so, who is doing the nurturing)?
2. What feelings are being expressed in the family?
3. How do the members relate as a family (is there communication, are they touching)?
4. What are the distances between the figures (which members are closest)?
5. Are the family members encapsulated, compartmentalized, or are there barriers between figures?
6. If action is occurring in the picture, what is the direction and which family members are involved?
7. What is the activity level of the family members?

Initially, the art therapist had reservations about proposing the art therapy portion of the Expressive Arts Group Assessment. In an individual art therapy evaluation at West Oaks Hospital the art therapist requests a series of seven drawings from the patient. In this new assessment tool, however, there are only two drawings available from which to obtain information. Whether or not what is obtained from the art portion would be valid was unclear during the initial stages of the group assessment's development. Further, the art therapist was concerned about whether an individual would be influenced by the drawings of other patients in the group. The results thus far suggest that, although there are some patients who are slightly influenced by the drawings of other group members, this influence is minimal, as the art portion of the assessment seems to be more individualistic in process. The impressions and conclusions obtained from the artwork seem to be accurate, particularly as they are confirmed or balanced by what is gathered from the other modalities. Areas to be improved upon in the art portion of the assessment include offering the patients a wider variety of art media, providing an opportunity for free art expression, and obtaining more drawings to determine information such as level of graphic development.

Music

As previously mentioned, the diagnostic information that is gathered is placed in six different descriptive categories. Because of the uniqueness of each modality, different diagnostic data are secured through each. Music therapy is the third modality introduced and it has been found to elicit: (a) intrapsychic states, (b) object relations development, and (c) how the patient

functions interpersonally, both on one to one, and in the group at large, which also gives information about family dynamics.

A step by step description of the music portion follows based in part on Collins' Psychiatric Music Therapy Assessment Tool (1984). During the first session, the participants are asked to describe themselves with choices from a song title list about how they feel today, how they have felt in the past, and what feelings they have about important relationships. Thereafter, each patient is asked to pick one song that is the most self-descriptive in the present. The rest of the session is spent listening to and discussing the songs. This exercise has been found to be relatively safe as well as a positive introduction to music therapy. It gives the members an opportunity to interact within a clear structure without having to be highly involved; nevertheless it provides much diagnostic information.

This song title exercise primarily accesses intrapsychic material, but it also is a means of assessing interpersonal skills. For example, it can tell us if the patient initiates contact or withdraws from the group, the amount of self-disclosure the patient can tolerate, and the appropriateness of the interaction. It also notes with whom the patient tends to interact (peer vs. therapist, female vs. male, etc.). After the assessment, the therapist reads through the lists, looking for themes. Often there are one or two recurrent motifs in the patients' choices. One young woman chose songs that fit into two main categories: (a) depressed and angry songs such as "Dazed and Confused," "Dust in the Wind," "State of Shock," and "I Want to Know What Love Is," and (b) a defensive stand that seems to cover up with songs such as "Getting Better," "Don't Stop Believing," "I Have Confidence," and "I Believe in Love." A man from the adult subtance abuse unit picked songs relating to the chemical abuse issue such as "The Enemy Within," "Hard Habit to Break," "Under Pressure," and then, feeling positive and better, such songs as "One More Chance" and "I'm Gonna Do It Right."

The number of songs chosen is also significant. Some patients pick 60–70% of the songs. This seems to point toward ego diffusion, a poor sense of self, and a possible loss of identity. On the other hand, some patients pick one or just a few songs, indicating more rigid, guarded defenses, or possibly that they have not yet developed an ability to abstract and express feelings through a metaphor such as music. It has been noted that it is difficult to find specific references on psychodynamic interpretations of musical behaviors and song lyrics in the literature (Collins, 1984). Thus, the authors' interpretations of the song themes are largely based on our past experiences with patients in music therapy.

During the second day of the assessment, the music portion centers around the expression of self through instrumental improvisation. The music therapist assesses a patient's ability to use music metaphorically and to translate whatever is conscious of the symbolic expression into verbal language. First, a warm-up exercise is introduced in which everybody, patients and the therapists, are encouraged to explore the different instruments in the room. This is also an opportunity to become familiar with them. The therapist assesses patients' abilities to deal with minimal structure (i.e., their risk taking, how they approach and play the instruments when they are not the focus of attention, which patients are self-initiating and which are passive-dependent). Patients' anxiety and comfort levels are also observed. Secondly, all are asked to pick an instrument that fits their mood, and then one by one to play their feelings. Here the focus is on how patients use the metaphor of sound to express a feeling and, of course, on how the patients deal with being the focus of attention.

The last music exercise is the group improvisation. Patients are asked to select one instrument. They are instructed to work together as a group and to create a piece of music wherein each can add a rhythm or a melody. They can at any time change or cease their involvement. Usually there is time for two improvisations. First, the therapist starts a beat and asks each patient to add to the basic beat. Then, a patient is asked to start the beat. The improvisation exercise provides a container for interaction but is not structured and has an open-ended format where free expression of self is encouraged. In this process, the assessment focuses on the amount of self-initiation, any dependency issues, ability to attune to others, needs for confluence, ability to be mutual, hunger for mirroring, and, of course, on how the music metaphor is used. In

addition, the focus is on how comfortable patients are with a nonverbal interaction and if they allow themselves to be spontaneous, playful, and creative.

The three main disadvantages of the group approach compared to the individual music assessment are:

1. The therapists do not get much information about the patients' music background, interests, or how their families relate to music.
2. It is not always possible to fully pick up on the strengths and talents through the use of music (music as a metaphor) because of the short time allowed for the assessment, and the performance anxiety involved in a group.
3. There is usually a stronger, more intense affectual response in the individual assessment, which probably is related to the above point regarding performance anxiety; and a more in depth process occurs with the instruments in the individual music assessment when more time is available.

However, the overall diagnostic information that the group assessment provides seems to be more complete and in depth than that provided by the individual assessment. This is because the modalities overlap, complement, and double check each other.

Processing

Processing is an essential part of the assessment in which all of the data are integrated through the therapists' discussion of each exercise. The structure for processing follows.

The three therapists first process the intrapsychic material for each patient. The tree drawing provides a basic starting point because of the extensive literature available for interpreting tree drawings for this information. To this is added the information from the song titles and related verbalizations, and the data from movement improvisation. Next, the therapists process the object relations data, largely drawing upon the patient's use of the mirroring exercise and the music improvisation. The family dynamics material is then reviewed; it is derived almost exclusively from the Kinetic Family Drawing. After this, the group dynamics information is processed, based on observations of the patient's interactions throughout the assessment, and the therapists jointly review the patient's use of, and response to, each of the three modalities. Finally, recommendations for treatment are decided based on all of the above. The patients are also asked for their input at the end of the assessment, and it is taken into consideration when making the decision for treatment recommendations. It is at this point that the therapists make note of patients' comments on past experiences with any of the modalities or media. This assists in the determination of transferential material. For practical purposes, one therapist per patient is charged with recording and writing the details that all three therapists have processed. Thus, if there are six patients in the group, each of the three therapists writes two of the reports.

Discussion

The authors have examined the issues, strengths, and weaknesses related to the assessment. One weakness is the difficulty in scheduling time when the three therapists can be available together to conduct the assessment and process the data. Nevertheless, the relative savings in time compared to that consumed when seeing each patient separately in each modality makes the multi-modality group method worth the effort.

Another concern is that the group method does not provide as much in-depth information as is sometimes desired regarding the patient's response to and potential use of each modality. For example, there is no time to learn of the patient's music history and background, which is often a helpful predictor in the usefulness of music therapy. Similarly, since there are only two pictures gathered from the patients, it is difficult for the art therapist to learn much about graphic development. As we evaluate this assessment tool, we are aware that, although we have a working model, it is still in a stage of development that may be advanced additionally. However, the authors see as a definite strength of the assessment the combined information that can be processed and integrated. This has good potential for accu-

racy as it comes from three therapists who balance one another. Often the same factors or trends seen in one modality appear also in one or both of the others. The converse is also true. One modality may help present an aspect of the patient not elsewhere seen. For example, a patient may draw a picture that suggests schizoid characteristics, but that same patient may show good potential for developing object relations in the music or movement improvisations.

The Expressive Arts Group Assessment format lends itself well to dealing with countertransferences. It is not unusual for each therapist to react differently to different patients. When this occurs, it is always processed among the therapists. The comparing of multiple reactions to the same patient has proved to be very helpful. For example, patients with borderline personalities or character disorders can be more easily identified when strong countertransferences arise and are processed together by the therapists.

The therapists also recognize male/female issues that may arise, such as when there are three female therapists serving as the authority figures in the assessment, and three or four male patients responding to that authority. It has been observed, for example, that "macho" male patients respond more receptively to the movement exercises when the department's male therapist is there acting as a role model.

Another advantage of the multiple approach is that many patient characteristics are played out and not just drawn out on paper. This is illustrated when transferences from family members are identified that help confirm evidence gleaned from the Kinetic Family Drawing. In the individual assessment approach, this information is not typically elicited as there are not as many opportunities for the personality characteristics to be acted out or played out. Character disordered patients, for example, have been found to try to please the therapist in an individual assessment, but in this two-day group assessment they are more likely to act out their character disorders.

Finally, as already noted, some aspects of the patient are exhibited in one expressive arts modality and not in another. Similarly, the Expressive Arts Group Assessment sometimes elicits information about patients that is not found in their other assessments from other disciplines, or from observations on the unit (ward). These aspects at times represent patient strengths and at times weaknesses not detected elsewhere because, unlike the verbal quality of other assessments, the Expressive Arts Group Assessment accesses material nonverbally.

Summary

The Expressive Arts Group Assessment was formulated to provide greater efficiency in use of time and of cost. This is one of its basic strengths. It further provides more than a cumulative effect in its multi-modality nature; the team effort does suggest that three heads are better than one. An affirmation of its value is the fact that it has won the respect of many physicians who order it for their patients as a helpful diagnostic tool. Truly, three heads see and hear and speak better than one.

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