Chapter 3

The art therapy room

The creative arena or ‘potential space’

The art therapy room or department is where the therapeutic relationship between therapist and client develops. The space is essentially a private place with a firm outer boundary which enables a sense of containment, security, freedom from intrusion and an atmosphere of calm and reflection. The layout, organisation and design of the room becomes a creative ‘arena’ or potential space for setting up and maintaining the ongoing therapeutic encounter between therapist, client and art materials. Art therapy rooms have been variously described by practising art therapists as ‘container’, ‘set apart space’, ‘sanctuary’, or ‘an asylum within an asylum’, depending on the theoretical approach of the therapist and the setting or institution in which the therapy takes place (Brown 2008).

Every client entering an art therapy room will use the room to form a unique relationship with that space and with the therapist. First impressions are important as this will be a place where trust is built and purposeful and thoughtful work will take place. The same space will be experienced differently by each client. The practical art room becomes a symbolic space as the therapeutic process gets underway.

Therapeutic work is generally undertaken within a framework of boundaries at a specified time each week. Each session lasts for the same length of time, usually 50 minutes. The client, who may have experienced great lack of constancy of relationships, finds that this space in the week is kept for her regularly; it is her space and her session. The therapist is a constant person for the client in that space. The art therapy room offers as near as is possible the same choice from the range of materials and workspaces in the room. This framework of safe boundaries protects the space and provides potential to explore internal preoccupations, worries, problems and disturbances through using the art materials and the relationship with the art therapist.

Whatever happens here is split off from everyday existence and is observed, rather than acted upon. This is crucial because, without this space set apart, there is the inclination to behave and respond spontaneously, as we do in our social relationships. Here the frame provides a setting where the therapist can
maintain a certain objectivity, a therapeutic distance. This allows the client to make a split which enables her both to regress and also to function as an observer of her own behaviours.

(Schaverien 1989: 149)

A well-organised and thoughtfully laid out art therapy room provides the necessary framework for therapeutic work. Light, warmth, enough room to move around, access to materials, wash basins and water gives a structure to the environment which includes a full range of good quality art materials such as paints, palettes, paint brushes, water pots, crayons, pencils, scissors, glue and an ample supply of paper. Modelling materials such as clay, model magic, and plasticine are always useful, along with access to other 3D materials such as magazines for collage, and ‘junk’ – cardboard boxes, cartons, etc. As artists, many art therapists are familiar with the various properties of different art materials and stress the need for good quality art materials (Schaverien 1992).

Figure 3.1 is an example of a well laid out art therapy room used primarily for individual and group work with children, families and also professional meetings. There is a table for working with art materials to hand, good storage space, bean bags, a sand tray, a doll’s house and a place to sit and talk. The layout of the room is designed to enable a safe and creative space to develop between client and therapist as they engage in therapeutic work. It is clean, free of clutter, and gives access to good working space on tables and around the room. Where possible a wash basin is ideal but not essential.

Figure 3.1 An art therapy room

Adaptation of the art therapy room to different client groups

Nowadays most therapy rooms are multi-purpose and shared with other professionals and clinicians from a multi-disciplinary team. Rooms shared with
colleagues are usually available on a clinic booking system. For those art therapists who do have a designated art therapy room, it is helpful to look at ways that this space can be designed and organised to best meet the needs of particular client groups and maximise therapeutic potential (Tipple 2006). One art therapist working with visually impaired people designed her department so that everything would guide the client to where she wanted to be. Hand rails all round the walls, tables with lips to enable her to feel the edges and to prevent things falling on the floor out of reach, coded paint brushes and palettes to indicate different colours, and so on (Broadbent 1989). Camilla Connell worked with cancer patients at the Royal Marsden Hospital, London and described how she adapted her practice to working by the bedside for those patients unable to move out of bed (Connell 2006).

Vera Vasarhelyi (2006) worked as a member of the multi-disciplinary team with children at Bloomfield Clinic, London, and she designed the art therapy space shown in Figure 3.2.

Figure 3.3 gives an example of a space designed for parent–infant work where mothers and their young babies will work together with the therapist on the floor sitting on cushions, with toys and materials all at a low, accessible level. In a similar way, an art therapy department within a nursery uses low chairs, sand trays and a variety of toys along with art materials safe to use for children who are under five (Figures 3.4 and 3.5).

The setting of the room significantly affects the art therapy encounter between therapist and client. There are many different styles of rooms and ways to organise
Figure 3.3 An art therapy room adapted for parent–infant work

Figure 3.4 The Art Shed
the working space. Many art therapists work part time, either in different institutions or in different parts of the same institution. In many settings, there can be shortage of space and a well-equipped studio permanently set up for sole use of the art therapy department may not be possible. Contributions from Damarell (2011), Michaels (2011) Garber (2011), Stein (2011) and Allaker (2012) all give a sense of the thought that has been given to practical considerations in establishing a room and making it possible for a symbolic space to flourish. Arguile (2006) describes the room in which he works with children with special educational needs:

The room is relatively clean for an art room. This is so that if children make a mess, it is seen as their mess, their chaos, and isn’t blurred or lost in other people’s chaos as may be their normal experience. Children learn the art of bringing order from chaos. For many, their experience of mess and disorder has always been negative because of deprivation. The lack of emotional holding has meant they live wrapped in chaos. In therapy the space is clear for them to put down their own chaos and creatively find their own order from it, and so readjust to their newly resolved situation. The layout of the room assists in this process.

(Arguile 2006: 30)
The importance of the boundary of the room – working with the internal and external

Each art therapy room will be formed by the forces within it and outside it. These will be as various as the personalities of art therapists, their theoretical orientation of practice, the effect of the client group as users of the service and the attitude of the institution to art therapy. The outer environment in which the institution is set will also directly and indirectly impinge upon and influence the sessions as clients make use of the content of the rooms and whatever is offered by the external environment.

(Lillitos 2006: 29)

Aleathea Lillitos (1990) was working at St Thomas’s Hospital, London, which has spectacular views across the river Thames in both directions and the main sights of the capital, with the Houses of Parliament and Big Ben opposite, and she describes how this view of the outside world has evoked memories, feelings and fantasies in a great many clients and has often played a vital part in their art therapy sessions.

Children have used the room and the furniture in a wide variety of ways; some have accepted the room as it is and have sat week after week in the same place, whereas others have wanted to rearrange the furniture to build a house, a boat, a camp or, like one little girl, to make ‘an office like the one that Mummy works in’. The locked cupboard also invites projections: a 7-year-old boy who had difficulty in accepting younger siblings expressed curiosity about what was inside it and made cardboard and clay models of it. Painstakingly, over several weeks, he constructed a model whose doors and drawers could be opened. Inside his cupboard he put ‘lots of babies’ bottles’, imagining that this is what the one in the room contained. It became clear that the cupboard symbolised both his mother’s body and mine as the ‘mummy’ therapist who had other sibling clients. With the aid of his model of the cupboard we were able to work through his fantasies about the inside of his mother’s body, his envious feelings about her ability to have babies and his jealousy towards the babies that she had had subsequent to him.

Although some seem to be oblivious to it, the view from the windows can and has played a large part in many of the children’s art therapy sessions. The Houses of Parliament and Big Ben are potent images in our society and are ripe for projection. Water, boats, and bridges have symbolic meanings as well. The River Thames that flows past the window can literally be a calm, pleasant strip of water where pleasure boats sail, or symbolically a deep, dark river with dangerous currents that can drag you under, or full of sharks and crocodiles that may bite.

Looking out of a window may seem to be an escape from the difficulties of therapy, but the external landscape can lead a child back into the fantasies
he or she may be wishing to escape from. Much to my exasperation, because I thought she was wasting time, a girl of 5 who was concerned about the disappearance of her step-father constantly gazed out of the window (looking for him). Then, in one session, she pointed to a small tug pulling a huge container and said ‘Isn’t that little boat clever, it’s pulling that big boat.’ I realised that she had, as it were, pointed out to me how small she herself was to be looking after her mother. Subsequently, we were able to go on to talk about how she felt responsible for the disappearance of her step-father and the fact that she took on the burden of looking after her mother now that he had gone. Rather than being an escape, the time she spent gazing out of the window was reflective and important.

(Lillitos 2006: 31)

The olden days – the ‘asylum within an asylum’

Since the 1930s, art therapy departments were situated in large mental hospitals for long term patients, some of who had lived there for many years. Before the advent of psychotropic medicine, long term hospitalisation was the main psychiatric treatment for those diagnosed with psychosis, schizophrenia, paranoia and delusional states of mind. These hospitals, usually placed in large spacious grounds away from main population centres, meant that the residents were separated from everyday life and sometimes became the ‘forgotten people’ (Skailles 1997).

Over the years art therapists have written about their experience of working within these asylums (Wood 1997; Skailes 1997; Morter 1997; Goldsmith 2006; Hammans 2006; Charlton 1984). Wood (1997) traces the history and growth of art therapy in psychiatry in Britain from 1938 and discusses the influence of different treatment approaches. In particular she cites the pioneering work of Edward Adamson (1984) and E. M. Lydiatt (1971), who established open art studios providing an atmosphere of peace and quiet contemplation and creative activity for patients who came to work there.

Adamson provided a very powerfully receptive container for many of the patients who worked with him. His way of inviting people to do some painting was very simple: he would sit down next to them and ask them if they would like to do some painting.

(Wood 1997: 153)

This model of working in open art studios was established in many of these large Victorian institutions. Charlton (1984) describes the impact and experience of institutional life.

Most of the long-term residents have experienced years of institutional care, they have been isolated from the culture of the outside world and do not know how to handle the exchanges involved in daily living. Much of their time still
seems to be spent in pacing the corridors of the back wards and if they wander beyond the hospital into local streets and shopping centres, they are stigmatized by their strange mannerisms and posturings, their ill-fitting clothing, their mutterings and their aura of isolation. Is it surprising that in this context many have maintained a rich inner-life, a personal culture where they have restructured a reality that provides a significant place for themselves?

(Charlton 1984: 174)

Art therapy departments within these institutions emanated a quiet and reflective working atmosphere as if time had stood still. Patients would wander in and out, take up their normal positions at an easel or table and continue the work in an open-ended way that they may have been doing over some years. These old studios became ‘an asylum within an asylum’ where residents could make their own choices, within the sphere of creative activity, without fear of the consequences. Implicit in the art-making process was permission to get messy, to experiment, to ponder, or to invent. The studios also became a home for residents’ ‘objets trouvées’ as described by Willoughby-Booth (1990).

Other long-established departments such as in Gogarburn Hospital once ‘bulged with the accretions of almost twenty years of creative work’. One man has requisitioned a corner of the main room, where he keeps his collection of fossils, books and other personal objects in preference to keeping them in his ward.

(Willoughby-Booth 2006; Brooker 2010)

The atmosphere in this studio-style space allowed creativity to flourish and when left to work on their own, some residents used the space to create pictures which were rich expressions of their delusional states of mind and at times fragmented, chaotic inner world. With little concern for western conventions of art such as perspective and proportion, some of the images were direct and original in style with the ‘raw quality’ which became associated with ‘psychotic’ art and the Outsider Art movement (Maclagan 1997). The Prinzhorn Collection (1880–1920) and Jean Dubuffet’s ‘Collection de l’Art Brut’ both contain the work of long-term patients from mental institutions collected mainly before the extensive use of drug therapy.

**Working with long-term psychotic patients — a specialist approach**

Anna Goldsmith, Head Art Therapist at Hill End Hospital for many years, developed a specialist approach to working with long-term psychotic and borderline psychotic patients, with the emphasis on developing a ‘whole person’ relationship. The large open space ‘as studio’ enabled individual art-making to proceed at the patient’s pace without interruption while one-to-one therapy sessions were
The art therapy room was planned at an appointed time to facilitate and develop interpersonal relating with the therapist. For those patients struggling with psychotic anxieties, loss of self-structure and ‘ordinary’ notions and experiences of inner world and outer reality, this structure facilitated mediation between symbolic and concrete aspects of relating. Equally it was flexible enough to meet the needs of other patients able to negotiate boundaries and relationships at a more ordinary symbolic level (Killick 1987; Killick and Schaverien 1997; Goldsmith 2006).

The geographical location, the layout of the hospital and of the rooms of the department within it made it a highly valuable space to accommodate this particular approach to this patient group.

The rooms existed as spaces in which what was inside a person could be put outside in an atmosphere of containment and safety, the level of which was dependent on that person’s own self-experience, the differing function and significance of the rooms and relations with the therapist as well as on our ability to maintain the experienceable structures (e.g. timing, confidentiality, care of work).

(Goldsmith 2006: 47)

The studio-style space where entering and leaving could be done autonomously allowed psychotic people to come when they ‘felt ready’ and leave when they had ‘had enough’, their relationship with the spaces being controlled by whatever aspects of themselves they were presently driven by.

_Figure 3.6 The art therapy room, Hill End Hospital, St Albans_
The proximity of the individual rooms to the larger spaces allowed a similar disengagement without that person having to leave the whole departmental space entirely. In this way any engagement that the psychotic person was able to make, even if it was only with the inanimate room space itself, was nevertheless an engagement and therefore a basis for negotiations that could be capitalised on by the therapist.

(Goldsmith 2006: 49)

A similar approach is currently offered at Studio Upstairs, based in London and in Bristol, which supports creative and personal recovery through arts practice by providing studio space for people in psychiatric care who are living in the community and want to pursue their own art work in this way. The Studio provides artistic resources, education and support within a therapeutic community setting to people experiencing mental and emotional distress and to those in drug and alcohol recovery. Studio Upstairs evolved from gaps in the services that were identified by the members in their common desire to be a part of something creative and human. The majority of members have not found sufficient support within the mainstream health services. It is a place where people can choose to develop relationships and with informed facilitation can determine how they use the studio. They can create and use art as a catalyst for personal and social change.

This working model involves a process of exploring complex human experience where art takes centre stage. Arts practice is a particular way of ‘being in the world’ in terms of feeling, thinking, perceiving, expressing and relating. The Studio encourages artistic practice as a serious endeavour, providing an inspiring holistic environment with access to a wide range of art materials and facilities, and supports the development of an identity as an artist. A strong sense of identity is key to self-esteem, confidence, finding a meaning and reason for living. Members, studio managers and volunteers practise and discuss their art together on an equal basis. As a result at Studio Upstairs everyone is either an artist or on their way to becoming an artist (www.studioupstairs.org.uk).

An art-based project with a similar philosophy is described by Sarah Parkinson, who set up an art therapy service as part of a new community mental health team in a local arts centre, which placed the art therapy service into the art community and town centre. Black Swan Arts was made up of separate art and craft studios, two galleries, a shop and a cafe. The art therapy studio was at the top of the building – a large attic room with windows on three sides, and a sink. The space was big enough for individual work as well as having enough room for groups of six or seven to move around with relative ease (Figures 3.7, 3.8 and 3.9).

Black Swan hosted contemporary, national and local exhibitions and some service users spent time in the gallery or cafe before coming to art therapy sessions and groups. Individuals frequently entered work for exhibitions, one with a solo exhibition in one of the galleries. The connection to the local art community with galleries downstairs gave the therapeutic space another dimension or outer frame from the private and separate therapy rooms.
Figure 3.7 The Black Swan Studio

Figure 3.8 The Black Swan Studio
Ellie wanted to take part in the public exhibition. Her thoughtful and serious art work in therapy were not the images she wanted to portray to her social group. Desperate she brought in some drawings that she asked her brother to make for her – the ‘skulls and crossbones’ drawings he is good at and that she admires. Could she show these as her own? She is not sure.

Joyce moves to the other end of the studio to make use of the whole table to push the paint around the paper, scratch out an image and work into it. She talks about her relief at being able to look at some of her frightening childhood experiences with another person. Downstairs she is exhibiting huge, gracefully drawn flowers with the local arts society who she joined on moving into the area.

(Letter to the authors from Sarah Parkinson, 2013)

Parkinson describes how she works with a variety of adult patients including fixed-term groups for people with eating disorders, mothers suffering from
post-natal depression, long-term groups for people living with psychosis, severe attachment disorders and personality disorders. Her colleague also works with children, adolescents and their families at the studio. Working in this setting raised many questions, such as the public/private nature of the work and anxieties about ‘being seen’ or discomfort about using an ‘arty venue’. This innovative venture required the centre’s staff to have discretion and heightened awareness of the social inclusion of mental health issues for all people who attended the arts centre.

**Moving into the community**

With the closure of the large mental hospitals and the movement into community care, art therapists in more mainstream therapeutic environments have adapted their approach to accommodate this transition and change. This required a very different type of art therapy room. Patients attending art therapy were now living at home and expected to turn up at specific appointment times. Morter (1997) described how the art therapy department was moved into a two-story converted coaching house which contained a large studio within which there was space to work privately or in a group. Where possible, work with patients who were already in art therapy continued their treatment within this new setting. For example, Darren was a young man who was seriously psychotic:

The small studio in which the work took place was a private room within the art therapy department. As well as the painting, drawing and modelling materials there were expanses of walls where paintings could be worked on or looked at. There were shelves where individual work could be stored, an electric fire, a window out into the grounds and a mirror. Other objects Darren used included particular books, comics, a blanket, a camera, and cassette machine. Initially and at later times, when particularly anxious, he would leave the room to pace up and down along the corridor outside. The way he used the space and the objects helped me to think about his inner world and his relationship to me. Despite the long periods of silence there seemed to be a lot going on in the space between us.

(Morter 1997: 222)

Maintaining the continuity of the relationship with Darren and building a safe space for the art therapy work to proceed within this new environment was paramount for his ongoing stability.

When Hill End Hospital closed, along with many of these institutions in the late 1980s, Goldsmith (2006) documents how the process of moving into a new community setting was complex for some schizophrenic and psychotic ex-patients who had become used to living in hospital.

For these people to return to us to continue their therapy required of them
The art therapy room

to wake up in the morning, with an un-ambivalent state about coming that would survive getting up, dressing, catching a bus, and having the bus fare. Then, enduring the journey, arriving in town, waiting in the office if you are early until you are fetched. Next, there is the experience of staying in a room with a person for a defined therapy session and with a time limit, to be followed by leaving and all the above in reverse, back to the flat.

These voluntary actions demand a good enough organising self/ego to see it through. It has to withstand the ebb and flow of thoughts and the constructions of threatening meaning that may be initiated by the slightest look a stranger on the bus gives, a chance word overhead, the sense of a body that burns and moves in response to, who knows what. To want to go to therapy means to carry a sense of desire and anticipation that can modify the fear and anxiety that relating brings. It means to be able to recognise the desire as one’s own and to feel it as ‘good’ as well as to trust another. These are not the givens of psychosis.

Andrew was a tall young man who at Hill End appeared one day at the garden doors that faced onto the large studio room, standing on tip toes and wearing camouflage trousers. He turned and left, to return again the next day. After a few days of this he made fleeting eye contact before he left. Eventually and bit by bit contact was made sufficiently to offer him a table to use when he was there. Later he could agree a time to meet in the side room with his work, but in the knowledge that he could bring it to a close whenever he wanted. Within a few weeks he was working for several days a week at his complex imagery and meeting with his therapist, whose job it was to see how he could talk to her and about what. He talked about his thoughts, how he made sense of the world, revealing more of his self structure whilst at the same time developing a negotiated close communication with another, the therapist, who in turn resisted the desire to breach his defences and look for who was behind it, i.e. the person inside who feels. In this way the focus of work consisted of helping him to negotiate more sustainable ways of ‘being’, in relationship to others.

His attempts to make the transfer to the new setting required clarity and constancy of identity and that his voice expressed agency to say who he was at the intercom. For a week or two it sort of worked out but then disintegrated. He couldn’t ‘land’ at the right time and place even though we, being also new to this, looked out for him eager to ease the transfer. However, this ‘gathering’ of himself left him without resources for therapy itself and he was unsettled and soon stopped. He was never at ease in the new small studio, about a sixth of the size. Going out of the studio door, instead of leading to a neutral corridor or garden space allowing him distance as in the hospital, it brought him into the space of others and therefore into mutual impingement. He stopped attending and we heard weeks later that he had set fire to his room, was admitted to the acute unit and then placed on the locked, low secure ward.
Presumably he fell prey to his anxieties and developed more intense symptoms. The outcome was that by being readmitted he created some relational certainties – patient and nurses – and a containment via the setting to hold everything together. He could also be ‘mad’ there and know it was in the frame of reference of others, more so than outside in public. The setting acted in place of a self structure when this was no longer sustaining for the level of anxiety and fragmentation. Over the next ten years or so, this young man settled, took self discharge, left the country, returned, was admitted several times over and finally engaged more usefully (for him) in the low secure unit over a long period of time (without always having to be discharged when the symptoms subsided). This enabled a slow process of development of relationships and skills within a containing structure and a subsequent move to a small staffed house, though he never wanted to return to Art Therapy.

(Goldsmith 2006: 56)

Art therapy outdoors: working with nature

Changes in policy and ways of working sometimes go full circle. The closure of the asylums where, as part of their therapeutic programme, patients worked outdoors attending to the large gardens, in the hospital farms, greenhouses and vegetable plots or maintaining the cricket grounds, heralded the end of an era of working in this way (Goldsmith 2006). Currently there is once again a move to work outside. Ecotherapy has seen a surge of interest in recent years, with psychotherapists of all modalities taking their practice out of clinical rooms into the great outdoors. By going outside the therapist and client are working together in neutral, often shared, public sites, where nature, space, landscape and elements become integral to the work (Jones 2012).

Vanessa Jones describes her specialist interest as an art therapist working within mainstream NHS adult, acute and community mental health services:

Indoors or outdoors, the art therapist’s role is essentially the same. For me, working outside is not a choice made because of the limits or disadvantages of being indoors, rather it reflects the benefits of working psychotherapeutically with the multidimensionality of nature. Being outdoors allows the art therapy process to be experienced across a range of domains (internal/external, self/other, concrete/symbolic, felt/imagined, soma/psyche) in a physical and embodied way (Soper 1995).

The first art therapy outdoors group began as a small pilot study, running as a closed group for 12 weeks. Referrals were open to those with a diagnosis of anxiety and depression. Working with an art therapist colleague, the group took place entirely outside, utilising fairly ordinary green spaces within the hospital. This group treatment intervention has become an annual closed group for adults of working age with chronic and enduring depression, complex anxiety disorders, social isolation and complex personal, social and relationship difficulties.
It runs from spring through to autumn, within an NHS Psychological Services team in London, incorporating mindfulness practice at the start of the session, with a shared walk through a range of locations within the hospital grounds and surrounding area. Group members are invited to gather natural materials and engage in sensory awareness exercises during these walks prior to art making and talking within a secluded garden courtyard space.

By working outdoors clients in therapy encounter in nature what is felt within directly, activating and articulating issues within the timeless yet ordinary visual language of nature itself. Jones (2012) maintains that working in relationship with nature and living ecosystems, however inauspicious, can facilitate an increased sense of agency and ongoing strategies to cope with personal difficulties. The outdoor world as a resource is free and readily available to all and it can be returned to independently as a form of sustainable self-help outside the stigma of services, offering ongoing benefit and self-reflection. Nature and natural settings offer an abundance of therapeutic opportunities and resources that we as art psychotherapists do well to consider and harness (Cimprich 1993; Jones 2012; Nakamura and Fujii 1992; Soper 1995; Ulrich 1984).

(Letter to the authors from Vanessa Jones, 2013)

**Working peripatetically**

Some art therapists may have a purpose-built art therapy room, but may use this as a base while travelling to visit clients in day centres or their homes. In a community environment the set apart space may not be ideal but needs to be good enough to provide an outer framework to the inner space that is created between therapist and client. One art therapist may be working across a borough in different schools and centres covering a wide geographical region. Pauline McGee (2006) worked for Aberlour Child Care Trust, a Scottish voluntary organisation funded by local authorities, urban aid, bequests, etc. The work stretched across Scotland covering family centres, intermediate treatment projects, two dependency units for women, residential homes for young people and children with learning difficulties, and also similar homes for emotionally disturbed children and adolescents, and, lastly, a drop-in centre and counselling service for young people. She was the sole art therapist and worked in several different projects over a normal week. In this situation the art therapist had to adapt her working method to each client group and staff team as she moved about the country. She also had to fit in to the often cramped space available. These practical difficulties add enormously to the normal pressures of working as a therapist. In spite of the frustrations, some degree of difficulty in the environment can give a sense of solidarity and facilitate group identity and cohesion. There is, though, a fine balance in making the work space possible, as poor conditions and lack of materials can add to the lack of sense of value, lack of identity and worth already experienced by clients.

Helen Thomas (2006) worked in education as part of a team working with children with emotional and behavioural difficulties. As the only art therapist, she
The art therapy room was working peripatetically without a secure base but covered a large borough using spaces in schools or units which varied from the dining room, part of kitchens, storage rooms, attics, cupboards and so on. Melody Golebiowski described how she facilitated art therapy for four different organisations in a different clinical context every day of the week, although she attempted to maintain continuity by using a studio model approach to her work (letter to the authors from Melody Golebiowski, 2013).

The use of rooms: case vignettes of working with children in art therapy

Clare Morgan, an art therapist working in education, described a number of different scenarios which require the necessary adaptation and flexibility to provide the ‘good enough’ therapeutic framework when children use the rooms in different ways. Working in educational settings, she travelled from one school to another and encountered many different rooms which became the therapy room for her weekly session.

A primary aim for therapists is to provide a setting for therapy which is consistent and as unchanging as possible from one session to the next. The room is the background against which and within which communication between the two people takes place. When this room is unchanging in every respect we know that what happens in the therapy is the result of something else – it is not a reaction to change within the physical setting. Many therapists are able to provide a consistent setting but often I am not. Also I am unable to provide a room which is free from the presence of others who use it at different times.

Sudden changes of room in particular are unsettling for the student as well as myself. Both of us have to adjust. Changes are undesirable but sometimes unavoidable. They have to be acknowledged and worked through in the session.

Sally

Both the student and myself will have some reaction to the room we work in. For children in a junior or primary school the room may already be familiar. There may be positive or negative associations. Sometimes a child will say something about the room as they enter for the first session. Six-year-old Sally told me at once that this had been her classroom when she was in reception. For her the room had positive associations. I may ask whether a child has been in the room before and in what context. Comments about the room may also be unconscious references to the therapist. Therapy in a kitchen may evoke associations to mother and home. I am sometimes asked whether we can make biscuits or cakes. There is both a concrete and symbolic reference to nourishment being expressed in this request as well as sometimes a wish to have an experience that may have been missed.
John

Some rooms raise anxieties. Very smart newly furnished and carpeted rooms are a case in point. Although obvious steps can be taken to protect the carpet and furnishings, mess can quickly be created, get out of hand and be distributed to unexpected places. If the room is very small art activities and play may be limited. I have found that children often have their own creative solutions to a room which seems inadequate in some way. They, after all, do not come with a preconceived idea of what the room should offer.

When eight-year-old John wanted to play football in a tiny room he solved the problem by making a tiny football out of rolled up paper and sellotape. Then he could kick it forcefully wherever he wanted within the very limited space available and there was no risk to the furniture, room or me. He also did not seem to think that hide and seek was impossible. Both of us could pretend that he couldn’t be seen underneath the table. A small room can, however, provide physical containment that aids a sense of security and intimacy, particularly when working with young children.

Billy

Working in shared rooms which contain all sorts of things that are not part of the art therapy materials raises some fundamental questions. How can the space and contents in a room that is not a designated art therapy room be used? What is included in the art therapy space? What can be used as part of the therapy? Can a child be allowed to use the objects that are in the room by chance or which may be introduced quite unexpectedly during the course of the therapy? What happens if something that becomes significant for the child is removed from the room?

An example of this was work with ten-year-old Billy. Billy had been referred because of his anger, frustration and unhappiness. He was often mean to other children and they were afraid of him. At home he would show his frustration if he didn’t get his own way. The only room available was the nursery, which was ideally placed on the other side of the playground. We would be uninterrupted and there would be no distractions from other people nearby. The room itself though was filled with the presence of the nursery children whose many artistic endeavours hung from the ceiling. Every wall and surface was covered with images, games or toys. The room was a treasurehouse of colour and redolent with activity, but how would Billy react to this particular room? The art materials looked lost on the table in such a busy looking space so obviously dedicated to very young children.

During the first session he began to explore the nursery. He opened some drawers and found something that he had ‘had at home when little’. It was a board with holes that you push coloured pegs into to make a picture. Billy used the pegs to write his own name and we were able to begin to think about his experiences of being little.
Billy’s mother had told me that she was called in to nursery school because he was ‘possessive and taking toys’. Now he could revisit a nursery and have a different experience. The nursery environment was now one over which he had total control and in which he need not feel any sense of inadequacy since he could easily master all the activities there. Only some of the nursery activities were chosen and these were usually repeated from one session to another so that a pattern gradually emerged and Billy could continue to work through particular concerns. For example, he used the adult dolls in the doll’s house to enable him to think about sex and adult relationships. He would often sit and play on the floor like a much younger child. His antagonistic and defensive front so evident in school could disappear. The nursery setting provided an opportunity for Billy to regress and express some of his concerns in a very direct way. It facilitated therapy by placing him in an environment which had once been the site of earlier difficulties.

Harry

Children often want to use the whole room and its contents for play. Children may find a different way of expressing something other than through the art materials, particularly through play. Sand tray, small toys, Lego and a doll’s house provide a rich variety of toys, although anything in the room may evoke associations and responses, such as cobwebs, spiders, radiators, light switches and so on.

It is informative to observe if and when this happens and to wonder about the possible meaning. Children tend to move away from the therapist and enter into their own play when they have made a connection and feel secure enough to do so. It can happen quite quickly or perhaps after many sessions if the child is insecure. It can be an important moment. It may mirror the developmental stage in infancy when the toddler is able to move away from mother and play a little further away but still in her presence. Sometimes a move away may, however, reflect a need to create a little distance from the therapist, perhaps to lessen the intensity of the transference. The child’s curiosity about or familiarity with the room encourages them to explore the space. If the move is made the art therapy space expands and the possibilities for play, expression and communication increase.

Ten-year-old Harry had communication difficulties. He sometimes stood in his classroom and growled and used objects to convey words. Harry was often silently angry, his body conveying his feelings. He came to therapy on sufferance, said very little and skilfully produced drawings which showed a defended world. People were always hidden in armoured tanks or unreachable and invisible inside buildings. Harry’s drawings were very detailed and showed close observation of what was drawn. He didn’t like talking about his drawings and didn’t like talking to the therapist. The intimacy of therapy was extremely threatening for Harry. At times there was a sense that using the art materials was a defence against relating because using them kept him busy. The sessions felt very uncomfortable and
The art therapy room

intense for both him and the therapist. Harry often looked up at the clock, conveying in this small gesture his longing for the session to end.

After several sessions Harry would sometimes get up from the table and walk round the room. The work was in a large classroom not used on a daily basis. Harry would point to things and ask what they were or what was inside them. Being away from the table seemed to offer some relief as he could focus on objects. He noticed and focused on things in the room that the therapist wasn’t aware of, holes in the worktop, uncapped pipes sticking up from the floor, the central heating control panel and then one day the infra red sensor high up in the corner of the ceiling. He told the therapist that it detected body heat. He went on to talk about a very small sensor that he had in his home, how it was situated in the spare room and the cable ran along to his bedroom, how it wasn’t working just at present. He talked on and on, the link to home leading to further associations. Exploration of the room and its objects provided a safe means of communication that was not otherwise available, and the meaning of this could be explored together with the therapist.

Martin

Children sometimes bring a special object from home to therapy but they may also want to bring in something from the school. Eight-year-old Martin was referred to art therapy because staff were very concerned about his state of mind. He showed extremes of emotion and could be very depressed and in floods of tears. When very young he had witnessed violence in the home and was an anxious and frightened boy unable to concentrate on learning. In the playground he hid his fears by behaving aggressively. He presented as a much younger child and developmentally had fallen behind. Martin was frightened by unexpected noises in school such as the sudden appearance of carpenters working near to our room. He evoked a maternal counter-transference as he did in members of staff. Although we were in a very small and containing medical room which contained a number of toys, he remained at the table with me using the art materials or the range of small toys the school had provided. One day he told me he had noticed a large box and asked if he could bring it into the therapy room.

We went to the hall together and after emptying it the caretaker brought it to our room. On its side Martin could easily lie down in it and when upended if he stood in it he couldn’t be seen. This box was immensely important and became a central feature of the therapy. It was a containing, warm dark place in which Martin could feel safe. It was the womb in which he could hide and admit that he did not feel the world was a safe place. He spent one session sealing it up so that no light got in when it was upside down. Later on he cut out a door and some windows. Sometimes it had to be mended as it became more fragile with use. Martin could lie down in it and pretend to sleep, he could take toys into it and play, he could be born from it. His attachment was such that when the therapy was unfortunately coming to a premature end he spent several sessions
laboriously cutting it up with scissors so that he could take it home in pieces, demonstrating his need both to attack it but also to save it.

In his play, Martin was able to communicate and process his thoughts and feelings through the use of the cardboard box as a large three-dimensional form showing his needs to be safe and secure. These many possibilities become available for art therapists in the knowledge that a flexible and adaptable approach can enable the child’s need to communicate and demonstrate his internal world experience at a symbolic level. The therapist sometimes also needs to be able to ‘play’ while maintaining safe boundaries and limits.

(Morgan 2006)

**Art therapy rooms and the containment of mess**

Working with art materials can be messy. The therapeutic value of different art materials resides in the possibility and potential to experiment with mess, and offers the opportunity to explore the patient’s internal relationship to mess, control and anxiety about loss of control (Lillitos 1990; Aldridge 1998; Sagar 1990). Ideally the room offers a physical container for expression of mess by providing washable lino floors, wipeable surfaces and essentially a working environment where mess can be created and also cleared up, thus creating ‘order out of chaos’. The art therapist offers the mental container in her capacity to think about and understand its meaning in the different context of its making. Sometimes a messy and chaotic art therapy room can be an indication of some process going on between therapist and client that is not being processed and contained, suggesting a sense of being overwhelmed and out of control.

Some art therapists may work with more constraints, such as on medical wards where using art materials and making any mess may be problematic. An art therapist working on a paediatric ward in a general hospital worked in one secluded area which enabled the children to work with the materials freely but in a contained way. Sometimes anxiety about mess resides in the possibility of what might emerge and the potential for ‘spilling out’ or non-containment of feelings. This can be projected onto the materials as a need to keep them under control and contained.

**Summary**

The art therapy rooms and working spaces for art therapists working in different settings vary enormously, but all of them attempt to provide a sense of permanence, consistency, a ‘set apart’ space or ‘creative arena’ for interactions to take place between therapist, client and art materials.

Considerations in setting up the room, its ongoing use and function of the space will be considered in more depth in the chapter concerning the image (Chapter 5). First, we shall turn to look at the reasons for this ‘set apart’ space and consistency of experience and the importance for the therapeutic process of art therapy.
Bibliography


**Videos**


*Art Therapy – Children with Special Needs* (1987) Tavistock Publications (shows Roger Arguile working with children in the art therapy department at St Mary’s School).