

PERSPECTIVES ON THE USE OF GLASS IN THERAPY

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Abstract

The contradictory properties of glass and its beauty have captured the imagination of artists in many cultures and throughout history. This article explores the physical dimensions of this medium in art therapy, and specifically analyzes the traits of glass, a neglected material in both art therapy literature and practice. The article explores technical and psychological aspects of the use of heated, melted, and stained glass. Several attributes of the material are given particular consideration. The fragility of glass is described in terms of opportunities for physical expression of withheld anger. The transparency, translucence, and reflectance of the material are discussed from a symbolic perspective, and clinical illustrations are provided. The issue of safety in art therapy glasswork is given special attention.



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Glass had never been one of the many media we offered to our patients. We first encountered its therapeutic usefulness when traumatized patients informed us that they were using the material, spontaneously, as a mode of emotional expression. Patients reported that some of the material's properties were of particular value to them. Glass could be broken, shattered, smashed, and crushed, producing explosive sounds and visually dramatic outcomes. Schreiber (1973) presented one of the earliest descriptions of a patient's drive to achieve emotional release by breaking glass. Her patient, Sybil, was quoted as saying that at times she felt so angry, she wanted to break glass (p.87), or smash a window (p.330). The aim of this article is to suggest some ways for using glass in psychotherapy and art therapy, and to discuss the potential risks involved. We will also discuss the possible impact of the use of this material on the therapist-patient relationship.

Historical perspectives on glasswork

It is difficult to establish exactly when glass was first introduced as an art material. Ball (1997) claims that glass beads found in archeological excavations in the Middle East were determined to be at least 4,000 years old. The ancient Egyptians, and later the Romans, developed glass blowing techniques that allowed the production of glass containers. Japanese and Chinese cultures also have assigned aesthetic and spiritual properties to glass. Early

glasswork in Japan dates back to the third century B.C. The use of glass flourished around the Mediterranean basin during the first and second centuries A.D., when glass was used as ornaments, artifacts of worship, tableware, and as colorful decorative elements set in windows. Many of the techniques of working with glass were developed in the Middle East, and included cutting, sanding, gold plating, enamel plating, and painting. The Europeans implemented some of these techniques during the Middle Ages, when glasswork was widely implemented to induce a spiritual atmosphere and grandeur in Europe's churches and cathedrals. During the fourteenth century, Venice became a world center for artistic glasswork. One of the prized secrets of the trade at that time was the art of diamond etching. With the discovery of the advantages of adding lead to glass, the English, in the nineteenth century, introduced various degrees of softness and luster to the material.

Today glass is widely used in architecture and in the plastic arts. Twentieth century artists started to use glass as their canvas. Marc Chagall's 12 painted windows decorating the synagogue of the Hadassah hospital in Jerusalem are a fine example of this form of art.

Materials in art therapy

Art therapy is unique in its use of materials to facilitate self-expression. The presence of the material in the therapeutic process transcends its essence as a tool. The material becomes a full partner, a companion, in the creative process.

Betensky (1987), a phenomenological art therapist, regarded art materials as active partners that challenge the patients' senses, and stimulate both their emotional arousal and their awareness. She saw the art material as becoming a part of the patients' phenomenological field. Materials can enable the patient to maintain, through them, a dynamic, interactive relationship with processes that are otherwise mostly elusive.

Rhyne (1984), a Gestalt art therapist, advocated a permissive approach in the prescription of materials in art therapy. She believed that if provided a wide enough choice of materials and ample time for experimentation, patients would spontaneously choose those materials that suited them best. She believed that art materials should be viewed as sensory stimulants that are most efficient in uncovering non-verbal sensory memories.

The developmental approach to art therapy regarded materials primarily as assessment tools. Kagin (1969) suggested that the sensory properties of the material can evoke age-specific reactions, and, therefore, could aid in evaluating the patient's developmental level.

Psychoanalytic schools of art therapy emphasized that the different media activate different levels of psychological functioning. Some support the ego-organizing capacities of the mind, some tap libidinal levels, and still

others have an exploratory quality. Some media challenge a sense of mastery, whereas others provide an opportunity for fun and play. Robbins (1994) pointed out that art media could be used to explore and work through psychological polarities. For example, patients who are naturally attracted to working with hard and resistant materials that require aggressive movements could benefit from a gradual exposure to softer, more pliable media requiring milder manipulations. Robbins (1994) provided another example involving armature wire. This material can be used both to create soft-looking rounded shapes, or spiky, aggressive projections.

Therapists are encouraged to give careful consideration to the specific materials they offer their patients for art therapy. Clinicians should familiarize themselves with the various working techniques and possibilities relevant to the suggested art material so as to minimize unnecessary frustrations and enhance the therapeutic use of the material. Rubin (1978) suggested that materials should be synchronized, in terms of their properties, with the patients' needs and skills. She likened the process of familiarization with the material to being introduced to a new acquaintance. This can be done cautiously or impulsively, by applying familiar exploratory styles or by venturing with daring innovation. The material is regarded as a partner in a dialogue, a partner possessing clear traits and characteristics that require negotiation. It is incorporated into the artist's phenomenological field of the self, and becomes a link between the artist's mind and his or her sensorium.

There are several dimensions on which art material can be classified. Kagin (1969) saw materials as possessing varying degrees of pliability, ranging from fluidity (e.g., liquids) to resistance (e.g., stone). The harder it is to process and manipulate the art material, the more energy is required to produce the desired expressive end. Working with resistant materials can promote awareness concerning the limits of the material, as well as the limits of one's own capacities.

Rubin (1984) differentiated between structured and unstructured materials. She suggested that the less structured the art material is in terms of the expected outcome, the greater the likelihood for projection of intrapsychic processes. Conversely, the clearer the qualities and boundaries of the art material, the greater the likelihood of accomplishing the intended result. Materials that possess clear boundaries can, with proper structured guidance, lead to ego strengthening accomplishments. More fluid materials, such as chalk, clay, or watercolors, can facilitate work that is not dictated by physical boundaries, or confined by them. This category of materials promotes an experientially expanding experience, and can trigger a sense of loss of control. This is a potentially regressive experience that can be enhanced if the material is wet, and

if it is manipulated manually, without intermediary tools (Kagin and Lusebrink, 1978).

Lusebrink (1990) classified creative art materials along the fluidity-hardness continuum. When considering two-dimensional work materials, she anchored finger paints at one end of the spectrum, followed by water colors, pastel colors, chalks, markers, and felt pen colors. She placed pencils at the opposite end. When three-dimensional artwork was considered, she classified the materials in ascending order of resistance: water-based clay; oil-based clay; wood; and stone.

Robbins (1994) classified art media as soft, brittle, breakable, hard, or sticky. He also tried to understand the rhythm and movement that the material dictates to the working artist. Not only was he interested in the degree of control that had to be exercised to effectively work with the material, but he also saw importance in synchronizing what he termed "the patient's inner and outer flow." Investment of forceful energies in the art process, such as in stonecutting and chiseling (outer flow), may trigger powerful pre-existing emotions, such as anger or crying (inner flow), that could, in turn, impede the patient's capacity to work with the material and its structural dictates. If a resistant material, such as stone, triggered rage, it would more likely be attacked than artistically sculpted. Although engraving and carving in wood may require similar rhythm and movement as working with stone, wood's characteristics can better "guide" the patient to the correct method of working with it.

To facilitate the encounter between the patient and the material he or she is working with, the art therapist should be conscious of predictable changes in the state of the material's matter, and of the patient's possible reactions to such changes. Robbins (1994) drew attention to plaster, which emits heat as it hardens. This is a surprising physical change to many novice artists, and can even be startling to some. Plaster hardens quickly, often in the patient's presence. This can be a disheartening experience to unprepared patients, as they discover that the material does not respond any longer to shaping attempts. The consistency of clay can also change over time, and may not be as plastic and malleable as it was during previous sessions.

The patient's ability to take risks and tolerate mistakes related to mishandling of the material's properties is also worth considering in the selection of materials for art therapy. Patients who face the stubbornness and unforgiving nature of their art material may benefit from processing flexibility in decision making and attribution of responsibility in less controllable situations.

What about glass?

Glass offers the artist a variety of contradictory qualities that were probably appreciated by the early Greeks, who labeled the material "liquid rock." A contemporary author, writing about glass, described it as a "most sur-

prising material . . . No other material is so strong, yet so weak, so beautiful and yet so practical" (Vose, 1980, p.24). In their book, *The History of Glass*, Klein and Lloyd (1984) described glass as "a remarkable substance, made from the simplest raw material, transparent, translucent or opaque. It is lightweight, impermeable to liquids, readily cleaned and reused, durable yet fragile, and often very beautiful" (p. 9).

To the best of our knowledge, no article on the use of glass in art therapy has been published to date.

Glass in Art Therapy

Most art therapists we talked with indicated that they would not include glass as an optional art medium and would actively discourage the use of this material, even if patients reported using glass in their artwork at home. Liora Somer first encountered the use of glass as an art material when a potentially suicidal patient disclosed that she used the material as her preferred means of emotional expression. The patient was strongly attracted to this material, and was preoccupied with its manipulation. The purpose of this article is to discuss the properties of this unlikely art therapy material, and to explore indications and counter-indications for its therapeutic use.

Safety first

It is understandable that the first response of many therapists to the idea of introducing glass into art therapy would be concern for the potential risks to both patient and clinician. It is, therefore, imperative to determine guidelines for safe work with this substance. This issue is particularly pertinent when patients with suicidal ideation or self-mutilating tendencies are drawn to it. Glass fragments can cause unintentional (or subconscious) cutting accidents, but can also be used intentionally in violent gestures. Suicidal patients could be tempted to use glass fragments to injure themselves. Therapists considering the use of glass in therapy need to ascertain their patient's ego-strength and capacity to resist self-destructive impulses. Proper patient preparation should include thorough training in the techniques of glasswork. There should be agreement on ways for at-risk patients to notify their therapists about the increased danger of self-injury. Provision should be made for making the material inaccessible during those times patients do not feel they can handle it safely. A careful preparatory training phase can deepen the sense of care and nurturing in the patient-therapist relationship. It enhances the therapist's faith in the patient's capacity to master the hazardous substance, as well as trust in the patient's commitment to the safety contract. Above all, this can add confidence to the therapeutic relationship at a time when both parties are embarking on a joint venture that is as rich in potential for formidable threats as it is in opportunities for self-discovery. This

mutual commitment to safety can re-create a time-regressed developmental stage, in which the child is encouraged to take controlled, growth-promoting risks under supervised (parental) guidance. Although such bonding processes are generally desirable in therapy, complicating transference issues may emerge in cases where patients have histories of childhood trauma and betrayal. Many of these patients may have initial concerns about being endangered by their caretakers, perhaps not unlike their own early familial experiences. Some testing of limits may also be expected, when patients will try to act out their despair, their self-loathing, and their compromised basic trust by responding with unsafe behavior. Such behavior can also be related to a need to elicit the therapist's protective behavior. This could help support the patient's belief that the therapist can and will keep his/her end of the bargain when the patient is no longer able to protect himself. Because therapist attention is advised when glass is used in art therapy, we would not recommend using this material in group therapy activities. Group settings do not permit the necessarily close supervision this activity requires.

The particular attributes of the material

Glass has unique characteristics that may trigger a variety of therapeutically relevant reactions. The various processing methods of glass can also be conducive to evoking different sensations, feelings, and memories. Glass can be melted and softly shaped while it is hot. Glass can be cut, sanded, broken, and shattered. Broken pieces can be soldered to form new shapes and designs. Solid glass is both smooth (on the surface) and sharp (on broken edges). It can be opaque, translucent or transparent, colorless or colorful. What follows are some examples of the usefulness of glasswork in art therapy.

1. Heating glass and glass blowing:

Fire has a mythical aspect to it. Many of our ancestors gathered around bonfires to share legends and war stories, and to bond. Bonfires provided opportunities for cohesion of the tribe and the molding of its ethos. Fire is, therefore, etched in our common subconscious mind. In modern society, controlled fire is mostly associated with pleasant images of candlelight intimacy, cooking, and cozy fireplaces. Art therapists who decide to soften glass by warming it with fire will note that some patients may be drawn to the burning flame, and hypnotically stare at it. This behavior can be trance-inducing, and may facilitate significant disclosure and uncovering of important psychological material. The rigid and fragile attributes of hardened glass can remind patients of themselves and of their hopelessness with regard to "changing without breaking." The process of heating the glass can become a powerful metaphor for therapy itself, the literal flame a

symbol for the "heat" of therapy. If this analogy is meaningful to the patient, therapy, much like the glass-softening fire, could be perceived as a facilitator of flexibility and personal change. Glass blowing permits an intimate encounter with the material, whereby the very breath of the patient shapes the glass container and gives it volume. The captivating feeling is one of breathing the person's own spirit, or essence of life, into the artwork, thus creating a powerful symbolic extension of the self.

2. Stained glass:

Glass fragments can be seen as symbols of a shattered life or a broken self. The display of broken glass fragments has been described by patients as a chaotic, useless collection of debris, lacking a cohesive shape, emitting an alienated, cold feeling, and seen as potentially lethal. Before soldering the pieces in the stained glass technique, the fragments' edges must be covered with adhesive copper tape. This procedure is necessary for bonding the glass pieces together, but it is also a protective procedure that reduces the risk of being cut. In the patient-material identification process, we noticed that this technique could also be seen as bandaging rough and broken representations of the self, and, therefore, experienced as a fairly soothing activity. Considerable physical and thermal energy is required for joining the glass fragments into a self-standing piece of art. For some of our patients, this has not only been a metaphor for their healing process, but also a statement about the potential effects of warmth and protection. Therapists can reflect on the process, discussing with their patient how wrapping, heating, and bonding are necessary steps toward achieving an integrated new entity.

3. Glass as a means for emotional abreaction:

Even though glasswork in art therapy usually requires concentration and self-control, the material can also be used to facilitate affective expression, particularly the loosening of suppressed anger and rage. Activities like breaking and smashing require the use of protective gear, such as eye goggles, long sleeves, and work gloves. Normally, it would be quite difficult to engage in this type of activity inside the therapy room. Therapists who feel comfortable conducting sessions outside their offices could suggest a remote location, where the hurling of bottles would neither endanger anyone, nor contradict any local ecology standards. An abandoned quarry or a garbage dump could be suitable sites. Advance verbal preparation is always recommended to explore the patients' interpretations and emotional reactions to the suggested change of setting. Glass can also be shattered in the office. If carefully wrapped, it can be hammered or stepped on with work boots. Although the crashing

sounds are considerably muffled with this technique, the material can provide a satisfying and empowering feeling.

4. Transparency, translucence, and reflectance:

When light falls on a glass surface, it can be reflected back, it can be absorbed and filtered through it, or it can be broken into its optic color components, resulting in a variety of potential visual effects. One of our patients enjoyed capturing the sun's rays in the stained glass pictures he had created and later mounted on his bedroom window. He was delighted in his ability to control the penetration of light into his space. Broken glass mirrors can also be used in collage. We encourage patients who choose to utilize the mirror's reflecting capacity in their artwork to explore their reactions to a finished product that accurately reflects their image. Invariably, they realize that they have created an opportunity to be literally included in their artwork. They can discover that their reflected representation is imbedded within their artwork. This allows patients to explore the perceived merger with the picture and their relationship with the other symbols represented in their artwork. Some may allow the artwork to frame their reflected facial image. Others may benefit from experimentally altering their reflected placement on the picture. Patients who integrate glass mirrors in their creations may find themselves conflicted about exposing their work to others, thereby allowing the onlookers' images to be reflected, instead of their own. On one occasion, negative reactions to the spontaneous use of glass fragments led one patient to apply a controlled, corrective exercise later in therapy. This patient was at first horrified to discover broken images of her face reflected from pieces of glass she imbedded in her work. The reflected images accurately expressed her subjective sense of a disintegrated, defiled, and unattractive self. As she progressed in therapy, this person was later able to deliberately cut a piece of mirror, coat its edges with copper paper, then solder it onto her artwork. As a result, she could observe her facial image reflected from her artwork as an intact unit.

Ordinary window glass, colorless and transparent, can also be a significant material in art therapy. Transparent glass is simultaneously present and absent. Although it can be physically present as a cold, isolating barrier, covering the entire artwork or parts of it, glass in a window or a picture frame barely interferes with the artwork's internal space. In fact, it leaves the picture completely exposed as it covers it. This artistic expression may manifest a sense of alienation or dissociation from the self or the environment. Through identification with the glass sheets, some patients express their need to "see and not be seen," to be present but unnoticeable. This type of reaction is not atypical in survivors of childhood abuse, as it expresses a fear of being hunted down and hurt. Glass sheets can also be imbedded in the background of the picture, can be

painted on, or can be an element of a collage. When integrated in a patient's artwork, these materials can represent an ambivalent disclosure, a conflict about allowing the therapist access to threatening intra-psychic material. One patient who had worked with pieces of sheet glass in our clinic was processing, during her verbal psychotherapy, her discomfort with feeling exposed. She constantly felt exposed to people. She felt transparent. She thought she was easy prey, at constant risk of being assaulted. She also firmly believed that her shame and disgrace were exposed, obvious to all. As a part of a coordinated therapeutic effort to enhance her ego-strength, it was suggested that she paint on the glass sheets so as to reduce transparency, or, alternatively, to allow graphic symbols, representing various aspects of the self, to show through. This helped the patient explore the notion that she was a complex person possessing a mixture of traits.

Conclusion

The notion of using glass in art therapy has not generally been well received among our colleagues. The reluctance to allow the use of glass in art therapy activities reflects, for the most part, therapists' lack of experience with the artistic use of the material. In our view, the notion that the deliberate therapist-sanctioned use of glass in therapy can compromise the patient's well-being is patronizing, in that the patient is regarded as an infant. If this line of reasoning were valid, it could also be argued that therapists should encourage patients to take public transportation to their sessions instead of driving themselves because they might be injured en-route in a car accident. The inclusion of glass as an optional material in art therapy can be considered in cases when the therapist is confident that the therapeutic relationship is firm. There is no difference between the use of glass in therapy and the use of a pair of scissors or a sharp cutting knife if the therapist is confident about his or her mastery of safe glasswork techniques, and if a secure working environment can be provided. The need for patient safety is ever present, and transcends any particular therapeutic technique. Clearly, even patients in "talk therapy," or those not in therapy at all, can pose a risk to themselves. We firmly believe that when patients feel drawn to working with glass, therapists should provide them with a supervised opportunity to explore the therapeutic possibilities offered by the material, instead of discouraging its use. In summary, we believe that therapists skilled in glasswork could encourage the use of the material when patients with whom they have developed a good working relationship spontaneously choose to use it in their artwork. Only those patients who evidence a reckless impulsiveness or are unable, by reason of mental, emotional, or physical limitations, to understand or follow safety instructions should be barred from the use of glass.

The clinical findings presented in this article are very preliminary, and, accordingly, warrant neither more specific recommendations regarding the therapist-initiated use of glass, nor identification of specific patient populations who might benefit the most from activities using glass. The clinical experience that led us to write this article stemmed from our work with adult survivors of child abuse who had been diagnosed as suffering from a dissociative disorder. Further clinical exploration and research is needed concerning the effects of glass as an art material in the treatment of other clinical populations.

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