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Art Therapy and Rehabilitation - A Holistic Approach: The Role of Art Therapy in the Holistic Medicine Model When Working with Physical Disability

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A Thesis

in

The Department

of

Art Education

and

Art Therapy

Presented in Partial Fulfillment of the Requirements
for the degree of Master of Arts in
Art Education - Option B Art in Therapy
Concordia University
Montréal, Québec, Canada

February, 1984

ABSTRACT

Art Therapy and Rehabilitation - A Holistic Approach:
The Role of Art Therapy in the Holistic Medicine
Model When Working with Physical Disability

Beverly Shapiro

Three art therapy cases of severely physically disabled adults in a convalescent and rehabilitation hospital are the basis for a study in conjunction with a review of literature pertaining to the holistic approach toward mind-body balance in healing physical and psychological disorders.

The concept referred to is that of psychosomatic medicine because it also deals with "somatopsychic" medicine - an area that has not been widely acknowledged or researched - the focus of this study. A description of the impact of disability on the affective life of the patient is investigated.

With this information and the presentation of the cases as clinical examples of the process of creative art expression and its effect, an evaluation of the results is given. Special reference is made to specific goals proposed in relation to fulfilling emotional needs and positively effecting rehabilitation, as may be inferred from the three illustrated cases. A brief summary of the art therapy process with regard to this population is then presented. Possible areas for future investigation conclude the thesis.

Dedication

I dedicate this thesis to all who are involved in gaining a deeper understanding of the human mind and body through expressive arts therapies.

Acknowledgements

I wish to express my sincere appreciation and thanks to:

Dr. Pierre Grégoire, my thesis supervisor, for his constant support and inspiration throughout my art therapy studies and internship.

Professor Michael Edwards, for his careful reading of this thesis and his valuable suggestions.

Professor Julia Byers, for her detailed reading and worthy comments.

Marie Watt O.T. (C) and her staff, for providing me with the opportunity to intern in art therapy with the physically disabled population.

My husband, Ernest, and children, Murray, Lorne, and Debra, for their patience, support, and encouragement during an intense two years in our household.

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I Introduction

1. Subject Area; Hypothesis to be Examined

The subject area to be covered in this thesis is the application of art therapy to the needs of the physically handicapped and their rehabilitation from a holistic point of view. The purpose is to investigate what art therapy can do for physical problems by working through the mind area with the concept of body-mind balance.

The assumption is that creative expression through art therapy can help the physically handicapped by fulfilling their psychological needs in terms of readjustment to existing circumstances and possibly, in a holistic sense, help bring about change in the physical disability and/or quality of life.

2. Psychosomatic - Somatopsychic: Definition

The model used in this study within the holistic approach was verbal psychotherapy in its application to psychosomatic medicine. In The Expressive Arts Therapies, Elaine and Bernard Feder point out the need for non-verbal expressive therapies such as art therapy in relation to somatopsychic as well as psychosomatic medicine (Feder & Feder, 1981, pp. 12; 52-53).

The term "psychosomatic" comes from the Greek words psyche and soma. Psyche means soul or mind "as a functional entity governing the total organism and its interactions with the environment" (Guralnik, 1977, p. 482). Soma refers to the physical organism - the body.

Lachman defines psychosomatic in terms of relationships between psychological processes and bodily organs, denoting the wholeness of an organism and conveying the idea that the psychological and the biological represent a unity. The term can also imply that although an organism is unitary, psychological and somatic aspects can be studied separately and considered by means of relationships between them. Lachman goes on to say that from this viewpoint -

> The term psychosomatic refers to the influence of psychological processes on biological processes. The influence of biological processes on the psychological ones . . .may more appropriately be called 'somatopsychic'. (Lachman, 1972, pp. 2-3)

3. Methodology; Limitations

To better understand the population being referred to, there will be a review of literature in the area of psychosomatic medicine, beginning with the holistic concept of disease and centering on body-mind balance in rehabilitation with severely disabled people. Chronic illness and factors involved in its treatment will be presented. A description of art therapy and its use in rehabilitation will follow. The theoretical background as well as the therapeutic approach in working with this population will be examined. Next a clinical study of three disabled patients working through the modality of art therapy will be described. The last chapter will include an evaluation of the art therapy goals listed earlier.

The presentation of information researched will be necessarily concerned with both physical and psychological aspects within the

framework of somatopsychic relationships. The emphasis in this study will be clinical. The area of concentration in the cases will be on therapeutic effect rather than on diagnostic and theoretical interpretation.

II Literature Review

1. Brief History of the Holistic Outlook on Healing

"For this is the great error of the day . . .
That physicians separate the soul from the body" (Plato).

The awareness of a distinction existing between body and mind and the realization of the possibility of approaching them as a unity appears to have been present for a long time. The Feders claim that even though the eighteenth century had been known as the "Age of Enlightenment" with regard to the increased understanding of the human body and its functions, nineteenth century English and American Victorians denied the body to an extent unparalleled in history. They go on to point out that "this debasement of the body was a vulgar or popular phenomenon" and intellectuals such as Thomas Carlyle and John Ruskin viewed body-mind and their interdependence in holistic terms (Feder & Feder, pp. 11-12).

Today physical and mental diseases are still largely considered separate entities and a person with symptoms in one area often gets medical treatment for that part alone. However there does exist presently, some insight and understanding of the importance of mind-body balance. The holistic outlook on life, health, and disease is becoming more acceptable. But the concept of a mind-body dichotomy has not disappeared and the Encyclopedia of Philosophy - 1967 edition, for example, still has no information under "body" (Ibid., p. 12).

In summary, even though one can attribute the rediscovery of the body and reemergence of the arts in treatment of disorders to the

development of modern psychotherapy (Ibid., chap. 1), the greater part of psychotherapy still remains verbal. This no doubt rests on the assumption that the psyche is in the head - the place of the intellect. In modern medicine a relationship between body and mind is acknowledged, but is almost always expressed as psychosomatic rather than somatopsychic (Ibid., p.12).

2. Related Publications

In reviewing the literature it was encouraging to discover that more art therapy with the physically disabled has been published by the American Art Therapy Association in recent years than in the past when most emphasis was given to obvious psychological illnesses. This tendency perhaps reflects a return to the holistic concept of disease.

Nevertheless, it is stressed that much wider study and control testing of the value of all the expressive arts therapies is necessary (Ibid., pp. 52-53).

In a recent publication by Bahnson, literature on the relationship between stress and cancer was surveyed. Along with the general concensus that the emotional factor can play a large part as one of the forerunners of the disease, it is now felt that there is a common background and personality makeup in many cancer patients - namely feelings of loneliness and hopelessness originating from lack of a protected and loving childhood. Development of a personality marked by self-containment, inhibition, rigidity, repression and regression, according to the author, often precedes cancer. This may involve somatic or cellular "regression" as well.

Suffering the loss of an important relationship before the onset of the illness, having no ability to express Hostile feelings, showing tension over the death of a parent - even many years previously, were the discoveries in a personal history test given to cancer patients by LeShan and Worthington (1956). This supported the observation by others in the field, that strong unresolved tensions concerning parental figures are characteristic of cancer patients (Bahnson, 1980, pp. 975-980).

These findings draw attention to the connection between mind and body. It follows that there is a need for people to be able to express at the non-verbal and thus less psychologically defended level as well as verbally, so as to uncover images and symbols that may give clues to the inner meaning of their lives and therefore of their illnesses. If conflicts can be resolved, it is suggested that energy can be diverted fo use in healing. Under the same assumption, if psychological traits can be instrumental in causing one's illness, then other inherent traits can be awakened and developed to enhance one's healing process.

A much publicized case of the patient's own strength to impel the forces of the body and mind in reversing disease is that of Norman Cousins, long-time editor of Saturday Review, who attributes a large part of his remarkable recovery from a painful degenerative disease to a well-developed will to live and to laughter. As a result of publishing Anatomy of an Illness in the New England Journal of Medicine in 1976, Cousins received thousands of letters from doctors in many countries supporting the measures he took to effect his own recovery. The consensus was that it was scientifically acceptable for him to state

in the NEJM article that "just as the negative emotions produce negative chemical changes in the body, so the positive emotions are connected to positive chemical changes" (Cousins, 1981, p. 143).

Similarly, by means of visual expression through art of his/her own creation, the patient has taken a step in the direction of taking charge, or at least giving self-fulfilling co-operation towards his/her own recovery.

3. Holistic Approach; Totality Concept

From the literature the following views of body-mind relationship can be summarized.

The "totality concept in medicine" (Menninger, 1938, pp. 353-361) existed even in Victorian times and is described by Henry Holland as far back as 1852:

> Human physiology comprises the reciprocal actions and relations of mental and bodily phenomena, as they make up the totality of life. - Scarcely can we have a morbid affection of body in which some feeling or function of mind is not concurrently engaged - directly or indirectly - as cause or as effect. (Grinker, 1973, opp. p. 13)

A hundred years later English and Weiss, in 1957, see problems of the body concurrently involving some feeling in, or performance of the mind, openly or obscurely, as cause or result. How much of the problem is emotional, how much is physical, and the relationship between them is, according to these authors, the true psychosomatic concept in medicine. In conclusion they quote Halliday:

> The individual may be studied by a psychological approach and the individual may be studied by a structural or physical approach. It is our techniques or methods of investigation which are diverse and multiple, not the individual, who is a unity. (English & Weiss, 1957, pp. 9-10)

The words "psyche" and "techne" in relation to man are respectively defined by José Arguelles as the inherent human skills with which to experience or perceive as a whole that which underlies the initial human impulse towards expression, and the counter-aspect which is connected with the performance of logic, analysis, language, and mathematics. He sees psyche as primary, relating man to nature, and techne as secondary, describing the unnatural structuring side of the person. Although these two aspects of human nature can function independently of one another, the amount of independence directly relates to the amount of imbalance, sickness, or insanity. They really cannot be understood separately (Arguelles, 1975, p. 4). Arguelles sees art as "the perfect marriage of psychic impulse and technical implementation" (Ibid.).

With regard to those who have developed or acquired severe physical disabilities, Whitehouse sees man as -

> an organismic whole: what affects one part of him, affects all of him. As internal and external forces act, he is ever changing and dynamic. He is not merely a cardiac, polio, or cerebral palsy, but a person who has among other influences, his physical or mental disability. (Whitehouse, 1955, p. 23)

He concludes that since the whole man must be treated, all treatment is total. All aspects - medical, social, psychological, vocational, or

economical - take on major or minor roles, depending on the situation and needs of the person (Ibid., p. 34).

4. Chronic Illness

Definition for purpose of the study. Physically this population can be characterized as having chronic illness which is defined by Roberts as -

> all impairments or deviations from normal . . . which require special training of the patient for rehabilitation; or may be expected to require a long period of supervision, observation, or care. (Shontz, 1962, p. 411)

According to Lipowski, such illness -

> implies a significant degree or irreversibility of the pathological process or damage to the body and the related disability. It includes such diverse conditions as congenital defects, acquired injuries and illnesses leaving residual damage, and incurable diseases with a progressive or remitting course. (Lipowski, 1975, pp. 29-30)

Psychological theory of response to disability. The psychological response of patients to physical illnesses naturally differ according to circumstances. Reasons for human behaviour derive, of course, from whichever theoretical standpoint is followed. Within the post-analytic frame of reference, Margaret Mahler refers back to infancy and the stage of "mother-infant-symbiosis", expressing her belief that from this supportive state of mother-infant dual unity "experiential precursors of individual beginnings are derived which,

together with inborn constitutional factors, determine every human individual's unique somatic and psychological makeup" (Mahler, 1973, p. 92), and in turn, how he/she will respond to illness.

Disability arising in an adult will tend to bring out underlying pathology, while the well-adjusted person will be inclined to absorb the disability as an inconvenience and not dwell on it as the main issue in his/her life (Kutner, 1971, p. 146).

Adaptation to pain or changes of body functions is not always easy and the ways in which a person adapts and whether or not he/she succeeds, depends on the total organization of the personality, its past, and dormant defenses (Fenichel, 1945, p. 257).

Even though there are many differences in the feelings of the physically and psychologically ill person, there are certain characteristic similarities as well, such as the loss of external interests and the upswing in self-observation and concern (Ibid., p. 258).

Psychological adjustment. The actions taken by the patient in connection with sickness are an aspect of his/her general coping behaviour and may be classified as "tackling, capitulating, and avoiding" (Lipowski, 1975, p. 14). Tackling is described as a tendency to adopt an active attitude towards challenges and tasks brought on by disease or disability. Extremely, it is a tendency to "fight" illness at any cost. Capitulating means adopting a passive attitude resulting in either withdrawal from or dependent clinging to others. A patient with such a reaction creates problems for the staff through poor co-operation, excessive demands for support, reassurance, and caretaking. Avoiding

means getting away from the immediate demands and challenges of the sickness. For this person, acceptance of disease signifies a threat to his/her self-concept of being independent or of being very vulnerable. This response usually shows up either by a marked degree of denial of being ill or by a display of manifest anxiety (Ibid., pp. 14-15).

Chodoff offers a classification and description of three major response patterns of psychological adjustment to chronic illness and disability. The first is that of insightful acceptance showing in lack of bitterness and hostility and is thus a positive response. The second is the denial pattern which manifests itself in a negation of the objective facts of sickness. This reaction is pathological only if it concerns the obvious facts and/or prevents the person from behaving in a way that shows understanding of his/her limitations and necessary treatment. The third is the regressive pattern and can hardly be called an adjustment. It is displayed by extreme dependence and passivity on the surface and often anger and hostility just beneath. Such a person accentuates his/her disability and demands full attention and care from the surroundings. He/she plays up his/her helplessness and suffering and uses it strategically to manipulate people by working on their compassion or feelings of guilt (Ibid., p. 30).

It is also to be noted that these classifications are deficient in the respect that they are "static and obscure clinical observations" (Ibid., p. 31) and that a patient may go through many other negative reactive experiences before settling in one or another definite response pattern. In reality, when working one must be aware of the changing dynamic aspects of each patient's illness behaviour (Ibid.).

Hospital influence. Another factor which influences the psychological responses of a patient who is institutionalized for treatment or rehabilitation is the hospital setting itself. Shontz describes "dependency on the institution" as an acting attempt on the part of the patient to cope with the problems created by the impact of the disability. This in itself may be one of the coping defenses against painful affect. Change and fear of change gives the hospital a positive attraction to the patient partly because the "outside" can be dangerous and threatening and accentuate his/her helplessness. The hospital can also offer a support system through contacts with other individuals who have similar or different problems (Shontz, 1962, pp. 425, 431).

Overall, although it is known that active disease processes usually are associated with some form of depression and bodily concern, psychiatric symptoms may occur in any individual who is hospitalized for treatment or rehabilitation and such symptoms may result from hospitalization rather than from the illness itself (Shontz, 1971, p. 49).

Even though the hospital is of considerable importance to a patient and in many ways fulfills his/her needs, it is also a fact that more attention has to be given to centres for treatment and rehabilitation. There is a strong need for reassessment and evaluation of the structure in which treatment occurs (Kutner, 1971, pp. 160-161).

Patient's attitude influence. Attitude and expectations of a patient can help to influence the progress rate in either direction. Negative expectation is made apparent by affects of hopelessness,

discouragement, apathy, or surrender. It is a condition of psychological and physiological decline and the sum of these attitudes, behaviours, and physiological processes is prone to failure or giving up. Hopelessness results in a complete slowing down of the physiological processes that are connected with the promotion and maintenance of life (Lachman, pp. 166-167).

"As a consequence of a somatic change, there may be extensive and profound indirect psychological effects - perhaps through social interaction - in addition to direct consequences" (Ibid., p. 4), such as having to accept a lower-level job and changing self-attitudes because of feelings of inadequacy or inferibrity (Ibid.).

Body image. The physically handicapped person in rehabilitation must also deal with the "emotion - charged body image" which has its start in childhood experiences. Disability may bring on regression which in turn activates infantile conflicts associated with the body image. As a consequence, the patient may display exaggerated or inappropriate responses such as fear, guilt, and childish behaviour (Shontz, 1971, p. 37).

The body image becomes tied to feelings of shame and guilt when the child fails to live up to parental expectations and ideals regarding body management. These same feelings are rekindled when disability makes one aware that one's internalized expectations are impossible. Normally the body image is preserved by self-communication. In affliction, the self-reinforcing monologue becomes purposeless and pessimism and negative emotional reaction result (Ibid., p. 37).

5. Rehabilitation

Definition. One definition of rehabilitation for any disabled person, including the child, the adult, and the aged, in all their capacities and possibilities is "the cultivation, restoration, and conservation of human resources" (Whitehouse, p. 22).

Psychological treatment and goal. It is emphasized that the therapist should work almost exclusively with problems and issues that are of immediate importance and concern to the patient taken as a whole. Therapeutic methods are not to change basic personality, but to help the patient to use his personality and mental powers to arrive at a solution and adjustment to concurrently existing circumstances. Such treatment, as well as being an adequate challenge for the therapist, is also the best way for achieving the required personality conversion of the chronically ill human being (Shontz, 1962, p. 440).

Motivation. There exists the unitary drive on the part of the disabled person to realize his/her capacities as much as possible. Giving in to a somatic disorder can appear to offer security and an ordered existence, but it does not promote growth and self-actualization which requires that problems be faced and tackled (Shontz, 1971, p. 37).

Disability creates two groups of problems. The first requires neutralizing the threat brought on by loss of significant capabilities and functions. The second requires finding new and positive reasons for living. This second group of problems cannot be solved before the first has been suitably settled: that is "lower level" necessities for physiological comfort and personal safety, and "higher level" necessities for interpersonal contentment and self-esteem. This is

in accordance with Maslow's concept of a hierarchy of needs (Shontz, 1971, pp. 37-38).

In a 1965 review of literature on motivation for rehabilitation Maslow's classification of needs was found to be helpful for organizing the discussion; but more recently, in 1971, there was a lessening of interest in theories of motivation and more consideration for relevant and practical meaning in research. Autonomous behaviour (1968) and achievement motivation (1969) were also suggested in the study of treatment potentials (Ibid., p. 38).

6. Art Therapy in the Context of Holistic Methods

Compilation of definitions. The late Margaret Naumburg, a pioneer in the field, saw art therapy as a method of symbolic communication by means of pictorial projection between patient and therapist. She said that such projection takes place through spontaneous art expression which allows the release of unconscious conflicts, fantasies, and dreams to be mirrored back to the patient as a kind of self-confrontation (Naumburg, 1966, pp. 1, 3, 14).

Harriet Wadeson adds to this, experiencing of an absorbing and intense process of activated creative energy that can have an exhilarating quality for both the patient and the therapist (Wadeson, 1980, pp. 11-12). Also cited by Wadeson is Edith Kramer's approach of emphasizing the integrating and curing properties of the creative process which does not need verbal consideration (Ibid., p. 13).

Carl Jung also regarded imagination and creativity as healing forces in themselves, when, to quote Robbins and Sibley, "feelings can

be followed beyond words and manifested in painting, sculpture, and movement" (Robbins & Sibley, 1976, p. 5).

Rehabilitation. The psychological theories underlying art therapy treatment for patients in rehabilitation are according to Helen Landgarten, based on similar principles to those cited in the literature review (pp. 14-15). The total person must be seen in terms of psychic and somatic healing, thus beginning or continuing motivation for self-acceptance and adjustment.

Landgarten sees the art therapist as providing materials which assist the patient to express emotionally through, for example, a simple scribble, shaky line, collage, or clay imprint. Also, she draws attention to the relationship between the therapist and the patient, and the empathetic acknowledgement of the latter's feelings during this traumatic period (Landgarten, 1981, pp. 335-336).

Hidden conflicts. Karl Menninger in his book, Man Against Himself, writes about people taking an active role in helping to create their illnesses, be they psychological or organic. He claims that it often appears as if -

> People elect misfortune - they elect misery, - they elect punishment - they elect disease. Not always, not all people, not all diseases; but this is a tendency to be dealt with - and one which is not ordinarily considered by medical science. . . . (Menninger, 1938, pp. 357-358)

He suggests that -

> self-destructive and self-preservative tendencies - psychological, physical, chemical - appear to carry on a continuous battle in

> the organism, and this battle is reflected in the psychological experiences and sensations as well as in the structural and physiological processes. . . . It would appear that these unconsious self-destructive tendencies at one time are manifested through conscious volitional expression and at other times through unconscious attacks on the internal organs or some part of the body. Sometimes there is a joint expression of both. (Ibid., pp. 360-361)

Following the psychoanalytic viewpoint that the conflict creating the problem often derives from deep unconscious parts of the personality, Menninger concludes that organic disease represents a form of self-destruction and goes on to say that research in this area helps to advance the idea of the human organism being the product of physical, chemical, psychological, and social energy - which he phrases as "the totality concept in medicine" (Ibid., pp. 353-361).

Menninger sees creative sublimation, such as in art, as one possible way of dealing with self-destructive, as well as other aggressive tendencies (Ibid., p. 440).

III Practical Application

1. Introduction to Clinical Setting and Population

In order to be able to set the context for the theoretical approach and specific goals used in the three studies, an introduction to the institution, conditions, and population will now be given.

The art therapy conducted at this convalescent and rehabilitation hospital was initiated as part of an internship and was in association with the occupational therapy department. It was organized as an adjunct to the limited ongoing treatment of certain recommended patients.

A patient was referred to art therapy when he/she had been showing negative affective states in coping with his/her illness, presenting themselves in some form of regression, negative attitude, bizarre behaviour, withdrawal, or flat affect. In other words, he/she would be manifesting some form of hopelessness which in turn produced a sense of helplessness on the part of the staff in trying to achieve the best possible outcome for the patient. This is in accordance with Arieti's model of non-coping or negative responses to physical disease (Lipowski, pp. 14-15).

As mentioned, this therapy was new to the institution and even though a psychiatrist was on the board and would interview and assess the patients described, there was no access to any scheduled verbal psychotherapy. Therefore art therapy was introduced with discretion. Shontz writes about the concept of psychological "amplification":

> To the severely disabled person, in a state of pervasive ambiguity, the slightest alteration in status often becomes a signal to be amplified. . . . A word, dropped casually by a therapist, is taken to be a full-scale prognosis. Referral to the psychologist is equated with a diagnosis of insanity. (Shontz, 1962, p. 435)

The recently-introduced therapy was short-term because of the nature of the setting. The patients either recovered sufficiently to function on their own or were eventually "placed" in a chronic-care institution. The last two patients to be discussed and presented were on such a waiting list and eventually were transferred when space became available. Each patient was seen once weekly. Time alloted for the session was one hour, but it fluctuated depending on the circumstances of the patient at the time.

2. Common Factors of Patients

Common to all three patients was some form of neurological illness; the first two cases manifesting a somatic cause and the third, deterioration originating from back injury. There was a prognosis in all three cases of no physical recovery from the existing bodily dysfunctions; in blunt words - no hope of ever returning to the independent way of living they once knew. Yet these people were continuing with their lives and thus still pushing ahead in a less visible, less progressive way.

> Chronic illness is not a static condition. The patient's situation is constantly changing and must, therefore, be

frequently reevaluated. Small increments or decrements of function in the severely disabled may alter the whole picture and evaluation of the patient's degree of disability and rehabilitation potential. (Ibid., p. 434)

3. Origin and Application

The effect in sickness of beautiful objects, and especially of brilliancy of color is hardly appreciated at all. . . . People say the effect is only on the mind. It is no such thing. The effect is on the body, too. As little as we know about the way in which we are affected by form, by color and light, we do know this, that they have an actual physical effect. . . . Variety of form and brilliance of colour in the objects presented to the patients is an actual means of recovery. (Florence Nightingale, 1860)

Bearing the above in mind, a "dream situation", taken in the visual sense of providing a chance for activating imagination and creativity, was a primary aim of the art therapy in this setting.

Ernest Harms in his article, The Development of Modern Art Therapy, writes about how art therapy originated from early cultures applying art and aesthetic elements as means of healing. With the coming of the modern age, the occupation of mentally ailing patients requiring hospitalization became a practical and therapeutic procedure. "Work therapy", as it was originally called, became occupational therapy and has thus remained. Art and aesthetic impulses were slowly incorporated into the occupational therapy program after the start of

the nineteenth century in the forms of directed art and handicrafts, as well as visual diagnostic methods which developed into projective techniques. These aesthetically expressive tasks were and still are used to gain insight into the understanding of the patients and their specific pathologies (Harms, 1975, pp. 189-190). Harms goes on to say: "Presently, however, applied occupational therapy views art therapy as a side aspect " (Ibid., p. 192). According to him, those who administer art therapy -

> not only implant technical abilities but a more or less rational and emotional impulse towards those things that express beauty. They implant a specifically aesthetic way of experience that has a definite kind of therapeutic influence. (Ibid.)

He then looks at the form of "art psychotherapy" - which he defines as -

> the application of art to mental and psychologically deviant conditions (Ibid., p. 191) ... . in which the entire therapeutic process actually takes place in an aesthetic experience and it was originally proposed by C.G. Jung, who devoted a substantial book to it [The Integration of Personality, 1940]. Jung centers the entire therapeutic process in an imaginary experience, expressing an unconscious pathology that slowly dissolves. (Ibid., p. 192)

4. Therapeutic Approach and Theoretical Background

Mindful of these and similar conclusions, my approach when

working with these patients was "humanistic - holistic" in that it focused on the totality of the individual existing in the "here and now" with a view towards individuation and self-actualization (Jung, Rogers, Maslow) within the framework of a trusting relationship.

The theoretical orientation used was particularly influenced by the ideas of two prominent existential psychotherapists, Carl Rogers and Rollo May. Rogers, who introduced the technique of "client-centered therapy", wrote an article entitled Learning to Be Free in which he used as an example the behaviour of prisoners in a concentration camp. When everything, including possessions, identity, and choice, was taken away from these people, there still remained "the last of the human freedoms - to choose one's own attitude in any given set of circumstances, to choose one's own way" (Rogers, 1963, pp. 4-5). On the same subject May states: "No matter how great are the forces victimizing the human being, man has the capacity to know that he is being victimized, and thus to influence in some way how he will relate to his fate" (May, 1966, pp. 32-33).

5. Limitations in Practice

The art therapy was limited to my experience and knowledge as an intern, as well as conditioned by its position as an adjunct to occupational therapy in a medical institution. Goals for physical and functional improvment were important and emphasized.

"Pictographic exercises" (Denner, 1967, p. 19) (see Case 2, p. 35 for description) and guided imagery were employed where necessary, in line with the aim of improving perceptual awareness and sensory motor

skills through active visual stimulation.

As is often the case, insights of the art therapy sessions have developed and changed somewhat in the light of subsequent experience and reflection.

Although there is some reference to analytic, post-analytic, and Jungian theories in the literature review, these concepts were not directly employed in the sessions per se. Rather, they were used in the pragmatic sense for technical purposes ("spontaneous scribble" - Naumburg; Case 3, pp. 43-44), or for pictorial comprehension ("Mandala" - Jung; Case 3, pp. 46-47).

6. From Theory to Practice: Hypothesis, Aspirations, Goals

Hypothesis. The art therapy measures employed to meet some of the psychological needs of this population and test the general hypothesis raised on page one will now be considered. It is assumed that, holistically, emotional readjustment to circumstances of physical limitation is necessary to help bring about change in the disability and/or quality of life.

Aspirations. By working with these patients in art therapy, it was hoped that a change in attitude towards the self and the illness could be promoted through creativity and imagination. This assumption follows Jung and Kramer who saw spontaneous expression through images as a healing potential, often in itself. Also, ego-building through risk-taking and self-accomplishment in the artwork can be regarded as analogous to confronting new situations in day-to-day life. As a communication tool, art is often less controlled and defended than words (Wadeson,

p. 9) as a means of expressing feelings and ideas, whether abstract or concrete. Furthermore, when verbal loss occurs, due to physical and/or psychological causes, imaging can help to ease the frustration of limited verbal interchange with others. The need to act out emotions can be recognized through art in an acceptable, workable form that often provides emotional release of conscious or unconscious hopes and/or concerns. Pictorial expressiveness can be considered together with all these aspects as it is the way of understanding the visual art language. At the end of each case example there is a summary discussion of four aspects in the art work - colour, motion, detail, and space filled (Wadeson, p. 327).

Indirect achievements such as functional improvement in activities of daily living can also be recognized to some extent through an increased sensory stimulation and awareness, as well as in the exercises of motor co-ordination provided by the art activity.

For the elderly, a recalling of the past through visual memories offers the chance to reflect on more productive years (Dewdney, 1973, pp. 249-254). This can help to compensate for a present seemingly static, passive existence. Butler describes the "life-review" as a "universal mental process characterized by the progressive return to consciousness of the past experience, and particularly, the resurgence of unresolved conflicts" (Zeiger, 1976, p. 47).

Rehabilitation goals. In researching the literature in support of such notions, seven goals were found in the article, Art Therapy with Newly Handicapped People by Judy Mass (1979). As well as being in accordance with approaching psychosomatic medicine from a holistic point

of view, these goals seemed relevant for the cited population.

Before listing them, Mass stresses the emphasis placed on "process over product. There is no pressure to accomplish or complete finished, polished art. This does not, however mean that the work is not completed, but that it is completed to the creator's satisfaction" (Mass, 1979, p. 45).

Her goals are as follows:

(1) Personal Growth: Mass writes that

"One can become more aware of the self and the environment through art; artistic growth parallels personal growth. To a newly handicapped person, growth lies in increased understanding of a new physical image and of new limitations (Ibid.)". This goal relates to the aforementioned aspiration of attitude change toward self and illness.

(2) Personal Expression:

"Art can become a new means of expressing, releasing, and understanding emotions. Sometimes feelings are expressed verbally, but alternative means of cathartic release can be equally effective" (Ibid.). This ties in with the idea of emotional release acted out through art therapy.

(3) Communication:

"Art work communicates feelings and ideas. For a person with aphasia art can become a new and important means of connecting with others. Sometimes the communication is abstract and sometimes quite direct" (Ibid.). This concept and goal can be directly in line with art acting as a communication tool and can apply in cases of any type of verbal loss, be it organic or functional.

These first three goals appear to be closely related and can be summarized as new forms of self-awareness and growth within a changed body-image arrived at through creative pictorial expression and communication.

(4) Perceptual Awareness and Sensory Motor Skills:

"Brain damage can cause loss of perceptual, tactile, and sensory motor skills. Art therapy can help to compensate for some of these losses" (Ibid.). This can possibly relate to functional improvement. Active stimulation through pictographic techniques (Denner) can also help the disabled patient to arrive at reachable goals by the use of simple visual-manual exercises which serve to improve physical control and self-esteem.

(5) Development of New Skills:

"Both children and adults can gain a new appreciation for colour, form, spatial relationships, and the entire range of experience art offers" (Mass, p. 45). This area can add to the importance of pictorial expressiveness in terms of personal content as well as to the functional improvement indirectly arrived at through new technical competency. Therefore Goals 4 and 5 can be seen as closely connected.

(6) Social Growth:

Group sessions provide social readjustment through the sharing of ideas and feelings while creating. Physical and psychological needs of the patients must be taken into account by the therapist in arranging the placement of the participants (Ibid.). Though valid, this goal was not directly attented to in these cases.

(7) Recreation and Relaxation:

"While hospitalized, many people feel guilty if they find themselves relaxing to the point of pleasure. Through art, however, people often find enjoyment that they can accept without guilt, and take with them a positive experience when discharged from the hospital" (Ibid.). This is connected with attitude change as well, owing to the potential healing of stimulating creativity and the imagination.

These goals will help to form a bridge between the review of the theoretical aspects and their implementation in the art therapy sessions which will be described.

The last chapter will provide a critical evaluation of the contribution of art therapy for this client population. This will be considered in relation to the three cases to be presented. The seven aforesaid goals, along with the life-review discussed earlier, will help to provide criteria.

7. Case Example 1

Identification and disease description. The first example is that of Mr. T., a 33 year old single male jazz musician and teacher, who was diagnosed as having multiple sclerosis three years before and was later confined to a wheel chair. On "better days" he would occasionally use a walker. Solomon notes:

> The so-called degenerative diseases of the central nervous system are often confused with psychological illnesses. . . . Many of these diseases also manifest disturbances of personality and of mentation. . . . Multiple sclerosis is a common disease of youth that is characterized by multiplicity of symptoms and

> signs. . . . Often, symptoms outnumber signs, and sometimes symptoms precede objective evidence of the disease. (Solomon, 1980, p. 333)

Presenting conditions. Mr. T. was assigned to art therapy when it was felt that he was not using his full potential and according to his chart, portrayed a very "carefree" attitude towards the therapies and rehabilitation that were offered to him at the hospital. He also appeared withdrawn and distant. He would often deviate from the subject when a discussion was in progress, not making sense, and at times displayed inappropriate euphoria. A psychiatric assessment found Mr. T.'s judgement to be somewhat affected in that his expectations continued to be very high, considering the nature of his neurological illness, and this tended to make Mr. T. frustrated and angry at himself and his disease.

It was also recorded in the hospital charts that the euphoria Mr. T. displayed seemed to be reactive and in keeping with his character rather than indicative of major psychiatric illness. Also of importance was the fact that Mr. T.'s father, to whom he was very close, had died three years previously and at about the same time that the diagnosis of his disease was made. This death was said to have been very traumatic for Mr. T. The final hospital psychiatric diagnosis was a multiple sclerosis reactive disorder with a possible character disorder. Mr. T. was seen for thirteen sessions.

Session 1. During the first session Mr. T. displayed skepticism of the new experience. In the records it was written that he could be motivated in areas that interested him or in things that

he found relevant. Through the subject of music Mr. T. was able to talk about his life. He talked about having played the guitar as well as having composed tunes. He had intended to continue his studies at university and to teach music. Although no visual images were made at this time, a relationship was establishing itself and hopefully would continue to develop.

Session 2. In the second session Mr. T. played a tape of his own musical composition. There was talk about the relationship of music to visual art. He observed some artwork and made some keen observations about it.

Series A: Slide 1. Toward the end of the second session Mr. T. began to draw. He tried to relate the sounds of music to lines, forms, and colour on paper. As he drew he seemed to become intensely involved and sometimes even became angry and mumbled to himself. After working on an image for a short while he applied heavy pressured "X's" on all the music-related lines he had made. It appeared as if he was making a point about having to give up his musical career. He said that the sun at the bottom was the symbol of his hope for a return to his music. When he was finished he sighed and seemed to be calmer in affect.

Specific goals. Specific goals for each patient, as well as each session, usually developed as cues from the patient appeared. Here the therapy was carried on with the goal of providing for Mr. T. an opportunity to become aware of some of his uncomfortable inner feelings through a non-verbal process which, if he chose to, he could later reflect on and verbalize.

Slide 2. This drawing in the words of the patient, was a

"dream of life". There was a girl - he called her his companion and wife, two children, and a home. The sun was shining large because he was out of the hospital, but a representation of reality which he phrased the "darker side" also entered the picture - the dollar sign - he wondered how he would provide for all these "dreams". Mr. T. drew himself small and alone beside the house. In actuality, an investigation was occurring at this time to find suitable lodgings for this man.

Observation. Mr. T. said that there was a dark and light side to him and he was often trying to show both in the picture. When he pointed out the dark area in the drawing he frequently pounded angrily at his thighs.

Slide 3. This picture portrayed Mr. T.'s representation of a person - a body cut off at the genital area - no legs, weak arms, hands that do not look useful, a sad face, no visible sexual identity (my feeling about the portrait). The colour chosen was black. Although not consciously stated, this picture appeared to visualize the patient's inner sensation about his body image. No "euphoria" was indicated here. Wadeson writes that: "Unexpected things may burst forth in a picture or sculpture sometimes totally contrary to the intentions of its creator" (Wadeson, p. 9). She explains that because art is a less customary communicative vehicle for most people, it is also less prone to control than verbalization (Ibid.).

Observation. As he drew Mr. T. conversed quietly with himself. He closed his eyes and tried to visualize the image. He appeared tired at the end of the sessions. There seemed to be a pronounced involvement

of his total self, both mind and body. After some sessions Mr. T. was seen working on his own in occupational therapy. This pointed to a change in attitude; he was known to have resisted this therapy.

Mr. T. often laughed at his incompetence with technique. The "playfulness" of the art activity was discussed. The lighter side of therapy was perhaps coming about. Winnicott sees playing in itself as a creative therapeutic experience in the space-time continuum and essentially important as a basic form of living that is intensely real for the patient. For him, the significant moment is that at which the person surprises himself/herself and not the moment of interpretation by the therapist (Winnicott, 1980, pp. 58-59).

Slide 4. According to Mr. T. this image was about more light and dark sides - his hope and his problem. The problem is more prominently visible. The shades, peach and light blue, used to indicate the hope, were positive colour symbols, he said. He had regressed a little in his illness and the art expression too, seemed to be losing some strength. He said that when alone he could always look to "Jesus-Dieu" ("J-D" in the picture). It may be noted that he made these initials enclose his problem by framing the entire page, containing it perhaps to keep his feelings in control (my interpretation). Mr. T. mentioned that he might turn to visual expression if he could not play the guitar after he was discharged. He appeared to have overcome his sense of inadequacy in technique.

Slide 5. Mr. T. continued to use his own code of symbols. This was a fairly self-explicit rendering in diagram form. An apartment had finally been found and here Mr. T. was visually trying to assess the

pros and cons of it. His regression was significant; whereas before he used the walker to come to the art room, now he came in a wheel chair. Perhaps discharge anxiety was also adding stress to his condition. His drawing was shaky and showed his physical weakness. Here red was negative, blue still positive, he said. He traced over his legs with blue. Mr. T. discussed his problem through the art. He was concerned about moving into a new neighbourhood to an apartment inhabited by elderly people (indicated by a head drawn in red with "50" written above). He was embarrassed about his illness. He again showed the "brighter side", saying that older people do not use drugs, illegal ones, that is. He did not explain this comment. His "dream girl" is still visible in blue (bottom right area).

Slide 6. The images here depicted for Mr. T. three activities he could hope to be able to accomplish to provide strength and support when living alone. He could give guitar lessons, relax, and have visitors.

Overview of sessions. Through the art therapy sessions Mr. T. was able to develop a code of image and colour symbols with which to visualize his hopes, express his concerns, and consider some viable solutions for a new life style; thus showing a more realistic way of coping with his condition.

He began to display more awareness of the need for physical rehabilitation when he started exercising - sometimes immediately after the sessions. It appeared as if his mind was slowly adjusting to his body condition.

Regression in Mr. T.'s psychological condition seemed to be

precipitated by apprehension about a new situation such as the prospect of setting up independent living quarters. This was to be expected. As mentioned, the stress of any change tends to be amplified for such a population (p. 19). It was hoped that the new form of expression developed by Mr. T. in his own style and through his own initiative would provide some new-found strength and understanding with which to handle changes.

Pictorial expressiveness. Pictorially Mr. T. used minimal colour for expression. Yet the ones he chose had significant meaning for him as he talked about specific colours associated with specific feelings (Slide 4). The gestural lines used in the diagrammatic style conveyed a sense of movement except for the "person", who appeared quite static. There was little detail in the pictorial contents; the pictures were not filled with specific identifiable features, but rather with just enough representation to illustrate the subject matter. Space was portrayed with little direct consciousness of the size of page being used. On the other hand, there seemed to be some awareness of paper area as lines and symbols usually encompassed a good part of the page.

In conclusion, it seemed that Mr. T. was using art expression mainly to reflect immediate concerns, not to develop new art skills. He did once mention his inadequacy in technique and at another time the possibility of art replacing music if necessary, but this was not the focus of his attention in the sequence of the sessions. (More discussion and evaluation of each case will be offered in the first part of "Analysis of Results", pp. 50-55).

8. Case Example 2

Identification and disease description. The second example is that of Mr. K., a 73 year old married man who had one daughter. He had been separated from his wife for some time. He was suffering from severe heart problems which led to further complications, and had one leg amputated as a result. Also, he showed mild to severe symptoms of senile dementia which manifested itself in "a loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning" (Williams, 1980, p. 107) " . . .resulting from atrophy of the brain in advanced age" (Wallerstein, 1964, p. 264). This disease is characterized by the first and foremost symptom of memory impairment, as well as impairment of abstract thinking, judgement, and impulse control (Williams, p. 108). "Personality change is almost invariably present in Dementia and may involve an alteration or an accentuation of premorbid traits" (Ibid., p. 109).

Presenting conditions. On the ward Mr. K. displayed very little affect toward any situation. He was disoriented in time and place, hardly communicated, used minimal speech, and was very slow in his actions. In the past Mr. K. was also known to be rather passive and flat, and so this behaviour may have been just an extension, brought on by a negative response to his disease, of his original personality.

With organic brain disease, the reaction of the personality to the disease, that is the struggle between endeavours to adjust to or even to utilize the organically determined symptoms and attempts to deny them, make up part of the clinical overview (Fenichel, p. 258).

In his charts the psychological evaluation described Mr. K.'s

longstanding apathetic and depressive patterns with poor prognosis for rehabilitation. On the ward he was portrayed as withdrawn, with little or no motivation. The psychiatric report summarized him as continuing to present a mixed picture of organic and some depressive symptoms. Mr. K. was seen for twenty art therapy sessions.

Series B: Slide 1. This is an example of one of the first drawings completed by Mr. K. When left to work alone he would perseverate, sometimes in one area, at other times on the entire page using one colour and breaking the endless movement only when told to change colours or stop. Even though Mr. K. said he was drawing a specific object - this time it was a tree - the initial shape would soon be lost in the persistent repeated action. In this picture the space was almost filled. He was aware of the page but it seemed as if he might easily have just gone over one area again and again. This type of response is said to indicate an organic mental disorder (Williams, p. 366).

Specific goals. For this patient simple exercises were used with the goal of improving visual-motor co-ordination as well as psycho-motor development. These pictographic exercises, which involved guiding of marks and shapes such as lines and circles as well as copying and outlining simple forms, are intended to stimulate the mind and allow for more interest in self-accomplishment through increased visible productivity.

Slide 2. Here Mr. K. was following instructions but finally got lost at the end and continued on and on (bottom right area).

Observations. It is interesting to note that at times this man

would respond verbally in a most appropriate way, almost as if he had regressed, positively in this situation, back to a time when he was functioning normally. It was as if something seemed to "click" for a while. This is a symptom of senile disease - rational and irrational behaviour intertwined - and the art exercises seemed to stimulate the former behaviour at times.

The Diagnostic and Statistical Manual of Mental Disorders states that "Dementia may be progressive, static, or remitting. The reversibility of a Dementia is a function of the underlying pathology and of the availability and timely application of effective treatment" (Williams, p. 108).

Slide 3. As the sessions progressed joint dialogues on paper produced more diversified use of the marker and showed a fair amount of response to visual stimuli. Here, with paint and a wide brush, Mr. K. was able to draw a straight line across the whole page from left to right, but not from right to left. When a change of colour was suggested, he chose it.

Even though there was limited comprehension and memory, notably of recent events, Mr. K. seemed to enjoy the sessions. He was responding well.

Slide 4. The exercises continued. His movement was slow and his marking pressure was weak, but it remained steady on the paper. In this exercise Mr. K. was asked to copy specific forms and fill in some already made, such as the light green triangles and orange rectangles. He could not produce the shape of a triangle. He tried, but was unable to make the two lines meet at the top end. The result was usually a

rectangle. He also followed instructions to make lines on the top and bottom. At the same time, he was encouraged to speak about the present and the past; he was also shown pictures in order to try to stimulate the senses.

Slide 5. Progress was visible. Here Mr. K. was able to draw human representation at a very early level of development. After producing some suggested shapes, he was asked to make faces in the circles, and he did. He even named each one and the names were written in for him. This seemed to indicate a brief look into the past, possibly involving, for this man, some form of life-review. Mr. K. had progressed well, from perseveration of movement, to control of line, to expression of human representation. The similarity of placement of the shapes in Slides 4 and 5 gives the impression that the images in Slide 4 came to life in Slide 5. The attempted triangles reappeared as narrow - ended rectangles.

Slide 6. At this time Mr. K. was showing more assertion, questioning things up to a point. He appeared to be less "flat" in general affect. It was noticed by the hospital staff as well as his daughter that a change had occurred. Mr. K. was more alert and aware.

Here he was asked to make three circles. He called them "three soldiers". No association was made to them. This was a childlike rendering, but it is a significant development from his earlier attempts at image - making. The variety of line could almost be called a composition in terms of this man's level of comprehension and awareness. The figures can be equated with the "encepholopod" - the shape that the 3 to 4½ year old child understands as how to depict a human image.

Slide 7. Towards the end of the series Mr. K. began by saying that he was painting the "U.S.A." This referred to some yellow which is now under the blue rectangle in the centre of the image. Then, with an initial suggestion from the therapist, he started to use different poster paint colours on his own, exerting more independent movement in general. He was now painting a flag. There were times when he also helped wheel himself to the elevator after therapy.

Observation. Associations to the images were sometimes asked for and responses often came in a witty, abrupt way. Referring to Slide 7, when asked what gave him the idea to paint these subjects, Mr. K. answered, "They belong here". "Why?" - "for some reason". "What reason?" - "a good reason". It almost felt as if one was being given an occasional chance to meet the young man inside the old man.

Deterioration. Those few weeks were the better times. Unfortunately, after eighteen sessions another change took place. Mr. K. arrived for therapy very lethargic and non-expressive in affect. He could not remain alert enough to continue to work in art therapy. For the last two sessions he was brought to the studio literally sleeping. The only response he gave was one of limited automatic perseveration on a paper with a pastel that kept dropping from his hand. Considerable deterioration had occurred in his illness. The sessions had to terminate.

Overview of sessions. The art therapy experiences shared with Mr. K. for the few months were genuine and stimulating for him. He seemed to be coming to better grips with life for awhile, appearing more energetic and assertive in his activities of daily living.

It is difficult to know in what way he was aware of his mental condition. In his most alert moments, when he worked for a full session, answered questions about his past, or even asked questions, he still had difficulty in relating words to images. It was as if the left and right brain hemispheres were not functioning in co-ordination with one another. Only during certain sessions, such as when he was able to create human representation, or when he could follow explicit instructions, did there appear to be some connection between both sides of his brain.

Mr. K. was later transferred to a chronic-care hospital.

Pictorial Expressiveness. Mr. K.'s use of varied colour was sporadic. It was usually initiated by the therapist, except as shown in Slide 7 when upon suggestion, he kept changing colours on his own; but the action resembled some form of perseveration. Colour change started with one shade beside the other, then continued with one over the other, repeatedly until he was told to stop. When alert, Mr. K. seemed to have enough energy to make lines across the entire page (Slide 3). But in Slide 7, when working more independently, he got caught up with one area, exerting that same energy on only part of the page. Detail was produced under guidance and again only on "alert" days (Slides 4 - 6).

In general, it was felt that Mr. K. had expressed and communicated more visually on paper than he was usually known to express verbally in most instances.

9. Case Example 3

Identification and disease description. The third example is

that of Mr. N., a 63 year old married man with one daughter. He was paralyzed from the waist down after back surgery with complications in 1979 that left him confined to a wheelchair.

The hospital chart reads that at 13 years of age, Mr. N. suffered a neck injury with fractures, which resulted in progressive weakness and deterioration of his back and four extremeties. This deterioration had been more pronounced in the past year. He had no use of his lower extremeties and a very limited use of his upper ones. He was dependent in all areas of active daily living, but remained continent. Pain was a major complaint for Mr. N. No further surgery was advised by neurological and neurosurgical consultants, and the report upon examination by a pain clinic, was that it had little to offer Mr. N. The psychological diagnosis was "reactive depression". It appeared that Mr. and Mrs. N. had lived with tremendous stress in the past as well. They had lost two sons - one from an infant disease discovered too late, and the other in a car accident as a young child.

Presenting Conditions. At this time Mr. N. had minimal use of the fingers of his left hand only. He was of sound mind, and could not accept his helplessness. He still had high expectations of himself. This situation was very hard for all who were involved with Mr. N., from the hospital staff to his family, especially his wife. Thus he was introduced as "a humiliated, embittered, angry, yet helpless man" (my notes), waiting for placement at a chronic-care hospital. Mr. N. was seen for 19 art therapy sessions. This was his only therapy as he was no longer being treated in occupational or physical therapy.

Specific goals. Physically handicapped people, such as Mr. N.,

may need to learn new ways of bodily functioning through remedial training which aims to develop and strengthen muscles, fingers and limbs. This can be assisted by visual arts techniques. Also, involvement in creative activity can be a further means to support and growth (Harms, p. 191).

The specific goal was to try to get Mr. N. to produce something on his own that he would accept. He was in fact, right-handed, but had only the limited use of his left hand. It was hoped that if he became sufficiently motivated, he would eventually consent to being fitted with a right arm and hand brace which would allow him to perform some tasks for himself. Thereby he might feel less helpless and accept his condition in a more positive way. The brace suggestion had been turned down so far by Mr. N. He needed functional gratification, that is, small visible goals, perhaps in the form of exercises that he could easily do without too much difficulty. As Rogers and May both expressed it: If circumstances cannot change, one's attitude can. No matter how helpless the situation, that choice is always there.

Response of Patient. Mr. N. was skeptical about whether he would be able to do anything at all in view of his severe handicap. "We'll give it a try", he said after much deliberation, "we have nothing to lose". This statement may have indicated that Mr. N. felt he had lost it all already - a resignation to the hopelessness of his situation.

Technical needs of patient. An oil pastel, coloured pencil, or marker was placed between two alternating fingers of Mr. N.'s left hand. He had no use of his thumb and would exert pressure on the paper by pushing across the page with the pastel in a perpendicular angle to it.

He would tire very easily, would have to stop often to rest, as well as have the pastel changed to the other two fingers to avoid too much strain in one area. The page would also have to be continually angled to the most comfortable position from which to work. Therefore the therapist was constantly involved in performing these physical shifts.

Series C: Slide 1. In the first session Mr. N. was asked to "just put any marks on the paper". He was hesitant, but he did, resting often. Right from the start it could be seen that he thought about the work aesthetically, when he wanted to choose "good contrasting colours". Oil pastels were used here. "My grandson could do better", he remarked. It was explained that this was his expression and image, something he had produced, here and now - hoping that he could accept it. He had mixed emotions. He was encouraged to produce associations to the open - ended grip shape, but Mr. N. found this concept hard to understand. He wanted his drawing to be a recognizable copy of something. With some reluctance, the shape created was imagined as a fishing net, a tennis net, a cobblestone road, or as a world diagram, seen on television.

People with physical illnesses can have a difficult time fantasizing (Lesser, 1981); coping seems to be easier when they think concretely: "pensée opératoire". Mr. N. wondered about the use and results of art therapy. He was only concerned with the finished product. He was always questioning, always doubting. The red lines moving across the page are fewer and weaker than the yellow, more stationary ones. They break in various spots.

Slide 2. In this session Mr. N. attempted to draw a shape and was dissatisfied with its position on the page. Here he used a coloured

pencil. It was suggested that he work out the problem rather than start again, which he had chosen to do at first. This drawing shows an improvement in motor ability, and greater acceptance of the results. His arm pressure is weak on the pencil. Mr. N. displayed some consciousness of design when he said he was sorry the paper was not square for this motif. The closed-in spiral shapes employed in the design appear to have little opportunity for growth and expansion.

Observation. Mr. N. was motivated to create, but proved very shaky in handling the material. He forced himself to continue. He was always determined to complete what he had started. His affect was still very bitter in general and yet he chose to produce aesthetic designs with which to express himself. Perhaps this could have been a denial of a morbid situation, but it was, for this man, a coping mechanism, in that it did not hinder an understanding of his limitations and gave him some pleasure in seeing the results of his artistic endeavours. Chodoff sees denial as -

> neither necessarily pathological nor maladaptive. Some degree of it may help maintain optimal psychic adaptation. Denial is pathological only it if concerns obvious facts and/or prevents the patient from behaving in a manner respecting his limitations and requirements of treatment. (Lipowski, p. 30)

Scribble technique. The spontaneous scribble technique was presented to Mr. N. It was first introduced into art therapy by Naumburg, who saw it as an extension of the psychoanalytic approach by helping to liberate spontaneous expression. Here it was employed primarily to offer an easier physical process with which to work.

Mr. N. was encouraged to draw without conscious planning by making a continuous and unpremeditated flowing line that crossed and recrossed the paper often and in irregular patterning. Following Naumburg to some extent, he would then be asked if he could find some suggestion of a design, or object; person, animal, or landscape. The paper could be turned to the other three sides also for ideas. Naumburg saw the purpose here not for diagnostic testing, such as in the Rorschach test, but rather as an original pattern in its own right, with possibilities of further development by the patient (Naumburg, pp. 15-16).

Slide 3. At first Mr. N. questioned the new technique. He wondered if it was because of his condition that he was asked to draw in this way, indicating, perhaps, concern with being "different" from others. This first image appears to display anger with the assignment by the forceful manner in which the black pencil is used, as well as by the gestural response of the patient while drawing it. For Mr. N. this reaction was physically exhausting, and he eased up at the bottom half of the page, appearing more trusting and calmer in affect and markings. The lines are more fluid and he made the effort to combine two colours.

Observation. As Mr. N. kept working with the scribble technique, he became more accepting of it. One could see that he had a flair for art and aesthetics. He wanted his work to be "pleasing" (his words) to others. He was hard on himself for results. He would get very upset if he misunderstood a request or if an issue was not clear enough to him. This again indicates psychological amplification of signals (p. 19) as well as the need for consistency and acceptance in the relationship, for someone in such a delicate position.

Slide 4. This scribble turned into a series of gestural loose rhythmic lines giving the impression of a scene. Each section has a different colour and direction of line - five different colours, five different angles or directions.

Notation. Mr. N. was now being fitted with a brace for his right arm and hand. He had finally agreed to try to use the right hand in this way.

Slide 5. This picture is an example of the pictographic exercises sometimes used with Mr. N. to encourage extension of movement by the drawing of broad lines and to stimulate gaining of control by filling in forms already drawn. Although Mr. N. was working well technically, his physical state was poor. He suffered constant pain and often had to stop to rest, being out of breath. When asked to draw lines as an extension of movement, Mr. N. chose brown and ran the lines horizontally across the page to form some type of base or footing for the sparse shapes, again possibly trying to bring reality into the picture (my interpretation in reference to Slide 1 discussion).

Observation. From here on Mr. N.'s art work was done with his right arm and hand, working together in a brace. An important goal had been reached. He operated with more ease, sticking to a freer style. It appeared as if he now felt more comfortable with the easier drawing techniques and at times even got excited about his work. His stroke was stronger and steadier. He performed faster and tired less often. He seemed to be more satisfied with the results. He called them "presentable designs".

Slide 6. This drawing portrays a more controlled effect.

Mr. N. was anxious to develop his art past the spontaneous scribble and he was able to with this new apparatus and the use of his right hand. The border design could indicate the need for a protective enclosing environment. Artistically, working from the borders involves less risks than starting from the centre; there is less speculation as to area involved; a framework encloses it, limiting the unknown.

Slide 7. This type of drawing could indicate greater confidence. Mr. N. drew a design from the centre with no borders. He was working alone now. He was straining, but seemed to be succeeding with hardly any help. He was pleased with the results which portrayed genuine design ability. Yet he felt he was rapidly disintegrating physically. His pressure on the pastel was weak, as can be seen.

Mandala. Mr. N. produced many drawings throughout the sessions in this form, especially during the last few meetings. From the Jungian perspective, he may have been unconsciously trying to order his life by the completion of a "mandala", a circular or four-sided design. The mandala, according to Jungian theory, can help to re-establish a previously existing order in one's life as well as to serve the creative purpose of giving shape to something new and unique emerging in the personality (Von Franz, 1964, p. 247).

Jung also concluded that, psychologically, mandalas -

> seem to express an attitude to and from the psychic centre of the personality. That the circle can go either way is attested by the fact that the pictorial production of a mandala by an individual can either arise from contact with one's centre, or help reach contact with one's centre. (Robbins

& Sibley, p. 102)

Mr. N. worked from the centre out except in the border design pictures that are empty in the middle.

Jung stressed that the only real adventure left for each person is the exploration of his own unconscious. The end goal of such a quest is the forming of a balanced relationship with the self or centre of the personality. The circular mandala may protray an attempt to achieve this balance (Von Franz, p. 231). These designs may have been a way for Mr. N. to begin to feel acceptance of himself as a whole person; a way to "individuate", using Jung's term.

Slides 8 and 9. These two are examples of the last drawings produced. He remained with one colour. He said that by doing so he could function more independently. This demonstrated a learned attitude of acceptance to work within limits and conditions. To earn a little independence, Mr. N. had to acknowledge certain losses. In terms of technical ability, the last few drawings are much more advanced.

Overview of sessions. Verbally Mr. N.'s language was generally one of complaints, but he eagerly looked forward to each session. This was displayed through his quick awareness and alertness to any change in visual surroundings the moment he arrived, as well as in a lessening of self-concern as he worked. Mr. N. seemed to come close to fulfilling established goals. His motor ability had improved to the extent that he was now using the brace to help feed himself. He seemed to have functional as well as emotional gratification through the art work. He had been made aware of an activity that he enjoyed and could handle almost independently. This, along with more acceptance of his

limitation, could allow for some feasible accomplishments along with some personal growth (refer to "Goals", pp. 40-41).

After seeing that something new and challenging was actually possible for him, Mr. N. consciously chose to use the art therapy setting as a place to prove to himself that he could develop concrete aesthetic designs. True he expressed disappointment with the results, but having to settle for less, he nonetheless tried, and worked hard to make something that pleased him.

Here I was often a private art assistant as well. Judith Rubin explains that -

> Because the work includes helping other people to create, there is also an element of education involved. But the teaching in art therapy is secondary to the primary aim, which is diagnostic or therapeutic. In other words, if an art therapist teaches techniques, it is not for the sake of the skill itself, but rather in order to help the person to achieve, for example, a higher level of sublimation or an increased sense of self-esteem. (Rubin, 1982, p. 57)

Mr. N. spoke about his past, but not in an emotional way. He seemed to want to leave it where it was. It is my belief that this patient was helped to become aware of his present potential by means of the aesthetic process of creativity within the forms he had chosen. Intellectually this man was fully alert. Emotionally Mr. N. needed lots of support.

Because he was transferred to a chronic-care hospital, the art

therapy sessions had to stop.

Pictorial expressiveness. Mr. N.'s pictorial expression was naturally bound by his extreme disability, and although he responded to colour, he kept to a limited number of combinations. For him, changing colours was an enervating physical procedure. Also, he limited the images to linear designs. However, he was conscious of paper shape and size in relation to what he drew (Slide 2), and tried to use the entire page for his productions. Detail was also confined to the linear style of expression, although it became somewhat more complex as the sessions progressed.

IV Analysis of Results

1. Evaluation

The overviews at the end of each case give indications as to the strength and validity of the specific art therapy experience and goals for the patient concerned. These were severely disabled individuals, yet when given the opportunity to perform in this new setting, each one in his/her unique way developed a new means of expression through images that otherwise might never have been realized.

As real and intense as the art experience had proven to be, the problem of how to develop the application of the theories still existed.

According to Hanna Segal, with reference to Melanie Klein:

> All creation is really a re-creation of a once loved and once whole, but now lost and ruined object, a ruined internal world and self. It is when the world within us is destroyed, when it is dead and loveless, when our loved ones are in fragments, and we ourselves in helpless despair - it is then that we must re-create our world anew, re-assemble the pieces, infuse life into dead fragments, re-create life. (Segal, 1952, p. 199)

If the wish to create stems from the "depressive position" and the capacity to create rests on a successful working through it, then the inability to accept and overcome depressive anxiety must lead to inhibitions in artistic expression (Ibid.).

For example, because Mr. N. (Case 3) was avoiding mourning the

loss of his able functioning and the subsequent acceptance of a certain amount of passivity in his life, he could never at this time, be truly open and direct in his artistic expression.

Considering the severity of such an illness and disability, the therapy was geared to alleviating stress and thereby, hopefully providing for improved quality of life.

Mr. N.'s artistic expression may have shown signs of inhibition, but doing it gave him the chance to be creative and strive to produce something aesthetic, and that in itself can be therapeutic and healing, as Harms states (pp. 20-21).

To test the contribution of art therapy in relation to the clinical material, the goals cited on pages 25 to 27 that share common factors will be grouped together for discussion as follows:

Personal Growth, Personal Expression, and Communication can be combined and measured qualitatively in terms of improved ego-function. The problems of sexual dysfunction and helplessness to a large extent, can bring feelings of guilt and shame. In one picture, (not shown) Mr. T. (Case 1) illustrated in diagrammatic style, the emotional anxiety of not knowing where he will live and how he will function alone, as a reason for his intermittent incontinence. This was extremely upsetting for him, as it brought all the implications of his illness to the forefront. Shontz writes about feelings of guilt and shame being rekindled when disability makes one aware that one's internalized expectations with regard to body management are impossible (p. 13).

Mr. N. rarely referred to his wife during the sessions. The

occupational therapy supervisor had mentioned that he was very nasty towards Mrs. N. Perhaps his attitude towards his wife was a reaction formation. Many concerns regarding their life together still had to be dealt with. Also, it was difficult to know how Mr. N. was accomodating his impending transfer to a "protective environment" - a chronic-care hospital. Mr. T. seemed to be able to express his concerns visually, but for Mr. N. these problematic themes appeared to be veiled over. Even though his pictures were of a design nature, Mr. N. was still going through the process of performing in this new, unknown way through a sequence of sessions. Each patient was demonstrating gradual understanding and acceptance of a new body image and new boundaries, thus allowing for some growth and development to occur. Mr. K. (Case 2) was not as consciously aware of this, but his new affective, enlivening state on the ward showed that some form of working-through had taken place.

Because he was known to rarely speak, the art therapy offered Mr. K. an alternative means of expression. Here he was able to share some of his confused thoughts and fleeting flash-backs with the art therapist through the shapes and subsequent limited verbal discourse. For Mr. K. this was a means of social stimulation as well.

Sharing the art image with the therapist can offer a new avenue of communication in a gentle form. The neutrality of the art helps to diffuse confrontive, self-conscious issues. This was seen in the visual expressions of Mr. T. (Slide Series A). When he drew his concerns on paper, he would subsequently figure out and illustrate, as well as talk about reasons and/or solutions for them. The issues were visible

to share, confront, and challenge.

Perceptual Awareness and Functional Improvement, together with Development of New Skills all involve art-oriented activities. The pictographic techniques benefitted Mr. K., by enabling him to follow simple art instructions and display more awareness and assertiveness on the ward, for a while. For Mr. N., as well as providing functional stimulation, these exercises and the spontaneous scribble helped him to reach the point of being satisfied to produce simple designs that eventually improved in skill and pleased him (Series C, Slides 3-5). The challenge of creating a visual image brings with it the desire of the resistant patient one day, to often let go and try again the next time.

The evaluation of pictorial expressiveness presented at the end of each case describes the individual development of non-verbal communication through the graphic characteristics of visual art.

Social Growth through group art therapy sessions was not attempted. Patients with extreme diversified handicaps would need more than one therapist to enact a group setting. The benefit of this goal is acknowledged, but not evaluated through these cases. It was mentioned that there was some social growth for Mr. K. through the one-to-one art therapy encounter (p. 52).

Recreation and Relaxation appeared to be reached in part for each by the overall affect that was seen to result from the therapy, but these goals were difficult to measure in terms of fulfillment because of the psychological issues that were also intertwined in the sessions. Mr. T., for example, always dealt with pertinent issues in

the art. Mr. K., when more alert, may have inwardly been very frustrated in his abortive attempts to image certain ideas although he did seem to enjoy looking at and occasionally commenting on his pictures. Mr. N. seemed to find it difficult to rid his guilt and allow conscious relaxation, yet the distraction that the art therapy gave him from his state of being showed that these goals were reached. He was always eager to work and "try another idea".

A life-review through the art work appeared to be touched upon slightly by Mr. K. in the middle sessions, when he seemed to be trying to represent people that he may have had some associations with, by naming each image he had drawn (Series B, Slides 5 & 6). On more alert days he would also talk about former times. Perhaps this limited recall of the past was one of the reasons for new assertion on his part in general. But the life-review as described in the literature model, was not enacted per se.

The issue of termination could not be planned in a regular way because Mr. T. was expecting to be discharged and Messrs. K. and N. were able to be transferred within short notice.

Although it was known that he would be leaving eventually, Mr. N. never made much comment with regard to this forthcoming event. He did say that he hoped the transfer would not interfere with his wife's winter holiday, and continued to reminisce about their winters together down south and the home they had to give up. Mr. N. sometimes brought up discussions pertaining to his past as he worked on the drawing, but not in direct relation to what he was putting on the page. The future that awaited this man of 63 at a large hospital for the

chronic-care elderly was not openly talked about as it might have been, but on reflection, it seems that such an involvement within so brief a therapy intervention may have made this an uncomfortable area to pursue at the time.

Mr. T. worked on termination and discharge through the art. In Slide 5 he portrayed such concerns and refused to come to therapy the following week. Often a patient has to have extra time to absorb and deal with pertinent issues. The affect and response can be viewed as resistance to the therapy, displaying possible need for control of the situation.

Mr. K. was not involved in such explorations. As mentioned, his sessions had to cease because of the progression of his illness.

From these observations, along with the overviews at the end of each case, it can be seen that a measure of fulfillment was reached with regard to the goals set up as criteria, in providing for some of the psychological needs of the patients at that point in time. These helped to refurnish the self-communication that is said to be defeated in misfortune (p. 13). Each goal involved physical as well as emotional experience for the patients, directly and/or indirectly. Both the mind and the body were affected. Therefore the art therapy was helping to provide treatment for the "whole" person (p. 8), and thus fits well into the "totality concept in medicine" (p. 17).

2. General Summary

When someone becomes severely physically disabled, his/her life is drastically changed. He/she needs strength from all remaining

faculties to help carry him/her through this body-mind-alert to a new, but less tempting life style which he/she must teach himself/herself to accept. For such a person, time passes very slowly, and if he/she allows thoughts of his/her more active past to drag him/her down, he/she can easily slip into a pathological, non-coping state, and develop mechanisms of denial and/or repression to block this stark awareness. Thus the mind cannot accomodate to the situation, and in turn, hinders the physical body from working towards rehabilitation within limits.

If prior to, or at the time when the vicious circle of mental and physical helplessness sets in, the person is given the opportunity to express himself/herself through images, rather than just in words, the creative process itself can be integrative and healing, and require little or no verbalization. Often it is easier to act than to talk; the infant learns to gesture before verbalizing.

Though he/she may hardly be aware of the process - time spent in different surroundings with workable material, total absorption in a direct art experience, as well as empathy and unconditional acceptance - can all help the person to come to better terms with himself/herself both mentally and physically.

When the person realizes that he/she is active and achieving once more, helping to create a new gestalt for himself/herself, hopefully he/she can become motivated to carry this attitude to his/her physical rehabilitation as well, allowing the natural combination of physical and psychological growth to occur again in a way that is possible for this individual, here and now.

3. Conclusion.

A human being is "ever changing and dynamic" (p. 8) and is naturally involved in a process of growth and creative drive through organization, integration, and self-accomplishment.

In the words of Meng:

> We do not think that the normal human being is one whose motor and mental abilities function effectively, but he is the one whose psychological activities run in a harmonious way; he conquers life anew each day. This is possible for the handicapped in his way, and it can be aided by mental hygiene. (Barker, 1953, p. 88)

He concludes that: "Everyone must carve his life out of the wood he has" (Ibid.).

The deduction from this study and experience is that further work is required to have better ways of grasping the issues presented. There needs to be a greater distinction between different types of disabilities and research with regard to how art therapy can help specific areas of illness. As Harms put it (1975), art therapy endeavours "remain on the level of individual experimentation and have not yet been developed into a method of instruction. Until some standardization is achieved, these attempts have only limited intrinsic value to the field" (Harms, p. 192).

The holistic belief in the value of body-mind balance with regard to both health and illness makes it important to correlate art therapy, physical disability, and rehabilitation. The holistic concept of placing emphasis on greater understanding of the human being as a

unity of internal and external forces affecting each other will motivate development of this study still further.

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