

**Art Therapy and Pediatric Hemodialysis:
Creating Therapeutic Space in an Open Unit Medical Setting**

Andrea Johnson

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ABSTRACT

Art Therapy and Pediatric Hemodialysis: Creating Therapeutic Space in an Open Unit

Medical Setting

Andrea C. Johnson

This research examines the fundamental qualities of how art therapy can help create therapeutic space within a medical setting. Therapeutic space is defined as the physical and psychological arena where the art therapist and client encounter the other. An art therapist working in a hospital is restricted by the physical limitations of the setting and often functions as a 'portable studio' who meets the individual where they are; psychologically and physically (Kalmanowitz & Lloyd, 1999).

Art therapy's essential qualities of containing emotions in a tangible product, and working with visual metaphor help foster a space where successful therapeutic work can occur. These essential qualities are particularly valuable in an open unit medical setting where privacy and opportunities to contain emotions are limited. Art therapy's promotion of autonomy, expression of feelings, control and creativity is highly beneficial for children living with end stage renal disease (ESRD) receiving hemodialysis in a hospital setting. As the art therapy sessions occur during treatment, there is a unique opportunity for the child to be witnessed and supported therapeutically by the art therapist. Impediments to art therapy in this setting include limited privacy, confidentiality, and disruption to the session. Despite the impediments, art therapy's essential qualities help create therapeutic space for psychological support, growth, and the creative expression of children living with ESRD.

DEDICATION

This research inquiry emerged from difficult and profound learning experiences from my second year placement at a pediatric hemodialysis clinic. This research incubated for many months as I sought to understand how art therapy can help create therapeutic space in an open unit medical setting that is neither spacious nor particularly therapeutic. I feel great satisfaction bringing this research to fruition. I am thankful to Creative Arts Therapies faculty Irene Gericke who repeatedly encouraged my curiosity of how art therapy can function in a medical setting, and to my research advisor Suzanne Lister, whose support and frankness has helped form this research paper. I also thank my fellow art therapy colleagues who have both enriched my learning experiences and have become dear friends.

My pursuit of becoming an art therapist has been deeply enriched by the support, guidance and love from my family. It is such a blessing to be so supported. I thank Dan Savoie for helping me to see the big picture time and time again. Above all, I thank the children and adolescents that I encountered at the pediatric hemodialysis clinic. I stand in awe of their resilience.

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ART THERAPY AND PEDIATRIC HEMODIALYSIS: CREATING THERAPEUTIC SPACE IN AN OPEN UNIT MEDICAL SETTING

Overview

The primary therapeutic work in psychotherapy occurs within the psychological and physical space of the session. In this regard, the fundamental aim of the psychotherapist is to help to create and maintain the safety of this physical and psychological space. An art therapist must achieve this task and additionally support the client as they engage in the creative process in the space of their chosen art media. Usually this is contextualized within a distinct, private room that offers the client a separate, ritualized therapy space. Art therapists who work in a medical setting and who follow the principles of medical art therapy often face the challenge of working in open units, where the standard tenets of an art therapy space are not available. The art therapist working in a medical setting therefore, has to be adaptable and creative in how they can construct the physical and psychological space of the therapy.

This research paper will explore how art therapy can help create therapeutic space in a medical setting, with a focus on how art therapy can help create therapeutic space in an open unit pediatric hemodialysis clinic. I will form the basis of this inquiry by reviewing the concept of therapeutic space from Jungian, psychodynamic, and humanistic perspectives in psychotherapy. I have selected these theories as they offer a relevant and varied articulation of therapeutic space. This will be followed by a review of Jungian, psychodynamic and humanistic art therapy. This will provide a basis to exploring concepts of therapeutic space in art therapy as defined by Ferrara (2004), Robbins (1998),

and Schavarien (1999). These authors have been selected as they provide diverse ways of understanding therapeutic space in art therapy.

My research inquiry will then move to determining what essential qualities of art therapy help create therapeutic space in a medical setting. I will review the literature by creative arts therapists (Avers, Mathur & Kamat, 2007; Berrera, Rykov & Doyle, 2002; Goodill & Morningstar, 1993; McDonnell, 1983; McKenna & Haste, 1999; Mendelsohn, 1999; Saroyan, 1990) who work in a hospital setting and also contend with the challenge of creating therapeutic space. At this point I will determine what essential qualities, that are unique to art therapy, help to create therapeutic space in an open unit medical setting. This research inquiry will conclude with an exploration of how these qualities can be applied in a pediatric hemodialysis clinic, the value of such application, and what unique qualities of a pediatric hemodialysis clinic impede the application of these qualities.

Present Research Rational

There is literature in art therapy regarding working with children who have been hospitalized (Councill, 1999; Heath, 2005; Malchiodi, 1999; Rode, 1995; Russell, 1999); however, there is limited discussion on the practical challenges, benefits and impeding factors of creating therapeutic space through art therapy in open unit settings (Prager, 1995). There is also scarce research on the use of art therapy in pediatric hemodialysis clinics. The absence of literature relating to the challenges of creating and maintaining therapeutic space in such a setting has prompted this research.

The primary aim of this research inquiry is to explore how art therapy can help create therapeutic space in an open unit medical setting. This historical/documentary research inquiry will consolidate research from the fields of psychotherapy, art therapy,

and the creative arts therapies to understand how therapeutic space is created and how this can be applied to the non-traditional physical environment of a pediatric hemodialysis clinic.

Research Questions

Primary Research Question

What essential qualities of art therapy help create a therapeutic space in an open unit medical setting?

Subsidiary Research Questions

- 1) How can these qualities of creating therapeutic space be applied within the public place of a pediatric hemodialysis clinic?
- 2) What unique qualities of the hemodialysis clinic impede the application of these qualities?

Methodology

This research project will be using a historical/documentary method. Historical documentary research gathers, selects, consolidates and interprets data from literature and various sources (Gilroy, 2006). For my research question I am interested in exploring the fields of psychotherapy and the creative arts therapies to elucidate the essential qualities of creating therapeutic space. This type of research design is appropriate to my research question as it is best suited to investigate the interrelationships of concepts and theories between fields (Research paper/project policies and procedures handbook: Creative arts therapies, 2007).

Data Collection

Consistent with the historical/documentary methodology, data will be drawn from

literature. I accessed relevant literature from the PsycINFO, ScienceDirect, PubMed, Academic Search Premier, and SAGE Journals databases. Keywords included: medical art therapy, pediatric art therapy, end stage renal disease, end stage renal failure, pediatric hemodialysis, psychological space, analytical space, transitional space, humanistic psychotherapy, Jungian psychotherapy, psychodynamic psychotherapy. For the section on pediatric hemodialysis I delimited articles and books within the past 10 years. For the theoretical sections in psychotherapy and art therapy on therapeutic space I delimited articles, books and references from the past ninety-five years in order to include ideas by Freud, Jung and Milner. The majority of the articles and books regarding therapeutic space in psychotherapy and art therapy, however, are from the past fifty years.

Data Analysis

As I am conducting theoretical research, my primary analysis methods are logical analysis, evaluation, and synthesis (Junge & Linesch, 1993). This process includes searching out the limits or contradictions within the various concepts of therapeutic space and working towards developing a more comprehensive, integrated, theoretical understanding of my research question (Junge & Linesch).

Operational Definitions:

Therapeutic space: The physical and psychological arena where the therapist and client encounter the other and communicate.

Child: Person from birth to 12 years of age.

Therapeutic Space in Psychotherapy

Therapeutic space can be summarized as the physical and mental arena where the therapist and the client encounter the other and communicate. Metaphors to describe the

elements and nuances of therapeutic space and how it is constructed have wide currency in psychotherapy and the creative arts therapies (Siegelman, 1990). Therapeutic space has been likened to the temenos, the circle and the vessel (Jung, 1946 as cited in Siegelman); the container (Bion, 1962 as cited in Mathew, 2005); the holding environment or transitional space (Winnicott, 1971); the therapeutic frame (Langs, 1979 as cited in Siegelman; Milner, 1935 as cited in Siegelman) and the protective shield (Khan, 1962 as cited in Mathew). The broad use of metaphor indicates both the challenge of communicating elements of therapeutic space as well as reflecting the different theoretical perceptions of therapeutic space. With the intention of creating a conceptual foundation to understand therapeutic space I will explore this concept as it has been defined from a Jungian, psychodynamic, and humanistic perspective.

Jungian perspective of therapeutic space

A Jungian perspective uses a variety of rich metaphor to express the containing features of therapeutic space (Kirsch, 2004). Carl Jung uses the metaphor of the circle, the vessel and the temenos to describe therapeutic space (Jung, 1946 as cited in Siegelman, 1990). Within this closed space, as the metaphor suggests, is also an open space where the therapist and the individual encounter the reality of the other and the transference relationship develops (Connolly, 2006). Jung locates similarity between what occurs in the analytic process to the work of the alchemists (Siegelman). Jung posits that the work of therapy is the transformation of unconsciousness into consciousness, and to discover the centre of the personality, which Jung refers to as 'the Self' (Siegelman). Jung references the process of therapy to an alchemical text which shows the characters

of the adept (a master of sciences) and his soror mystica (mystical sister) who set up inner transformation through the stages of “blackening, putrefaction, union in a bath, and dismemberment, to the ultimate production of a hermaphroditic child that embodies the opposites” (Siegelman, p. 176). This union of adept and soror parallels the therapist and individual in therapeutic work: “the patient becomes conjoined with disowned or unconscious aspects of himself as to become both individuated and more able to hold in consciousness the opposites that he or she contains” (Siegelman, p.176).

A Jungian approach places great importance of a well bounded, and sealed area as “an essential protection for the dangerous work of gaining access to, and transforming, unconscious impulses, fantasies, and images” (Siegelman, 1990, p. 178). Under this approach the establishment of a stable and intimate space, as achieved through using a distinct, private room, are necessary features for successful therapy (Connolly, 2006; Wharton, 1985). This bounded space is created to exclude external reality, to reduce visual space and to limit distractions of sight and touch (Connolly). Connolly points out that an auditory space is also created, which plays a fundamental role in facilitating regression. In this space, regression can be facilitated as the distinction between the external, internal, the inner world of the analysand and analyst are blurred (Connolly). Abramovitch (1997) reminds that the well bounded physical environment itself is a major contributor to the holding or containing function.

Therapeutic space, from a Jungian perspective, does not arise from a contained space alone; an appropriate emotional atmosphere, the psychological space, is a necessary feature of Jungian psychotherapy (Abramovitch, 1997; Connolly, 2006). Jungian psychotherapists place significance in explicitly expressing the psychological boundaries

that will govern the therapeutic relationship (Dehing, 1992). Dehing asserts that the psychotherapist must define the conditions in which he or she intends to work, and how the sessions will be organized in regards to time, place, fee and confidentiality. These invisible containing features are established in order to help create optimal conditions for symbolization (Green, 1986 as cited in Connolly).

Psychodynamic perspective of therapeutic space

The objective of psychodynamic therapy is to derive meaning from the client's experiences, to support the client's grasp of their emotional processes that can offer new ways of locating solutions to problems, which in turn can become generalized to new situations (Oliver, 2003). Therapeutic space in psychodynamic literature points to the preservation of strong boundaries relating to role (Owen, 1997, 1999). These non-negotiable boundaries are articulated at the onset of the therapy, expressing the parameters in which the therapeutic relationship will be contained (Owen, 1997). By offering this clarity, the intention is to give the client an awareness of the status of the relationship, their role, and how they can expect to be psychologically held and contained within the therapy (Owen, 1997, 1999). This perspective posits that firm boundaries mark off the session as a protected therapeutic space (Owen, 1997). Within this space, the client and therapist can work together towards analyzing unconscious motivations and communications (Freud, 1915 as cited in Owen).

The use of metaphor to describe therapeutic space finds currency in the psychodynamic orientation. Bion (1962 as cited in Mathew, 2005) and Winnicott (1971) present metaphors that relate to safety and containment. Bion likens the creation of psychic space to the relationship of the container/contained (Connolly, 2006). Bion

suggests that the therapist functions similarly to the mother in her ‘maternal reverie’ where the mother internalizes her infant’s “un-thought thoughts and un-felt feelings” (Ogden, 1986 as cited in Connolly) and confers meaning onto them. Through this process the infant experiences, absorbs and eventually identifies with the organizational capacity of his/her mother (Mitchell & Black, 1995). Bion contends that this experience of the container/contained creates an inner space, or capacity, for emotional breadth and depth (Connolly, 2006). This experience is re-constellated in the therapeutic relationship where the psychotherapist’s internal state may help produce a capacity of growth in the client (Connolly).

Winnicott (1971) understands ideas of space or dimensions of therapy differently, and describes this space as a transitional space, a potential space, which is situated on the borders between outside and inside, between internal reality and external reality, and occupies a potential space of illusion, being, and creativity (Winnicott, 1971). Similar to Bion (1962 as cited in Connolly, 2006), Winnicott posits that potential psychological space as first occurring within the mother-infant relationship and can be understood as being re-constellated in psychotherapy (Winnicott, 1971). Winnicott suggests that potential space hypothetically exists between the infant and the object (mother) at the end of the infant’s experience of being merged with the object (mother). This potential space is located at the “interplay between there being nothing but [the infant] and there being objects and phenomena outside [the] omnipotent control [of the infant]” (p. 100). The infant moves toward separating from mother as mother decreases the extent of adaptation to her infant’s needs (Winnicott). The creation of potential space is connected with the infant’s feeling of confidence related to the mother’s dependability, “confidence being

the evidence of dependability that is becoming introjected” (p. 100). Winnicott suggests that the fate of the potential space that was created between the infant and mother strongly affects the infant’s subsequent experiences of relating to others, affecting their ability to depend and be contained by another. This experience of potential space is reconstellated in therapy, where the individual has the opportunity to experience security and reliability through the therapist, moving eventually towards autonomy apart from the therapist (Winnicott).

Humanistic perspective of therapeutic space

A humanistic orientation in psychology explores what it means to be fully human and how that understanding offers illumination and fulfillment to the individual’s life (Schneider, Bugental & Pierson, 2001). Psychological humanism emerged in the mid-twentieth century as a reaction to the prevailing psychological theories of behaviorism and deterministic Freudianism that reduced people to mechanistic collections of psychic components (Hansen, 2000; Schneider et al.). A reductionist mindset was determined as an obstacle to garnering an understanding of the true experience of the person as a whole, which is cited by psychological humanists as an essential process for effective psychotherapy (Matson, 1971 as cited in Hansen). Humanistic psychologies include existential psychology, Gestalt psychology, and social psychology as well as the formulations of the personality created by Carl Rogers, Gordon Allport, Henry Murray and Rollo May (Hodnett, 1982).

Carl Rogers can be understood as a central figure and spokesperson of the humanistic psychology movement (Kirschenbaum, 2004). Carl Rogers contends that humans are self actualizing, moving towards development and well being, and whose

development may become obstructed or stuck (Conradson, 2003). Rogers worked with his clients towards producing a change in their emotional experiences of relating to the world, promoting the discovery of new ways to live more satisfactorily and resourcefully (Oliver, 2003). Rogers maintained that this process encouraged his clients to overcome or work through obstructions in their development (Oliver). Rogers identifies three conditions for positive growth in the facilitative relationship of the therapist to the client: a) an unconditional positive regard that accepts the client as they are as a mix of negative and positive feelings and impulses, b) empathy, and c) congruence (to be real, genuine or congruent in the relationship) (Kirschenbaum). Rogers believes that the client has the tendency and the ability to understand his/her needs and problems, to garner insight, to reorganize his/her personality, and to follow up with constructive action (Kirschenbaum). In other words, Rogers understands the client as the expert of insight and self understanding (Conradson).

As the humanistic orientation is egalitarian in nature the articulation of therapeutic space differs from Jungian or psychodynamic approaches (Conradson, 2003). In the application of Rogers' three conditions; unconditional positive regard, empathy and congruence, a therapeutic environment emerges within which the client can work towards growth (Conradson). Similarly to the aforementioned approaches, this creation of a psychological space is a key element of successful therapy. The literature does not reflect the specificities of the physical environment where the therapy occurs (Conradson; Oliver, 2003). In the absence of this literature it may be that Rogers' three conditions are the essential features that can foster and promote therapeutic work, giving the person-centered humanistic orientation a versatility regarding the locations and environments

where therapeutic work can occur.

Conclusions

The creation of safety, respect, and empathy are common currents that underlie Jungian, psychodynamic, and humanistic psychotherapy. The stability of role, privacy, and expectation of space can be understood as features which vary in their perceived value and function. The metaphors used to describe therapeutic space according to a Jungian, psychodynamic and humanistic orientations often use location to help explain psychological space in psychotherapy. Psychological space, or the imagined space that is perceived between the therapist and the client as perceived by both parties, cannot be physically located (Schwartz-Salant, 1988). While the aforementioned metaphors support the process of understanding the concept, they must not be confused for the concept that they are describing.

The context of therapeutic space is an important feature in all three therapies, differing largely on the theoretical thrust of therapy. These three perspectives on therapeutic space also offer a starting point in assessing the applicability of orientation when working in art therapy in a medical setting.

Art Therapy

In its most basic and essential form, art therapy can be understood as the synthesis of art within the process of healing (Case & Dalley, 1992; Rubin, 1998). Art therapy is broadly defined by art therapists as a therapeutic modality that makes use of the non-verbal language of art for the purpose of communication, expression, insight, personal growth, and transformation within a therapeutic relationship (Dalley, 1984; Malchiodi, 2007). Art therapy involves the creation of tangible products that externalize our internal

landscapes, recording meanings, feelings and experiences (Malchiodi). It is a unique therapeutic modality that physically documents the therapeutic process and offers the opportunity to see transformations and patterns in feelings, events, thoughts, events, and themes over the course of therapy (Malchiodi). The concepts of creativity, transference and countertransference are major, central features of art therapy and can be understood as the main axis to which the art therapist aligns her theoretical orientation and understands her client (Dalley; Waller, 2006). Ultimately, the function of art therapy can be understood as bringing awareness, support and change to human disorder through the process and product of art making, in a psychological and physically safe environment with the presence of an art therapist (Dalley).

The presence of the art therapist as a witness and facilitator in individual and group art therapy is a central component to healing, recovery and reparation (Dalley, Rifkind & Terry, 1994; Malchiodi, 2007). Self expression in the presence of a helping professional can provide acceptance, encouragement, motivation, and positive affirmation which encourage personal growth and heightened self esteem (Malchiodi). Although the presence of the therapist is integral to all forms of therapy, the art therapist has the dual task of being present to both the individual and the art work that is being created.

Malchiodi posits that effective art therapy relies on the art therapist's ability to observe another's creative process acutely, sensitively and not intrusively (Malchiodi). This style of observation is done in conjunction to the awareness of the temporal, spatial, verbal and non-verbal aspects of the individual's behaviour within the interpersonal exchange. Not to diminish the role of the client, Dalley & Rifkind (2003) have referred to the art therapy as containing a triangular relationship where the art therapist and the client work together

to understand the art process and product of the session.

Jungian art therapy

While Robinson (1984) expresses that Jungian art therapy is not a consolidated, prescriptive orientation he sheds light on how the Jungian art therapists may situate art therapy. Robinson suggests that Jungian art therapists view and respect the artwork of the art therapy session in the same way that they understand dreams; as a metaphorical means of describing an individual's condition, as a base to resolved dilemmas, and as an indicator of profound and meaningful symbols. One viewpoint of Jungian art therapy proposes that the artwork straddles between conscious and unconscious worlds, offering a dialogue of the two (Robinson). The image, as a message from the psyche, is layered on many levels and can be interpreted according to Jungian concepts of consciousness, archetype, and symbol (Edwards, 2001). In Jungian art therapy, the image can never be considered to be completely readable due to the multiple levels of potential meaning as gleaned by the client (Edwards).

Wallace (2001) makes use of Jung's ideas of the active imagination in art therapy. The concept of the active imagination presupposes that truths "reside in the unconscious... and [are] manifest in the archetypal images as represented in the collective unconscious" (Wallace, p.95). The use of the Self, the central archetype which stabilizes and regulates imbalance, plays an important role in the creative process in art therapy (Wallace). Wallace expresses that to set the arena for the active imagination to thrive the individual must empty the mind, cultivate an experience of mindfulness, experience the variety of images that are presented mentally without judgment or qualifiers, and then transform this experience into expressive form. Wallace situates this

process as accelerating the creative potential within the client as they move towards growth and development.

Psychodynamic art therapy

The psychodynamic model as applied to art therapy places value on opportunities for externalization, transformation and subsequent internalization of inner states (Johnson, 1998). Johnson expresses that inner states are projected externally on the art media, transformed by the creative process and then are re-integrated and internalized by the client in mental health promoting ways. Johnson refers to the inter-subjective space between the client and therapist as the 'therapeutic play space' where the client externalizes their unknown and can attain transformation, or a movement inward, towards the known (conscious). Within psychodynamic art therapy there is an emphasis on the transference and countertransference relationship, which can be understood as being additionally communicated through the art process and product (Rubin, 2001). Dreams are used as sites in psychodynamic art therapy for free association in verbal and visual arenas, and are understood as processes of condensation, reversal, symbolization, and other defense mechanisms (Rubin).

The understanding of art making as a form of sublimation finds particular applications in art therapy. Kramer (2001) locates the act of sublimation as a transformation of unacceptable id impulses to ego-regulated activities. While art making can be a source of sublimation, their relationship is not mutually exclusive (Kramer).

Robbins (2001) uses elements of object-relations theory as a basis of his psychodynamic application of art therapy. Robbins summarizes the concept of object relations theory as follows:

...it refers to the who and what in which a person's libidinal energy is invested.

By libidinal energy I mean that constitutional reservoir of energy and life that is part sexual, part aggressive, but is more than either. It is the fuel that motivates us to reach out and find contact in the world. (p. 58).

Art therapy can be understood as being a site of potential reparative space where the object world can be investigated (Robbins). Object relations theory applied to art therapy can be understood as a method that organizes and searches for a variety of impressions, from multiple levels of awareness, to bring about growth, reparation, and change in the client.

Humanistic art therapy

A humanistic approach to art therapy is based on three principles; people are not seen as mentally ill but encountering difficulties in their ability to cope with life; therapy involves creative expression to bring about self actualization; and, the aim of therapy is to support the individual relate self-actualization to trust and intimacy in personal relations as well as to search for life goals which are self transcendent (Garai, 2001). The humanistic art therapist works in many ways as the humanistic psychotherapist, with the intention of creating a non-judgmental therapeutic environment that can support the polarities of the individual's emotional expression and aspects of their personality (Garai). Humanistic art therapists see the art making process as being inherently healing (Garai). Humanistic art therapists view art making as a means of giving form to the emotional experiences of the individual, without the intention of dismissing the emotion (Garai).

A humanistic art therapist regards the concept of creativity differently than a

psychodynamic art therapist. In the latter there is an emphasis on “deficiency compensation” (Garai, 2001) which understands creativity as emerging from the sublimation of the libido. Humanistic art therapists and Jungian art therapists overlap in their understanding of creativity, sharing roots in Jung’s ideas about collective unconscious, archetypes, symbols, and the value of dream interpretation (Garai). Humanistic art therapists also situate their understanding on the concepts put forth by a) Rollo May who asserts that art making brings something new into being, enlarging human consciousness (Garai), b) Moustakas who asserts that creativity involves self renewal, growth and self actualization (Garai), and c) Langer, who situates creativity as a driving force in individuation and identity formation (Garai).

Conclusions

Jungian, psychodynamic and humanistic forms of art therapy have converging and diverging elements. All three orientations embrace the notion of externalizing internal experiences; however, they have different perspectives on what ‘drives’ this expression. This brief review of theoretical approaches in art therapy contributes to determining the essential qualities of art therapy and their application in an open unit medical setting. I will further expand this process by exploring specific authors in art therapy who have focused on the concept of therapeutic space.

Art therapy and therapeutic space

Ferrara’s concept of therapeutic space in art therapy

Ferrara (2004) writes specifically on therapeutic space in art therapy, drawing upon her experiences of working with individuals of Cree heritage. While she does not represent one of the theoretical orientations exclusively she does refer to Winnicott’s

(1971) idea of transitional space within her book 'Healing through art: ritualized space and Cree identity' where she forms her argument on therapeutic space in art therapy. Ferrara pays particular attention to the interrelationship of therapeutic *space* and *place* in art therapy, positioning these features as being intimately interwoven in function and structure. Ferrara refers to Lefebvre's (1991) ideas on the production of social space and expresses that an art therapy space can be understood as containing three interconnected dimensions: a physical space, a mental space, and a social space. The physical space creates the boundaries; the walls of the room, the experience of privacy, a limited supply of art materials, and the experience of confidentiality (Ferrara). Ferrara refers to this component as the external landscape where the therapy occurs. The second dimension, mental space, refers to the mental discourse that occurs in the therapeutic space through the art making and the reflection necessary for dialogue about the created art object. The third dimension, a social space, refers to the interpersonal interactions between the art therapist and client within the therapeutic encounter (Ferrara).

In general, art therapists make use of the physical space that is available in the setting in which they work (Rubin, 2005). This room can be an office space, a hospital waiting room, or in the corner of a classroom (Rubin, 1998). An amorphous physical space becomes articulated into a therapeutic space when it is granted meaning by an individual, defined by an experience attached to or associated with the place (Freshwater, 2005; Tuan, 1977). In this sense the space where the art therapy is held becomes articulated through the development of familiarity, and regular, consistent maintenance of location. A physical space in which art therapy is held also has explicit boundaries that are created by the art therapist. These boundaries include physical and psychological

safety achieved in part through privacy and confidentiality and the emergent trust in the therapeutic relationship. This helps to create an environment that the individual perceives as safe enough to create art and engage in self reflection.

Through the maintenance of stable elements; the physical space, art therapist, art materials, and ongoing engagement, a sense of continuity is created and “contribute[s] to the ritualization of the art therapy experience” (Ferrara, 2004, p. 97). Ferrara points out that the art therapy ritual extends further than being a matter of routine; it retains a privileged distinction as it occurs within a controlled and delineated space to which there is restricted access. Both the ritual objects and acts in the art therapy space, such as the art materials, the art making and the art work created in this space can have special expressive, communicational qualities for the client (Ferrara). Both client and art therapist enter into specific roles in this space, as articulated in the development of the transference relationship.

Robbins' concept of therapeutic space in art therapy

I have selected Robbins as he articulates therapeutic space from a psychodynamic and object relations approach in art therapy. Robbins (1998) defines therapeutic space in art therapy as therapeutic workspace and pays attention to the roles that the therapist and the client play in creating and maintaining this environment. This therapeutic workspace is described as transitional in nature, optimally functioning from the deep interpersonal connection between the therapist and client, followed by the use of art making in this workspace (Robbins). Robbins states that successful art therapy occurs when the therapist and client are in the active process of working towards being present with each other within the intersubjective space of the therapeutic relationship. A successful presence, on

behalf of the therapist, is one which retains awareness of the playful, meditative, and mirroring interactions within the therapeutic workspace. In developing a trusted, safe therapeutic workspace, the art therapist works to safely contain the “deep projections of the client and offer an empathic mirror that becomes cornerstone for a new internalized self/object identification” (Robbins, p. 10). Robbins identifies this concept of creating a therapeutic workspace as being a primary task of art therapy.

Schavarien's concept of therapeutic space in art therapy

Schavarien is a Jungian analyst and art therapist who has been included in this research due to her depth of discussion on therapeutic space in art therapy. Schavarien (1999) underscores the importance of the safety provided by the boundaries of art making as essential in preventing the process from becoming overwhelming, and even potentially dangerous. Working from a Jungian perspective, Schavarien uses the metaphor of the “real and metaphorical frame” (p. 64) and the “picture within a frame” (p. 64) to describe the importance of boundaried space in art therapy. Schavarien describes the outer frame as the tangible, physical space where the therapy occurs; a place of privacy that is contained by the walls of the room and the door. This outer frame is also established with the consistent art materials and furniture that are located in the therapy room. Schavarien expresses that the outer frame of therapy is also created by the boundary setting of the therapist, who outlines the time of the sessions and the limits of the relationship. Additionally, the Jungian art therapist creates boundaries about the created art object regarding how it will be stored in the therapy. Schavarien refers to this real frame as a substructure that establishes the therapeutic alliance and the real therapeutic relationship. Within this outer frame is an inner space, which Schavarien refers to as the “inner

sanctum of the analytical art psychotherapy setting” (p. 65).

Continuing with the metaphor, Schavarien (1999) describes a picture that is contained within the real and metaphorical frame. Schavarien refers to this picture space as being distinct from the therapist, and is the private space in which the client can explore and develop relationships. In this space the client is offered the opportunity for self analysis within the safe boundaries of the paper (or art media) where the client can express their inner landscape. While Schavarien points out that this picture space is distinct from the therapist, in that it is largely a dialogue and space for the client, the witnessing function of the therapist permits an auxiliary involvement and relationship to the image. Schavarien identifies art making as a “formative element in the establishment of a conscious attitude to the contents of the unconscious” (p. 12) and imparts that this understanding of art making as distinguishing Jungian art psychotherapy from Jungian psychotherapy.

Negotiating space in a medical setting

I will now move away from discussing art therapy from a broad perspective and approach the topic of art therapy in a medical setting. I will explore the creative arts therapies in a medical setting first to elucidate some of the challenges and responses to negotiating space while working in a creative arts therapy modality. From this basis, and the abovementioned literature in art therapy, I will explore the essential qualities of art therapy. The particular way that an individual understands and negotiates space in a medical setting strongly relates to the role that he/she plays. The role of the patient, medical care professional, and mental health care professional are widely varied, each role contending with particular challenges. Using literature on creative arts therapists who

work in a medical setting (Avers, Mathur & Kamat, 2007; Barrera, Rykov & Doyle, 2002; Goodill & Morningstar, 1993; McDonnell, 1983; McKenna & Haste, 1999; Mendelsohn, 2001) I will examine how the creative arts therapist uses her modality to compensate for the physical challenges of working within a medical setting.

Creative Arts Therapy

Literature from drama therapy, music therapy, and dance movement therapy (DMT) with hospitalized patients indicates that the therapy occurs in a variety of places within a hospital setting, such as bed-side and in designated rooms (Barrera, Rykov & Doyle, 2002; Goodill & Morningstar, 1993; McDonnell, 1983; McKenna & Haste, 1999; Mendelsohn, 2001; Saroyan, 1990). The aforementioned literature does not outline the descriptions of the physical space of therapy in great detail. What emerged from the literature, however, is an emphasis on promoting opportunities for the client to create their own personal space in the setting. In addition, the literature points to the building a safe psychological space between patient and creative art therapist as a fundamental priority of the creative arts therapist.

McKenna and Haste (1999) facilitated drama therapy within a distinct room in a hospital setting where they encouraged their clients to create their own personal space in the institutional setting. The value of creating a distinct space is echoed by Saroyan (1990) who points to the importance of creating a safe therapeutic environment, both physically and psychologically, in music therapy when working with hospitalized patients. McDonnell (1983) adds that the music made in the music therapy session can create an additional space in the therapeutic encounter. This music can be understood as creating an auditory dimension to the patient's environment that offers the patient control,

autonomy, and opportunities for non-verbal emotional expression. Avers et al. (2007) describe music therapy as offering the pediatric patient the opportunity to control an aspect of their environment and harness their ability to make choices. Songwriting was also considered to provide an opportunity to be expressive and autonomous (Avers et al.). Barrera et al. (2002) discuss music therapy that is done at bed-side and comment on the similar potential for expression and autonomy.

Mendelsohn (2001) also writes on therapy done at bed side but from a dance movement therapy (DMT) perspective, remarking on the various techniques to bring the pediatric patient into expressive movement. The use of scarves and balls were outlined as devices used to bring the patient into movement, play, and initiating verbal and non-verbal dialogue with the dance movement therapist. Goodill & Morningstar (1993) note a lack of material on DMT with a pediatric population which was confirmed in the current literature review process.

Gathered from this brief review is the notion that creative arts therapists use the unique qualities of their modality to help create therapeutic space in a medical setting. In the absence of a demarcated, private room, the containing qualities of the creative modality, in addition to the patient-creative arts therapist relationship becomes a key means of creating therapeutic space. While the qualities of the modality cannot fully offer the same experience of privacy, there is a concerted, adaptive effort towards developing a potential space for a therapeutic encounter. Art therapy in a medical setting functions similarly to DMT, dance and music therapies, in that its essential qualities help create therapeutic space in a medical setting. The determined essential qualities of art therapy will now be delineated.

Essential qualities of art therapy

In sub-optimal art therapy settings where the physical space does not afford an opportunity for privacy, quietness, and confidentiality, the art therapist must build a strong therapeutic alliance which offers the individual an experience of safety. In addition to the therapeutic alliance, the art therapist relies on the essential qualities of art therapy to help create a safe space where the patient feels contained and supported enough to express their experiences. I believe that the essential qualities of art therapy are creating a tangible product and working in visual metaphor. These two qualities are unique to art therapy due to the breadth and depth to which they are encouraged. These qualities allow for opportunities for the patient to contain and code their experiences in a position of control while also offering the patient a product or residue of the art therapy session.

Tangible Product

Dalley (1984) describes the therapeutic outcome of making something, a tangible product, as an essential quality of art therapy. The creation of a tangible product acts as a container to the emotions and experiences of the individual, as it provides an object that the individual can communicate with and through in verbal and non-verbal communication. It physically documents the therapeutic process and allows the individual the ability to view transformations and patterns in feelings, thoughts, events and themes over the course of therapy (Malchiodi, 2007). In addition to offering containment the creation of a tangible product allows the client to experience distance. By distance I am referring to the client's conscious control of how intimately they can communicate their emotional experiences in visual form. Also, in the creation of an art folder in art therapy, the client is offered an additional means of containment and distance for their

expressions.

The process of externalizing an internal experience into a concrete form is identified as an essential quality of art therapy and can be understood as an artistic means of communication (Johnson, 1998; Malchiodi, 2007; Robinson, 1984; Rubin, 1998). The outcome of making something can offer the client a valuable substitute for communication when speech is underdeveloped, impaired, or rejected as the principal way of communicating (Dalley, 1984). In this sense, art therapy is an inclusive modality that supports the expression of a variety of people with different needs and abilities. By externalizing the image from one's inner landscape, a dialogue with the self is initiated and is supported within the therapeutic relationship between client, art therapist, and the image (Dalley, 1984; Dalley & Rifkind, 1993).

Working with visual metaphor

An essential quality of art therapy is working with visual and verbal metaphor (Levine, 1999; Robinson as cited in Dalley, 1984; Rubin, 1998). Levine points to the valuable subtlety of metaphor which supports the creation of new entities assembled from the blending of incongruent frames and levels of experience. Levine sites this creation as an escape from the client's experiences of imperfections, or faults in their language to represent their emotional experiences.

Metaphor can be understood as providing a shelter for the self. Levine (1999) suggests that because working with metaphor is less threatening than direct confrontation it allows the individual to work with more fragile parts of the self. This can be especially valuable when clients are expressing anger, aggression, love or sexuality, or other experiences which may be difficult to express verbally. Metaphor finds wide currency in

the creative process regardless of age. The art therapist will support the exploration of this symbolic communication differently based on the needs and developmental level of the client. Children for instance, make wide use of metaphor in their play as they attempt to organize and understand their lived experience. The art therapist working with this age group often supports the child by staying within the metaphor in empathizing, playing with the metaphor but not counteracting it, with the underlying intention of returning the feelings connected with the metaphor back to the child for them to integrate and accept (Levine). Simply put, metaphor provides distance.

Application of essential qualities

The application of these essential qualities is embedded within the therapeutic relationship between the therapist and client. Rubin (1998) underlines that ideal physical conditions for art therapy, such as a private setting with adequate lighting, working surfaces, an accessible water source, adequate space of storage and for display of art materials are rare. Rubin remarks that the most critical framework in art therapy is not the physical but rather a secure and safe psychological framework of the therapeutic relationship. This framework is maintained by the art therapist's predictability, steadiness, and a consistency of materials at its most rudimentary level (Levine, 1999; Rubin). Rubin contends that this psychological safety within the therapeutic relationships is what holds the therapy in suboptimal settings such as at a child's bedside in a crowded, noisy hospital unit. Creating a space of safety is a primary task of the art therapist, a place where they can feel metaphorically held (Rubin). Under these safe conditions, the patient experiences security and confidence in creating a tangible product and working with visual metaphor. Rubin points out that creating a safe space, especially in suboptimal

environments, is more of an art than a science and can be understood as requiring creativity and adaptability on the part of the art therapist. Despite therapy settings that do not offer the preferred physical frame Rubin eloquently reminds, “art is a quiet place, even in a noisy room” (Rubin, p. 142). As art therapy supports the experience of inner reflection to external expression it can be understood as a resilient, versatile, and valuable means of working therapeutically with individuals.

The application of art therapy in a medical setting has been described in detail by Malchiodi (1999) who coined the term ‘medical art therapy’. My research will continue with a review of medical art therapy which will be followed by a description and review of pediatric hemodialysis; and finally, a discussion of ongoing art therapy treatment for children living with end stage renal failure that occurs within an open unit medical setting.

Medical Art Therapy

There are many demands placed upon children who live with a chronic illness that are a result of the pervasive short and long term sequelae associated with their disease (Malchiodi, 1999). The adjustments to daily living, altered nutritional regimens, physical activity limitations, and school absences can be challenging for the child to integrate and understand (Malchiodi). In addition to daily effects of chronic illness, the impact of hospitalization compounds the psychosocial stress of the child (Rode, 1995). Medical events and environments can overwhelm the child’s coping capacities despite clear information about the procedure, preparation about the event and a responsive environment (Rubin, 1999 as cited in Malchiodi). In conjunction with the unfamiliarity of the hospital setting, which can be perceived as strange, unfamiliar, invasive, and

frightening (Malchiodi), the pediatric patient is placed in a passive role with scarce opportunity to assert control and mastery in his/her environment. These experiences have the potential to be traumatic, as an experience that is too difficult or overwhelming for the young child's ego to assimilate (Rubin as cited in Malchiodi). Primary sources of stress in the pediatric patient that strain the child's coping skills include separation of the child from his/her primary caregivers and relocation to a new setting, loss of control which results from hospitalization and illness, and lastly anxieties and fears about medical procedures that can cause pain or harm, and the fear of dying (Golden, 1984 as cited in Rode, 1995; Malchiodi).

Medical art therapy provides a site where a child who is physically ill, undergoing aggressive medical treatment, or who experiencing trauma to the body can regain a sense of control through the use of art expression and imagery (Malchiodi, 1999). As it encompasses both self expression and the creative process, art plays a strong therapeutic role in helping children cope with short and long term sequelae associated with physical illness, injury, impairment, and medical procedures such as pharmacological interventions, surgery, and hospitalization (Malchiodi).

Art therapy in a medical setting requires more than a helping professional who introduces art materials to the pediatric patient. An understanding of the complementary and interfacing relationship between play therapy and art therapy are necessary facets for a therapeutic exchange in a medical setting (Malchiodi). Axline (1969) describes play as the child's natural medium for self expression and posits that the nature of play's fluidity and constant development is complementary to a child's narrative of illness. Axline further describes the child's narrative of illness as constantly being in a state of formation

due to the interplay of environmental and psychological forces (Axline). Play incorporates language, objects, scenarios, and feelings from the everyday experiences of the child and of the child's significant relationships (Levine, 1999). Play is important for the emotional, physical, and cognitive development of children (Cameron, Juszczak & Wallace, 1984) where the child works through and masters rather complex difficulties of the past and the present (Bettelheim, 1987). Through play the child assimilates his/her experience of the world and makes sense of this experience in order to make it part of themselves (McMahon, 1992). Winnicott (1972) describes play as an area that mediates between the inner reality of the individual and the shared reality that is external to individuals. This area can be contained within the art therapy session in the play objects, the art objects, and within the therapeutic relationship (Waller, 2005).

Children also communicate their lived experiences through their art making (Axline, 1969; Rubin, 2001; Winnicott, 1971). Art can be understood to be a visual language for children and a developmentally appropriate form of communication of perceptions and feelings, especially for young children who may not have the cognitive abilities to express themselves with words (Kramer 1979; Rubin, 1984). Understanding this interplay between art therapy and play therapy, and how children use art and play to organize and understand their lived experience is essential for successful therapeutic exchange, emotional reparation, and conflict resolution (Malchiodi).

There is a tremendous value for the child's mental health care team to try to understand the child's experience, or personal narrative of their illness, because it illuminates how to support the child (Constrada, 1999). Broyard (1992, as cited in Rode, 1995) reflects that "the patient's narrative keeps him from falling out of his life and into

his illness... [giving] his anxiety a shape” (p.19). Medical art therapy provides an opportunity for the child to express their experience of illness, which in turn can be relayed to the child’s mental health care team by the medical art therapist. The child’s struggles, strengths, potential gaps in education, fears, and anxieties relating to their illness and its treatment as expressed in art therapy session inform the child’s mental health team about current needs for support. Malchiodi (1999) highlights the valuable role of arts-based assessments in medical art therapy as a means of understanding the child’s perception of their illness and medical treatment as well as serving as a preparatory activity for the young child. The art expression of a child experiencing illness has also been useful in helping caregivers garner further understanding about how their child both conceptualizes and perceives their body image, and can also address and clarify their physical symptoms (Malchiodi).

Other unique conditions are that the medical art therapist must be knowledgeable of the medical conditions and procedures, the physical and psychosocial effects of illness, the medical health care system, and medical ethics (Malchiodi). In addition, the medical art therapist must consider the cultural reality of the medical setting that the patient experiences during their illness (Rode, 1995). The focus of the medical art therapist, with the aforementioned knowledge base, is to create a safe space where emotions can be communicated and safely released, where traumatic events and feelings can be mastered.

Art therapy in medical setting encourages activity, mastery and problem solving. In creating an image that relates to their illness experience, such as an upcoming or recent surgery, art making in a therapeutic relationship encourages the child to turn passivity into activity and assists the child to master an experience that otherwise would be

challenging to assimilate (Heath, 2005; Picarrillo, 1999; Rubin, 2001). The active qualities of cutting, arranging, making, doing, and constructing are valuable in helping to alleviate feelings of lack of control and helplessness as experienced in their hospitalization (Doyle, Hanks, Cherny & Calman, 2004; Malchiodi, 1999). For a child who is facing ongoing invasive medical treatment, the use of art making allows the opportunity to work with difficult issues at a safe distance in a position of control (Cameron et al., 1984). This idea of control is echoed by Bach (1990) who promotes a non-directive approach to art making as it introduces an opportunity for the child to assert control and autonomy. Rubin points out that this experience of “tak[ing] charge, even in the small sphere of a piece of drawing paper is vital when a youngster is not able to control either the medical condition or the intervention of others.” (Rubin, 1999 as cited in Malchiodi, p. 10).

Childhood is a delicate and important stage of life in which children develop physically and emotionally towards a stronger sense of self (Jung, 1959) as well as developing their capacity to adapt (Piaget, 1967 as cited in Waller & Sibbett, 2005). Medical art therapy supports the development of resiliency while also offering opportunities for normalization. Through art therapy, the child can organize and work through traumatic medical experiences; it offers a site where adjustment and adaptation are supported and promoted. One of the aims of medical art therapy is the support of quality of life, the promotion of hope, and opportunities to increase one’s sense of inner control. Art expression is a normalizing activity (Malchiodi, 1999) which capitalizes on the essential work of childhood (Rollins, 2005). While medical art therapy supports the expression of illness related challenges, art therapy allows for opportunities to focus on

something else besides the illness, disability, or dysfunction (Rollins).

Medical art therapy provides a site where a child can explore his/her body image. Hospitalization and the effects of illness almost always contribute to an increased sense of powerlessness and vulnerability (Cameron et al., 1984; Rode, 1995; Waller & Sibbett, 2005). Travis (1979) suggests that children living with a chronic illness have disposed of their body as it becomes a supervised object for medical staff to exert absolute rights over, through constant observation and in influencing its responses. The body image of an individual living with end stage renal failure ESRD is challenged by the accompanying changes in weight, appearance of skin, and surgical scars (Fleming Courts & Boyette, 1998). Cameron and colleagues posit that art therapy can be a supportive and helpful modality in supporting children who are hospitalized as they contend with their body image. Common expressions of conflict often appear as exaggerations, omissions or additions to body parts (Cameron et al.). The use of body tracings are also cited as a valuable way to explore body image as it incorporates exploring internal and external body parts, offers a distanced means of looking at a threatening illness, and promoting adjustment to changes in the body (Cameron et al.).

Pediatric Hemodialysis

End stage renal failure occurs when the kidneys, two bean-shaped fist sized organs, cease to be able to eliminate metabolic wastes and toxic materials in the body (Gutch, Stoner & Corea, 1999). Each kidney is made up of over one million minute units called nephrons that drain into the kidney pelvis (Travis, 1976). Blood is filtered through the nephrons, where water and metabolic waste products are removed (Travis). The chemical balance of sodium, glucose, chloride ions, and amino acids are reabsorbed to

the blood stream through the membranous walls of the nephrons (Gutch et al.). The waste products (urea, uric acid, creatine, nitrates and sulphites) reach the renal pelvis and leave the body as urine through the ureters, bladder and urethra (Wright, 2004). The two major functions of the kidneys are to eliminate metabolic wastes and toxic materials and to ensure that the body's fluid environment maintains a stable composition (Gutch et al.).

The most common reason for renal failure in children is congenital abnormally formed renal tissue, or renal dysplasia (Wright, 2004). Renal dysplasia negatively impacts the nephron's filtering function (Travis, 1976). Over the course of many years or months as the functioning nephrons decrease the remaining nephrons must take on an increased load (Gutch et al., 1999). The initial million nephrons decrease to only a few thousand units which are insufficient in regulating the sodium, glucose, chloride ions, and amino acids (Travis). As these wastes from the blood cannot be filtered successfully and be excreted from the body they enter the blood stream (Travis). This creates a toxic internal environment referred to as uremia (Travis). Uremia occurs as the kidney function decreases to 10-15% of its original functioning potential which places the individual in end stage renal failure (Gutch et al.).

The effect of uremia produces widespread sequelae in the body. Uremia affects the cardiovascular system by prompting hypertension (unusually high blood pressure), atherosclerosis (a hardening of the arteries), and myocardial functioning (muscular tissue of the heart) (Gutch et al., 1999). This results in edema, chest pain, cough, and shortness of breath (Gutch et al.). The gastrointestinal manifestations of uremia include nausea, vomiting, and poor appetite (Gutch et al.). Constipation is a frequent experience for individuals in a state of uremia and correlates with nutritional regimen of the individual

in end stage renal failure (Gutch et al.). The individual must consume food with low salt, potassium, phosphorus, and have low water consumption restrictions (Gutch et al.). In conjunction with their low appetite, the joy of eating may be compromised.

Neurobiologically, the individual can experience numbness or tingling, confusion, weakness, restless legs, seizures, burning feet, memory defects and twitching (Gutch et al.).

Uremia affects the endocrine system through growth retardation, bone disorders, amenorrhea and impotence (Gutch et al., 1999). Growth failure is connected to protein-calorie malnutrition (due to lack of appetite), disturbances to their water and electrolyte metabolism, metabolic acidosis (due to the kidney's inability to excrete ammonia), anemia, renal osteodystrophy, and hormonal factors that have been disturbed by end stage renal failure (Warady, Fine, Schaefer & Alexander, 2004). Uremia affects the immune system by decreasing infection resistance and affects the hematological system by causing anemia (Gutch et al.).

End stage refers to the end of the full functioning of the kidney, but the life of the child can be prolonged through long term dialysis treatment (Warady et al., 2004). The dialysis machine functions as an artificial external kidney and sustains the life of the individual until a suitable kidney transplant is possible (Travis, 1976). The child's blood is pumped out from a determined vascular access point into the hemodialysis machine (Gutch et al, 1999.). In latency aged children a central venous catheter is placed into a large vein in the neck or chest (Gutch et al.). The child's blood travels through tubes to the dialyzer, the artificial kidney, where water and solutes are removed and the cleaned blood is returned to the child's body (Gutch et al.). The dialyzer is a semi-permeable

membrane that separates two compartments; a blood compartment and a dialysis solution compartment (Gutch et al.). Blood moves through one side of the membrane and the dialysis solution moves in the opposing direction. This process is referred to as ultra filtration and occurs until adequate dialysis occurs (Gutch et al.). This treatment is required 3-4 times a week for 4-5 hours per treatment (Wright). It was once a terminal sentence to be diagnosed with end stage renal failure; only within the last fifty years has it moved into the realm of chronic illness (Eiser, 1985). While hemodialysis treatment prolongs the life of the child as they await a kidney transplant it does not ensure the child's existence. In a recent long term study by the Canadian Institute for Health Information (2008), the five year survival rates for children receiving hemodialysis were noted at 84%.

Effects of treatment

There are many challenges inherent in receiving hemodialysis. The first stage of hemodialysis is preparing the site which involves the nurse removing the dressing from the previous treatment, cleaning the area around the central venous catheter and preparing the catheter for treatment. The nurse assesses the central venous catheter and inspects the stitches that secure it to the body. If the stitches are detaching from the body, a call is made to the doctor who will re-stitch the area around the site during the course of treatment. The dressing removal, cleansing, and potential stitches can be an uncomfortable, painful, anxiety producing experience for the child living with end stage renal failure. While receiving hemodialysis treatment, the child may experience several side effects due to the result of expedited fluid removal from the body and problems with vascular access. Children who are receiving treatment may experience hypotension, or

low blood pressure due to the ultra-filtration rates, resulting in the child feeling faint (Wright, 1999). Hypertension or high blood pressure may occur which signifies excessive levels of fluid in the vascular space which results in headaches (Wright; Gutch et al., 1999.). The child can also experience rigor, or shivering, which usually occurs 30 to 60 minutes after the dialysis treatment is started (Wright). Towards the end of treatment a high temperature is commonly observed (Wright).

There are numerous psychological effects that can occur in the child living with ESRD receiving hemodialysis. Psychological responses to the disease include anger and anxiety and depression (Burke, 1991). The treatment process is considered to be highly stressful for a young child (Wright & Kirby, 1999). The adjustment to illness, accommodation to invasive treatment, coping with the threat of death, incorporating the treatment into the life routine, and modification of physical activities challenge children's coping abilities and are considerable sites of stress (Wright & Kirby).

There are many adverse psychosocial affects for children in end stage renal failure (Garrison & McQuiston, 1989; Travis, 1979). For a child in end stage renal failure, the demand of treatment prevents the child of attending school regularly (Travis). Research indicates that this causes the children to be treated differently by peers; it produces social alienation in that it prevents the child from participating in important social events which causes a deduction in self esteem (Eiser, 1985; Travis; Fukunishi & Kudo, 1995; Garrison & McQuiston). Due to the frequency of treatment, children often develop a substitute relationship with the medical care staff (Eiser). As well, the subsequent growth retardation due to uremia and a restricted nutritional regimen has been found to affect the child's self image (Eiser; Garrison & McQuiston; Travis). The child living in end stage

renal failure must comply with a rigid nutritional regimen that is low in phosphorus, sodium, potassium, with limited water intake (Garrison & McQuiston; Travis). The restriction of the child's participation in vigorous play activity due to the attached central venous catheter, required nutritional adherence, and frequent absences from school due to treatment make conformity and acceptance by their peers more difficult (Eiser; Sourkes, 1995).

In daily living, Hughes (as cited in Eiser, 1989) describes that there are 8 basic emotions that are challenged by chronic illness in childhood: independence, love and affection, security, acceptance as an individual, self respect, authority and discipline, recognition, and achievement. The child's experience of dependence, on medical staff, medical equipment, and nutritional regimens contradicts his/her need for independence and personal mastery. Travis (1979) expresses that the chronically ill child experiences love and affection in a different way from their primary caregiver. The parent who would have supported the autonomy and self esteem of their latency aged child directs the child into the realm of dependence, submission, and passivity (Travis). This impedes a latency aged child's ability to gain further autonomy from his/her parents and is reminiscent of earlier child-parent interactions. The child's illness can alter how the parents interacted with their child pre-illness. Eiser identifies common interactions from the parent to the child as hostile rejecting, overindulgent, disruptive to attachment formation and overprotective. The experience of these parent-child interactions significantly affects the child's experience of love and affection (Travis).

There are distinct demarcations between the experiences of a healthy child versus a chronically ill child in relation to his/her experience of mastery. In healthy children

natural disappointments and frustrations are overcome as the child has a realistic expectation that mastery of the situation will occur with growth (Eiser, 1989). The lives of chronically ill children do not hold the same certainty as their sense of mastery is inhibited, which results in doubts about attaining independence and achievement (Eiser). While the life of a child living with end stage renal failure is prolonged by dialysis until kidney transplantation the possibility of dying is an ever present uncertainty. Even with a kidney transplant the child still faces existential risks due to organ rejection (Travis, 1979). The child in normal development is attempting to control the functioning of his body while at the same time as he is consolidating ego controls (Eiser). For the child who has a chronic illness asserting control over the body is profoundly impeded (Eiser). For a child in end stage renal failure who has a limited range of foods that they s/he can eat, food defiance is a common expression of asserting control. Ultimately, as the child needs food to survive, the young child is defeated by the parent in the struggle for food (Eiser).

Children living with end stage renal disease and who are receiving hemodialysis are confronted with the task of cognitively organizing his/her experience of the illness into their self concept. Constrada and Ashmore (1999) define five substantive attributes of the experience of chronic illness: the identity of the disease; perceived cause(s); its timeline; consequences; and controllability. The physical sequelae of the child's chronic illness functions as a constant reminder of these attributes and forces change upon how the young individual defines his/her self concept (Constrada & Ashmore). How a child approaches this task is strongly linked with his/her developmental capability. In early latency this comprehension centres on contamination (Eiser, 1985) and the idea of illness as a punishment (Rode, 1995). In later latency the idea of illness moves towards

internalization; that the illness is internal but comes from the external (Eiser). For a child in early latency this narrative can be difficult to verbalize, due to the difficult emotions that it arouses as well as due to the child's limited ability to verbalize these emotions.

With this basis I will now examine art therapy in a pediatric hemodialysis clinic, drawing upon the literature review in art therapy and pediatric hemodialysis that I have developed in this research paper. The following section will also be informed by my second year internship experiences of working within a pediatric hemodialysis clinic in a large urban centre.

Art therapy in a pediatric hemodialysis clinic

Art therapy in a hemodialysis clinic contrasts the standard physically containing, private therapy space (Bondi, 2005; Robbins, 1998; Rubin, 2001). A pediatric hemodialysis clinic is an open unit that typically consists of a head nurse, a technician, and three nurses, as well as up to six children receiving dialysis in one large, open room (Gutch et al., 1999). The room in which I held my internship was approximately 400 square feet, with the patients' chairs and dialysis machines lined up side by side along the wall facing the door. Although there were windows in the clinic, the chairs were faced in the opposite direction. The room was filled with medical equipment, storage units and dialysis machines, with limited space for family members and nursing staff to move around. While it was an option to pull the curtain around the hemodialysis chair to create a distinct place for art therapy in the clinic, this was seldom used as it prevented the nursing staff from monitor the health of the child and the status of the machine.

The function of the hemodialysis clinic space is to provide medical treatment in an open, accessible setting. Consequently, this space and its primary function is not

conducive for privacy, and ensuring the standard tenets of an art therapy space; one that ensures confidentiality, limits interruption, and offers freedom to create mess (Rubin, 2001; Wadeson, 1987). Art therapy in a dialysis clinic, occurring while the young patient is receiving treatment, is the interruption. The child's presence in the clinic is to receive life sustaining treatment thus, the art therapy sessions were consistently and appropriately interrupted by nurses, doctors, and other patients. For this reason, privacy and confidentiality were difficult to maintain. The clinic where I held an internship position was also noisy, filled with the sporadic sounds of machine alarms beeping, nurses talking, tutors working with the children, movies and video games being played, and children crying.

Despite the inherent challenges of a working in a public space, safety can be achieved within the relationship of the art therapist and young child. With the absence of physical boundaries demarcating the therapeutic space, it is pivotal that psychological safety and boundaries are established for the young child within the therapeutic relationship. Rode (1995) identifies this as the primary task of the art therapist who works in a medical setting. Kearney (2000) and Hutchison (2005) who write from a medical perspective, echo this important task of creating a safe relationship where the child can be supported in his/her efforts to regain integrity and wholeness in the face of illness. With an absence of a distinct, four walled containing room, the art therapist physically becomes 'the room' and psychologically becomes the container in which the child can "pour out their feelings and fantasies; and [where] a responsive, articulate voice...can help them to clarify, explain, and make sense of what is going on inside" (Rubin, 2005, p. 27).

Typically within a hospital setting where the patient is immobile while receiving treatment, art therapy is brought to the patient through a portable studio (Kalmanowitz & Lloyd, 1999; Prager, 1995). This portable studio consists of a variety of materials brought to the child via an 'art cart' or storage container that can meet the child where they are physically receiving treatment (Prager). This is practical for a child who is receiving hemodialysis treatment and must remain stationary in the chair for the 4-5 hour length of treatment. I had the opportunity to meet with pediatric hemodialysis patients twice a week for seven months. While the seating place where the child received medical treatment varied, I believe that my reliability as art therapist, the therapeutic alliance, the ongoing art therapy engagement, and consistent art materials brought through an art cart helped to create a ritualized space as previously explored by Ferrara (2004). With the absence of a private room, the continuity of the physical objects (art materials and art cart) can be understood as ritual objects that contributed to the creation of a portable studio.

An art therapist working in a pediatric hemodialysis clinic serves the special role of being present and witnessing the child's process of receiving hemodialysis. The art therapist also functions as an attentive adult who is not responsible for his/her medical treatment. Despite the support, gentleness and patience of the nurses, this treatment is invasive and painful. The process of dialysis, literally cleaning the blood, visibly shows the child's blood moving from the body through a central venous catheter and winding tubes to a large, beeping machine which then returns the blood to the child's body. This process can be anxiety producing for the young child and confronts the young child with existential questions.

Sourkes (1995) writes about existential anxiety experienced by children living with a chronic illness and remarks that this is often addressed through the child's art making and play. Sourkes speaks of the curiosity of the child living with a chronic illness in regards to the distinction between being alive and being dead. While noting that there may not be any form of self reference in the play or art making, Sourkes reflects that this play or art making is an indication that the child is struggling with understanding their existence. Sourkes describes that themes of 'dead-alive' may recur in a quasi-ritualized form as the child attempts to work through his or her comprehension of existence. Sourkes describes that this often emerges in the child's dreams in predominating monsters and threatening animals. Sourkes comments on the oral aggression of the images, both in the child's dreams and in their artwork as paralleling the invasiveness of the disease process itself.

Incorporating play into art therapy, specifically through puppet play, was a valuable means of supporting the young child's expression of their experiences. I offered an assortment of hand puppets contained within a brightly decorated sack to latency aged children within the clinic to promote self representation, objectification of feelings, and the expression of illness related concerns. The puppets that I offered at the hemodialysis clinic included animals, people, birds, sea creatures, vehicles, a wide range of fairy tale figures, and a variety of puppets representing career people which included medical staff. It was observed that puppet play provided a valuable opportunity for the young child to address his/her existential questions, concerns, and ideas about death. Walker (1989) promotes the use of puppets within a therapeutic relationship in a medical setting as it offers the child an opportunity to talk through a readymade object. Part of my initial

inquiry about the child's experience of hemodialysis was approached through hand/finger puppets; the distance provided by the puppets served as an age appropriate, non-threatening way for the child to talk about his/her experiences. Puppet play was often used in conjunction with art making and provided an additional means of working in metaphor. Understanding play and the use of puppets in art therapy was regularly discussed in supervision and was actively researched.

McBride (1997) comments that the process of activating the puppet as being inherently empowering as it offers the child opportunities to wear, activate, manipulate the movements, speak with, teach, and instruct the puppet. The use of puppets is particularly valuable in a hemodialysis clinic as it shifts the child from a playing a passive, receptive role to taking an active and dynamic position of control. Walker (1989) comments that in activating the puppets the child is offered opportunities to express a variety of emotions such as love, anger, fear, and aggression. In the acceptance and witnessing of the art therapist, the child discovers that it is okay to express these emotions (Walker). The child's use of puppet play informs the art therapist, and subsequently the child's mental health team, how the child organizes his/her experiences while highlighting coping strategies, strengths, and emotional needs.

Art therapy in a medical setting provides an opportunity for the young child to express existential issues, identify lifestyle restrictions, explore the challenges of managing symptoms, identify strategies and resources, maintain a sense of normalcy, harness a sense of control and autonomy, achieve developmental tasks, and to be distracted from the demands of their illness. White, Richter, Koeckeritz, Munch, & Walter (2004) identify many of these themes as valuable issues to address with the

individual who is living with ESRD. Kearney (2000) also supports the discussion of these themes as the individual navigates through their chronic illness. Kearney offers the reminder that ESRD is not one state of health but rather numerous states with arduous transitions between them. Medical art therapy offers the young individual living with ESRD a valuable opportunity to have their difficulties witnessed and supported through the presence of the art therapist and the creation of an art product as they negotiate their experiences of illness.

Application of essential qualities in a hemodialysis clinic

A safe, psychological framework and strong therapeutic alliance between the art therapist and pediatric patient provides fertile ground for the essential qualities of art therapy to thrive. This is in part achieved through the development of boundaries, an explicit explanation of the nature of the relationship, and the establishment of the duration and times of the art therapy session. The application of the essential qualities of art therapy, creating a tangible art product and visual metaphor, within a pediatric hemodialysis clinic is embedded within this secure therapeutic encounter. The creation of an art object and the use of visual metaphor can be parallel processes. The creation of a tangible art product is achieved through the accessibility and variety of materials, as well as the support to explore these materials within the therapeutic encounter.

As a pediatric hemodialysis is a unique, un-typical art therapy environment accommodations and adaptations are required. One such example is the limitations of creating a large mess in the clinic. There is a certain amount of sterility that is required while the pediatric patient receives hemodialysis therefore the use of hospital gowns, sheets, or painting smocks, can be used in such a way as to prevent the child from having

their tubes contaminated while also having their dialysis site accessible. Large food trays can be used to contain art created with paint and water. In the absence of a large desk space, a side table with adjustable levels can be used. The art therapist must have a creative attitude in this setting and be able to see potentials in the available equipment and space.

Despite the public nature of the setting, an application of the essential qualities of art therapy is possible and offers the pediatric patient a beneficial and valuable site for to be expressive, to be attentively witnessed, and to be emotionally supported by an adult. Through the essential qualities of art therapy, the art making process, and the therapeutic relationship pediatric patients receiving hemodialysis are offered containment and a certain degree of privacy given the function of the space and the delivery of medical treatment. As the challenges associated with end stage renal failure, on a medical, psychosocial, personal and existential level, are intense, it is of great importance that these children are emotionally supported. The essential qualities of art therapy help to create a therapeutic space in a pediatric hemodialysis clinic, on a physical and psychological dimension, where the art therapist and the pediatric patient can encounter the other, and where therapeutic work can thrive.

Impediments to application

Part of the challenge associated with the creation of an art product is its visual accessibility by other individuals within the clinic. Observations and remarks from interested nurses and fellow patients often limit opportunities for the art product to remain private and confidential. The essential quality of working with visual metaphor allows the patient to symbolically disguise his/her expression to a certain degree, and is

an essential quality that is significant in a setting where privacy is limited. The safe space between art therapist and child is often interrupted by other individuals in the clinic. This results in the art therapist and child engaging in a continuous effort of creating and testing safety within the therapeutic encounter, more so than if the therapy was facilitated in a private room. The art therapist in a hemodialysis clinic must also act as the child's advocate in trying to build a space of privacy and power for the child, a position that the child sees both verbally and non-verbally protected by the art therapist.

One of the challenges of facilitating art therapy in a hemodialysis clinic is trying to find time where privacy and continuity are possible. As hemodialysis interrupts the child's schooling, on-site teachers meet with the pediatric patient and as well as other professionals such as child life specialists. One of the impediments to art therapy in general in this setting is staying on top of logistical coordinating, which may vary on a daily basis depending on the medical needs of the child. For example, a child may be scheduled for stitches, or a meeting with their doctor. While interruptions cannot always be avoided, the art therapist can work to plan around medical treatments and other visits (Prager, 1995).

A significant aspect of working within a pediatric hemodialysis clinic is the potential variations of the child's physical health. There are many contributing factors that affect the daily health of the child living with end stage renal failure that are both controllable (for example relating to a deviation in his/her diet) and uncontrollable (such as his/her response to medication). In my experience it was quite common for the child to not feel well enough to meet in art therapy due to the effects of their medical treatment. Part of the routine of entering the hemodialysis clinic was assessing the individuals'

status, noting which child started their treatment earlier, and planning the timing of the art therapy sessions (with the child) around the time when the child could be expected to feel well. Sessions at the end of treatment were usually avoided, as the children typically experienced physical discomfort at that time. The initial establishment of boundaries within the therapeutic relationship reflected this need for flexibility; the child was presented with the opportunity to meet for art therapy twice a week for up to 45 minutes per session, the time loosely established as being in the morning or in the afternoon. This is significantly different than standard therapy sessions that have a set weekly time, but was a necessary element of working within a pediatric hemodialysis clinic.

Practicality of theoretical orientation

Within this research paper I have explored the concepts of therapeutic space according to Jungian, psychodynamic, and humanistic orientations in both psychotherapy and art therapy to determine what essential qualities of art therapy help to create therapeutic space in a medical setting. While the art therapist working in a pediatric setting generally works under a medical art therapy model, literature relating to the relevance and importance of a broader theoretical orientation of the art therapist working within a medical setting could not be located. I believe that the nature of this setting greatly influences the choices, orientation and practice of the art therapist, and that certain theoretical positions relating to therapeutic space are more compatible to this setting than others. Based on my experience and the literature gathered from this research paper, I would position a humanistic approach to art therapy as offering the most versatility and applicability in an open unit medical setting.

The basis of a humanistic approach to creating therapeutic space in art therapy is

strongly rooted in the application of Rogers' three central ideas; of unconditional positive regard, empathy, and congruence (Kirschenbaum, 2004). In contrast to a Jungian or a psychodynamic orientation, a humanistic orientation does not demand a demarcated, private therapy space. A humanistic orientation places a greater value on the creation of a safe psychological space and offers greater adaptability to where the therapeutic relationship can physically exist. The nature of a pediatric hemodialysis clinic makes it difficult to uphold the necessary physical space as dictated from a Jungian or psychodynamic orientation. The ease of applicability of these orientations in an open unit medical setting is impeded by the setting itself. It is beneficial for an art therapist working in an open unit medical setting to consider how their theoretical position corresponds with their physical working environment and to be attentive to potential incongruity.

Conclusions

In sub-optimal settings where privacy and confidentiality cannot be assured the essential qualities of art therapy, creating a tangible art product and working in visual metaphor, are key contributing factors that help to create therapeutic space. These factors thrive within a therapeutic relationship where the client feels psychologically safe. Literature in psychotherapy from a psychodynamic (Mathew, 2005; Mitchell & Black, 1995; Oliver, 2003; Owen, 1997, 1999; Winnicott, 1971), Jungian (Abramovitch, 1997; Connolly, 2006; Dehing, 1992; Siegelman, 1990; Wharton, 1985) and humanistic perspective (Conradson, 2003; Hansen, 2000; Hodnett, 1982; Kirschenbaum, 2004; Schneider et al., 2001) discuss therapeutic space and emphasize the fundamental importance of creating a safe physical and psychological space where the therapeutic relationship can flourish. Literature in art therapy from a psychodynamic (Johnson, 1998;

Kramer, 2001; Robbins, 2001; Rubin, 2001), Jungian (Edwards, 2001; Robinson, 1984; Wallace, 2001) and humanistic perspective (Garai, 2001; Rubin, 2001) also points to the foundational elements of creating a safe psychological and physical boundary in therapy.

Ferrara (2004), Schavarien (1998) and Robbins (1999) discuss therapeutic space in great detail, emphasizing specificities of safe psychological and physical space in art therapy. Ferrara explores the concept of space and place in therapy, and offers that an art therapy space is created from the overlap of three interconnecting dimensions; a physical space, a mental space, and a social space. Ferrara discusses how ritualized space and ritualized objects become articulated in art therapy through the maintenance of stable elements, namely the physical space, art materials, art therapist, and an ongoing engagement. Robbins refers to the therapeutic space between the client and therapist as the therapeutic workspace and discusses the process in which a “new internalized self/object representation” can emerge (p. 10). Schavarien offers the metaphor of the “real and metaphorical frame” (p. 64), and the “picture within the frame” (p. 64), to explain the interrelationship and boundaries between therapist, client, and his/her artwork.

Literature relating to creative arts therapists working in a hospital setting (Avers et al., 2007; Barrera et al., 2002; Goodill & Morningstar, 1993; McDonnell, 1983; McKenna & Haste, 1999; Mendelsohn, 2001; Saroyan, 1990) highlights the value and importance of the essential qualities of the creative modality in creating a space for safety and an opportunity for expression. It appears that the essential qualities of the particular creative arts therapy compensate for the limitations of physical space in a medical setting.

Both the literature (Dalley, 1984; Dalley & Rifkind, 2003; Johnson, 1998; Levine,

1999; Malchiodi, 2007; Robinson, 1984; Rubin, 1998) and my experiences suggest that the unique essential qualities of art therapy, the creation of a tangible art product and working in visual metaphor, support opportunities for expression and for protectively coding emotions in an open unit medical setting. An important model for the art therapist to employ while working in a pediatric hemodialysis clinic is Malchiodi's (1999) concept of medical art therapy. This model focuses on supporting the young child's process of coping with the pervasive emotional and physical sequelae of his/her disease. My personal experiences and the literature (Councill, 1999; Heath, 2005; Picarillo, 1999; Rubin, 2001; Russell, 1999) show that medical art therapy uniquely promotes opportunities for activity, autonomy, mastery, control, exploring body image, and creative expression. An essential aspect of medical art therapy is an understanding of the interfacing relationships between art and play therapy (Malchiodi). In addition it is important to understand the communicative and expressive function of play and art making in children. Axline (1969) and McMahon (1992) highlight how play provides opportunities for the child to assimilate and make sense of his/her experiences of the world. Axline, Rubin, and Winnicott (1971) also emphasize the function of art making in children as it offers opportunities to both communicate and organise his/her lived experiences. The artwork and play of children is often metaphorical which allows the young child to work through lived experiences from a position of distance.

A benefit of art therapy in a pediatric hemodialysis clinic is the role it plays in promoting and supporting the child's expression of his/her narrative of illness. This is encouraged through art making and play. The literature (Malchiodi, 1999; Rode, 1995) and my experiences suggest that an art therapist can best support the expression of a child

living with a chronic illness by having a working knowledge of his/her illness, related medical procedures, medical ethics, and the cultural reality of the physical setting where the treatment occurs. The content and quality of the art making and play are helpful sites for the child's mental health team to understand how the child both perceives and is affected by the illness (Constrada, 1999). One way that this is achieved is through arts-based assessments that are conducted in the initial encounters with the child. This provides a means of understanding the child's perception of the illness and medical treatment, as well as serving as a valuable preparatory activity.

Due to the breadth and scope of the physical, emotional, and psychosocial effects that ESRD has on children, it is imperative that the art therapist working in this setting be knowledgeable of this disease and its pervasive sequelae. In addition, it is important that the art therapist working in this setting has a relative level of comfort with illness and the medical procedures associated with this illness (Malchiodi, 1999). Pediatric hemodialysis is a painful and invasive medical treatment that becomes required when the child's kidneys are no longer able to eliminate toxic wastes from the body resulting in uremia (Gutch et al., 1999). The dialysis machine functions as an external artificial kidney that cleans the blood and returns it to the child's body, sustaining the life of the child until a kidney transplant is possible (Gutch et al; Travis, 1976). This treatment is required three times a week for 4-5 hours per treatment (Wright, 2004). Both the state of uremia and the process of hemodialysis produce widespread physical sequelae in the body that affects the cardiovascular, gastrointestinal, neurobiological, and endocrine systems (Canadian Institute for Health Information, 2008; Gutch et al., 1999; Travis, 1979; Warady et al., 2004; Wright, 2004).

Children living with end stage renal failure requiring hemodialysis face a myriad of psychosocial and emotional sequelae as a result of his/her illness and associated medical treatment (Burke, 1991; Constrada & Ashmore, 1999; Eiser, 1985; Fukunishi & Kudo, 1995; Garrison & McQuiston, 1989; Sourkes, 1995; Travis, 1979; Wright & Kirby, 2000). The associated short and long term effects place considerable stress on his/her experience of self esteem, mastery, and locus of control. Hemodialysis treatment is disruptive to daily living and prevents the child from attending school regularly (Travis, 1979). Research indicates that this causes children living with ESRD to be treated differently by peers; producing social alienation, reduction in self esteem, and challenges to peer acceptance (Eiser, 1985; Fukunishi & Kudo, 1995; Garrison & McQuiston; Travis). Surgeries, such as the removal of the kidney and the ongoing process of locating vascular access sites, result in the ongoing accumulation of physical scars. My experiences and the literature (Eiser; Garrison & McQuiston; Travis) suggest that these surgical scars and the growth retardation associated with ESRD profoundly affect the child's self image (Eiser; Garrison & McQuiston; Travis).

Although art therapy in a pediatric hemodialysis clinic stands in contrast to a typical private therapy space (Bondi, 2005; Robbins, 1998; Rubin, 2001) the potential of art therapy in this setting should not be overlooked. As the child must remain stationary during hemodialysis treatment, art therapy can be brought to the child through an art cart where the materials and the therapist become the 'portable studio' (Kalmanowitz & Lloyd, 1999). I have found that this concept and its nuanced perspective on psychological containment in sub-optimal settings to be a valuable internal structure for the art therapist to adopt in her process of trying to create therapeutic space in an open unit medical

setting. In line with Ferrara (1999) I believe that a ritualized therapeutic encounter can occur within an open unit medical setting. In the absence of a four walled room my experiences and Ferrara's research suggest that the reliability of the therapist and continuity of physical objects (art cart and materials) contribute to the child's experience of a ritualized therapeutic encounter and ritualized objects. Through my experiences I have observed the significant role that art therapy plays in providing unique opportunities for the child receiving hemodialysis to play an active role where his/her creativity, autonomy, and emotional experiences are encouraged and supported by an attentive adult who is not in charge of their medical treatment. This experience is of great benefit to the young child during his/her treatment as it counters his/her dominant role of being a passive and receptive patient. My experiences also suggest that art therapy provides the young child with a witness to his/her process of receiving hemodialysis; a process which inherently promotes existential questions, and concerns.

One of the inherent challenges of working in art therapy in an open unit medical setting is limited privacy and confidentiality. Art therapy's emphasis on visual metaphor is a useful means for the client to consciously, unconsciously, and symbolically code their expression. These qualities help compensate for the limited privacy in a public medical setting. Based on my experiences and the literature (McBride; 1997, Walker, 1989) the use of puppets with latency aged children in this setting was determined to be a useful and empowering projective tool that supports the child's process of expressing his/her experiences of illness. Puppets provide the child with an age appropriate, readymade object that can be used to speak through and explore various emotions at a safe distance. My experiences suggest that the quality and content of the puppet play are helpful sites

for the art therapist and mental health team to understand how the child perceives his/her illness while highlighting his/her strengths, coping strategies, and emotional needs.

My experiences support Prager's (1995) assertion for the art therapist to actively participate in ongoing logistical coordination with other health care professionals, teachers, and mental health professionals when working in this setting. In contrast to a typical therapy session, the time of the art therapy sessions in this setting was determined with ongoing input from the child from a) an assessment of the child's health, b) noting what point the child was at in their treatment, and c) whether the time conflicted with a tutoring session or a visit from the doctor.

In analysing various theoretical bases, a humanistic framework appears to be a compatible theoretical orientation for art therapists working in an open unit medical setting. This orientation does not have rigid specificities for the physical therapy space. With the impetus of a humanistic orientation being Rogers' ideas of unconditional positive regard, empathy, and congruence (Kirschenbaum, 2004), it can find applicability in untypical therapy settings.

The essential qualities of art therapy and a strong therapeutic alliance help to create therapeutic space in a pediatric hemodialysis clinic where the emotional and creative integrity of children living with end stage renal failure can be nurtured and supported. Presently, art therapy in pediatric hemodialysis clinics is not common but should be considered as a valuable and beneficial ongoing therapeutic intervention for children living with end stage renal failure. Further research on the application and effectiveness of art therapy in both pediatric hemodialysis clinics and open unit medical settings is recommended.

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