

Art and Story:

An Art Therapy Program for Women who have Experienced Breast Cancer

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Abstract

Art and Story: An Art Therapy Intervention for Women who have Experienced Breast Cancer

Shannon Byrnes

The goal of this research was to create an effective art therapy program that could address the need for ongoing care for women who are survivors of breast cancer. The program, entitled *Art and Story* is rooted in feminist and narrative theory and on the current literature in art therapy and cancer care. This research first explores a body of literature on breast cancer history, physical, psycho-social perspectives, feminist and narrative theory and theory from art therapy. The final component of the research is the program based on themes extrapolated from the literature and also is built from my own experience in working with cancer patients as an intern art therapist. The aims of the *Art and Story* program are: to encourage empowerment through creative storytelling, to provide opportunities for making meaning from one's illness experience, to promote healing of body and mind through creative activity, and to break feelings of isolation by building a group culture. The eight week program incorporates a variety of arts-based interventions designed to meet these goals. This program is a preliminary guideline as to how an art therapist could work with a group of women who have experienced breast cancer.

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Art and Story:

An Art Therapy Program for Women who have Experienced Breast Cancer

Introduction

The goal of this research project was to create a short term art therapy program that addresses the ongoing care needs of women after the life-altering experience of a breast cancer diagnosis. The art therapy program I designed encompasses various art and storytelling interventions that aim to meet psychosocial and meaning-making needs for women who have lived the experience of breast cancer. My process of creating this unique program involved researching literature related to art therapy and women with breast cancer, integrating what I learned from my work with cancer patients, and creating arts-based therapeutic interventions. I found a body of information on art therapy and art making with cancer patients, however there were few structured programs. Also lacking from the literature were programs for specific populations such as survivors of breast cancer. My work as an intern art therapist at a community wellness centre has influenced this project. I worked for eight months with cancer patients and their family members, trying different arts-based interventions. This experience led me to inquire further into how art therapy can provide a space for people to express what is not possible to express only in words. The physical, psychological, social and spiritual impact of cancer was evident in the profound art making and discussions that took place in a supportive therapeutic frame. I was deeply moved by my experience at the wellness centre and this sparked my interest in creating a program that could benefit women with breast cancer. The question guiding me along the way was “how do I integrate theoretical knowledge

and my experience as an art therapy intern to create an effective art therapy program for women who are survivors of breast cancer?”

The *Art and Story* art therapy program that I have created encourages women to share their experiences through personal artistic expression. The program is grounded in feminist and narrative theoretical approaches and research from multidisciplinary fields. Storytelling through art-making becomes a frame within which to address issues surrounding the experience of breast cancer. The literature points to ongoing psycho-social care needs for women after their medical treatments (Cappiello, Cunningham, Knobf, & Erdo, 2007; Davis, 2004; Dreifuss-Kattan, 1990; Janz et al., 2007; Malchiodi, 1997; Serlin, Classen, Frances, & Angell, 2000; Thewes, Butow, Girgis, & Pendlebury, 2004). Also, the literature shows evidence of disruptions in women’s capacity to make meaning from their experience (Collie & Long, 2005; Kasper, 1994; Rosenbaum & Roos, 2002; Thomas-Maclean, 2004). Art therapy and art-making with women with breast cancer has been investigated, however, there is much room for further inquiry (Collie, Bottorff, & Long, 2006; Hoffman, 2004; Oster et al., 2006; Oster, Magnusson, Thyme, Lindh, & Astrom, 2007; Lusebrink, 1999; Ponto et al., 2003; Predeger, 1996; Puig, Min Lee, Goodwin, & Sherrard, 2006). This research has resulted in the construction of a short-term art therapy program designed to address psycho-social needs and disturbance in meaning-making for women who have experienced breast cancer. The focus on the interconnection of the psychological and social is central to this paper as breast cancer is a disease attached to complex social meanings. Meaning making is also a focus of this paper. Arthur Kleinman, a psychiatrist and anthropologist notes that meaning is embedded in narratives: “the illness narrative is a story the patient tells, and significant

others retell, to give coherence to the distinctive events and long-term course of suffering” (1988, p.49). I define meaning-making in the context of this research as a process whereby a person develops stories to understand the illness experience. These stories can be told in art therapy through visual and verbal means. Personal stories told by those who experience illness are vital sources of knowledge that can be valued along with biomedical and empirical sources of knowledge about disease and treatments. This proposed art therapy program encourages and validates personal storytelling as a site for understanding the illness experience. People tell and re-tell stories to make sense of trauma and ultimately to heal. This art and storytelling program could be implemented and evaluated for its effectiveness by therapists, health care professionals and the participants themselves. The program entitled *Art and Story* is a preliminary exploration on how a short term art therapy program might benefit women who have experienced breast cancer.

Methodology

This research methodology is comprised of a literature review, historical analysis and construction of a program. The first component of the research is an in-depth literature review of theories, history, and programs related to the phenomenon under study. The second component is a unique art therapy program grounded in a synthesis of research from multi-disciplinary theory and treatment programs. Theoretical research creates new knowledge by critiquing and integrating pre-existing theories (Borowsky-Junge & Linesch, 1993). This research integrated several areas of research to create new knowledge in the form of an art therapy intervention. Furthermore, in building this knowledge I also took historical context into consideration. Historical analysis is useful

in acquiring knowledge in unexamined areas (Marshall & Rossman, 2006). Authors note that there is a need for more patient-centered knowledge on the breast cancer experience (Collie et al., 2006, Thomas-Maclean, 2004). This research attempts to address this lack in the breast cancer literature by synthesizing research from multiple disciplines and creating a program that could act as a space for women to address their continuing healthcare needs after medical treatment.

This research relies on the assumption of social constructionism. This is the view that reality is socially, politically and psychologically constructed (Patton, 2002). Social constructivist researchers explore multiple perspectives in approaching the phenomenon under research rather than seeking an absolute truth (Patton, 2002). Triangulation in this research from multiple fields of study including feminist theory, narrative theory, art therapy, social work, nursing, psychology, sociology and bio-medical expands the possibility of perspectives. Patton (2002) notes that social constructivist research requires focus on reflexivity: how the researcher's own experience and background affect how she understands and acts in the world. I am aware that my background influences the choices I have made in creating this program. My experience in the field has been as an intern art therapist at a wellness centre for those affected by cancer, running groups and seeing individual clients over a period of 8 months. This experience, along with my theoretical orientation factor into the choices I have made in the research process. I am also aware that my personal background also affects how I conduct research. With regards to this research I am aware that my lived experience is different from that of women who have experienced breast cancer, as I have not experienced this disease myself. I have been affected by close family members and friends who have been through the cancer

experience and who continue to live with the effects of this profound, life-altering event. This personal experience has informed my choice to do research in the area of cancer treatment.

The goal of this research was to create an effective art therapy program grounded in current literature from multi-disciplinary fields. The results are framed by a social constructivist perspective, taking the position that background and experience shapes how a person takes action in the world (Patton, 2002). The program is a starting point for implementing an art-therapy intervention that addresses the psycho-social and meaning-making needs for women who have experienced breast cancer.

Literature Review

Breast Cancer: Physical, Psychological, Socio-cultural Impact, and History

Incidence, treatment, and survivorship

Breast cancer is the most common cancer in women. According to the Canadian Breast Cancer Foundation (2009) one in nine women in Canada will be diagnosed with breast cancer in her lifetime. There is room for hope, as there have been greater survival rates with the improvements in screening and treatment, and the incidence of breast cancer in Canada has stabilized. Also, women diagnosed with this disease have an 87% chance of surviving for five years post-diagnosis. Also noted by the Canadian Breast Cancer Foundation, one in every 28 Canadian women will die from breast cancer, meaning that two-thirds of the women diagnosed with breast cancer in Canada will live with or beyond the disease and its treatment. Current biomedical treatment possibilities include radiotherapy, surgery (lumpectomy or mastectomy), chemotherapy, and hormone

therapy. Hormone therapy is generally given as ongoing treatment after surgery, chemotherapy or radiation therapy.

These statistics show that breast cancer is prevalent in Canada, yet many women are surviving the disease and living beyond it. So what exactly is living beyond the disease? This is a central question in this research as the journey of breast cancer does not seem to end with medical treatment; rather is a life-long process with its continuous challenges and life changes. The biomedical definition of survivorship is living 5 years disease-free after treatment (Thewes et al., 2004). Psychosocial perspectives define survivorship as a process, beginning with diagnosis and living through and/or beyond the diagnosis (Cappiello et al., 2007; Thewes et al., 2004). This definition is more expansive, encompassing many stages of the cancer journey. The focus of this research paper is on the survivorship phase, meaning women who are in the post-primary treatment phase. The research aims to address ongoing care needs beyond initial medical treatment. There are several views on terminology for those who have experienced cancer. Throughout this paper I am using alternating terminology of “women who have experienced breast cancer” and “breast cancer survivors” to accommodate the differing views. Cathy Malchiodi (1997), an art therapist who has worked with breast cancer survivors, stated that art therapists should be sensitive to the needs of women who want to overcome the identification of “victim” by adopting the identity of “survivor”. However, not all women will identify with the term survivor. Marta Hall, a book artist who created work from her breast cancer experience has offered a poignant and poetic argument against the term survivor: “I hate the term cancer survivor. It implies some people win. Some people lose. It implies there is a point in time when there is an answer. I am living with cancer. The

emphasis I on living” (2003, p. 24). Also throughout this paper I will refer to both the therapist and client as “she” where they are ambiguous terms. This is because I am working from a feminist frame and I am replacing the universal “he” with “she”, and also because of the fact that I am a female therapist and the clients with breast cancer I am referring to are female.

Physical and psychological impact

It is well documented in the literature that the experience of breast cancer can greatly impact a woman’s physical and psychological well-being (Cappiello et al., 2007; Davis, 2004; Dreifuss-Kattan, 1990; Janz et al., 2007; Malchiodi, 1997; Serlin et al., 2000; Thewes et al., 2004). The physical impact from cancer treatments can continue beyond the initial phase of treatment, with ongoing symptoms also impacting the psychological well-being of women. In a semi-structured interview of 20 women Cappiello et al. (2007) identified the information and support needs of women who are breast cancer survivors. They identified fatigue, sleep difficulties, fears of recurrence, anxiety, need for information on transition from treatment to survivorship, and struggle to return to “normal” life. Thewes et al. (2004) looked at the needs of women affected by breast cancer in the survival phase of 6-24 months post-treatment. They found the physical impact included fatigue, breast pain and arm pain, and problems with lymphodema. Fear of recurrence was the central theme of emotional impact of breast cancer. The lifestyle and career impact was greater for younger women who were involved in their careers at the time of diagnosis. Janz et al. (2007) in a sample of 1372 women after breast cancer treatment noted that the physical effects of treatment affected quality of life. Fatigue especially had an impact on quality of life. Quality of life impact

includes emotional distress, fear of recurrence, and difficulties returning to social roles. There is a notable impact of physical symptoms on the overall health of a woman who has undergone treatment for breast cancer.

One study suggests women who have had the experience of breast cancer are more likely to suffer from long-term or severe psychological distress than women in the general population (Davis, 2004). Malchiodi (1997) identifies the following psychological issues involved in breast cancer: feelings of loss, reactions to the medical community, seeking causes both externally and internally, possible guilt and self-blaming, and the desire to be called a survivor rather than victim. Dreifuss-Kattan (1994), writing from a psychoanalytic perspective notes that the loss of a breast inevitably follows with a depressive reaction. There are feelings of helplessness, fears of death, and mourning for a former way of life. Undoubtedly, the physical and psychological issues in the breast cancer experience can carry on beyond the initial medical treatment phase. Janz et al. (2007) state that the predominant focus is on care throughout treatment process and therefore they call for more support for women with breast cancer following the initial treatment phase. The literature strongly implies a need for ongoing psychosocial care.

Socio-cultural impact and meaning making

The social impact of breast cancer may inhibit women's capacity to make meaning from their own experience (Collie and Long, 2005; Kasper, 1994; Rosenbaum and Roos, 2002; Thomas-Maclean, 2004). Thomas-Maclean (2004) has studied the impact of breast cancer on embodiment: the intersection of body, society, biomedical forces and social forces. Her concern is that existing theory on health and illness does not capture the complexity of the meaning of a cancer experience, especially what it means to

experience bodily trauma. In her research she interviewed five women about their bodily changes after breast cancer and identified the following themes: how it feels, managing appearances, and treatments without end. Women in this study told intimate stories about how they felt in their bodies after the loss of a breast. In one vignette a woman commented:

It's (numbness) a different feeling. There's feeling there, but yet, it's not, ah, it's.

. . . I can't describe it. The sensation is completely different. . . there are times that I swear my prosthesis is hurting out at the nipple. Body is not fully sensitized.

One's body is present, but only partially so. (p.203)

This candid account gives a sense of what losing one's breast is like: a sensation of numbness, a loss, yet a lingering presence of an absent breast. Thomas-Mclean argues that her research revealed what would otherwise be silenced in culture. The expression of the daily feelings and struggles in coming to terms with an altered body were valued and listened to deeply in a way that otherwise might not have been possible in these women's lives.

Rosenbaum and Roos (2002) have provided a framework of predominant cultural meanings of breast cancer in North American society. These include: "1. breast cancer as equated with death or, alternatively, as manageable and survivable; 2. treatment for breast cancer as compromising to a woman's identity, femininity, and self worth, and 3. breast cancer as an experience that should not be openly discussed" (p.153). With regards to the first category, the authors noted that women face a contradiction of death versus survivorship. In their interviews with women they noticed this contradiction. One vignette offers a poignant portrait of this struggle as it lives in a woman's psyche:

There were two weeks in the beginning of all this I really felt like I was an ill person. I just was overwhelmed by the word “cancer”. Cancer does mean “life threatening, death”. And until the surgery is done. . . I think that fear of cancer is also kind of there. It’s cancer, but I’m going to take this one step at a time. So I’m remembering and looking for all the stories about women who had their surgery 25 years ago and 10 years ago. And those are the stories I want to focus on. Of course, I’ve had fears of dying. But I’m not going to deal with it that way. I keep talking about getting well. But all around me I hear, once you have cancer you are never the same (Rosenbaum & Roos, 2002, p.162).

With regards to the second category, women who have had a mastectomy confront social ideas that they might be “less feminine”, “less whole”, and “damaged goods” (Rosenbaum & Roos, 2002, p.166). The last pervasive social meaning involves the silence surrounding breast cancer. The authors noted that this due to two predominant ideas: that cancer should not be talked about, and the second, that breast talk is not acceptable in general, yet at the same time breasts are only acceptable to talk about in an over-sexualized manner. The authors acknowledged that these predominant social meanings may or may not be readily embraced by women who have had breast cancer. The predominant frames of meaning may also constrict a woman’s capacity to make meaning from her experience in her own words. The authors also commented that quantitative approaches to the research on meaning have also limited possibilities for understanding meaning in the context of breast cancer, as they are imposed onto the participants by the researchers.

Collie and Long (2005) have identified blocks to meaning making for women with breast cancer. These blocks include: fears of not being validated, not having the opportunity to express oneself, dominant discourses about breast cancer, and feeling powerless within the medical sphere. In the illness experience there is a sense of losing one's power to the authority of medicine. Collie and Long's research indicates that women need opportunities to make meaning from their experiences in order to move beyond these roadblocks. The authors also stressed the importance of accepting meanings that women themselves find important and to work to change dominant discourses that impede meaning making.

Breast cancer history and social constructions of an illness

Lerner (2002) traced the history of breast cancer treatment and uncovered how this history is intertwined with the prevalent socio-cultural climate. Removal of the breast in the case of breast cancer goes back to the 2nd Century A.D. to the Greek physician Galen. In the 1890's in Europe the Halsted radical mastectomy became the standard treatment for breast cancer: this surgery involved removal of the breast, surrounding lymph nodes and the chest wall. This surgery was performed on all women with breast cancer, regardless if the disease was localized or spread. Halsted and other surgeons were aware that the procedure did not work for cancer that had spread to other areas of the body, yet they continued to promote the operation as "the cure" for breast cancer (Lerner, 2002). Radical surgery for breast cancer took off in the United States in the early 1900's as well. In the 30's the medical language adopted military language in treatment: "victory over breast cancer required a carefully planned military campaign" and an "increase in the caliber of our weapons" (Haagensen, 1956, p.587; McDivitt, 1971, p. 269, as quoted

in Lerner, 2002). Women's bodies thus became battlegrounds for surgeons to remove "enemy" cells. In the 1950's in the United States the idea of personal responsibility for health perpetuated self-blaming attitudes in women with cancer. The prevalent ideal was that women were responsible for their health and for the health of their families. Women who took responsibility by receiving early detection and a radical mastectomy were endowed with a cure, but those who delayed treatment were considered negligent and would most likely die (Miller and Perdergrass, 1954, as cited in Lerner, 2002). It wasn't until the 1970's that research began to show that the radical mastectomy wasn't any more effective than surgeries that were less invasive. Yet, in spite of research findings it took time for the radical mastectomy to wane as the predominant treatment. Lerner notes that women have historically been treated as passive patients, with little power to contest a physician's authority. With feminist activism in the 1970's awareness about breast cancer increased. Women began to empower themselves in seeking treatment and questioned dominant biomedical views. Partial mastectomies or lumpectomies replaced the radical mastectomy, although 5,000 radical procedures were still done in the U.S. in 1983. Today, military themes continue to prevail in discourse on "the fight against cancer".

Thorne and Murray (2000) have tracked the social constructions of breast cancer through history. They identified three time periods: Victorian Era, Postwar Era and Contemporary Era and describe the predominant cultural stories about breast cancer in these periods of Western culture. In the Victorian Era the ideal was the "an angel in the house": a frail and delicate woman, devoid of physical and mental power. In the Postwar Era the ideal was a masochistic woman who suffered in silence for the sake of her husband. She existed for the sake of her husband and family, caught in the institution of

motherhood, unable to express her pain or desires. In Contemporary Era there is a strong breast cancer movement and are many choices for women in terms of how they will respond to the illness. Thorne and Murray identified several areas of the breast cancer experience: treatment, research, fund-raising, support and education, activism and private anguish. Although women now have more options and there doesn't seem to be any one ideal, the intersection of all of these areas could be overwhelming and confusing. Also, the history of women's social roles continues to impact how women experience their illness today. Clearly there are many hindrances to meaning making in the breast cancer experience due to the interactions of physical and psychological impact, and historical, socio-cultural constructions of illness.

Feminist Perspective

Feminist research paradigms

Feminist theory has much to offer in the study of breast cancer and the social constructions of the disease. Of course, this does not ignore the biological reality of cancer; rather feminist theory can be used as a lens to examine the complex interactions of the private experience of breast cancer and the medical, social, and political spheres. We have seen previously the historical analysis of cultural influence over time of breast cancer (Lerner, 2002; Thorne & Murray, 2000). Feminists are concerned with how knowledge has been male-biased through history. Medical knowledge has traditionally been acquired through the study of the male body as the norm, and also research and medical professions have been dominated by men. This historical bias has affected women in terms of what type of treatment they receive, as well as how their bodies are culturally perceived and valued, and as to how much power they have in decision making

process about their own illnesses. Adopting the stance that the personal is political and taking a feminist position with the issue of breast cancer means examining how personal experiences of breast cancer interact with socio-cultural realities. Also it means addressing the historical male bias in medical knowledge, and contributing to a feminist re-construction of knowledge that includes the perspectives of women.

Letherby (2003) has discussed three paradigms in feminist research: feminist empiricism, feminist standpoint theory and feminist postmodernism. First, feminist empiricism employs the traditional methods of science, yet adopts these methods from the perspective of women. This stance is based on the assumption that knowledge is objective; that the truth is “out there” waiting to be discovered. In the feminist empiricist view, more truth needs to be uncovered by feminist researchers to address a historical male-biased knowledge base. Feminist standpoint theory takes the position of building knowledge from the standpoint of women themselves. Standpoint feminists take a subjective, rather than objective view of knowledge building. As knowledge has been male biased through history, the feminist standpoint project is that knowledge must be built from the subjective position of women to dismantle the bias. Postmodernism takes the position that there are no universal theories, no single reality, and no stable, coherent self (Letherby, 2003). “Postmodernism points to the social construction of reality and how some interests may be served by particular constructions. This is useful for feminist researchers who are concerned with the social construction of gender, gender difference and so on. . .” (Letherby, 2003, p. 87). Constructionist feminism, in the postmodern stream of thought, attempts to break down the category of “women” into multiple categories, such as ethnicity, class, sexual orientation in order to encompass a diversity of

women's stories (Bloom, 1998). In the social constructivist endeavor this breakdown is necessary so that there are no essential "truth" claims about women that may erase the notion of difference. Thus "women" does not become an over-reaching category that attempts to speak for all women, excluding women who may not fit into the prescribed category. Standpoint and empiricist position resort to the categorization of "women" as an essential essence, whereas postmodernism accommodates a diversity of women, breaking down the category into a multiplicity of lived experiences.

The debate between essentialist and postmodernist feminism is beyond the scope of this paper. I am taking the constructionist position of maintaining the awareness that when I use the term "women who have experienced breast cancer" that this is a broad category encompassing a diversity of women coming from various backgrounds, and having various life experiences. Women's individual voices are pivotal in the feminist effort to reconstruct knowledge. These voices need to be heard, each individually, engaging in stories, dialoging difference within the shared experience of breast cancer.

Feminist research and breast cancer

Feminist theorists value the personal voices of women as the center of meaning making and locate women's voices within the larger social fabric. They define meaning in terms of the public and private: meanings imposed by the dominant culture and those created in personal lived experience (Kasper, 1994). To focus in on the standpoint position and how it has been used as a way to construct knowledge about breast cancer we can refer to the research of Ann Kasper (1994). She has investigated how women managed threats to body and identity and how their resolutions affected their sense of themselves as women. She conducted a qualitative study of 29 women who are breast

cancer survivors. She worked from standpoint theory, placing women's subjective experiences at the center of inquiry. In open-ended interviews with 29 women who are breast cancer survivors she asked the question: can you tell me about your experience with breast cancer? The purpose was to understand each woman's subjectivity and uniqueness in the breast cancer experience. The first stage of analysis engaged the women themselves to choose the part of the interview that was particularly meaningful to them. Next, Kasper developed themes of meanings for each woman's experience of breast cancer. Lastly, she looked at how women's personal meanings of breast cancer conflicted with socially-imposed meanings. Her project is explicitly from a standpoint perspective, however she crossed into the constructionist realm as she looked at how women's personal stories conflict with dominant stories of the culture. She considered that the culture creates stories and that these stories may or may not resonate with a personal story.

Taylor (2000) also approached meaning making from a feminist standpoint epistemology. Specifically, she studied the positive meaning making process of women with breast cancer. With her research findings she theorized a psychosocial trajectory of creation of positive meaning. This trajectory included the phases of encountering darkness, converting darkness, encountering light, and reflecting light. Taylor found that it was important for women to encounter dark feelings such as depression, feeling overwhelmed, and anger in order to transform the tragedy of illness. She commented that some people do become stuck in this feeling of darkness. Exploring the trauma was an important process along the path of moving towards healing. Taylor's research focuses in

on positive meaning. She acknowledged that not all women fit the trajectory: some women did not arrive at a point of positive meaning making.

Feminist approaches and art therapy

Art therapy from a feminist position could be especially beneficial for women with breast cancer. Parallels have been drawn between art therapy and feminism: “Creative arts therapists and feminists have in common not just their problems with the establishment, but we both are holistic and emphasize positive aspects of psychological functioning such as creativity, personal growth, innovative problem solving, divergent thinking, flexibility, spontaneity, self-esteem, self-actualization, and personality integration rather than the negative aspects of illness” (Talbot-Green, 1989, p.259). Both art therapy and feminism engage in non-pathologizing, wellness approaches to psychological health.

Some researchers claim that feminism has not influenced art therapy enough. Susan Hogan (1997) has argued for a more gender aware art therapy. She noted that to do this art therapy must critically engage with social constructions of gender and develop a stronger awareness of power relations in the client-therapist relationship. She continued to comment on how representations of women (and men) set up roles that can become oppressive. She proposed that art therapists have a unique position where they can see these roles as they are represented in imagery and can explore the conflicting messages of our visual culture. Another prominent art therapist, Cathy Malchiodi (1997), has taken a feminist perspective in her work with breast cancer survivors and has recommended using art and writing as a form of empowerment. She has also shown art by women with breast cancer to inspire clients to create from their own experience. Art therapists

working from a feminist position have much to draw from feminist theory and feminist artists.

Some breast cancer artists have critiqued standards of feminine beauty in visual culture. Matuschka, a photographer who photographed herself post-mastectomy, nude in a “fashion magazine” pose, subverted the expectations of the viewer of the female body in dominant culture. Amaya (2004) noted that Matuschka’s photograph, “Classic Nude”, suggests that “beauty, normalized by the canon, which includes the ideas of symmetry and femininity as scarless unblemished skin, may hide the asymmetry of patriarchal society, and may hide the scars of technology” (p.561). She stated that in the photograph Matuschka’s body becomes a visible record of underlying realities of power relationships in a patriarchal and industrial society. Her subversive photography is inspiring to women who choose not to hide the scars of their post-mastectomy bodies and who choose to reject prescribed standards of female beauty. Also noteworthy of Matuschka’s situation is that her mastectomy in 1991 was an unnecessary operation.

Israel has defined feminist therapy as a therapy that liberates women from sex role stereotypes, minimizes the power differential between the therapist and client, and promotes the right to self-actualization (as cited in Joyce, 1997, p. 89). Joyce (1997) has identified the first goal of feminist therapy is to help women to overcome oppression. This means women in therapy choose how they want to change. Women’s choices may or may not include social action. She also identified how feminist therapists work to reduce the power differential between client and therapist: this means the therapist is more transparent about personal and professional values, training and expertise so that the client can make an informed choice as to the therapy she is getting into. Also there is

a focus on the client's voice in the goals of therapy and evaluation of therapy as the process takes place. Davis Halifax (2003) defined feminist psychotherapy as a practice that enables a supportive, collaborative, empowered, therapeutic relationship and she purports that this relationship will effect change in the client's outside world. These feminist strategies in psychotherapy enable the woman receiving therapy to be an expert on her own life story.

Integrating theory

Feminist research paradigms, the history of breast cancer, the intersection of physical, psychological and social realms of experience of breast cancer and feminist approaches to therapy can be the grounds from which an art therapist might consider working with a group of women who have experienced breast cancer. Creating a feminist-based program means understanding that breast cancer is a complex experience, with intersecting biological, psychological and social impacts. A feminist-aware program also means considering that the opportunity to create meaning in a personal way may not have been available due to factors such as constricting socialized gender roles or dominant discourses on breast cancer and women's bodies. Adopting feminist values as a therapist encompasses finding ways to work with women to empower them to tell their own stories freely and to become experts on their own life experiences.

Narrative Approach

Narrative and postmodernism

A central notion of narrative theory is that people make meaning and develop a coherent sense of self through an ongoing process of storytelling (Freedman & Combs, 1996; Neimeyer, 1998; 2000; 2006). The assumption of the narrative approach is that

people are natural storytellers and that multiple stories and meanings are possible in a person's life. Also in this view is the idea that the self is in a state of flux; the self is defined as multiple and changeable, rather than as a stable core essence (Neimeyer, 2000). According to Freedman and Combs the narrative, postmodern view holds that: 1. Realities are socially constructed. 2. Realities are created through language. 3. Realities are organized and maintained through narrative. 4. There are no essential truths.

Following this view realities are constructed and maintained in our social world: ideas, beliefs, practices come out of social interaction over time. Also realities are created by language, by how we share and engage in interacting. The organization of realities occur through narrative: "In striving to make sense of life, persons face the task of arranging their experiences of events in sequence across time in such a way as to arrive at a coherent account of themselves and the world around them. . . This account can be referred to as a story or self-narrative" (Freedman & Combs, 1996, p.30). Thus stories are the site for people to make sense, or make meaning, from the world and their place in it. In the social constructivist view, storytelling occurs in a cultural context: the stories people tell are dependent on the way they have been socialized. Lastly, the postmodern idea there are no essential truths means that facts cannot be arrived at objectively, as there is always a subjective interpreter. There are no un-biased views of reality, as there is always someone through which this knowledge is filtered. With this framework of postmodern theory in mind, what does it mean for therapy? How does someone work on, for instance, "self-esteem" if the self is not a stable essence? The postmodern, narrative position asks therapists to re-consider concepts that form a basis upon which we practice.

Narrative approach to psychotherapy

The self, in narrative theory, is considered as existing in a state of constant flux with social interactions it comes into contact with. Perhaps then, it seems that working on “the self” seems like a challenging task to bring to therapy. However, the opportunity to see the self as malleable has much to offer in the realm of therapeutic interventions. With this fluidity, people can chose the stories they want to tell about their lives in therapy. White and Ebston’s (1990) narrative therapy approach was born out of a narrative, constructivist view of reality. The narrative therapy approach assumes that people have an abundance of experience that lies outside of dominant storylines that come from society or significant people in the client’s life. White and Ebston advocate the generation of alternative storylines in therapy. They begin the process by inviting the client to externalize the problem: by separating from the problem, the client is freed to look at other aspects of the self from a non-problem perspective (White & Ebston, 1990, p.39). The problem, for instance, “the depression” is not seen as an innate part of the person, but rather as the problem itself. Thus the person does not need to blame herself for what is wrong within her. The client is then encouraged to explore alternative stories beyond the dominant, problem stories: these alternative stories are referred to as “unique outcomes” (p.15). The client can see ways that the problem does not take over and that the alternative stories provide more empowering narratives to organize her life. With these unique outcomes the client can actively “re-story” her life, creating new possibilities beyond the problem story.

Neimeyer has advocated that narration brings continuity to life experience and helps us to realize where we stand in relation to others (2000, p.237). With this narrative approach awareness of the social locations of both therapist and client are important as

well as understanding of power structures of culture and institutions (Neimeyer, 1998). People's stories are embedded within a particular culture which may intersect or not with the therapist's culture and background. This awareness is important to reduce misunderstandings and so that the therapist does not make assumptions about the person receiving therapy. Neimeyer engages clients in techniques to promote empowered storytelling. One technique he employs in therapy is called "Chapters of our Lives" in which he invites clients to treat their lives as autobiographical texts (Neimeyer, 2006). First, clients fill out a "table of contents" outlining significant moments in their lives, and then invite them to go into detail on setting, characters, plots, themes and goals. In a group setting he invites clients to do the table of contents for the first part of session and then share with a partner. He then travels around the room, listening for resonant themes. This process encourages clients to become active authors of their own life stories.

Illness as narrative

Arthur Frank (1995, 2007), a sociologist and a cancer survivor has written about the stories of deep illness. Frank has identified three types of illness narratives that occur: restitution, chaos, and quest stories. These are frameworks for a multitude of stories that take place in the case of illness. First, the restitution story is the most culturally accepted form of illness narrative: this narrative is the story of falling ill, suffering and then having successful treatment and coming back to health. Frank has acknowledged that this type of story is real in a lot of cases, and it is to be honored and validated, however there are also other forms of stories that need to be listened to. The second narrative he has referred to is the chaos narrative. This is when medical problems persist: there is pain, disability, and unsuccessful treatment. This leads to social problems, including loss of ability to work,

stress on relationships and financial strain. He stated that deep listening is necessary. The dilemma with this story is how to honor the chaos while leaving open the potential for change. He noted the tendency to label an ill person as “depressed” is unhelpful if it is not seen as a valid reaction to an awful circumstance. A third narrative that might emerge when restitution is not possible is the quest story. In this type of story the illness becomes a quest from which something can be learned, and the learning can be shared with others. The appearance of the quest story is the point when a person can make meaning from the experience. There is a process of letting go of an old way of being and a shift to a new form of self. It does not necessarily mean that the person is healed in the sense of a cure, but that the illness experience has effected personal change. Frank stated that these three narrative forms can take place at any point of an illness trajectory, and do not necessarily take place in sequence. His key teachings for caregivers of those who are deeply ill are: 1. To hold a sincere belief that the story you are hearing does not need to be changed. 2. To try to hear exactly what story the person is telling, 3. To remember the person is living a story that is theirs to tell. This wisdom speaks to the value of listening to the client and not putting expectations of a certain type of story onto the authentic story they are revealing.

The narrative metaphor and breast cancer

The theories and techniques of narrative therapy may be helpful in working with women with breast cancer. For instance, Malchiodi (1997) has noted the tendency of guilt and self-blame in women with breast cancer. Perhaps with externalizing the problem, a client might be able to see that she does not need to blame herself for getting cancer. At the same time, cancer is a bodily reality and so it becomes problematic to conceptualize

the cancer as “externalized” when it is embodied and when there may be a lot of pain. The “Chapters of our Lives” technique (Neimeyer, 2006) may help a client to consider the greater picture of life: that cancer is only one part of her life story, although perhaps the most consuming and all-pervasive aspect of life if it is the here and now. Also in creating alternative stories or in narrating one’s life as chapter, it may be anxiety-provoking to think of the future, depending on one’s prognosis, stage in treatment, and fears surrounding death. Working with women with breast cancer through narrative might entail an acceptance of any type of narrative, and attending to the types of narrative that might come up: restitution, chaos, and/or quest. The metaphor of narrative could be quite salient to work with this population as it opens possibilities for telling stories that lie outside of those that are predominantly told. The narrative approach places the person in a creator role of her own life and opens opportunity to express and possibly repair stories of suffering.

Integrating feminist and narrative theory

Feminist research from standpoint and postmodern epistemologies value women as creators of knowledge. Feminist therapy follows by valuing women as experts on their lives and providing opportunities for self-empowerment. Feminist theories seek to understand women from their own voices and they identify social structures that may impede them from finding their own personal meanings (Kasper, 1994; Taylor, 2000; Malchiodi, 1997; Wilkinson, 2000). Wilkinson (2000) discussed the experiential approach (the standpoint position) as a tradition in feminist research that focuses on individual experience. Narrative and storytelling is an approach that has been used within this tradition. The benefits of an experiential feminist, narrative approach is that it

captures complexity and gives voice to marginalized women (Wilkinson, 2000).

Narrative theories see the individual as in a process of creating ongoing stories about her life: this process is influenced by the social context in which the person is embedded (Freedman & Combs, 1996; Neimeyer, 1998; 2000; 2006; White & Epston, 1990).

Narrative therapy engages clients in empowering conversations about their lives. The feminist and narrative approaches together value women's personal struggles as reflections of culture (Brown, 2007). These two approaches also meet where they consider storytelling as a site for meaning making and consider subjective meanings situated within social context. The focus on stories can provide a richness of detail on people's lives, and can perpetuate further understanding of the lived experience of breast cancer. Narrative and feminist approaches in art therapy can engage women in the process of telling the stories they desire to tell.

Art Therapy, Art Making and Cancer

Art therapy and cancer care

Medical art therapy is an emerging stream in the discipline of art therapy. Medical art therapists work with those who have experienced bodily trauma and illness, and generally work in hospital settings. Medical art therapy enables clients to form a living record of their internal experience of illness or symptoms (Long, 2004). People with serious illness use art as a way to summarize their life, to reclaim power, to create a lasting visual legacy and affirm existence (Malchiodi, 1997). Malchiodi (1999) outlined that medical art therapy has been used with patients to facilitate recovery, to mobilize coping skills, and to help them to find personal meaning in the experience of serious illness. Literature on art therapy with cancer patients includes some empirical studies on

relieving symptoms (Bar-Sela, Atid, Danos, Gabay & Epelbaum, 2007; Monti et al., 2006; Nainis et al., 2006; Nainis, 2008) and much clinical and case study material (Borgmann, 2002; Dreifuss-Katan, 1990; Matho, 2005; Minar, 1999; Luzzatto, 1998; Morley, 1998; Zammit, 2001). Art therapy and art making with women with breast cancer has been researched in various ways: as a way to promote coping (Oster et al., 2006), as a way to understand one's culture and boundaries (Oster, Magnusson, Thyme, Lindh, & Astrom, 2007), in exploring sandplay and dreamwork (Lusebrink, 1999), as a way to enhance emotional expression, spirituality and psychological well-being (Puig et al., 2006), as a public storytelling process (Ponto et al., 2003; Hoffman, 2004), and as a way to promote meaning-making (Predeger, 1996; Collie et al., 2006). Also, various programs on art therapy, art making, and/or creativity and cancer have been discussed or reviewed in journals (Deane, Fitch, & Carman, 2000; Ferris & Stein, 2002; Goll-Lerner, 2005; Heiney & Darr-Hope, 1999; Luzzatto, 2000; Serlin et al., 2000; Visser, 2008). Some research has been undertaken in the area of cancer care and art therapy. This research paper reviews all areas of research on art therapy and cancer care but focuses on pertinent works related to psychosocial needs and meaning making needs of women with breast cancer.

Art therapy and symptom reduction

Studies on art therapy as a way to reduce symptoms related to cancer and its treatment focus on mind-body approaches: looking at the interaction between physical and psychological processes (Bar-Sela et al., 2007; Monti et al., 2006; Nainis et al., 2006; Nainis, 2008). Empirical research in this area looks promising and could create a pathway to more evidenced-based practices in medical art therapy. For instance Nainis et al.

(2006) in a study of 50 inpatients with cancer found that after one art therapy session there was a reduction of 8 out of 9 symptoms on the Edmonton Symptom Assessment (ESA). This study especially showed a correlation between the art therapy session and a decrease in tiredness and anxiety. The qualitative portion of the research included the question: "how did you perceive art therapy to change your overall well-being?" Answers from participants indicated that art therapy was relaxing, it helped to distract them from their symptoms, it was productive and worthwhile and a pleasant activity. Similarly, Bar-Sela et al. (2007), in a study with 60 cancer patients found decreases in depression and fatigue after an art therapy program. Both of these studies were not randomized and controlled, however, they show great promise for further inquiry in this area.

Monti et al. (2006) ran a study on a psychosocial intervention called Mindfulness-Based Art Therapy (MBAT). This was an 8 week program that combined mindfulness based meditation with supportive group art therapy. They found that as compared to the control group, those who experienced art therapy showed decrease in distress and increase in quality of life. The control group was matched in terms of disease stage, however, the group consisted of those on the waitlist for the treatment and they did not receive any treatment at all. It is therefore inconclusive whether the combination of meditation and art therapy can account for the improvements in the participants' conditions. The study would be more effective if the control group received a different type of therapy to compare the results of art therapy with. Further inquiry into the efficacy of mind-body approaches to reducing physical and psychological symptoms could be fruitful. These studies suggest that art therapy can have a positive impact on

physical and psychosocial functioning, and also that meditation in conjunction with art therapy may benefit cancer patients.

Clinical perspectives on art therapy and cancer care

Several art therapists have written from a clinical perspective on their work with cancer patients (Borgmann, 2002; Dreifuss-Katan, 1990; Matho, 2005; Minar, 1999; Luzzatto, 1998; Morley, 1998; Zammit, 2001). These writings are rich with detail on the experience of living with cancer and the therapeutic relationship. Also, they offer many helpful themes and suggestions for art therapists working in this field.

Luzatto (1998) reflected on her work with cancer patients and identified three main themes: the body, creativity and respect for the negative. She commented that the presence of bodily trauma is striking in working in this field, and also reflected that physical pain is interconnected with psychic pain. In her sessions she began by dialoguing with the client about the physical pain and then moved to deeper psychological associations related to the pain. These factors work together to enable creative expression, a feeling of control over art materials, contact with the unconscious and a meaning-giving factor. Her definition of meaning is: that which emerges out of relationships between visual elements in an art piece and corresponds to relationships in the client's inner world. She emphasized the importance of respecting and honoring negative verbalizations and images in art therapy with cancer patients as there is such a prevalent climate of positive thinking, and need to put on a brave face when underlying feelings might not reflect these predominant expectations. She also advocated guided meditation, a development of personal imagery, and the transformation of that imagery over time in working with cancer patients.

There is a strong connection between art-making and the body in working with cancer patients. Dreifuss-Kattan (1990) inquired into the restorative nature of creativity on the body in the experience of mourning and loss incited by cancer. She stated that artists at work move into a heightened state where they are sensitive to the subtle feelings of the body. She believes that “psychological self-repair through writing and artistic expression always contains the unconscious wish that the finished product might re-establish the physical intactness that is being destroyed by the cancerous process” (p.135). As there has been an assault on the body, the image-making process can be seen as a way to repair this bodily trauma and thus restore a sense of wholeness.

Minar (1999) wrote about how art therapy with cancer patients can help them to cope with the emotional pain linked with the physical and medical components of the disease. She identified the therapeutic goals of allowing the ventilation of feelings and discovering inner strength. In her experience with group work she has found that the cohesiveness of the group can help to address feelings of isolation. Also, reflective of Luzatto’s suggestions on respecting the negative, Minar commented that art therapy is an accepting environment where clients do not need to put on “a happy face”.

Case studies on art therapy with cancer patients give rich and detailed accounts of the cancer journey. Zammit (2001) has provided a detailed case study of one client’s creative process of painting and drawing through her journey living with multiple melanoma. The illness transformed her life and she devoted much of her energy to her spiritual growth through art.

Matho (2005) has outlined an account of the therapeutic process of a woman with breast cancer in her last stages of life. She noted that the client worked to value her

femininity, build self-identity, and claim a “lost voice”. The presence of bodily pain was also quite strong in the therapy sessions. In one session the client created a body out of clay and insisted that she create from one large piece in order to maintain a sense of physical and psychological wholeness. Matho noted that the client’s process of art therapy was evidence of “the interdependence of mind and body working together as a dynamic unity rather than a duality” (Wood, M.J.M., as quoted in Matho, 2005). Mind and body are deeply connected in working with cancer patients: physical pain can translate into psychic pain. This is evidenced in art therapist’s accounts of their clients’ art and of the therapeutic process.

Art therapy and art making groups in cancer care

The literature up to date has shown that art therapy and art making programs for cancer patients have made a positive impact on well-being (Deane et al., 2000; Ferris & Stein, 2002; Goll-Lerner, 2005; Heiney & Darr-Hope, 1999; Luzzatto, 2000; Serlin, et al., 2000; Visser, 2008). These programs vary in structure and approach and are rich with information on how one might approach facilitating an art therapy group for a population of breast cancer survivors. Most programs have incorporated guided imagery or relaxation techniques with art making. Luzzatto has given a structured outline of how she runs 10 week groups, with specific goals and activities. The goal of the program is to promote healing of individuals through strengthening the inner self and trusting the environment. This means that the role of the art therapist is encouraging a self-valuing process through developing personal imagery and fostering an environment of trust in the group. Luzzatto begins each session with a guided visualization; this is followed by a structured project and demonstration of techniques. The images are placed on the wall at

the end of session and there is time at the end for group discussion, provided that the individual consents (this is optional).

Another structured intervention program called “the healing journey” adopted the guiding metaphor of a journey for the illness experience (Goll-Lerner, 2005). Participants included cancer patients and others with serious injury or illness. This 10-week program focused on holistic well-being: considering the interconnection of physical, emotional, psychological and spiritual dimensions of health. The program had assigned readings and a different topic to discuss each week. Also, the program involved a combination of guided imagery, art making and movement.

A dynamic, less structured 10 week program for cancer survivors called “Cancer, Courage and Creativity” has combined art, drama, poetry, movement, ritual, myth and mask-making (Ferris & Stein, 2002). The goals for participants were to adopt the skills to address the unknown and to find meaning in illness. There were some structured activities, but the facilitators attended to the individual and group needs and responded to them as the group progressed. Fairy tale and myth were incorporated to “expand the field of perception”, enabling participants to connect their stories to mythical themes. Allowing a space for empowered storytelling is important in the program as “the cancer survivor often believes what they are feeling and thinking is wrong: no story is the right story that will please everyone” (p.48). The authors outlined an ethic of a culture of creativity:

To value the ability to respond to one’s own emotions and give them form through artistic expression; to notice one’s judgment of self and comparison to others and to strive for increased compassion; to respect the body and to listen

more closely to its needs; to find meaning in one's creative action, relationships and life story; and to define bravery as emotional honesty and risk taking rather than heroic physical strength. (p.49)

A six-week art therapy program called "Healing Icons" (Heiney & Darr-Hope, 1999) was co-facilitated by a nurse-psychotherapist and an artist. This program's goals included: developing a nurturing community, creating space for emotional healing, finding meaning in the cancer experience, and acquiring self knowledge. The first session was introductory and educational and discussed the use of icons in art history.

Participants brought 10 small objects imbued with personal meaning and power to the next session and begin constructing a sculptural icon. Over the course of the program the icon was built. There was also a journaling component to the program. In the written evaluation the following benefits of the program were identified: decreasing isolation, expressing feelings, gaining new perspectives and improving coping.

Deane et al. (2000) reviewed a program in Toronto that combined art education and art-therapy (although it is unclear whether the facilitator was an art therapist). The goal was to help people to explore personal feelings about their cancer experience in a supportive group environment. The program ran for 16 weeks and involved experiencing and learning about an art collection in a museum, followed by studio time. The participant rating of the program in questionnaires indicated that the benefits of the program were that it broke isolation because they were able to have a shared experience with other cancer survivors and that they were able to achieve a degree of self-actualization.

Visser (2008) reviewed an art therapy program in the Netherlands that incorporated art and visualization and imagery exercises. He interviewed 35 patients, and measured quality of life, mood state and experienced meaning of life. The findings were that a search for meaning in life increased after the program. These various art therapy and art educational programs have yielded positive results. They provide guidelines on goals and activities for group facilitators. The programs that incorporated evaluation by participants provide insight and information on how they were effective. More qualitative evaluations and empirical research on what is effective would be beneficial to promoting more wide-spread use of art therapy as a valid approach to working with cancer patients.

Group art therapy with breast cancer survivors

Art therapy groups for cancer patients have been shown to benefit participants, yet no structured art therapy programs specifically for women with breast cancer in the post-treatment stage have yet appeared in the literature. Support groups and group psychotherapy have been shown to benefit women with breast cancer (Serlin et al., 2000). Serlin et al. recommended that patients with the same disease participate in a group to achieve a strong level of shared understanding. Furthermore, they recommended forming groups of breast cancer patients that are in the same stage of the disease to address similar concerns and further increase this level of shared understanding.

Art-making and art therapy with breast cancer patients has focused in different areas: as a way to promote coping (Oster et al., 2006), as a way to understand one's culture and boundaries (Oster et al., 2007), in exploring sandplay and dreamwork (Lusebrink, 1999), as a way to enhance emotional expression, spirituality and psychological well-being (Puig et al., 2006), as a public storytelling process (Ponto et al.,

2003; Hoffman, 2004), and as a way to promote meaning-making (Predeger, 1996; Collie et al., 2006). This research takes interest especially in narrative and feminist perspectives of art therapy with women with breast cancer. The studies reviewed have taken studio-based approaches to art making rather than structured interventions.

Predeger's (1996) research inquired into the experience of breast cancer and art-making with a feminist participatory design, where women were co-creators of knowledge. The themes that came out of the process included actualizing the need to express, losing control and gaining control, illuminating a changing perspective, transcending and becoming braver, connecting with sisters, creating a safe harbor, fueling the creative spark, celebrating the feminine and Womanspirit (Predeger, 1996). Predeger defined Womanspirit as "the unifying essence underlying personal and collective knowledge" (1996, p.48). This collaborative process honored women's experiences and identified meanings that were important to them. This explicitly feminist standpoint project built knowledge based on the standpoint of women and finding unity in the experience of womanhood.

Perhaps the research most pertinent to this review is recent work by Collie et al. (2006) on a narrative view of art and women with breast cancer. They sought to understand the personalized meanings of the breast cancer experience within a social context. They stated that there is a large gap in patient-centered knowledge on what is therapeutic in the experience of breast cancer. The research design employed the feminist experiential approach with a narrative frame. They sought to understand how women with breast cancer utilized art making and art therapy to create meaning. They conducted in-depth interviews with 17 women. There were four themes identified in this process:

“a) Art and Art Therapy as a Haven, b) Getting a clearer View, c) Clearing the Way Emotionally; and d) Enhancing and Enlivening the Self” (p.765). Collie et al. (2006) concluded that women with breast cancer utilized art making as a way to guard a sense of self, to find personal resources and to create meaning. They called for creating conducive conditions for women with breast cancer to create meaning, for accepting meanings that the women themselves find important, and for work on changing dominant discourses that limit their meaning making capacity. Feminist and narrative inquiry into the meaning of breast cancer experience has begun with small samples of women. The literature on how women with breast cancer create meaning through art needs to be filled out by more stories from a diversity of women.

Relevance of Research to Art Therapy

An effective art therapy program for women who have experienced breast cancer can incorporate goals and activities based on what has been done in art therapy with cancer patients. Also, to take into consideration are themes identified in feminist and narrative research with women with breast cancer. The research in these areas is limited and so there is much room for further inquiry into creating such effective programs. Ideally, a combination of both quantitative and qualitative research inquiring into the process of art-making and art therapy by a diversity of women with breast cancer could shed light on how professionals might provide effective care. Also ideally, more research on the personal experience of breast cancer including the women themselves as co-researchers in the process could enhance the lacking body of patient-centered knowledge in this area.

Review of Theory

This research has looked at the psychosocial and meaning-making needs of women after primary medical treatment for breast cancer and has explored an array of theory from feminist, narrative, art therapy, and other perspectives. The connection between physical and psychological symptoms and pain was a theme running throughout the research (Bar-Sela et al., 2007; Cappiello et al., 2007; Davis, 2004; Dreifuss-Kattan, 1990; Janz et al., 2007; Malchiodi, 1997; Monti et al., 2006; Nainis et al., 2006; Nainis, 2008; Serlin et al., 2000; Thewes et al., 2004). A theme that came up in research on art therapy groups was the need to break feelings of isolation through shared understanding with those who have gone through a similar experience (Deane et al., 2000; Ferris and Stein, 2002; Heiney and Darr-Hope, 1999; Luzatto, 2000; Minar, 1999; Serlin et al., 2000). Also predominant was the lack of personal meaning making opportunities for women after a breast cancer diagnosis (Collie and Long, 2005; Kasper, 1994; Rosenbaum and Roos, 2002; Thomas-Maclean, 2004). Feminist and narrative perspectives value women's struggles as reflective of culture (Brown, 2007). As has been documented, there are many roadblocks, including physical, psychological and socio-cultural issues, which may impede women's capacity to make sense of the illness experience. A feminist narrative position values storytelling as the site for meaning making and allows opportunities for women to tell their authentic stories, including those that may not fit dominant, culturally acceptable storylines. Telling stories through verbal and visual expressions is an act of self-empowerment in the experience of life-threatening illness and its related medical treatment.

Program Goals and Structure

The *Art and Story* program design is based on the knowledge synthesized from an in-depth literature review of the psychosocial needs of women after treatment for breast cancer, theories from feminist and narrative perspectives and on art therapy perspectives with cancer patients. This short-term group would run for 8 weekly 2 hour sessions. Ideally the group would consist of 6-8 participants so that there is a comfortable level of workspace and interaction and sharing that can occur. Luzatto (2000) has noted that short-term groups have been effective with cancer patients for improving mood and quality of life. Also, she has recommended that short-term groups may be even more effective for cancer patients rather than long-term interventions.

The aims of the *Art and Story* program are: 1. To encourage empowerment through creative storytelling 2. To provide opportunities for making meaning of one's illness experience 3. To promote healing of body and mind through creative activity, and 4. To break feelings of isolation by building a group culture. Based on a feminist and narrative paradigm the participants are seen as experts on their own life stories and can use the therapeutic space to tell stories from their own experiences, as they would prefer to tell them. All stories and images are accepted, whether positive or negative, complete or incomplete. There is no right way to tell a story or to create art. Activities ignite the creative response and encourage a range of possible art expressions. Each individual will interpret the activity differently. No special art skill is needed; individual creative expression is encouraged in a non-judgmental atmosphere.

I developed therapeutic goals for the program from the aims of the program. These are guidelines for more in-depth treatment plans for the group and for individuals.

Additional objectives for individual clients can be created in collaboration between therapist and client to aid clients to actualize the goals. The therapeutic goals include:

1. To be an expert on one's own life story.
2. To find personal meaning in the illness experience.
3. To connect mind and body in the healing process.
4. To value a sense of self and to build connections to others.

The structure of 2 Hour Sessions is as follows:

1. Check in ritual: go around circle and check in
2. Guided imagery to encourage mind-body connection
3. Guided art activity
4. Writing in journals
5. Discussion

To begin each session clients will develop a check-in ritual. This can be a simple around the circle and each client says a few words, or it could be the passing of a talking stick, or choosing a colored stone from a bowl and saying something about it. There are many options. This quick check-in (about 5-10 minutes) is to enable participants to check in with how they are feeling that day. Also, this gives the therapist an understanding of any significant changes or events in the person's life. The guided imagery will be the same each day, and will be a progressive body relaxation. This activity (about 5 minutes) is to quiet the mind and allow participants to relax their bodies. The studio art activity will follow. When clients are finished the art portion of the session they will be invited to write in a journal about their work. Based on Pat Allen's (2005) concept of "witness writing", participants will be invited to let their images speak to them and have a "voice".

If they are blocked they can ask questions such as “what are you saying to me?” “What story do you have to tell?” or “Who are you?” and let the image respond: “I want to tell you. . .” or “I am. . .” At the end of the session there will be time reserved (about 30-40 minutes) for sharing the work and for discussion. Sharing the work will be optional. The purpose of the discussion is to encourage self-expression and build shared understanding in the group, not to critique the quality of artwork. A group ethic of non-judgment and acceptance of images and stories will be established. Confidentiality will also be respected in the group.

Week 1: Past-Present-Future Collage

On the first day of the program there will be a check-in exercise and an orientation on art therapy. Also there will be a discussion on the goals of the program, and group rules will be established collaboratively. A guided progressive relaxation to quiet the mind and connect with the body will follow. This same guided relaxation will be offered at the beginning of each session. The purpose of the past-present-future activity is to begin the 8 week journey with a collage story, considering a timeline of past, present, future. This activity will set the tone for the 8 week process as it invites participants to tell an expressive visual story about themselves as they are. Materials can include pre-cut collage images from magazines, art books, newspapers, etc., glue, scissors, a variety of drawing and painting materials, and various sizes and colours of paper. Participants will be invited to collage a visual story of their lives “as they are right now”, incorporating their past, present state and feelings and thoughts about the future. The project is open-ended: participants can do three pieces or incorporate the timeline onto one piece of paper, and can choose whatever materials they want to use to tell their

stories. After they are finished with the visual portion, participants will be encouraged to write about their visual story in journals. After this workshop and after every workshop, participants will be invited to put their work on the wall and share with the group, if they want to.

Week 2: Mandala Story

This activity builds from the previous week and invites participants to tell the same story of past-present-future, but to consider the shape of a circle, and how this might change the story. The goal is to look at one's story and consider it from another perspective. A circle evokes the idea of the eternal and so could give a wider perspective on a psychic conflict or issue. Materials can include pre-cut collage images, coloured paper, glue, scissors, multiple drawing and painting materials and pre-cut background paper in the shape of circles. Participants will each be given a circle and will be invited to first find a symbol or image of importance to place at the centre of the circle. Next, they will be invited to collage the story around this central image. Again, participants can journal about their process, inviting their images to speak to them, and they can share with the group at the closing discussion.

Week 3: My Body, My Story

This week participants will be invited to get into pairs and trace each other's body outlines on large pieces of poster paper. The goal of this activity is to build trust between group members and also to get in touch with what the body has to say. If it is not physically possible for some participants to do this, the activity can be adapted. A participant could create a body outline by drawing on a smaller piece of paper or a body outline template could be offered by the art therapist. Material for this activity can

include a large roll of paper, collage materials including pre-cut images, glue, scissors, coloured paper, tissue paper, small 3D objects such as feathers, buttons and sequins, glue, and various drawing and painting media. Participants will be invited to tell a story of what their body has to say. They can use a combination of words and images to portray their expression. Witness writing and group sharing will follow the art activity. At the end of the session participants will be invited to bring 5-10 small objects with them to the following session. These objects can be anything that holds particular meaning for the participants and that they are willing to incorporate into a sculptural piece.

Week 4: The Story Box

This week's activity involves constructing a 3D story box with found objects. The idea of the activity is to use the inside and outside of the box to explore "what stories you tell to the outside world, and what stories you tell on the inside". The aim of the activity is for participants to reflect on what stories they tell about themselves and to consider alternate stories that they hold inside and do not always tell. Also the inclusion of participant's objects can infuse the project with personalized meaning. Materials can include a variety of different sized boxes: i.e. Shoe boxes, jewelry boxes, participants' own objects, natural objects, feathers, beads, and other collage materials, magazine images, drawing and painting materials, glue, and scissors. Participants will be invited to explore the inside and outside of the box, attaching objects as they wish. Once the construction is finished participants will be encouraged to write about the stories on the outside and write about the stories on the inside of the box. Sharing the stories with the group is the closing ritual this week.

Week 5: Group Stories

A group story is an activity where participants pass a sheet of paper around in the circle, building images as a group. The aim of this session is to encourage group interaction and cohesion. At this point in the group participants will be more comfortable with one other and a group activity could encourage further connections. The materials can include large sheets of paper, folded so that there are six or eight squares (depending on number of participants), various drawing materials including oil and chalk pastels, felt pens, pencil crayons, watercolour pencils and crayons, felt pens, charcoal, and conte crayons. Drawing media works best as the drawings will be passed around and there will not be time for paint to dry. Participants will be instructed to fold their papers into squares. Ideally there should be one more square than number of participants: i.e. 8 squares for 7 participants. However, the activity can be adapted. Participants start a story in the first square and then pass it on to the next participant. The next participant draws in the second box and then passes the drawing again. The images rotate until they return to the original artist. The artist then completes the last image to complete the story. Next, participants write out what the story has to say in their journals. This activity can be repeated without folding the paper into individual squares as well, so that mark making from individuals interacts more closely. Again, participants are invited to write out the story in their journals once they receive the final image.

Week 6: Doll-Making

The doll-making workshop involves creating a small fabric doll, using a simple wrapping method. The aim is to foster a sense of wholeness of mind and body, as the process itself is like “mending” and the product like a talisman. The materials needed are pipe cleaners, scrap fabrics, stretchy tights or nylons cut into strips, beads and other

adornments, wool, glue guns and any other objects that participants would like to incorporate into the doll. The process begins by creating a pipe cleaner skeleton, and then participants can flesh their doll out by wrapping the limbs with layers of fabric and secure the fabric with a glue gun. Stretchy tights or nylons work really well. Participants can then add fabrics for clothing, jewels, and wool for hair. This is a framework to start from, but the dolls can be built in whatever creative way participants choose. Another suggestion is for participants to write intentions for their doll on small pieces of paper and then wrap them right into the doll's body so they are kept safe within the doll as hidden messages. These intentions could be anything from wishes for healing, empowering messages for the self, secrets, mantras, or prayers. Doll-making is a longer process than other activities so the writing portion will occur in the following session.

Week 7: Telling the Doll's Story

This week participants will continue with the doll and create a story about their doll. They can think of the story as a fairy tale or myth of their character. The aim of this workshop is to build a story that participants can identify with from the safe projective distance of using a doll and thinking of it as a fairy tale or myth about the doll as the main character. Participants could also choose a fairy tale or myth they are familiar with to draw inspiration from. Brun (1993) has stated that the archetypal themes in fairy tales allow for clients to work through personal crisis with a sense of protection. Stories can bypass defenses and bring to light those aspects of consciousness that are beyond awareness. The story can be written, drawn, collaged, or painted. Participants may want to create a small book or scroll. At this point in the program participants will be more

comfortable with the materials and can freely choose their media for expression. At the end of this session participants are invited to share their dolls and stories with the group.

Week 8: Mapping the Journey

This last session is dedicated to closure. Clients can look over their work and reflect on the experience of art therapy. After looking over the art from all the sessions, participants will be invited to create a closing image that “maps the journey” of the eight weeks. The participants are free to choose their own art media. The goal of this last day is to close the group and to reflect on the process. Open-ended questions that could be asked are: “did you experience any change?”, “how was your experience of art therapy?” or, “did you learn anything about yourself?” Also this is a time where participants can say what they liked or didn’t like about the program. At the end, participants can bring their artwork home with them, and will be able to keep tangible visual records of their 8 week journey through art therapy.

Role of the Therapist

The role of the therapist in this program is to support the individual participants on their journeys and also to facilitate the group process. The approach of the program is more “art as therapy” and studio based, rather than the in-depth process of more long term psychotherapy. This means much of the group time is focused on studio work, although the frame of therapy and the presence of a therapist will differentiate the group from a recreational art group. The therapist is responsible to introduce the art therapy space as a supportive and non-judgmental environment where participants are free to express any images they need to express. The focus is on the creative art process, rather than on art product. As participants may be vulnerable, may be recovering from medical

treatments and may be experiencing psychological distress it is important that the therapist be sensitive to the issues women with breast cancer encounter. The therapist must support and encourage the group to support anyone who is in distress during the group process. The therapist can communicate that it takes great strength to share difficult stories, that these stories are acceptable in the group and that they remain confidential. Art therapy is a place where the negative and the positive can be expressed; there is no pressure to “be positive”. This is a space where women can support each other and tell the stories they wish to tell about their journeys through cancer and through life.

The structured activities are geared towards the program’s goals and encourage storytelling through varied media such as painting, drawing, and collage, sculpture, doll-making and writing. At the same time the activities are open-ended enough so that participants can make their own empowered choices of subject matter and materials they wish to explore. It is possible that there will not always be time to complete the activity each session. The therapist can be flexible and allow for more time in the next sessions if needed, or drop an activity if participants need more time to work on something. It is important, however, to maintain the frame of the opening ritual, the relaxation and the time at the end for debriefing. What happens during the studio time is guided by the participant’s creativity as much as possible, with the therapist assisting with materials and intervening only if participants are completely stuck for ideas.

Summary and Conclusions

My initial question, “how do I integrate theoretical knowledge and my experience as an art therapy intern to create an effective art therapy program for women who are survivors of breast cancer?” led to a process of weaving together several areas of

research, my experience in the cancer care field, and my personal creative reflections. My choice was to root the program in feminist and narrative perspectives as these views can capture the complexity of women's lived experiences. The therapeutic goals of this program, based on the needs of these women as identified in the literature, are to be an expert on one's own life story, to find personal meaning in the illness experience, to connect mind and body in the healing process, and to value a sense of self and to foster a sense of connection to others. This program could be implemented in cancer care in the future and could be evaluated by researchers, art therapists and participants themselves. The need for more patient-centered knowledge in the area of breast cancer can be addressed through this program by offering a space for personal storytelling. The answer to my research question has become a preliminary investigation as to how an art therapist could work with women who have experienced breast cancer. My hope is that the intervention will be an empowering experience where women can tell their own stories, find meaning in their illness, and experience transformation through creative expression.

This research would not have been possible without my experience in the classroom and especially in the art therapy room over the past two years of my learning. It is a culmination of making sense of the multitude of experiences I have shared with fellow students, professors and clients in therapy. I decided to focus on cancer research because I have been personally affected by family members and friends with cancer. This was the original reason, but with more experience I became more passionate about the cause of breast cancer. Breast cancer touches on many issues I find are troubling and perplexing in our modern society: femininity and what it means to be a woman, toxins in the environment, bodily and psychological trauma related to medical care, and ultimately

the question of death and dying. Mostly what inspired me to pursue this project were the women I worked with at the cancer wellness centre. Much of the program I built has resulted from trying art ideas in group and individual sessions and getting feedback on what worked and what didn't work. The sharing in groups was especially powerful as I became witness to the connection that women who have been through cancer can create together. I witnessed women move from a sense of isolation and fear at the beginning of a group to developing a greater sense of connection to others and to building important new relationships. Women seemed to be able to relate strongly to each other in ways that were not possible with family members. As a therapist this was inspiring to witness and help facilitate. I have found that being able to make sense of a senseless event in therapy allows people to heal, whether that is by physically feeling better, by working on relationships, by improving self-esteem, by expressing emotions, or by dying with dignity and resolve. As a health care provider I strive to work towards the goal that women will have a stronger voice and greater choices in the care they receive and feel greater empowerment in telling their own stories of illness and health. Meaning making through personal storytelling is the vehicle that moves a person through a traumatic event and restores the life force. My hope is that in the future there will be even greater possibilities within and beyond the health care environment for storytelling.

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