

Art Therapy
A Viable Adjunctive Intervention for Adults Diagnosed with Cancer

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Abstract

Art Therapy: A Viable Adjunctive Intervention for Adults Diagnosed with Cancer

Shelley J. L. Cameron

Little has been published specifically on the practice and application of art therapy with adults diagnosed with cancer. Using a literature review as the primary methodology, this research explores the viability of the art therapy modality as an adjunctive intervention within the treatment plan of adults diagnosed with the disease of cancer. Situated within the context of "Medical Art Therapy", a broad but brief overview of the current practice of art therapy (and art as therapy) with this population within medical settings is presented. By examining the oncology patients' psycho-social issues/tasks of coping with pain, loss (bereavement), and (for some) terminal illness, within theoretical and practical application of art therapy frameworks, contributions to be made by this field's practitioners, within these areas of cancer treatment and care, are evaluated. Of the adjunctive art therapy pain intervention models described, that of Landgarten (1981) is the most comprehensive, encompassing, and replicable. Research conducted outside the field, by Bach (1966, 1975, 1990), Simonton, Simonton, and Creighton (1978), and Achterberg and Lawlis (1984)-- which laid the foundation for the examination of somatic and/or prognostic evidence in the art of individuals with cancer, and the studies which have followed by those within, are reviewed as possible art therapy assessment and intervention models. In conclusion, the main points of this research are reviewed, with additional criticism offered, and recommendations are made for future research.

This phase of my personal journey toward self-healing is lovingly dedicated
To the memory of my mother,

To my grandmother, uncle, friends Géraldine, Dorcas and My;
who have also been my sources of inspiration

And to each and every one of the individuals diagnosed with cancer
with whom I hope to practice as an art therapist in the future.

Special thanks to Jean-Eudes and Nicole
without whose compassion, generosity of spirit, and emotional support
this goal might never have been reached

TABLE OF CONTENTS

INTRODUCTION	1
METHODOLOGY	7
THEORY, AND PRACTICAL APPLICATION OF ART THERAPY	11
Art Therapy in the Context of Medical Settings	11
Psycho-social Issues/Tasks of Oncology Clientele	21
An Overview of Pain	21
An Overview of Loss	29
Terminal Illness	38
RESEARCH CONTRIBUTING TO SOMATIC AND/OR PROGNOSTIC EVIDENCE IN ART	48
Bach	48
Perkins	51
The Simontons	55
The Evaluation of a Cancer Patient's Mental Imagery Through Her/His Drawing	59
Achterberg and Lawlis	68
Graves	74
CONCLUSION	78
BIBLIOGRAPHY	92

INTRODUCTION

Ever since my official acceptance as a student enrolled in Concordia University's Graduate Art Therapy study program, one of my long-term goals has been, as a future practitioner of art therapy, to largely include adults diagnosed with cancer--females especially--within my clientele population. Like a great many others, my life has been touched by the devastating physical as well as psychological effects of this potentially life-threatening disease. Preceded by one of my father's brothers a decade or so earlier, over eighteen years ago, eight months after being diagnosed, my mother died of cancer during her fifty-third year of life. I was seventeen years old. Not long after, her mother was diagnosed with a different type of cancer which necessitated serious surgery. The cancer metastasized and she died. Within about the last five years, one of two elderly female friends has undergone the same or a similar surgery and the other has been treated with radiation therapy. When just over two and a half years ago, a dear girlfriend, only a few years my senior, received the diagnosis of cancer and had to have serious surgery, I began to relive some of the gamut of my earlier experience as an immediate family member, including feeling somewhat helpless in what seemed a hopeless situation and fearing the witnessing of a loved one's prolonged suffering. In addition, because of the similarity in our ages, I became faced with my own mortality. Furthermore, I have since experienced being informed by my physician that results from an annual check-up had revealed the presence of abnormal cells (therefore, potentially cancerous) within my own body. My response to the news, like that of many individuals who receive a diagnosis of cancer, was one of shock mixed with a deep fear. After agonized waiting for several necessary months, testing was repeated and to my extreme relief no irregular cells were present.

This renewed a feeling of passive victimization--helplessness (Dreifuss-Kattan, 1990; Kern-Pilch, 1980; Lichtenthal, 1985; Maguire, 1990), which may often be accompanied by hopelessness (Berenson, 1988; Hurny, 1990; Simonton, Simonton, & Creighton, 1978)--which I once believed, and as a result of my research now know, cancer

sufferers may also deeply experience. I want the fruits of my research herein and beyond to, ideally, bring to an end, or, at the very least significantly diminish this prevalent feeling. I believe that the practice of art therapy will provide both me, and my future adult oncology clients, with a forum which will empower me/us to play a more active role in contributing to the quality and, most likely related, hopefully, even the quantity of their daily existence. Admittedly, it is difficult to conceptually define the term "quality of life". However, using a modest and realistic approach to this issue, there appears to be a growing consensus among individuals within the framework of the health-care field that this is a multidimensional construct composed minimally of the patient's functional status, disease-related and treatment-related symptoms; psychological functioning, and social functioning (Aaronson, 1990). It is, largely, the subjective assessments by the individual with cancer as to where s/he is and where s/he wants to go in these domains which is being referred to here.

The origin of the personal motivation and the extent of subjective investment which compels my pursuit of the hypothesis of this paper--that art therapy is a viable adjunctive intervention within the treatment plan of adults diagnosed with the disease of cancer--are by now becoming evident. Both this research process and my determined interest in professionally pursuing the utilization of the discipline of art therapy within the treatment plan of adult cancer sufferers, are, in part, external means through which I hope to internally counteract and bring to a more complete, overdue resolution the painful experiences of my mother's diagnosis of cancer, her treatment, her suffering--physical and psychological, and eventual death. I am cognizant of the high probability of countertransference by identification with female cancer clients as maternal figures. I also feel, however, that these cumulative life experiences will provide me with the knowledge and a depth of understanding ensuring an empathic ground with my oncology clients which may be therapeutically invaluable for them. I am fully aware that these self-imposed tasks which lay before me probably fall within Maslow's and Polanyi's descriptions of

heuristic research as "acts of love" (as cited in Klein Parker, 1983) While these are not always comfortable, as is demonstrated in the writings of both Klein Parker (1983) and Moustakas (1967), I remain steadfastly guided by Joseph Campbell's advice to researchers--that of "follow your bliss" (P Grégoire, personal communication, Fall, 1994). The "thesis-equivalent" product resulting from this phase of my journey toward self-healing, represents my heartfelt desire as a student to make a contribution to the body of research informing the continued promotion and growth of the theory and practice of the field of art therapy

During the past two years' formal study within this university's graduate art therapy program, I never abandoned my original hope of eventually practicing as an art therapist with adults having cancer. This was despite the fact that the curricula and students' internship sites for the most part focused on the traditional practice of the profession of art therapy with psychiatric populations. Fortunately, I knew that the clinical work I am interested in doing has been done, by my first year internship supervisor, although he seems to be one of the few in Canada who has practiced art therapy with cancer clientele. Even from among the varied multitude of presentation offerings at the American Art Therapy Association's (AATA), twenty-fifth annual conference in Chicago in November 1994, to my extreme disappointment there was only one art therapist (American), known for her work within my clinical area of interest, speaking on this topic and promoting the therapeutic benefits for cancer patients (Malchiodi, 1994) Out of the over one thousand other conference delegates, there were only two additional individuals whose presentations were distantly related: one is an art therapist (Waller, 1994) and the other is not (Tartakoff, 1994). A fourth person, a Canadian art therapist named Judy Weiser, who practices with the oncology population using photography as the medium, was also in attendance. It was then that the extent to which, as a practitioner, I will be an art therapy pioneer became far more profound.

A brighter, more promising professional future, for an art therapist who wants to work with individuals with cancer, was reflected in a small portion of the 1995 AATA conference offerings. With the significant increase in art therapy-oncology presentations (now up to four in number--one designated a special lecture, and an additional pertinent day-long course--each briefly described in this paper's conclusion) came the delayed realization of the correlation between an annual conference's theme and its agenda. Last year's theme entitled "Weaving New Visions: Art Therapy in Collaboration with Allied Professions" had more specific relevance to my area of interest than the broader theme of the previous year "Reflecting the Past, Envisioning the Future."

There have been other sources of encouragement as well. Hoping to gain some exposure and experience in this area, my interest in working with cancer clients was made known. During the year of my first art therapy internship, my practicum supervisor presented me with the opportunity to work briefly with one of his clients who had cancer. She was an attractive, soft-spoken, middle-aged Greek woman with whom I met for about four sessions. To my disappointment, however, without explanation, she stopped attending.

Within the duration of this same internship, I enthusiastically attended, with the hope of gaining contacts as well as knowledge and further understanding, an on-site case-conference presentation given by Drs. L. Hoffman and N. Szkrumelak on the topic of cancer bone marrow transplant patients. It was reported that one adult case patient "when she felt debilitated due to her illness and/or chemo, would often withdraw into herself, using painting to soothe herself" (Hoffman & Szkrumelak, 1994, case-conference hand-out). This patient believed in color therapy as well, of which she seemed knowledgeable, and had been encouraged by the first mentioned physician to bring her art work in to the hospital. She agreed to his suggestion that her art could be used to prepare her for the transplant. This process encouraged the patient to come to her own understanding of what her art revealed, she was offered help with interpretations of her

imagery, although not by an art therapist, and the art-making itself was therapeutically oriented. A few slides of her paintings were shared with the audience, and their content impressed me and was enlightening. I was excited by and hopeful of this seemingly successful merger of the medical knowledge, technology, and treatments and this creative, expressive therapy.

However, when Dr. Hoffman was approached by my supervisor as to the possibility of my participation as an art therapy intern with some of the hospital's oncology patients, the idea was turned down. Dr. Hoffman believed the medical staff would not be supportive. I then realized, disappointedly, there is still much progress to be made in bringing together medical practitioners' focus on the physical/technical aspects of disease treatment and belief in and acceptance of the necessity of attention to their patient as a person, which art therapy as an adjunctive intervention modality can provide. Preparation for the successful promotion of the practice of art therapy's applicability within a medical context seemed dependent upon learning much about "the other's" setting, practice, beliefs, clinical objective, and facilities, and determining how to bridge the gap between delineation of medicine and mind, that is, body and psychotherapy.

Having stated in this introduction my personal position, which has informed the content of this research paper, I will now proceed by describing the accumulative process of this research paper's methodology. A private review and examination of the many aspects of my past oncology experience, supplemented by my familiarization with the work of the Simontons (Simonton, Simonton, & Creighton, 1978)--the philosophy and theory underlying their psychological approach to the treatment of cancer, and its practice served as a foundation from which to begin. A succeeding search for more literature of relevance to my hypothesis, primarily by practitioners within the field but including that of a few without, culminated in this research paper's ensuing primary literature review. This is composed of individual, consecutive discussions of the oncology population's very important psycho-social issues/tasks of coping with pain, loss, and (for some) terminal

illness--each of which will be presented within a current theoretical as well as an art therapy practical application framework. Preceding these will be a similarly presented broad but brief overview of the current practice of art therapy in the context of medical settings, which serves as a contextual introduction. Presented next will be the research conducted primarily by Bach (1966, 1975, 1990), (Perkins, 1977 and Cotton, 1985), the Simontons (1978)--the guided imagery and visualization which they developed specifically for cancer clientele, Achterberg and Lawlis (1984), (and Graves, 1982)--all of which investigates the somatic and/or prognostic evidence in the art primarily of individuals with cancer. In the conclusion I will review the main points of this paper's individual sections, offer some criticism, and make recommendations for future research.

METHODOLOGY

This research paper's methodology, outlined below, comprises numerous consecutive procedural steps. The research process began with using myself as a primary source of information, and documenting exhaustively from memory the range of personal as well as interpersonal experiences and observations from onset to end of my mother's illness, an emotionally difficult, but beneficial purging/cleansing task. Reflecting upon these, hypothetical explanations and possible immediate and long-term effects on myself as well as members of my family were then considered. As I proceeded it became clear that what over half my lifetime ago I considered a very personal experience, to which my mother's and family members' privacy was consciously desired and protected, to my surprise today inspires similar response to a significantly noticeable degree. However, suspicious that many aspects of my oncology-related experiences and observations are generalizable to those of others confronted with similar circumstances, the aim of this taxing, insight-provoking review exercise was to enable me to identify prominent issues which could be purposefully examined within the context of this, and possibly future, research. Next I considered and recorded how art therapy as an adjunctive intervention within the treatment plan of adults diagnosed with cancer might be psychically as well as somatically beneficial and rewarding to such clients.

Close examination of the seminal work of the Simontons, originally known to me only by name and reputation, and for the fact that their cancer treatment program includes a drawing component, now seemed a natural direction in which to go. Carl Simonton, a radiation oncologist by profession, and psychologist Stephanie Matthews-Simonton are the founders of a widely recognized Cancer Counseling and Research Center in Fort Worth, Texas. Their work is firmly grounded in mind-body communication. A classic text on the psychological causes and treatment of cancer, their fascinating and inspirational book entitled Getting Well Again: A Step-by-Step, Self-Help Guide to Overcoming

Cancer for Patients and their Families was co-authored by close associate James Creighton

An initial browse through the Simontons' book grabbed my attention as its contents seemed to be about my past oncology experiences and, to my joy and relief, to address all of the questions, beyond the scope of this paper, to which I so much wanted answers. Informing myself of the Simontons' already publicly and professionally accepted philosophy, theory, and practice served as a useful foundation from which to further expand my knowledge. Their holistic, in their words, "whole person approach" to cancer sufferers' treatment matches my personal sensibilities and care-giving philosophy. In addition, their cognitive-behavioural based treatment program gives cancer patients the opportunity to play a proactive role in their desirable recovery from disease which appeals to me. I hope that some of what I learned may be applied to my future goal of practicing art therapy with adults with cancer.

The succeeding research phase was a literature search beginning with the pursuit of journal articles, or the like, specifically documenting the practice of art therapy with adult oncology clients, including those terminally ill. I wanted to know if such clinical work is being done, and is being written about. If so, in what kind of sites, where on-site, within what context, and with what oncology diagnostic populations is it being practiced? Also, what art therapy approaches/interventions and media are being utilized and for what clientele and with what frequency? A minimal number of resources were located (Kern-Pilch, 1980; Lichtenthal, 1985, Rudloff, 1985, UCLA Jonsson Comprehensive Cancer Center, 1983). Testimonial articles by two women who on their own have effectively used art expression as a means of coping with, and processing, their serious bouts with cancer were also found (Crawford, 1991; Lynn, 1995). A search then ensued for articles including reference to the profession's intervention with cancer clientele, adults especially, but in general as well (Mango, 1992b, Musick, 1978, Petzold, 1982).

Much to my surprise and enthusiasm, in the process, my search uncovered a few articles discussing the existence of a branch of art therapy heretofore unbeknownst to me-- that of "medical art therapy", that is, the practice of art therapy within medical, as opposed to psychiatric, settings (Malchiodi, 1993a,b, Rosner David, 1995)

In addition, more subject relevant resources were gleaned from some articles (Bach, 1966, 1975, Mango, 1992b; Minar, 1992; Minar, Erdmann, Kapitan, Richter-Loesl, & Vance, 1991) These included more books, by art therapists as well as others outside the field, which explore the use of art therapy or art expression, primarily drawing, with individuals suffering from cancer, or the physically ill. A selection was made of those which appear the most relevant to my hypothesis (Achterberg & Lawlis, 1984; Bach, 1990, Dreifuss-Kattan, 1990, Siegel, 1986, 1989)

A review of the presentation abstracts from within a selection of American Art Therapy Association annual conference proceedings exposed a few other related resources as well (Baron, 1987, Effler & Sestak, 1978, Graves, 1982, Halperin-Eaton, 1987; Jeppson, 1983, Kurtz, 1978, Perkins, 1977, Ravenscroft, Bruhn, Sims, Datel, & Jensch, 1979, Rosner, 1982, Wolf, 1979) As will become clear in my review of the literature which is to follow, within the context of oncology, there is much more written about art therapy practice (Cotton, 1985; Council, 1993, Ravenscroft, Bruhn, Sims, Datel, & Jensch, 1979, Scudder Teufel, 1995, Sourkes, 1991) and research (Graves, 1982, Perkins, 1977) with the child population/pediatrics than with adults. Fortunately, where deemed appropriate extrapolations to the latter age group have been made from this literature.

The final stage of my research methodology initially entailed a review of the issues I earlier identified as being prominent in my personal experience of witnessing a loved one suffering from the disease of cancer. Next, issues which are recurring in the research literature sources were determined. Three common areas of concern were then chosen to be elaborated upon in theory and practice. These are the cancer patient's pain, experience of losses, and (for some) terminal illness. In addition, due to the exciting assessment, and

intervention possibilities opened up for the art therapy practitioner by the literature examining somatic and/or prognostic evidence in the art products of individuals with cancer, a review of this subject was added. A second literature search was initiated to locate relevant supplementary support sources.

THEORY, AND PRACTICAL APPLICATION OF ART THERAPY

Art Therapy in the Context of Medical Settings

"[I]t is certain that art therapists have been active in providing their services to a variety of patient populations in medical settings" (Malchiodi, 1993a, p 66) 'Medical art therapy' is the term which "has been applied to the specific use of art therapy with individuals who are physically ill, experiencing trauma to the body, or undergoing aggressive medical treatment such as surgery or chemotherapy" (p 66) A more precise definition for the practice is unattainable as "medical art therapy varies as much as the practitioner, the population, and the setting in which it is presented" (p 66). The goals of medical art therapy are achieved by utilizing expressive modalities to meet an ill person's needs for exploration of her/his disease experience in a way that is most comfortable and accessible (Malchiodi, 1993a) This seems to encompass any hospitalization as well as rehabilitation and, if necessary, impending death.

The horizons of the field of art therapy are continuing to expand. Over the last two decades, numerous art therapists have contributed knowledge on the application and efficacy of art therapy with individuals suffering from arthritis (Lusebrink, Turner-Schikler, & Schikler, 1992); acquired immune deficiency syndrome/AIDS (Piccirillo, 1995, Rosner David & Sageman, 1987; White, Fenster, Franklin, Rosner David, & Weiser, 1991), asthma (Gabriels, 1988); burns (Appleton, 1993, Levinson, 1986; Levinson & Ousterout, 1979; Russell, 1995); endometriosis (Bernstein, 1995), tuberculosis (Rosner David & Ilusorio, 1995); intestinal problems (Lillitos, 1990); and, most relevant here, cancer (Baron, 1987, 1989; Cotton, 1985; Council, 1993; Dreifuss-Kattan, 1990; Jeppson, 1983; Kern-Pilch, 1980; Mango, 1992b; Minar, 1992; Minar, Erdmann, Kapitan, Richter-Loesl, & Vance, 1991; Perkins, 1977; Rudloff, 1985; Scudder Teufel, 1995; Sourkes, 1991).

A great many of these new applications of art therapy may stem from the "relatively recent developments of liaison psychiatry, that branch of psychiatry which deals

with the psychological adjustments and sequelae seen in the medically and surgically ill" (Effler, & Sestak, 1978, p. 56) "It stresses recognition and expression of feelings related to hospitalization and illness, encourages social interaction and formulation of supportive relationships, and provides appropriate mechanisms for the handling of stress" (Kern-Pilch, 1980, p. 3). Kern-Pilch outlines, as follows, the roles played by an art therapist within this context. S/he assists the communication between the patient and her/his family and members of the medical staff and brings the concerns of the patient into sharper focus, plays a significant role in providing the patient with psychological support, becoming a trusted ally who sympathetically listens to her/his fears and doubts and helps to alleviate them; s/he supplies the patient the opportunity for expression, through art, and an energy outlet for vocational and avocational normally channeled activities which sustain her/his sense of personal worth and with this comes the fulfillment of the human needs of choice and control, at a time when these are limited due to illness and hospitalization. The patient's art-making serves as a self-enhancing, strengthening, and self-satisfying outlet for positive expression of energies that might otherwise find expression in the patient in negative ways. (This issue is addressed clearly within the case study by Rudloff (1985)) In the process, the patient is given an alternative focus away from her/his health condition and can give to others out of her/his healthy self. Contact with other patients and staff is facilitated, as is a more active patient role in recovery.

Malchiodi (1993b), on the other hand, associates medical art therapy's rapid emergence as an important treatment modality in the field of arts medicine with the advent of psychoneuroimmunology and the ever-growing interest in the mind and body connections. The aforementioned scientific discipline is defined by Lerner (1994) as "an interdisciplinary field of study that proposes that the mind, the neurological system, and the immune system are a deeply interrelated single system" (p. 19). This is what the Simontons and Achterberg and Lawlis advocate. They would definitely agree with Lerner (1994) who elaborates, stating that "in [this] and allied fields of behavioural medicine and

health psychology, a growing body of research has indicated that is often *matters* to the physical course of disease what is happening in the emotional and mental processes of the patient" (p 19)

Council's (1993) statement that "traditionally, art therapists have used [patients'] artwork to identify psychopathology and to resolve internal conflicts" (p 78) seems in agreement with that of Musick (1978)--that "art therapy has been used mainly to assess and treat difficulties primarily psychological in their origin" (p 63) Elaborating, Council (1993) writes that "the medical patient, in contrast, may not only need to resolve internal conflicts, but also to negotiate physical illness and/or disability so that she or he may continue to grow and develop as a person" (p 78) Malchiodi (1993a) explains,

"There are distinct differences between art therapy conducted in a psychiatric milieu and art therapy in a medical setting [M]edical settings may have different objectives than psychiatric milieus, one obviously being the primary concern for the physical care of the patients Although psychological dimensions of treatment are important in a medical setting, the first goal is to expediently treat the presenting illness or physical condition." (p 66)

As to "the use of drawing to assess and promote physical (as distinguished from mental) health [the subject of a later section of this paper, this] has not been studied extensively." (Musick, 1978, p 63).

Since patients in a medical setting are, by definition, medical patients, art therapy is never the primary intervention (Effler & Sestak, 1978). In agreement, Council (1993) writes "In the medical setting, art therapy may be considered as an adjunctive treatment, since patients come to the hospital primarily for medical treatment" (p. 78). Therefore, art interventions must be designed to be in accordance with and complementary to the overall medical treatment of each individual patient All parts of the patient's experience must be addressed in order to facilitate her/his optimal coping and readjustment. This requires the art therapist to be knowledgeable of the particular illness, its conditions, treatment, the client's medical status--physical as well as psychological, hospital routines, procedures

involved in each individual case. It is these elements which have a strong influential effect on the client's creative process and products, as well as the art therapist's intervention.

Both art therapy, a professional domain, and art as therapy--something "artists have instinctively known for centuries of natural healing tradition" (Weiser, 1991, in Crawford, 1991), are definitely being utilized as adjunctive intervention modalities within the treatment plan of adults who are suffering from cancer. Both adjunct individual and group art therapy interventions are currently being practiced with adult male and female in-patient as well as out-patient oncology clients, in a variety of sites and, in a couple of cases, even in the person's home (Cotton, 1985, Dreifuss-Kattan, 1990, UCLA Jonsson Comprehensive Cancer Center, 1983), both as crisis care and long-term psychotherapy of several months, before, or after, any one or a combination of the three traditional medical cancer treatments of surgery, chemotherapy, or irradiation. Session frequency ranges from everyday to once or twice per week, with duration of ten to fifteen minutes up to two and a half hours. Clients range in age from young adult to geriatric. Of these clients, the types of cancer included lung cancer, adrenal carcinoma, breast cancer, gynecological cancer, a brain tumor, osteogenic sarcoma of the knee (a type of bone cancer), leukemia, cancer of the bladder and rectum, lymphoma, Kaposi's Sarcoma, and metastatic cancer--in varying stages of progression, with varying prognoses.

Art therapy and art as therapy are being conducted in a variety of on-site locations. These diverse therapeutic spaces, the approaches/interventions utilized therein, the art activities and the media available, as well as the physical and psychological conditions of these differing client populations are largely interdependent. Out-patients offered the opportunity of doing art as therapy, for reasons of emotional security possibly, seemed to prefer not to venture far from the waiting room area in order to do so, even when a more spacious, semi-private art-making space is available (UCLA Jonsson Comprehensive Cancer Center, 1983). Continuity of the creativity location, the therapeutic, non-threatening art experiences and supplies between weekly or less frequent appointments

seems most suitable for clients. The group atmosphere of such a potentially busy and open public arena dictates that the art-making be tidy and quietly engaged in so as not to be intrusive to non-participants who are present. In addition, these activities should be highly appealing, spiritually elevating, have the capacity to distract [from, and temporarily relieve, patients' physical and emotional distress, during what can be an uncomfortable anxiety-provoking waiting period], [due to hospital routine and medical procedure interruptions] be possible to complete in a short period of time, have a high probability of success [so as not to further injure these patients' already shattered self-esteem], and be easily transportable by the patient when s/he is ready to leave (Jeppson, 1983, UCLA Jonsson Comprehensive Cancer Center, 1983)

Art therapy has been especially recommended for out-patients who have come to a site to receive infusion treatments of anti-cancer drugs, a process requiring several hours and marked by boredom (UCLA Jonsson Comprehensive Cancer Center, 1983)

Neither the out-patient waiting room environment nor the art created within it by this group of cancer patients easily fosters many traditional art therapy techniques (Jeppson, 1983). These individuals have not actively sought such intervention as part of their treatment. Focusing on interpretation of their imagery, unless initiated by the patient, might be seen as intrusive and unwelcome, adding to their anxiety (UCLA Jonsson Comprehensive Cancer Center, 1983). "It [is] not advisable to encourage [these clients] to look inward or to deal directly with their pain, or to attempt, in this unprotected space, to help them loosen their defenses in order to come to grips with their situation" (Jeppson, 1983, p. 46). Therefore, "crafts production may be the most efficacious concept for clinic waiting room activity (and some in-patients) [parentheses added]" (UCLA Jonsson Comprehensive Cancer Center, 1983, p. 14). Patients, with a variety of short-term art projects that have a visible end, are helped to both establish realistic goals (Brechner, 1981, in Jeppson, 1983) and to defocus their attention from long-term goals they cannot achieve (Brechner, 1982, in Jones, 1982). Applying the humanistic, Rogerian client-

centered psychotherapeutic approach seems the most appropriate in this setting (Jeppson, 1983; UCLA Jonsson Comprehensive Cancer Center, 1983) The cancer patients are supplied with a forum in which they can guide the course and content of their self-expression and interaction with the art therapist, thereby nurturing her/his feelings of control of her/his situation The latter takes on a very reflective stance, furnishes ego support and encouragement (Jeppson, 1983) and "help[s] the patient to clarify and gain insight into his/her . . . problems" as he/she is psychologically ready and willing to do so (UCLA Jonsson Comprehensive Cancer Center, 1983, p. 5) "When art therapy is used with a client-centered model, it may be used either as a stimulant or a facilitator to initiate dialogue or to add a graphic dimension to the clarification process" (p. 5)

For out-patients within their home setting even arts activities engaged in on one's own seem to "have a powerful meaning, a reaffirmation of hope and expressiveness, even when little strength remains" (UCLA Jonsson Comprehensive Cancer Center, 1983, p.14). They may also serve as "strong motivational forces for individuals who are recuperating, clearly not dying, as well as for persons who are close to death" (p. 14)

Art therapy is also practiced with oncology in-patients, on wards, at bedside, including within medical and surgical intensive care units and protected as well as infectious isolation rooms where they are administered potent anti-cancer drugs An open studio approach has seemed appropriate for patients who show an interest in working with art materials and want some degree of socialization, as long as the individual patients' problems and needs could continue to be adequately addressed within this context (Effler & Sestak, 1978).

At least one site provides each of its in-patients who will be hospitalized for a while with small journals with blank pages and traditional art materials such as watercolors and pens, which they are encouraged to use to draw pictures (Jeppson, 1983) Products made by patients between sessions with the art therapist are discussed as the patient desires. A portable art cart, baskets or binders are being used to make the art therapist's

task of transporting art supplies easier. Patients may have available to them large, lightweight, easy to manage lap-boards, with clips to secure the paper in place, as well as easels. Color paper, pre-cut in small sizes and small natural materials such as leaves, shells, pressed flowers are being used in collage work, to design greeting cards, bookmarks, cards. Even miniature flower arranging activities and small terrarium planting projects are engaged in. Patient interest in fabric and liquid paint for creating embroidery images has also been shown (UCLA Jonsson Comprehensive Cancer Center, 1983).

Sessions with in-patients may tend to be longer in duration than those with out-patients. The length of these individuals' stay, which may vary from one or two days to a week to ten days, or a few months or more, largely determines the extent to which a therapeutic alliance is built. As is the case with out-patients, the presence of accompanying parents, siblings, and/or friends may hinder this process, and patient confidentiality and boundaries cannot be easily maintained within such a non-traditional, less contained, therapeutic framework.

How the individual with cancer feels physically and/or psychologically may fluctuate from session to session, and this must be taken into consideration. Her/his decision as to participate or not must be respected. The art therapist may need to assist a patient in her/his physical involvement, making necessary, sometimes innovative adjustments, either because of the limitations of the patient's bodily condition, or accompanying medical apparatus, such as an IV pole, and with the choice of media, tools appropriate to the circumstances. There are times when the art therapist may help a patient get started, or may create alone, with a patient watching on. S/he can serve as a model to the client, preparing her/him for what is involved once s/he is willing or able to participate, possibly removing some of the anxiety or fear of trying (Kern-Pilch, 1980). A client can also direct the art therapist's choice of materials, colors, subject matter, and placement. Sometimes the patient eventually is drawn into the activity and will end up

finishing what the therapist started. Doing something creative together is another possibility.

For cancer patients who are hospitalized in reverse isolation rooms where they may remain for weeks, even months, coping with, and adapting to, the effects of institutionalization may be difficult Hill (1945), as cited in Rosner David (1995), wrote of his experience as a tuberculosis patient recuperating in a sanatorium "[I]t is true to say that a bed patient can be described as existing rather than living It is as an important spectator that the patient is forced to view events watching rather than participating in the daily round, like a frustrated witness at his own trial" (p 135) To these physically and emotionally isolated individuals art therapy intervention is critically important (UCLA Jonsson Comprehensive Cancer Center, 1983). To them there may seem to be nothing but unending time and to be able to become a participant in the filling of some of it seems welcomed. Hill (1945) also wrote, "I was increasingly aware that time, which had been 'marking time' for some weeks past was now definitely halted and stood still--very still! And with this dread realization came the happy discovery of how to set the pendulum in motion again, by the simple act of drawing--drawing the nearest objects to hand " (in Rosner David, 1995, p 135).

An art therapy program is somewhat constrained by maintenance of sound isolation principles which, for example, require that no organic materials be permitted and media be limited to pens, watercolors, brushes, paper--all of which must remain in the isolation room for sterility purposes The art therapist, who must first scrub and don a mask before entering the room, can be a much welcomed visitor, known by her/his eyes and hands For the patient who cannot see the face/identity of the art therapist (and for the therapist) the building of a trustful relationship can be difficult (Conlon, 1995) For the art therapist who has never personally experienced such *real* isolation and *real* ostracization because of "being different" from everyone else, empathy, at least initially, also may not be forthcoming (Conlon, 1995). "[M]ost important is the potential for using

the created art as media for communication" (UCLA Jonsson Comprehensive Cancer Center, 1983, p 3) and for building rapport with the therapist which is useful when the patient is ready to verbally communicate (UCLA Jonsson Comprehensive Cancer Center, 1983) Neither external disruptions to sessions nor a lack of their regularity and continuity are major issues in working with these patients

In hospice services for individuals with cancer "traditional art therapy may not have a clear role but arts activities do" (UCLA Jonsson Comprehensive Cancer Center, 1983, p 10) Dreifuss-Kattan (1990), on the other hand, does practice traditional psychoanalytic art therapy with terminally ill cancer patients, at times even within the sick person's home Serving as a theoretical framework, the role of the process of creative expression in illness is interpreted by Dreifuss-Kattan (1990) "in terms of psychological self-repair in the face of multiple losses and as reparation in view of one's own death, that is, as a means of unconsciously connecting with an intact inner good object" (p xiv) This psychooncologist sees the process of art psychotherapy as being analogous to the theory of Winnicott (1971) In her writing, focusing primarily on adult cancer patients, Dreifuss-Kattan (1990) states that the art work which a client creates exists in a transitional space (the area between her/his subjective world and external reality as represented by the art therapist) and becomes, for the client, an invested transitional object, keeping separate yet interrelating these inner and outer realms The investigation and interpretation which a client's tangible projections of her/his inner images allows provides her/him, within the safety of the confines of the creative process, with psychological support, and facilitates a mutuality between the client and the therapist This engenders the development of a primary partnership between these individuals, resembling the relationship between the playing child and her/his available, yet unobtrusive, mother. The terminally ill patient can, through creativity, express the, at times, overwhelming separation anxiety evoked by her/his impending death. "Within the context of the transference... [which expectedly emerges within the therapeutic relationship] the [art work] . becomes a safe playground

for the patient to exhibit his inner world and to alleviate separation anxiety, fear of loss, and fear of death" (Dreifuss-Kattan, 1990, p. 212) By accepting and mirroring back a client's anxieties, the art therapist enables the patient to reintroject them, that is, to assimilate them as part of a genuinely supportive experience. The cancer patient can more deeply overcome her/his separation anxieties by introjecting the therapist as a good object, with whom s/he has bonded.

"Within the art therapeutic treatment the therapist contains what has been put into her by the patient and so becomes the equivalent of a good mother who provides a safe space, a framework, and a medium where the patient threatened by death can move freely between illusion of union and the fact of separateness, as happens in the transitional phase of infancy" (p. 212)

In writing about the interpersonal dynamics associated with the leukemia patient, Dreifuss-Kattan (1990) describes these individuals' tendency to unconsciously experience powerful but ambivalent wishes for a psychic reunion with the lost, good object and to seek reattachment to it via the external world, by establishing a protected, secure, significant relationship with someone else. The psychotherapist may be viewed as the embodiment of the totality of the healthy parts of the patient's self (Dreifuss & Meerwien, 1984a, in Dreifuss-Kattan, 1990, p. 191), yet the wish for a merger with her/him may be denied by the patient because of the threat it poses to her/his psychic integrity, and independence, both already significantly diminished by her/his illness evoked regression. However, the patient's art work, functioning as a transitional object, helps to guarantee the required inner distance from the therapist, thus avoiding fusion and preserving the client's desired measure of autonomy.

The terminally ill cancer patients' art works, representations of the client-therapist bond, may also function as good-bye gifts and, because of their ability to out-survive the dying individual, an ensurance of her/his most common fantasy--immortality. This can lessen the fear of death which is experienced by all cancer patients, independent of their illness prognoses (Dreifuss-Kattan, 1990).

Another unique benefit of the profession of art therapy, in treating individuals with cancer, is the therapist's ability to recognize and mirror the client's creative expression of split-off feelings, such as anger and jealousy, which might otherwise be repressed or denied, and make these accessible so they can be worked through and integrated. With the therapist being experienced by the patient as a good, intact object, which her/his negative feelings cannot destroy, the cancer patient's defense against such strong emotions can be relinquished. This results in her/his sense of emotional freedom, which can facilitate the task of self-repair. The disease of cancer threatens sufferers' sense of self and is experienced as a narcissistic lesion. One of the art therapy discipline's principal tasks is to attempt "to reveal the intact, healthy, creative parts of the self, disclose them to the patient and thus heal the rift" (Dreifuss-Kattan, 1990, p. 190)

Psycho-social Issues/Tasks of Oncology Clientele

Experiencing physical pain, loss (bereavement), and (for some) terminal illness have been identified as prominent realities within the lives of individuals having cancer, based on my past oncology experience and repeated references to such within the literature. Each of these psycho-social issues/tasks will be chronologically examined within this section of this research paper--first, within a theoretical, and then a practical application of art therapy, framework, for the purpose of illuminating the valuable and diverse contributions to be made by this modality within these areas of oncology patients' treatment and care.

An Overview of Pain

Numerous articles by art therapists (including Dreifuss-Kattan, 1990, Jeppson, 1983, Lichtenthal, 1985, Ravenscroft, Bruhn, Sims, Datel, & Jensch, 1979, Rudloff, 1985, UCLA Jonsson Comprehensive Cancer Center, 1983), other professionals working with oncology populations (Aaronson, 1990, Cunningham, 1992, Holland, 1990, Simonton,

Simonton, & Creighton, 1978), a cancer survivor (Crawford, 1991), and a journalist (Jones, 1982) confirm that individuals with cancer may experience physiological, in addition to, psychological pain

The major fear of all cancer patients is that they will have to endure physical pain (Holland, 1990) In fact, this symptom is often the most frightening aspect of these individuals' disease (Simonton et al , 1978) When pain is experienced it is often fearfully associated with recurrence or metastasis (Simonton, Simonton, & Creighton, 1978) and illness progression itself is perceived as synonymous with devastating pain, inadequately relievable (Dreifuss-Kattan, 1990) Pain makes cancer patients feel powerless (Dreifuss-Kattan, 1990)

In actuality, not all cancer patients suffer from pain which is physiological in origin--some experience only minor discomfort (Jeppson, 1983), and the frequency of this population's physical pain is not as great as generally perceived (Holland, 1990) "Each form of cancer has its own natural history and characteristic behavior Similarly, each therapeutic intervention carries with it specific toxicities" (Aaronson, 1990, p 101) Nevertheless, pain is included within a core set of identified physical symptoms which are commonly reported by cancer patients, either as a result of the disease or of the treatment (Aaronson, 1990) The incidence of pain is largely determined by the primary site of the tumor (Dreifuss-Kattan, 1990), with pain usually the result of such a growth pressing on bones or nerves (Jeppson, 1983). Fifteen percent of individuals in the early stages of this disease, and sixty percent of those with metastasized cancer suffer pain (Holland, 1990) According to Twycross (1980), as cited in Dreifuss-Kattan (1990), during the terminal phase of this illness the latter percentage of persons experience severe pain, with possibly a third of these dying with it unrelieved Twycross (1984), again cited in Dreifuss-Kattan (1990) states that in cases of leukemia and lymphoma pain is relatively unusual, in people with primary bone tumors, cancer of the buccal cavity, and genitourinary cancers it is

more common--eighty-five percent, eighty percent, and seventy-five percent (males); seventy percent (females), respectively

"Pain is a dual phenomenon consisting of both the patient's perception of the sensation and [her or] his psychological reaction to that sensation. One's pain threshold varies according to one's mood and...morale" (Dreifuss-Kattan, 1990, p. 107). The emotional states of anxiety and depression, which can result from experiencing pain, can modulate the intensity of the cancer sufferer's pain (Dreifuss-Kattan, 1990). They can cause muscle groups to tense, which, in turn, increases pain (Jeppson, 1983)

In addition to hurting, pain can also cause the cancer patient to experience additional symptoms, including any one, or a combination, of the following: insomnia, anger, irritability, agitation (Holland, 1990; Jeppson, 1983) and hunger or inability to eat (Jeppson, 1983), which can have an effect on the cancer sufferer's quality of life and her/his ability to cope and adjust.

Distinguishing which real, tangible elements of a cancer patient's pain are physical and which may be psychological is almost impossible. Therefore, the treatment of pain must take into account both a patient's physical state and her/his emotional state (Simonson, Simonton, & Creighton, 1978). "Ignoring mental and social factors [in intervention] may result in an otherwise relievable pain's remaining unameliorated" (Dreifuss-Kattan, 1990, p. 107).

Within several of the optimal management of pain approaches including pharmacological, psychological, and behavioural, as well as rehabilitation to effect its control (Holland, 1990) art therapy, as an adjunctive intervention, has a place. The successful adjunctive pain management interventions utilized by art therapists Shapiro (1985), Landgarten (1981), and Halperin-Eaton (1987) are those which will be described herein. The first three applications although specified for chronic pain patients, seem like they could also be beneficial for oncology clientele experiencing pain of a lesser extent. In addition to the similarities between some or all of these modalities, which have yet to be

stated, each is firmly grounded in mind/body connection Halperin-Eaton (1987) states that art therapy is acknowledged as a catalyst to enhance this.

All three of the modalities to be described have the same goal, which is to help clients make the connection between their somatic pain and psychological aspects of their life, thereby fostering a new understanding of their symptoms and pain This results in the therapist and clients' mutual desire of minimizing or dissolving the latter's pain and decreasing or, ideally, eliminating the patient's dependency on medication and improving her/his quality of life. The potential for cancer patients to develop an addiction to drugs needed for control of pain, a concern of the medical establishment (Rudloff, 1985), as well as the patients themselves is thus addressed (Jeppson, 1983)

Of these three "whole person" pain treatment approaches, that of Shapiro's multidisciplinary team is based on the alexythmia concept and the ideas of Menninger The former postulates that some individuals are unable "to release tension through verbal, gestural, or symbolic channels" and are left with somatic outlets as their only means of ridding themselves of stress (Shapiro, 1985, p. 44) Hence, their emotional conflicts seem to receive expression through physical symptomology Menninger (1938, in Shapiro, 1985), believes that an individual actively creates her/his illness, whether organic or psychological in origin, through "unconscious, self-destructive tendencies that they express either through conscious volitional acts or through unconscious attacks on the internal organs or some other part of the body", or both (p 44) Menninger (1938), as cited in Shapiro (1985), proposed "the totality concept in medicine" which is based on the idea that human organisms are the product of physical, chemical, psychological, and social energy--a possibility which Menninger states medical science does not ordinarily consider.

Shapiro (1985) furnishes her clients with "the opportunity to explore their lives and conflicts through metaphorical and symbolic representation--that is, through the art experience" (p. 45). She is very supportive and encourages spontaneous artistic self-expression, responds to any comments, the art process, and its imagery, evoked

According to Lesko, Massie, and Holland (1987); Pfefferbaum (1989), and Sanger (1991), as cited in Councill (1993, p. 79), "disturbances of body-image and self-esteem are reported to occur widely in cancer patients " Shapiro (1985) helps chronic pain patients to develop a stronger sense of self by activating their "imagination and creativity--healing forces in themselves whether or not their art products are talked about" (p 45)

A couple of techniques are employed by Shapiro. First, at the beginning and end of twelve individual one-hour weekly art therapy sessions she requests that her patients do three specific drawing tasks. These are to draw a person, a family activity with her/himself included, and a plant from observation--pictorial tasks believed to correspond with the client's body image, perception of family dynamics, and awareness of environment, respectively. Not a formal study, the therapist wanted to see if there was any detectable change in the imagery expressiveness over the course of treatment. In the end, the degree to which the artwork reflects resolution of the clients' problematic issues varied from client to client.

In addition, Shapiro encouraged her patient to describe physical pain using a drawing. When completed the patient was then asked to use different colors showing the degree of pain s/he felt in various parts of the body to create something more satisfying. In effect, the client is thus able to successfully deal with her/his pain by symbolically transforming it through an act of creativity. This is very similar to a technique used in the work of Halperin-Eaton (1987), which will next be described.

Halperin-Eaton (1987) describes group art therapy experience. Clients' day of physically strenuous exercise is followed by twenty minutes of highly structured relaxation exercise using the pain reducing techniques of Gendlin (in Halperin-Eaton, 1987): visualization, imagery and tension/reduction to attain the goals of increased imagination, and mind/body relaxation. To facilitate clients gaining "an awareness of pain or disease in its various stages and work towards increased states of health and attitude development"

(p. 41), the succeeding art therapy exercises are very similar to those used by Carl Simonton.

The imagery developed in the art therapy drawing process focuses on clients' coping strategies, the goal being to help them increase the availability of their inner resources and options for developing pain-coping skills. First, clients are requested to create a picture that reflects their experience. Similar to Shapiro's technique, these individuals are then asked what transformative quality her/his image needs to become more complete. Returning to their artwork, within it they further develop a source of healing or wellness that was previously absent.

Within Landgarten's (1981) multidisciplinary team approach to patients with chronic pain, the modality of art therapy is utilized for patient assessment/diagnosis, treatment, and prognosis for pain self-management, which is the ultimate goal overall. Clients are assessed in the initial session using the House-Tree-Person test. Three separate color pictures made of each of these are requested from the client, who is afterwards to free associate giving information about each one. When treatment is ending, this procedure is again administered in order to assess if the client has experienced any changes in body image, self-esteem, and attitude toward pain.

"The visual arts are...able to express abstract qualities and feelings with great precision, and...one of the hardest to describe, is that of physical pain" (Miller, 1984, p. 133). "[B]y itself a patient's [verbal] account does not always enable the physician to reach an accurate assessment of the intensity of [her/his] pain" (Dreifuss-Kattan, 1990, p. 107). To gain insight into the client's perception of her/his pain and to begin to deal with the pain and her/his attitude towards it, Landgarten asks the client to "draw yourself and your pain", thereby concretizing the pain. An on-going record of the patient's description of her/his pain is maintained by the therapist requesting, at various intervals, for the patient to "make a plasticene symbol of your pain today". The results serve as a source of comparison for both patient and therapist and as the latter's diagnostic tool.

To determine the degree to which a patient is preoccupied with pain the individual is requested to paint three consecutive pictures "of your own choice". The success of the self-management program can be seen when later the same requests reveal a change in the patient's free-choice subject matter, indicating interest in externalities rather than obsession with one's physical discomfort.

"Chronic pain patients frequently see themselves as passive victims with no control. They often experience their pain as an impingement from the environment" -- something which functions by itself and is to be alleviated by an external medical source (Landgarten, 1981, p. 351-352). It is, therefore, essential for the art therapist to help the patient see how her/his perception of the pain inhibits its self-management. First, the patient is instructed "to create a plasticene abstract symbol of your pain today". Then s/he is asked "to create an abstract form which stands for yourself", and finally, a role-play technique is employed. The client is directed "to give a voice to each art form"--one for the pain, the other for her/himself. A dialogue is to follow between the two forms. Whatever the art therapist's interpretation of the client's view of her/his pain leads to a discussion of pain self-management.

The art therapy autogenic training portion of this pain self-management program has four successive technical parts: a relaxation exercise; imagery induction; reinforcement of pleasant, painless feelings; and comparative assessment. For the patient to attain a relaxed or meditative state s/he is given Japanese watercolor brush, sponge, watercolors, felt pens and paper with which s/he is to slowly, leisurely paint broad horizontal bands of color with varying tones of greens, blues, and purples consecutively onto two separate pieces of paper. S/he is to concentrate all the while on each color's tone and intensity and how the paint spreads across the pages. Next, with her/his eyes closed, patient is instructed to mentally picture a pleasant experience of which s/he is then encouraged to verbally share the sensory details. Upon opening her/his eyes the client is asked "to record your active imagination through a painting." The third part of the client's

autogenic training serves to reinforce the positive feelings of the former pleasant experience. The client is asked "to use the plasticene to form abstract symbols of how you felt during the trip." Lastly, the client has an opportunity to see what gains s/he had made through these self-management techniques. Requested to "sculpt your pain" as it was before using one's active imagination and then after may reveal to the client that s/he had experienced practically no pain during the fantasy exercise. This may then engender in her/him a feeling of optimism in the growing ability for self-controlled pain reduction.

In addition to helping the client minimize her/his pain by self-management reinforcement, Landgarten (1981) states that the art therapist can also help the client gain insight into the "payoffs", or secondary gains of pain s/he may be experiencing. The patient is asked to "make a picture collage of the benefits of having pain" and may be surprised by what s/he reveals to her/himself. Dependency and resentment issues may surface and can be dealt with at a later stage in therapy.

Zittoun (1990) writes very briefly about secondary gains of cancer in general. Simonton, Simonton, and Creighton (1978) also state that physical pain may be means for a cancer patient to "benefit" from her/his illness. That is, it may serve a number of important psychological functions. "External rewards of pain" influence the patient's external environment--others and their behaviour toward the patient. Cancer patients' spouses and family members can unconsciously frequently reward their loved one for being ill rather than getting well by offering their love, support, and caring only until the patient regains her/his health. "Internal rewards of pain" for the patient can also exist. Physical pain may function as a diversion from examination of one's emotionally painful life conflicts. It may be unconsciously substituted for emotional pain because it is the more bearable, particularly if a patient fears s/he lacks the necessary skills to deal with emotional pain, or has no hope for conflict resolution. It may be consciously difficult to do but self-examination of one's possible "rewards" of physical pain can help a patient begin to alter her/his thoughts and behaviours which are contributing to the pain.

S/he may need to acknowledge that s/he is important, demand that her/his needs be met, and give self-permission to act in emotionally satisfying ways, so as not to have to continue to use pain as justification to have her/his needs fulfilled. A reduction in pain may be the result.

A cancer patient may be able to recognize that s/he is contributing to her/his pain by becoming aware of thoughts and/or reactions to life events which are occurring at the time the pain is experienced. Either exposure to stressful situations can be limited or a patient can change her/his response to these. An overall negative recovery expectancy may also be a contributor to pain. Once this has been identified by the patient as a pain influence, s/he has the ability to modify such thoughts. More regular practice of the Simonton's (1978) relaxation-mental imagery process (described on pages 57-59) can reinforce a positive expectancy. The patient's developing increased belief in health recovery may result in lessening her/his level of fear, thereby reducing muscle tension, and further decreasing pain (Simonton, Simonton, & Creighton, 1978).

An Overview of Loss

Confronting loss is an inevitable fact of life. Individuals with cancer may fear, and have to sustain, any number of stress-provoking losses, which are the consequences of the various stages of their disease, its treatment, and/or their hospitalization experience. Collectively, the writings of art therapists Malchiodi (1993a), Jeppson (1983), Rudloff (1985), Effler and Sestak (1978), Dreifuss-Kattan (1990), and Council (1993), to name a few, as well as a cancer survivor (Crawford, 1991), reveal that the feared and/or experienced losses of this population are psychological, physical, social, and/or behavioural in nature. They may include the cancer sufferer's loss(es) due to change(s) in self concept (feelings of self-esteem, self-worth; sexual self; competence); body image (body wholeness; bodily function, mobility); freedom of choice, independence, control; and lifestyle (familiar role(s) and expectations in personal relationships, at place of

employment, at home; family structure; separation from loved ones, income, recreation and leisure time activities). The effects of these often multiple losses can be frightening and overwhelming to a person with cancer.

"In adapting to losses, it is normal for a patient to experience grief" (Eifler & Sestak, 1978, p 57), and so, to be able to more fully comprehend this aspect of a cancer sufferer's existence the subject of bereavement has been examined. The literature available on art therapists' investigations of the application of their discipline with individuals going through such difficult grieving life experiences is limited (including Cocuzza-Zambelli, & Riegelman, 1981; McIntyre, 1990; Raymer & McIntyre, 1987, Simon, 1981; Speert, 1992, and (indirectly) Malchiodi, 1992). The literature also focuses most specifically on dealing with the loss of a loved one through death, and, primarily features intervention with child and adolescent populations. However, some useful information, relevant to the other kinds of losses formerly described, has been extrapolated.

A period of bereavement is a tumultuous, painful, albeit critical, time of healing entailing the rebuilding and reordering of the griever's world (Raymer & McIntyre, 1987). The predominantly written about symptomatic reactions to loss, which must be consciously experienced and gradually worked through in order for healing to take place, are anger, sadness, loss of self-esteem, and guilt. Depression, fear, helplessness, blaming, pain, anxiety, emptiness, confusion, loneliness, and withdrawal may be experienced as well.

It may be thought that the mental and/or physical stress of bereavement lies in its excess but actually it results from failure to properly complete the mourning process, which leads to a state of conflict (Simon, 1981). There are many reasons that this may occur. Some individuals may not even know that they are bereaved. Others, although conscious of the sense of loss, may not recognize the need to express their feelings. In those who have suffered a psychic death of the self (or loss of wholeness), which may occur when intense emotion has remained unconscious or been repressed (what might be

called psychological death), feelings of bereavement may be less obvious (Simon, 1981). A lack of support, approval, and opportunities for the grieving to express their experience, can also result in their many thoughts and emotions being repressed and left unresolved. Serious psychological, physiological, sociological, and behavioural problems can be the result. "When mourning and grief work are successfully completed [on the other hand], the individual will grow and find increased strength" (Raymer & McIntyre, 1987, p. 34).

There are three general bereavement "phases"--each of a different duration and with its own symptomology and task(s) (Raymer & McIntyre, 1987). As with any trauma, shock is the first of these phases. This lasts for several weeks or months and is characterized by numbness, inability to feel, going through the motions. A normal reaction, serving as a form of self-protection, shock prevents the bereaved person from experiencing the full impact of her/his loss. The denial or disbelief of the bereaved allows the postponement of her/his dealing with the tragedy of loss until s/he is ready.

Intense disorganization, characterized by disturbances in concentration, sleep, eating, repeated uncontrollable crying, somatic symptomology, rage, depression, and guilt, represents the second bereavement phase. This can last for many months and ends with the griever's intellectual and emotional acknowledgment and expression of the loss. If symptoms are repressed, rather than expressed and worked through, a serious blockage to healing is created.

Choosing to reenter life with enjoyment again is a goal included in the final phase of reorganization. This is a time of occasional peacefulness, more pleasant and bittersweet memories, and feelings of less intensity.

"The idea that art making can be helpful in processing a loss is certainly not new" (Malchiodi, 1992, p. 114). Johnson (1987) proposes that psychological trauma is the *origin* (sic) of art; that "humankind may have developed art to alleviate or contain feelings of anxiety, fear, crisis, and threat" (Malchiodi, 1992, p. 114), "motivated by a need for catharsis and for gaining control" (Johnson, 1987, p. 13). It is no wonder then that

"the creative arts therapies hold so much promise as a reparative force" (p 13) McIntyre (1990) writes "Societies have used art therapeutically throughout the ages . to cope with changes in life As far back as the Neanderthal people, art was used to give form and meaning to the life and death cycle" (p 16) Arnheim (1967) states, as cited in Raymer & McIntyre (1987, p. 34) and McIntyre (1990, p. 17), that "art is an indispensable tool in dealing with the tasks of life". Dissanayake (1994) believes that art-making is a *special* kind of behaviour which shares features with those of ritual and play and that this "should help us to appreciate why it can be a powerful means of engaging attention and working through disorder and uncertainty" (p. 20). She also closely associates artistic behavior with anxiety, "in that its earliest occasions seem to have been concerned with "something to do" in times of uncertainty" (p. 21)--that is, it served to negotiate transitions between one stage or state and another, which certainly applies to the suffering of a loss and coming to a resolution of one's grief. Peckham (1965) and Hatcher (1985) have observed "that the desire to self-express through an art form is often heightened at times of mourning" (Malchiodi, 1992, p. 114)

"Most art therapists would ..agree that art expression is well suited to the therapeutic needs of anyone who has experienced a loss" (Malchiodi, 1992, p 114). Several such professionals have consistently observed "the power and potential of art to help identify, cope with, and/or heal the pain experienced during the process of recovery from loss" (p 114) "[O]ur knowledge about visual form, the art-making process, and the psyche is essential in assisting the individual who wishes to explore and work through the pain of loss in visual art" (p 118).

The art therapist working with the bereaved must understand and facilitate the normal manifestations of grief (Raymer & McIntyre, 1987). The therapeutic environment s/he provides such oncology clients is supportive, structured, safe, and trusting "Affect is the root of all grief and the creative process gets to that root" (McIntyre, 1990, p 18). Acting as a catalyst for the creative process, the art therapist gives grieving clients the

much needed opportunity, encouragement, and permission to express their many conscious, as well as potentially potent unconscious, unresolved feelings, thoughts, and experiences toward the loss(es) they have suffered so these can be confronted and processed.

Art-making "seems to appear spontaneously in the attempt to express the deep suffering one experiences when confronted with a significant loss" (Malchiodi, 1992, p. 114), as though the bereaved feels "compelled to work it through in art" (Simon, 1981, p. 135). It is a client's expression of the emotions underlying her/his sense of stress which is the first stage of the three-stage bereavement art process (Simon, 1981). There are also three stages to the treatment of an individual suffering from psychological trauma (Johnson, 1987). The first of these stages is described as the time when the client needs to gain access to her/his trauma in a safe and controlled way, in order to overcome its denial. The moratorium of art-making (i e., the allowance of self-expression of one's experience because it is in art form (P. Grégoire, personal communication, Spring, 1994)) offers something very valuable to the well-being of cancer patients. Clients have appeared to respond to art therapy "much more quickly than through traditional verbal therapy" (Raymer & McIntyre, 1987, p. 29). In addition, "the grief process seems to be hastened by drawing on [an] individual's creative skills" (p. 29). There may be less client content censoring than in the other traditional verbal therapy interventions because the art component of this dynamic triadic relationship is not viewed by the patient as threatening. Johnson (1987) writes that the "concrete and impersonal transitional space of the artwork is more safe than the abstract and personal one of the transference" (p. 11). He elaborates by stating, "Instead of the discussion of a feeling, one has a discussion of a picture of a feeling, a less threatening situation for the patient because the picture is concrete and external to the self" (p. 11). The traumatized individual can thus dissociate her/himself from the content of her/his imagery, and without impairing her/his cognitive

state. This preserves the client's sense of personal control and integrity which is very important in her/his treatment (Johnson, 1987).

Articles by Jeppson (1983), Musick (1978), UCLA Jonsson Comprehensive Cancer Center (1983), Lichtenthal (1985), Effler and Sestak (1978), and Prager (1995), to name a few, point out the importance of the art therapy modality desirably enabling its clients contextually to feel a renewed sense of control and independence which have been limited in their lives during illness. Giving a client the choice to decide whether or not s/he will participate in a session, at which site location (e.g., bedside or art studio), what materials will be used and how, what will be created, to whom the art product will be shown and what will be done with it is empowering her/him which is a valuable healthy counterbalance to the helplessness often present in grief (McIntyre, 1990). At the same time, the art therapist, aware that confrontation with loss may have diminished her/his client's ability to take risks (Raymer & McIntyre, 1987), must also be able to recognize when a client faced with such possibilities is caused anxiety, perhaps because of her/his indecisiveness for example, and know when and how to appropriately intervene so as to surmount the client's unwillingness or inability to proceed. In the process of creativity risk-taking can be reinstated (Speert, 1992) and then slowly reintegrated into other aspects of the griever's life (Raymer & McIntyre, 1987). "One of the most powerful aspects of art expression in processing loss is the ability to address fear [which many oncology clients experience] through the art process" (Malchiodi, 1992, p. 117). Once involved in drawing, painting, or constructing the fear dissipates. "After all, just confronting that blank paper or the untouched materials - clay can be the most courageous of acts when one is in extreme psychic pain" (p. 117).

The second stage of the bereavement art process is the containment of the client's expressed suffering, while it is slowly being converted into mourning (Simon, 1981). Dreifuss-Kattan (1990) writes, "The creative work of the cancer patient often becomes the container for all the shifting emotions, especially fear and grief that are experienced in the

course of the illness and treatment" (p 4). The art therapist also serves as a receiver and container of her/his client's expressions S/he can mirror or reflect verbal and /or nonverbal elicited and/or suggested symbolic communication, validate the other's experience, and importantly exemplify valuable emotional acceptance and understanding of it Art therapy sessions which explore themes initiated by the client or the therapist, which are related to the client's experience of loss, can be therapeutically beneficial. A few thematic examples are self-concept, body image, and family

Seeming to parallel his second art process bereavement stage is the second treatment stage of individuals suffering from psychological trauma when "the patient needs to engage in a lengthy working-through process in which the trauma can be acknowledged, re-examined and conceptualized, resulting in a modification of its intensity" (Johnson, 1987, p. 9). This is largely accomplished by the arm's length position of the client in art therapy which "allows a re-working of traumatic experience over and over again, at times indirectly, at times directly" (p 11), as the patient's ego allows.

According to Simon (1981) a bereaved client's habitual style of artistic expression, whether drawing, painting, or working in clay, reveals more about her/ him, her/his attitude toward life, than does the content of the creative work. The client's artistic style expresses her/his response to bereavement and may, as well, lead her/him to modify a maladaptive response so the mourning process can be properly completed. That is to say that, changes in the grieving individual's pictorial style provide a means of both assisting and monitoring the course of the mourning process. The two main stylistic categories of artistic expression which have been identified by Simon are "traditional style" and "archaic style". The former is characteristic of the Western tradition of art, with the perceptions and concepts organized and motifs from the artist's culture drawn upon. The art work can be "traditional massive" in character, having a naturalistic effect, or "traditional linear" which is a more intellectual approach, dominated by classical forms. When a grieving individual's habitual style is traditional and s/he is conscious of feelings of mourning her/his

realistic representation of conventional subject matter serves as a vehicle for mourning, with feelings being released during the artistic process that have deep significance to the subject. Conversely, when emotional grieving is unconscious this traditional mode of art expression is inadequate

Primitiveness characterizes the "archaic style", with shapes, colors as the expressive vehicle rather than ideas or subjects. Spontaneous, unthinking response to the art materials facilitates sensuous or emotionally charged gestures. Collectively these markings may suggest an image to the client and afterward be elaborated upon. These energizing symbols are reminiscent of what Freud referred to as "phylogenic inheritance" and Jung's "collective unconscious" (Simon, 1981). The archaic style of expression has two characters as well. The shapes within the dominantly sensuous "archaic linear" style are flattened by enclosing lines. Within the "archaic massive" style, on the other hand, shapes are heavily filled in, with boundary lines not containing very adequately. Such work is invested with emotions that dominate and interpret the sensuous experience to some extent.

A client's change of style may be subtle or gross. Traditional and archaic features may become united or linear and massive treatments reversed. What these changes indicate is a modification of the client's underlying habitual attitude because of its proven inadequacy to the present situation.

Boegel and van Marissing (1991) describe the art experience as functioning as a basis for healing from loss on two structural levels, the concrete and the archetypal. By the first is meant "the concretely visible and tangible reality" (p. 14) of a personal creative act. The other level is the collective meaning which clients' varying concrete realizations embody. According to them, Jung states that "healing starts where we remember resources behind the 'personal'" (p. 15). Malchiodi (1992) also writes "When art expression is used to access the inner life of the individual who is grieving a loss of the self..., the realm of the transpersonal is inevitably touched" (p. 115). Boegel and

van Marissing believe that each creative act brings about change and transformation; the "external" movement involved in creativity causes "internal" movement in the artist and forces her/him to have a different inner perception

The externalization and concretization of a grieving individual's inner world can be a painful but also cathartic experience. It is a means of increasing her/his self-awareness, developing understanding, and acquiring control over one's grief. Malchiodi (1992) describes the art therapist as a needed "responsible witness and guide [who] illuminate[s] the [grieving] process and [gives] the appropriate and knowledgeable response to that which is expressed in visual form" (p. 118). Simon (1981) states that without the "companionship and security of a therapeutic relationship" a bereaved client cannot work through her/his conflict(s), which is what is necessary in order to process a loss (p. 135).

The actual creation of a concrete, tangible product which long outlasts the art therapy sessions in which it is produced, has numerous advantages. It is a record of client activity which cannot be denied, erased, or subjected to distortions of memory. As already described, it can serve as a focus for discussion, be referred to or reviewed as desired, may reveal emerging patterns, and provide both the art therapy practitioner and the oncology client with an index of on-going therapeutic developments which could be encouraging and motivating. "[T]he art productions [of an individual] may reflect the various stages of [her/his] adjustment to loss" (Effler & Sestak, 1978, p. 57). Rudloff (1985) writes, for example, that her patient's (Michael) realistic portrayal of himself with only one leg (following the other's amputation) suggested a positive development--that he was coping with the reality of his loss. As well, these art products are unique individual statements by the art therapy client which, with her/his consent, can be shared with those personally and/or professionally involved with the case for the purpose of enhancing therapeutic progress.

The final stage of the art process of the bereaved brings the ultimate resolution of grief (Simon, 1981). This resembles the third and final stage of treatment for trauma when the patient rejoins the world and is "able to go on with one's life" (Johnson, 1987, p 9)

Terminal Illness

Dying is another inevitable fact of life. The greatest loss with which an individual diagnosed with cancer may be faced and have to cope, as a consequence of the disease, is the loss of her/his own life. The number of individuals with life-threatening illness requiring service is growing as a result of an accelerating upward progression in life expectancy in the Western world since 1900, advancements in medical care and technology, movement toward hospice, legislative mandates (Learner, 1976, in Tate, 1989) and a significant increase in the passage of time from the onset of a life-threatening illness until death (Feifel, 1973, as cited in Tate, 1989). More dying is now happening in hospitals and nursing homes as opposed to at home as was common in the past (Tate, 1989). The need for the services of art therapists to help in fulfilling the needs of those who are terminally ill (and members of their families) has also increased (Tate, 1989). These professionals have much to contribute to the dying being able to make the most of their last days (Kern-Pilch, 1980; Lichtenthal, 1985)--what Kubler-Ross (1969, in Kern-Pilch, 1980) defines as "maintaining the quality as opposed to the quantity of life" (p. 7)

Feelings of bereavement are natural for those nearing their own death (Simon, 1981). There is also a sequence of grieving stages an individual goes through once s/he is told or becomes aware that s/he is dying which have been identified by Kubler-Ross (1970) as cited in Effler and Sestak (1978), Lichtenthal (1985), and Melcer (1983). These are denial, and isolation (Miller, 1984); followed by anger, bargaining, depression ("as the actuality of the prognosis is realized" (Cotton, 1985, p. 55)), and acceptance. Cotton (1985) refers to the first three stages as the "no, not me" reaction, the "why me" phase, and "hoping for more time" respectively. The outcome of the fifth and final stage,

she states, can be either positive or negative. "[P]eople often oscillate between two or more of these stages" (Miller, 1984, p. 133).

Death is one of the most difficult subjects to talk about in contemporary Western society (Miller, 1984). We appear to have adopted a preference towards a scientific, or outward view of the world, sacrificing the inner or mystical aspects of life. However, science, reason, and consciousness are not able to contribute a great deal to our understanding of death and this is one reason for many of the problems we experience related to death (Miller, 1984). We have an incredible ability to deny mortality, for example, sometimes blatantly and overtly and even in the most extreme circumstances -- when death is imminent. Fromm (1973), cited in McIntyre (1990), attributes this to an "inability to grieve" (p. 18). Our reluctance toward, and tendency to avoid, its discussion or confrontation in any way has resulted in giving death some of the qualities of a taboo (Miller, 1984), which, in turn, denies individuals openness to grieve (McIntyre, 1990). McIntosh (personal communication, Spring, 1994) was surprised to find, during his experience as an art therapy intern, at a palliative care unit, that this exists even among members of oncology caregiving staff--and at a site where eighty percent of all admissions are terminal (Munro, 1984). Aries (1976), cited in Miller (1984), refers to our modern society's "interdiction of death [which] paralyses and inhibits the reactions of the medical staff and family" (p. 128) involved with the terminally ill client. Perhaps at the center of this phenomenon is what Munro (1984) writes about in her enlightening and informative book, entitled Music Therapy in Palliative Care, the inevitable confrontation with one's own finiteness and/or the threat of impotence in conquering this life-threatening disease, both of which have been personally experienced as has already been mentioned in this research paper's introduction.

For individuals living in hospices, aware of their physical decline, having little hope of improved circumstances in the future, sensing that life is coming to an end, one of their principal areas of concern is likely to be the approach of death--"a crucial area of work

that is sometimes neglected" (Miller, 1984, p. 128). The subject in Kern-Pilch's (1980) case study exemplifies this concern well. These individuals "are more vulnerable to, and less able to defend themselves against, those fears that a close proximity to death can bring" (Miller, 1984, p. 127). According to accumulated data, dying is made easier when the dying individual feels understood and can express her/his feelings, fears, hopes (Tate, 1989). Yet, many hospitals do not provide counseling services for those individuals facing impending death (Miller, 1984). Caregiving professionals working in institutions within the medical field have been trained primarily to concentrate on attending to a dying individual's physical needs (Tate, 1989; Weiss, 1984), with the focus being on the extension of the patient's life (Tate, 1989). The transition from working to save a patient to allowing her/him to die can be extremely difficult for the staff (Councill, 1993). Once death becomes inevitable caregivers are unprepared to sufficiently address or cope with the patient's psychological process of dying (Tate, 1989). Decisions made by the staff and family regarding the patient's treatment may be felt to be responsible for the individual's imminent death (Councill, 1993). "It can become more emotionally comfortable . . . [for members of the staff] to devote their time to the drip or the ECG machine (where they might feel they can have some control, and, even if the patient dies, at least the equipment is working properly), than to become involved with the patient as a human being" (Miller, 1984, p. 132). Miller also writes that in hospitals actual mechanical devices can sometimes be used to distance and defend ourselves from death. As a result, "the dying patient can become isolated, reduced to the status of a component of the apparatus they are supposed to be served by" (p. 132).

Denial of the circumstances is often in the guise of protecting people from distress (Miller, 1984). Over-protective family-patient interactions can also isolate the patient, prevent her/him from being actively involved in and committed to life when it most counts (Simonton, Simonton, & Creighton, 1978). The Simontons and their colleague discourage any "babying" of a cancer patient as it suggests the others' belief that the

patient cannot deal with life as it is or make a decision. This stance may mislead or diminish the patient. A family member's conscious or unconscious adoption of the role of so called "rescuer" of the cancer patient is considered detrimental by Simonton et al. (1978)--in fact, destructive--actually contributing to her/his physical and psychological incapacitation. It can reinforce her/his passivity and robs the sufferer of the power to solve her/his own problems. A cancer patient may also take on the "rescuer" role, most frequently efforts of "protecting" family members through non-communication of her/his own fears and anxieties

Dishonesty over death can create distance and awkwardness in relationships (Simonton et al., 1978) Avoiding dealing with potentially painful subjects--death especially--has the effect of closing down communication in areas, which at this time, are important for the patient (and family members) to be willing to confront. It, thus, inhibits or suppresses everyone's abilities to express the feelings being experienced, not allowing for their resolution With an opening of communication channels, feelings of inadequacy and guilt in the patient, members of her/his family and involved staff may tend to be mitigated (Feifel, 1973, in Tate, 1989). The psychological strength and health of the cancer patient are improved when her/his emotions are potentially dealt with and resolved (Simonton, Simonton, & Creighton, 1978).

Otherwise the dying patient, who may be experiencing a loss of self-esteem and identity at this time, suffers emotionally as well as spiritually (Weiss, 1984) Isolated and non-communicative, her/his mental, physical, and emotional conditions can deteriorate (Weiss, 1984). A tendency toward regression may follow (Weiss, 1984) Like denial, this is also a common defense in the service of the ego during a patient's coping with/ preparation for, the end of life--an adaptive mechanism of the patient, "occurring in order to maintain an inner balance which has become threatened" (Melcer, 1983, p. 13). It may signify the patient's attempt to resolve a previously uncompleted growth stage. Sick people may become faced with existential questions and "in the search for the meaning and

the integrity of one's life, [s/he] often reverts to [a] particular point of developmental fixation" (p. 13) "Classic psychoanalytic theory and the Eriksonian psychosocial theory both shed light on the psychodynamic aspect of regression" (p. 13). Weissman states that "[V]ery sick people oscillate between regression and restitution" (in Melcer, 1983, p. 13). Melcer (1983) states that the successful resolution of Erikson's last psychosocial phase of the stages of the life cycle, "Integrity vs. Despair", is implied as a prerequisite of preparing for death. "To die with dignity is the wish harbored by most people" (p. 13) and according to Erikson (1980, in Melcer, 1993), this is attainable with one's positive resolution of the integrity phase. Such an acceptance of one's own life cycle is arrived at through a process of reworking the events of one's life. "In the face of death this becomes the recurrent and dominating issue" (p. 13).

One art therapy intervention technique which facilitates this, and is used in both individual and group sessions, to focus the terminally ill individual's creative expression and verbal exchange, is the life review process. In addition to being given as a thematic directive, ranging from simple (Kern-Pilch, 1980; Zeiger, 1976) to complex, (Bergland (1982) for example, combined pre-verbal visual images with written and spoken memories in a developmental time line, beginning with childhood and ending in late adulthood), this exercise may also be initiated by a client (Rudloff, 1985). It provides a valuable opportunity for the art therapist to get to know her/his client and learn about her/his life. Butler (1963) describes the life review process as "normal, natural, universal, positive adaptational mental response "activated at any developmental/biological stage of life [in response] to time of loss/change" (in Bergland, 1982, p. 121; Zeiger, 1976). Conscious or unconscious, defended against or not, it may be prompted by an individual's "realization of approaching dissolution and death" (Butler, 1963, in Zeiger, 1976, p. 47) "This process need not be restricted to the elderly. Life review is the material of growth and change in any developmental stage of life. It can be used in groups working with transitions of any kind" (Bergland, 1982, p. 130). Life review "presents the occasion to focus on one's self

and reflect upon past values and situations, present circumstances and future goals" (Butler, 1963, in Bergland, 1982, p. 121). It is "a looking back process that has been set in motion by looking forward to death" (Butler, 1963, in Zeiger, 1976, p. 47). "[A]t its most active the life review process stimulates the patient's recall and examination of not only pleasurable past happenings but more importantly painful memories" (Zeiger, 1976, p. 47). A client may attach her/himself to memory and begin to talk more about her/his past "because in the present objects of pleasure become fewer and more distant. Pleasure comes to be identified more and more with the past" (p. 47). This is clearly evident in the Kern-Pilch (1980) case study.

Past unresolved conflicts may progressively consciously surface in this life-review process and these then can be reexamined. If the process is completed and these successfully worked through and integrated, a "wisdom" or "serenity" may be attained by the client (Butler, 1963, in Zeiger, 1976, p. 47). This exercise may give new and significant meanings to a client's life and also prepare her/him for death by mitigating fear and anxiety (Butler, 1963).

Art therapists Perkins (1977), Jeppson (1983), Cotton (1985), Minar, Erdmann, Kapitan, Richter-Loesl, and Vance (1991) have all used art expression with the seriously or terminally ill, to help them express their feelings and face issues surrounding their death. A review of Perkins' (1977) and Cotton's (1985) work will be featured in an ensuing section of this research paper. In addition, Lichtenthal (1985), Rudloff (1985), and Kern-Pilch (1980) have each very sensitively written a case study about their individual art therapy interventions with an adult terminally ill oncology client. All of them chronicle the development and value of a therapeutic alliance between patient and therapist, fostered, at least initially, by means of engagement with art materials.

Several issues which these last three articles touched upon stand out in my mind. For the patients whose family and friends rarely visit (Kern-Pilch, 1980; Rudloff, 1985), who are utterly alone with no one to help them cope with this last difficult life journey,

the support, companionship, and the interpersonal connection the art therapist offers the dying individual seems even more invaluable. Kubler-Ross (1969) has shown in her outstanding work on the psychological needs of dying patients, "how important it is for the patient to have a sufficiently intimate companionship while working through the anger and fear of being bereft of life" (in Simon, 1981, p. 135). Melcer (1983) states that individuals in the final stage of life have "an overwhelming need for relatedness" (p. 18)--which, he continues, "is not always met nor expressed. However, the establishment of a bond is a necessity if dying is to occur as a progressive outcome of life" (p. 19). One of the ways in which this relatedness can be achieved is through the patient's transference, with the art therapist possibly taken on as her/his "auxiliary ego"--the internalized "good object" (Melcer, 1983). The Lichtenthal (1985) case study discusses this as well. According to Melcer (1983) the desirable "peaceful passage towards death requires a positive sense of the early internalized object" (p. 16).

Lichtenthal's (1985) candid discussion of her countertransference experience while an art therapy graduate student with chronic cancer working with a woman of similar age up until the client's death from cancer struck a personal chord. I was both inspired and encouraged by her courage and strength--if this is something she could do, then I too, with my personal experience of this disease, may be able to carry on the work I wish to do in the future with adult oncology clients.

Rudloff (1985) raised the valid and important practical question of what is an art therapist's role within the therapeutic relationship when a terminally ill client becomes either too physically debilitated or too emotionally withdrawn to continue to engage with the art materials? She views it as changing to that of providing a steady, caring presence, perhaps a kind of "escort" for the dying individual as s/he nears death or as a witness to her/his process of transformation. Faced with this during her intervention with her case study subject, this author interestingly describes how she and her client come to mutually agree upon the patient's art-making being replaced by the powerful, therapeutic act of

touch. The delicacy with which the termination of the patient-therapist relationship with members of this client population must be handled is highlighted as well in the article by Rudloff (1985).

Weiss (1984) believes art therapy can make dying, the last life process, a meaningful experience. She envisions dying as a sacred part of life, rather than the sad conclusion to existence. Miller (1984) sees our life task as "to work towards death as an acceptable occurrence, the consummation of life, rather than its negation" (p. 129)--"the important conclusion of the growth process, but still part of growing" (p. 128). He advocates that the art therapy modality is uniquely suited as an intervention for the terminally ill. This judgment is based on several factors. We have at our disposal the ability to think in primordial images--explained by Jung (1933) as 'symbols which are older than historic man; which have been ingrained in him from earliest times, and, eternally living, outlasting generations still make up the ground-work of the human psyche' (in Miller, 1984, p. 130). Miller believes that the illumination with which these symbols provide us is required in order for us to contemplate, and by necessity, instinctively acquire an understanding of an eternal theme such as death. Through art therapy terminally ill clients have a natural venue for these symbols and by using their own artwork as a way of thinking in primordial images they are able to come to terms with their situation in a way that conscious thought might not have facilitated. Tate (1989) writes that "symbols are created to reach a level of reality that cannot be achieved in any other way" (p. 115). He quotes Tillich (1957) as writing "There are within us dimensions of which we cannot become aware except through symbols" (p. 115). In order to work effectively with dying individuals, Tate (1989) stresses that the art therapist must have an understanding of what appears to be universal death and rebirth symbolism, examples of which are Jung's (1959) archetypal mandala and its variations--spirals, coiled snakes, and soul windows.

Art therapy facilitates clients to express themselves when they may be having difficulty doing so with words, and enables "the unsayable to be said" (Miller, 1984, p. 128). Boegel and van Marissing similarly write that "The impulse to express is the desire to approach what is unspeakable and elusive. How can you get access to the mystery of death?" (p. 15). Councill (1993) states, "The power of art to give expression to profound existential themes and the relationship with the art therapist can be a strong support to the patient when words are too difficult either to say or to hear" (p. 85).

The expression of a dying individual's anger, fear or acceptance of death in visual form, as opposed to being verbally communicated, is more readily acceptable and, thus, can importantly avoid, or at least circumnavigate, the previously referred to interdiction of death (Miller, 1984). This author offers several explanations for this. First, an art therapy client's art work usually does not address any particular person and therefore her/his artistic statement is more likely to be left to stand. Its viewers will not be emotionally triggered, as they may be by words, to raise a wall of desensitizing remarks around it, thereby permitting the dying individual more freedom to communicate her/his feelings. Another feature of art therapy, pertinent to the terminally ill, is that visual art can express the infinite and the oblique in ways not possible with spoken language.

A third virtue of this intervention modality for this population is that "visual images are capable of working on many levels and of expressing seemingly contradictory ideas and feelings simultaneously", for example, anger and depression, or acceptance and fear (Miller, 1984, p. 132). McIntyre (1990) seems to agree with this, writing that "Visual art allows for expression of multiple feelings in a single image" (p. 18). The articles by Tate (1989) and Miller (1984) discuss the emotional ambivalence toward one's own condition which is common in the terminally ill. Both authors believe that art therapy has a vital role to play in facilitating these individuals' expression of this "duality of feeling" (Miller, 1984). Tate (1989) refers to a study by Gordon (1978) in which the imagery of Rorschach inkblots, as perceived by respondents who were unaware that they were dying,

were "interpreted [by the researcher] as referring to death; furthermore these symbols betrayed attitudes of both resistance and also of surrender to it" (p. 117). "The Rorschach responses may lend weight to the theory that the wish for life and the wish for death do co-exist in the psyche and that their predominance may increase with nearness of death even when awareness is not conscious" (Gordon, 1978, in Tate, 1989, p. 117-118).

Miller (1984) feels that it is vital that the terminally ill "are able to fluctuate in this way, and that they are also able to come to terms with death in their own way and their own time" (p. 133). "It is beneficial when conflicting...feelings are symbolized, labeled, or expressed" (Tate, 1989, p. 119). "When emotions are clarified via symbols, they can be tamed and broken into small acceptable components..." (Horowitz, 1978, in Tate, 1989, p. 119).

RESEARCH CONTRIBUTING TO SOMATIC AND/OR PROGNOSTIC EVIDENCE IN ART

The earliest important research examining the somatic aspects of a patient's condition and/or her/his disease prognosis as evident in her/his art expression product appears to be by Bach (1966, 1975, 1990), a Jungian psychoanalyst. The research of the Simontons (1978) and then Achterberg and Lawlis (1984) followed and further laid the foundation for this area of inquiry. In addition to the research by Perkins (1977), and Graves (1989) (and Cotton (1985) and Baron (1989) to a lesser degree) described below, the work of other art therapists (Kurtz, 1978; Lichtenthal, 1985, Rudloff, 1985, Wolf, 1979) has also offered support to these theses. "The intimate connection between mind and body, psyche and soma, becomes increasingly apparent when exploring the imagery and artwork of an individual with cancer" (Baron, 1989, p. 148) According to Baron (1989),

"Helping professionals are placing increasing significance on an individual's imagery and art as a way of recognizing and following physical conditions present in the patient's body. The art therapist, who is trained to speak the language of art, is in an optimal position to utilize these messages to influence attitudes blocking the healing process" (p. 166).

Bach

Spending much of her time in hospitals, for decades Bach collected and reviewed data--her work focusing mainly on the study of the "fundamental interrelationships between psyche [soul] and soma [body] on the one hand, life and death on the other", through the use of drawing with terminally ill children, the majority of whom had cancer (Krayenbuhl, 1966, in Bach, 1966, p. 7). Her theory is not clear cut and dry, but Bach's thesis (and conclusion) was that body conditions, physical illness, treatment, even disease prognosis are all reflected unconsciously in the choice of particular colors--values, archetypal motifs, and symbols within the patient's art expression. Bach also concluded

that the spontaneous drawings serve as a record documenting the child's unspoken wants, needs, and anxieties as well.

Bach (1966) writes,

"[T]hese spontaneous drawings... reflect the signs of physical disease in specific recurring colors, shapes, numbers and symbols. They also indicate invisible and 'silent' processes in the body as well as improvement under treatment. They may point to the locus of lethal illness and of metastases. Moreover, the forecasting signs they contain may be of help to the physician prognostically and in the assessment of probable life expectancy" (p. 64)

The complexity of Bach's description of her multilevel color evaluation element results in this aspect of her procedure being difficult to decipher, and therefore duplicate. It has been understood, however, that predominant values of a child's imagery colors have been found to give direct information on her/his prognosis. The number of objects in a drawing has been thought by Bach (1966) to reveal the patient's inner awareness of how long s/he has to live. She writes, "As to prognostic implications of our observations, these drawings contain strong indications that the patients know deep within themselves [she refers to this elsewhere as the children's "inner knowingness"] not only whether they will recover, but also when their lifetime is coming to an end" (p. 64). Kurtz (1978) similarly proposes that some part of the creator 'knows' what is happening to the body and what will happen. Bach (1966) states "it cannot be emphasized enough that we have no 'theory' of numbers as anticipatory idioms in the language of spontaneous paintings. Here, and also in regard to the significance of certain colours, we are taking note of repeated empirical facts which we have collected over the years, and it is from such observations that we have learned and ask our questions" (p.56).

As an aid to orientation in describing and evaluating pictures, Bach developed, and tested, the idea of dividing a drawing into four distinct quadrants, each assigned a meaning and considered to represent an aspect of the self. This concept, for which she is well known, is referred to as the quadrant assessment theory of drawing analysis. Bach states

that empirically this has been found to be of indicative value. The direction of movement in the client's art is of great importance as it can indicate either illness recovery or physical health taking a downward trend. The upper right (plus-plus) quadrant represents the present, the situation in the 'here and now', facing to the right may indicate a positive phase in the patient's existence. The upper left (minus-plus) quadrant is a 'transpersonal area through which the spirit/soul "goes out of life" into another kind of life. The lower right (plus-minus) quadrant indicates the potential future or recent past somatic state, something close to consciousness. The lower left (minus-minus) quadrant is associated with negative aspects, related to 'downward' trends in the patient's physical health, moving towards darkness, the doubtful, the unknown, the unconscious. Objects in this quadrant, or movement in the direction of the lower left may be predictive of increasingly poor health or lack of response to medical intervention. "What is in or near the centre [of these quadrants] is frequently of 'central' significance. An empty centre can be equally revealing. Then the question why this should be so, has to be considered" (Bach, 1966, p. 17)

The analysis and evaluation of a patient's spontaneous pictures should be systematic, a time consuming, laborious exercise it seems, as this will ensure that each of the forementioned ways of assessment makes its own contribution to the total evaluation (Bach, 1966). Working on the basis of the Jungian concept of universal unconscious, this researcher attempts to demonstrate the presence, and possible meaning, of archetypal motifs within these patients' artwork. Yet, Bach (1990) cautions against relying on these symbols alone to arrive at the psychological significance of the drawings. It is also critical to observe how these support the other pictorial elements and their relation to parallels from other civilizations. Related to this, Furth (1988), who was once Bach's co-worker and who has incorporated her methods into his own practice, expresses his concern that therapists' use of quadrant assessment theory in evaluating artwork may prevent them from viewing the picture as a unified whole. He cautions against the danger of strictly

wanting to apply quadrant explanations to a picture since the personal significance of an individual's images and their placement may not always reflect similar meanings.

According to Furth (1981), applying Bach's theoretical framework to the artwork of the adult population will similarly reflect these individuals' current psyche/soma condition. In my opinion, however, research with this particular oncology population must be conducted in order to test this generalization. Bach (1966) herself states that she is aware that her study of the spontaneous pictures of severely ill children "can be neither final in all details nor exhaustive, nor should its findings and evaluations be rashly generalized. Such work, ...requires modifications...and calls for further investigation" (p.63). The quantification of Bach's substantial, collected observational data, into a rigorous methodological system, by which the validity and reliability of her projections can be established, and with which other researchers can compare their findings, is highly desirable.

Opening up, and giving visibility to, this realm of exploration of the interrelation between psyche/soma is perhaps the greatest significant contribution of Bach's work, to the field of psychosomatic medicine.

"Moreover, these pictures can build a bridge between doctor and patient, the family, and the surrounding world. Indeed, their meaning and what it implies could guide the healing professional [and family members] to assist especially the critically ill patient in living as near to [her or] his essential being as possible, whether in recovery or before [her or] his life circle closes" (Bach, in Siegel, 1986, p. 160).

Perkins

Following Bach's hypotheses, Perkins (1977) conducted a preliminary study which explored how a quantity of the drawings of twenty seriously ill life-threatened children, aged between three and twelve years, related to the progress and characteristics of their diseases. The majority of these children were clinic out-patients, had some form of cancer, and a prognosis that was poor or doubtful. Perkins' subjects had access to the

same art materials in one room and the art work was done independently. Media included colored chalk, watercolor markers, paint, and crayons

A preliminary overview of the art work for color frequency analysis suggested some configuration for future investigation. There was consistent use of considerable quantities of the color black by all children who were in the life-threatened group, and one who was not. (There was a control group of fifteen healthier children making art as well.) The color black was generally consistent with negative affect in the children. Exceptional quantities of red, the color most consistently used by both groups' subjects, were in all the pictures of the life-threatened children. Cotton (1985), who based a case analysis of a dying six year old leukemic child on Perkins' work, arrived at similar observations, which suggests consensus. Perkins' subjects' verbalizations associated the color red to "blood" Bach (1966) describes red's significance to children as "burning" or "tumor" red, which symbolizes the burning, painful force of the disease (Bach, 1990), although the appropriateness of this interpretation may be modified according to the context of a drawing.

In viewing individuals' images based on the diagnosis of a life-threatening illness, as Bach (and Cotton, 1985) did as well, "it is impossible to believe that a researcher's feelings, personal beliefs and value systems are somehow magically excluded" from such an inquiry, therefore, the concept of her/his objectivity can be challenged (Jansen, 1995, p. 18). This seems particularly evident in Perkins' three brief case studies, said to exemplify the subjects' recognition of their approaching deaths, and of the bodily changes occurring in the disease process. In my opinion, several of this researcher's assumptions originating from these respondents' artwork seem far-fetched, based on conjecture fitting to the study, despite her goal to examine the artwork "without presupposition for whatever significant content might be found" (Perkins, 1977, p. 9). Regarding the pictorial symbols used by the life-threatened children, these have "inevitably been assumed to be linked with aspects of death and dying" (Jansen, 1995, p. 13). Throughout the art,

the snake and a house, possibly the most commonly projected self-symbol were repeated (Perkins, 1977). Feedback not forthcoming, the significance of the snake to these subjects, although difficult to determine, simply interpreted, is said to have appeared in each child's mind to represent a threat (Cotton, 1985; Perkins, 1977). Perkins (1977) proposes its appropriateness, as a symbol of transformation, in the artwork of children facing death. Ten out of sixteen children's houses showed "possible indications of their diseased state [that is, symptom projection] within the body of the house" they drew (p. 10). One interesting characteristic of some of the houses drawn by the life-threatened children (and none of the control group subjects) as well as Cotton's (1985) subject, is what Bach (1966, 1975, 1990) refers to as "a soul window", a transpersonal aspect--a small, often circular window located under the eaves of the house. According to Bach, in Swiss folklore it is through here that the soul of a recently deceased person leaves a house. Perkins states that she is unaware of such a belief in the United States (where her study, and Cotton's, were conducted). Whether this is a reflection of Jung's supposition of a collective unconscious, or just a coincidence, is not determinable here. I do not doubt that similarities in thematic content recur in the artwork from a specific client population, such as this, however, as the results of research by Jansen (1995) suggest, "the images created by individuals who are terminally ill, are not solely about living with chronic illness" (p. 17).

Like Bach, using the quadrant composition theory, Perkins (1977) and Cotton (1985) have documented symbolic similarities. The visual depiction of paths going from the right to the upper left, and the appearance of the setting sun in this quadrant, are both predictive evidence of their creators' impending death. All but one of the life-threatened children consistently drew the sun in the upper left corner. Tate (1989) states that in art therapy, symbols and events drawn on the left of the page are positively correlated with the past while the right side more often portrays the future. He offers the explanation that

perhaps these "life-threatened [subjects] subconsciously knew that their future is limited or that 'their sun was setting'" (p. 116).

Perkins' reported study findings and conclusions seem to concur with those of Bach (1966). The artwork of most of the seriously ill subjects shows definite symptom projection (clearly exemplifying their awareness of disease process) and/or awareness of their own approaching death--as typified by choice of color, page composition and symbol usage (Cotton, 1985; Perkins, 1977). Although "a lack of conscious comprehension of the significance of such indications was common among most children producing diagnostically significant drawings" (Perkins, 1977, p. 10) these pictures indubitably suggest that "something knows" (p. 11). The validity of art as an index of a young patient's conscious or unconscious awareness of and response to her/his illness is unquestionable. Extensive uncovering therapy was not done with the subjects to examine the ramifications of their images. Sounding very unscientific and vague, Perkins reports that "[T]he images seem to speak for themselves" (p. 12). As is largely the case in Bach's (1966) work, the personal verbal associations and interpretations of their creators do not seem to be given primary importance. Death anxiety appears to exist fairly consistently among these studied subjects, often made evident in the usage of symbols "suggesting a generalized threat to the child's security" (p. 12).

Concluding this preliminary examination of the possibilities of such research, Perkins (1977) admits that this artwork evaluation is not a strictly controlled study of the data, nor is it statistically validated. In addition, the conclusions are drawn from only a small sample population group and the observation only short term (a six month period). Furthermore, says Perkins, the common subject matter of these respondents does not necessarily have validity to a larger group. Areas identified for future investigation are further evaluation of the quality of death anxiety and awareness in children, the symbol content among life-threatened children, and the utilization of art as a projective tool for seriously ill children.

The Simontons

Incorporation of aspects of Simonton, Simonton, and Creighton's (1978) theory and/or its practical application in several art therapy articles (including Baron, 1987; Halperin-Eaton, 1987, Kurtz, 1978; Malchiodi, 1993; and Musick, 1978) is indicative of the long-term influence their work has had on practitioners in this field and/or their clients.

A relaxation technique and mental imagery process play key roles in the Simontons' psychological cancer treatment approach. Both are among the most valuable tools the Simontons found to help patients learn to believe in their ability to recover from cancer and regain health. The patient's depressive attitudes of helplessness and hopelessness, significant factors in the development of cancer, can be confronted and altered by this dual process.

The pleasurable and energizing relaxation technique which the Simontons developed is a derivative of the program of "progressive relaxation" technique derived by Dr. Edmond Jacobson (in Simonton et al., 1978). Step-by-step instructions can either be followed from a cassette recording or read aloud by someone else. Sufficient time must be allotted for the participant to complete each step in a comfortable, relaxed manner.

The relaxation process is capable of reducing, through adequate discharge, the patient's bodily effects of the cycle of tension and stress. A major source of the latter being the at times overwhelming fear of cancer which frequently plagues its sufferers. This, in turn, often results in beneficial change in a patient's perspective and attitudes. Her/his "will to live" can be strengthened, and the desirable possibility of developing a more positive expectancy of disease outcome is increased. The patient's fear from feeling out of control begins to be tempered by the realization that s/he is capable of exerting some influence, or power, over her/his own body. It may have become thought of as being untrustworthy, a traitor, the enemy, toward whom the patient has become alienated but its re-acceptance may now occur. It can again become regarded as a source of pleasure and

as an important and valuable feedback source. This helps the patient's sense of control return and her/his belief in the ability to work with her/his body toward regaining health.

Participants in biofeedback experiments who learned how to control their physiological states frequently reported that they were not able to command their body to alter its internal state, but instead, had learned a visual and symbolic language by which they communicated with their body. The mental imagery process is a technique derived from biofeedback and is an effective motivational tool commonly used in many different disciplines for altering expectancies. It is also an important tool for self-discovery, a means of communication for accessing what lies in one's unconscious, and for making creative change in other areas of life.

The mental imagery process is to be used by the patient once s/he has achieved total physical relaxation. This serves to reduce tension that could distract the patient from concentrating. During the mental imagery process a participant creates a clear mental statement/image of desirable events, what one wishes to happen. By repeating this statement s/he soon comes to expect that the desired event will actually occur. The result of this positive expectation is the person begins to act in ways which are consistent with achieving the desired outcome, which in reality helps bring it about, functioning like a self-fulfilling prophesy. While the patient pictures her/his body regaining health and pre-disease problems as solvable, progress toward health is being made. S/he experiences a growing sense of confidence and optimism.

The purpose of the mental imagery process is to create positive beliefs that will activate the patient's body's defenses against disease. Learning to use mental guidance to produce physical change should strengthen the patient's belief that s/he can use her/his mind in support of her/his body. The successful experiences of thousands in using mental imagery to control body states suggested to the Simontons that used in conjunction with standard medical treatment it might be a way through which cancer patients could effect physical changes and beneficially influence their immune systems to become more active in

fighting their illness, perhaps even alter the course of a malignancy. In the Simontons' "and some other imagery techniques, the immune system is considered to be the mechanism by which the body actively combats cancer. . . [However] some researchers believe that other host resilience factors may contribute to life extension. [A critical point worth mentioning, then, is that] the immune system may or may not turn out to be the most important system by which psychological practices modulate cancer survival" (Lerner, 1994, p. 165).

The Simontons recommend that the following version of relaxation-mental imagery process activity be practiced by their clients in its entirety three times a day for ten to fifteen minute duration each time. Again, instructions can either be followed by cassette recording or read aloud by someone else, and plenty of time must be allowed for the participant to complete each step. Once having attained relaxation from head to toe, the participant is to mentally picture her/himself being relaxed and comfortable in pleasant, natural surroundings. Details of color, sound, and texture are to be pictured for two to three minutes.

The majority of the numerous ensuing mental imagery process steps are specifically the cancer portion of this activity. Next, the patient is to mentally picture her/his cancer either in realistic or symbolic form. The cancerous cells should be envisioned as being very weak and confused. The fact that our bodies destroy thousands of such cells within a lifetime should be kept in mind. While picturing the cancer, a patient should realize that her/his recovery requires that the body's own natural defenses return to their normal healthy state.

If the cancer patient is undergoing conventional treatment, s/he should mentally picture it coming into her/his body in a way that is personally comprehensible. It is suggested that radiation be envisioned as a beam of millions of bullets of energy hitting any cells in its path; normal cells being able to repair any damage suffered as a result while cancer cells are not because they are weak. This is one of the facts upon which radiation

theory is built. The recommendation for chemotherapy treated patients is that the drug be imagined as entering her/his body through the blood stream. It should be pictured as acting like poison. The normal cells, to be portrayed as being intelligent and strong, are not readily induced by such. The absorbent and weak cancer cells, however, are easily killed by it. Once these have died, they are to be seen as being naturally flushed out of the body.

The body's white blood cells should now be envisioned as being very intelligent, very strong and aggressive, and composed within a vast army. They come into the area(s) where cancer is located, recognizing and destroying any abnormal cells in their path. There is no contest between them--the white blood cells will always be victorious in this battle. The cancer should now be mentally pictured as shrinking in size, continuing until it finally disappears. All the while, the patient should be envisioning her/himself as gaining energy, a better appetite, and being able to feel comfortable and loved within her/his family.

If pain is being experienced within the body, the patient is to picture the army of white blood cells flowing into that area and soothing the pain. In fact, whatever the remaining problem the patient is to command the body to heal itself. The body is to be visualized as becoming well. The patient is to imagine her/himself being well, free of disease, and full of energy.

The dead cancer cells are to be envisioned as being carried away by the white blood cells, and flushed from the body through the liver and kidneys, and eliminated in urine and stool. This is representative of the positive expectancy the patient wants to happen.

The accomplishment of one's life goals and the fulfillment of one's life's purpose can now be envisioned, as well as family members doing well and other interpersonal relationships becoming more meaningful. Priorities in life should now be clearly focused on. Having strong reasons for being well will help the patient to get well.

The patient should visualize her/himself doing this relaxation-mental imagery exercise three times a day, and staying awake and alert to do it. Positive reinforcement such as a mental self pat-on-the back should be given for participating in one's own recovery. The remaining steps of this process are to let the muscles in the eyelids lighten up, prepare one's self for opening the eyes and becoming aware of the room, do so, and resume usual activities

The Evaluation of a Cancer Patient's Mental Imagery Through Her/His Drawing

"Imagery is potentially important in healing because it may, in some circumstances, act as a blueprint or set of instructions to the body, as an intermediary between thoughts and physiological changes" (Cunningham, 1992, p. 107). With time, as the Simontons witnessed the experiences of more patients, they came to recognize the tremendous importance of examining the specific content of a patient's mental imagery, and its determining effect on her/his state of health, that is, whether it is enhancing or impeding the treatment of her/his disease. Baron (1989) believes that "individuals using imagery need direction" and warns, "images can harm as well as heal...it is vital not to rely on verbal reports of one's imagery process, but rather to use subsequent drawings...to observe that an individual is shoring up defenses through imagery, rather than tearing them down" (p. 167). The Simontons came to realize that their patients' imagery revealed their underlying beliefs toward their disease, and recovery expectancies. Baron (1989), having much the same philosophy as the Simonton research team, in her practice of art therapy uses very similar imagery and art techniques and has also found that "the artwork and imagery of the cancer patient provide needed clues to individuals' attitudes and the subsequent effect these attitudes may be having on their present and future physical state" (p. 149). Imagery and events being experienced in the patient's life the Simontons also identified as being correlated. In addition, they discovered that the imagery content was consistent with the patient's psychological state at the time of its execution and therefore

could be used as a source of feedback on the patient's psychological progress or lack thereof.

As a result, the Simontons began to request that every three months, following the completion of all the individual steps of the relaxation-mental imagery process, their patients draw a sketch of their created mental imagery and then describe it aloud to them. The idea behind this is that analysis of the imagery documentation will help identify a patient's current beliefs and attitudes toward participating in her/his health. Cancer patients' early drawings can be compared with more recent ones, revealing how their beliefs in dealing with cancer have evolved. An explanation for the Simontons' choice of time frame is not given. Considering their rationale for implementing this procedure (as discussed above), in particular, their belief that a patient's mental imagery can have a negative effect on her/his state of health, and impede her/his treatment, the lengthy interval between examinations of their clients' tangible imagery seems potentially damaging.

Sounding oversimplistic, the Simontons state that any desirable alterations in a patient's imagery and symbols can be made thereby changing her/his beliefs and attitudes to be more compatible with health recovery. Baron (1989), on the other hand, is not as simplistic in assumptions, and writes "The imagery and drawing of the cancer patient do not exist in a vacuum, nor can they be changed through the suggestion. The colors an individual chooses, where symbols are placed on the page, and the intensity with which illness is drawn have roots deep in the individual's psyche" (p. 150). Here, "the art therapist's skills are called into play to point out how individuals may increase the positive power of their symbolism and grasp its negative ramifications" (p. 167). In this way, like the Simontons, Baron "encourage[s] modification of the art for the purpose of effecting positive physical as well as emotional change" (Wadeson, 1989, p. 3). Whether the former action actually does ensure the latter desired results remains an open question. "The extent to which the altering of an individual's image will concretely change the course of disease still remains to be seen" (Baron, 1989, p.167).

The Simontons' patients are fully informed of the purpose of the drawing procedure. They are encouraged to embrace the whole relaxation-mental imagery process, including this additional periodic graphic element. Further, their attitudes toward the entire process, as well as any changes in their imagery are to be recognized as an important guide to their psychological states, and therefore, important sources for personal reflection. This encourages the patient's active participation in the process of expectancy and her/his taking a measure of control over it

In consultation with Dr. Jeanne Achterberg-Lawlis, a research psychologist, the Simontons developed a list of criteria that can be used to evaluate the content of a patient's mental imagery. It came to be their observation that the cancer patients who fared the most well within their cancer treatment program consistently came to develop imagery generally containing eight significant features or symbolic qualities. The symbols themselves vary from patient to patient. The cancer cells are confused, weak, and soft--capable of being broken down. The cancer treatment is strong, powerful, and clearly capable of destroying the above. Significant interaction between the treatment and cancerous cells strengthen the imagery--the impact of the former on the latter visible and comprehensible. The normal, healthy cells which are affected by cancer treatment are strong enough to repair any suffered damage which is minimal. The white blood cells are vast in number (an army), easily overwhelming their opponents--the cancer cells. These white blood cells are intelligent, very strong, aggressive, eager for battle, and, without a doubt, capable of promptly seeking out the cancer cells, overpowering, and destroying them. The dead cancer cells are flushed out of the body normally and in a natural process. By the completion of the imagery process the patient sees her/his body as healthy, vital, energetic, and free of cancer. Patients see their goals in life as being reached--their life's purpose fulfilled.

According to the Simontons, the most crucial symbol of the imagery process is the white blood cells which represent one's belief in the ability of her/his body's natural

defenses/healing process. The white blood cells symbols and their potency have been interpreted as representing the extent to which the sufferer wants to live--the life-sustaining, nurturing part of her/him that will help her/him to get well. In using imagery and art with clients having cancer, Baron (1989) has found that "the size, shape, color, and density of one's white blood cells became representational of how individuals viewed their body's healing resources" (p. 166). The Simontons stress the importance of the white blood cells being envisioned as stronger than, and outnumbering, the visualized cancer cells and being more vividly portrayed within the imagery as the most potent factor in defeating the malignancy. The symbols of cancer and its potency have been interpreted as representing the self-destructive, toxic parts of the individual that want to die--the part that is killing her/him. They also believe that the way in which the patient depicts her/his cancer treatment is a communication of her/his belief in its level of potency. The way in which the flushing of the dead cancer cells out of the body is depicted is interpreted as a communication of a patient's level of confidence in the body's natural and normal functioning. The presence of some form of magic or divine intervention to assist with the process is indicative of a stronger belief in the powerfulness of the cancer. A patient's desired final outcome, the Simontons believe, is portrayed in how s/he envisions the self at the end of the imagery process. In addition, how the patient pictures her/himself in the attainment of life's goals is said to communicate the extent of the patient's reasons/commitment for living, as well as the level of confidence in belief of her/his health recovery: this phase of the mental imagery process being highly significant. Once analyzed, images that need strengthening or changing can be identified, and alternatives that contain more positive expectancies can be suggested to the patient.

The Simontons have identified the problems patients commonly face in creating the most recovery effective cancer cells, cancer treatment, white blood cells, flushing out of dead cells, healthy self, and goals imagery. As well, they propose the possible correlated inhibiting beliefs. The following are a few of the specific, practical mental imagery

suggestions which they offer for overcoming some of these problems, and for creating a more positive recovery expectancy. A patient who experiences difficulty visualizing cancer is advised to imagine a mass of gray cells located within the body where cancer is known, or believed, to be present. The purpose of suggesting this neutral color is one aspect of the psychological cancer treatment approach's attempt to neutralize patients' often strong emotional feelings about cancer--black and red being the colors which people commonly use to describe their cancer, and which have strong emotional connotations. Treatment should be made personalized and visualized as a helpful friend and ally who is working with the patient to beat the disease of cancer. Patients whose attitudes have been changed in positive, supportive treatment directions have reported reduced treatment side effects. In cases where the white blood cells imagery needs to be strengthened, patients are to project onto a screen in their mind's eye a clear image of those cells as fish swimming within, and consuming, the gray cancer cells. Then the patient is to imagine her/himself as one of the fish, act as the leader of the pack of fish, and take the rest of the fish into an attack. S/he is to experience the sounds and emotions of being one of the fishes eating the cancer cells, destroying them, and cleaning up the remaining debris. Another piece of advice in visualizing these white blood cells is to attribute them with strong traits or characteristics which one admires in oneself. To help create positive, effective mental imagery of a healthy self, two approaches are recommended. The self can be pictured engaged in activities which were enjoyed when the patient was healthy, or s/he can experience the overall feelings s/he has had when well. Visualizing oneself when one was the healthiest and creating present images of such feelings is another. For the goal imagery, patients are encouraged to see themselves as reaching their objectives and enjoying the satisfaction of having done so.

Presented in a straightforward, easily comprehensible style, the Simontons' cognitive-behavioural cancer treatment program may sound deceptively simple. Yet, these practitioners assign their clients tasks which, based on my understanding of

psychodynamic issues, involve considerable psychological work. Experienced in the best of circumstances, changing one's attitudes, belief system, personality in terms of self-perception, behaviour, outlook on life and one's problems, and attaining new, improved skills for coping with stress, for example, is very difficult to face, let alone accomplish. The Simontons write that oncology patients need a great deal of personal courage [and strength] to be willing to try to alter the course of their cancers through their mental and emotional processes. I would add to this that tremendous self-discipline and dedication are required to invest the time, effort, and mental energy which a commitment to their program necessitates.

Another of my criticisms centers on the controversy which surrounds the Simontons' premise that an individual's reaction to stress and other psychological factors play a significant role in her/his susceptibility to the disease of cancer, contribute also to the progress (or recurrence) of it, but are capable, as well, of influencing improvement in her/his physiological condition and contributing to health recovery. Critics of the philosophy of self-healing have raised serious, legitimate concerns regarding the potential negative consequences of a cancer patient's adoption of this theory. One of the dangers is that by accepting that one actively participated in the onset of her/his cancer, identifying and assuming the responsibility for the ways in which this occurred, the individual with cancer may suffer from the burden of guilt, "which is the other side of the coin of supposed psychological control over the development or spread of the disease" (Spiegel, 1990, p. 363). Adopting the belief that through one's efforts the cancer patient can control--even reverse, the disease process (cure) and make one's self well again, may not only promote unrealistic expectations but also instill a sense of fear. The patient may become mentally and emotionally guarded against repeating her/his inappropriate stress-coping mechanisms, negative attitudes, and maladaptive behaviour, on which the Simontons place emphasis (Berenson, 1988). This, undesirably, adds to the numerous disease-related stresses which s/he is already having to deal with. If, by practicing the

Simontons' techniques, significant physiological results are not forthcoming (that is, the cancer is unaffected) the patient may blame her/himself. A lapse in health (metastasis or recurrence) may be interpreted as a personal failure, and evidence that s/he did not do her/his part in recovery, did not try hard enough, do her/his relaxation - mental imagery process, for example, frequently, or well, enough (Berenson 1988).

The Simontons (1978) write "it is not our intention to make anyone feel guilty or frightened--that would only make matters worse" (p. 70). Instead, they hope that if a cancer patient personally identifies with the psychological process which they describe as frequently preceding the onset of this disease, that s/he will receive it as a call to action and make changes in her/his life. Despite the Simontons' intentions, some individuals with cancer, who have read and interpreted their techniques, without careful explanation and guidance by a professional, experience such overwhelming guilt and fear that they become immobilized, which, of course, is clinically unproductive (Berenson, 1988)

My third and final criticism to be briefly introduced follows. In the opening chapter of Simonton, Simonton, and Creighton's book (1978) they report the results of a study they conducted "aimed at distinguishing the effects of emotional and medical treatments to demonstrate scientifically that the emotional treatment [which they were providing] was indeed having an effect" (p. 10). The statistical findings which they quote are nothing less than impressive. Over a four year period, of the 159 patients diagnosed with medically incurable malignancies who were treated, the median survival time (since diagnosis) of the surviving 63 patients was double the life expectancy for this population based on national norms, as well as that of a matched control group who received medical treatment only. Even the patients in the study who died had a survival time one and a half times longer than those within the control group. The authors state, in their ensuing introduction of the description of the theory on which their psychological approach to cancer treatment is based, that those chapters "are not an effort to prove the validity of [their treatment] approach to the scientific community" (p. 13). Written as a

psychological self-help guide to overcoming cancer for patients and their families, not presenting a rigorous empirical methodology may be understandable but, in my opinion, it does disservice to their work. Not only could this result in stronger scientific evidence of the effectiveness of the psychological treatment approach to cancer which the Simontons are proponents of, it would also make other researchers' evaluation of their study experiment possible, enabling the assessment of its validity and reliability, as well as provide the means by which to conduct studies attempting to replicate the Simontons' findings.

Cunningham (1992) advises caution in drawing strong conclusions from these findings, explaining that the people choosing to engage in such special complementary cancer care "are in many ways different from average, being younger, more enterprising, of higher socioeconomic status, and so on" (p 63). Further supporting a bias of the sample of experimental subjects who were studied by the Simontons, which could severely limit any generalizations of their findings, is the suggestion that these researchers weed out all but the cancer patients who are most determined to succeed, and benefit from their program. That is, the Simontons make a concerted effort to enroll in their program only those individuals having a positive attitude toward treatment, goals for living, a will to live, and a strong and positive belief that they will survive the disease of cancer (Johnson, 1990).

Furthermore, of particular relevance to this research paper's hypothesis, no definitive conclusions can be drawn regarding the benefits the utilization of the Simontons' mental imagery protocol, the process of drawing the imagery and the resulting imagery evaluation and, if needed, revision may have on a cancer patient's health recovery. As one of several components of the Simontons' comprehensive treatment program it is impossible to isolate the cause of any improvement in a participant's physiological condition. It could result from any one or a combination of a number of confounding variables, such as the orthodox medical treatment s/he is simultaneously engaged in, other

treatment interventions also incorporating relaxation and visualization techniques, the group and individual psychotherapy sessions, and lifestyle change (diet, and/or regular physical exercise for example), or possibly from the placebo effect. According to Cunningham (1992), to date no scientific studies with adequate controls have been conducted

“where mental imagery has been used as the sole or principal treatment mode to affect serious ‘organic’ diseases like cancer. Also, equivocal results have been obtained in those few studies where attempts have been made to influence the immune system with imagery.. , and in which rigorous comparisons have been made to a control untreated group. [However] this does not mean that imagery cannot affect immune function or disease progression, only that it is as yet unproven by conventional standards” (p. 108-109)

Siegel (1986, 1989), a surgeon, also advocates mind-body approaches to cancer. He follows in the footsteps of Bach (1966, 1975, 1990) and Simonton, Simonton, and Creighton (1978) using imagery and a drawing component with cancer patients, considering these useful diagnostic, therapeutic, and prognostic tools. Unlike the latter, and Achterberg and Lawlis (discussed below), however, Siegel is not comfortable with promoting to his patients their adoption of warfare-like disease imagery, which he believes goes against the sensibility of most of us and patients' sources of inner strength. To individuals for whom this aggressive imagery approach is unsuitable he proposes alternative visualizations in which the cancerous cells, instead of being attacked and killed, are ingested as a source of growth and nourishment. The physiological effectiveness of aggressive vs gentle imagery in reversal of cancer is a source of debate among imagery practitioners (Lerner, 1994). Siegel relays many anecdotes about patients who have experienced a temporary, and at times permanent, regression of apparently terminal cancers. Such evidence alone cannot be conclusive. A presentation of research data would carry much more weight. Yet, the efficacy of Siegel's imagery techniques, like those of the Simontons, have not been subjected to experimental test.

Achterberg and Lawlis

Believing in a relationship between imagery and the healing or disease process, Achterberg and Lawlis (1984) further expanded upon their colleagues' (Simonton, Simonton, & Creighton, 1978) work, refining a theory and practice of a technique which they refer to as "body/mind imagery". The IMAGE-CA [cancer] technique which they developed is a psychological instrument for analyzing the imagery content of cancer patients, which "reflects their attitudes about their disease and treatment as well as any belief they might have in their innate ability to overcome the illness" (Achterberg, 1985, p. 188). As in the work of the Simontons, a correlation has been shown between the optimism in a subject's imagery and her/his resistance to disease progress, at least in the short-term. Using this diagnostic assessment tool, which they empirically tested, both the effectiveness of a patient's imagery is evaluated, the future development of her/his disease is predicted, and a plan to treat the cancer can be devised

During the development of their IMAGE-CA technique, Achterberg and Lawlis' (1984) research plan had two goals to come to a broader understanding of cancer patients from an holistic perspective--to be able to explain their behaviors in general but also how they behaved towards their disease, and to formalize this understanding to enable other health professionals to reach the most effective level of communication with the cancer patient, which sounds reminiscent of Bach (1966). These researchers believed that for medical practitioners to develop a better understanding of disease management, they needed new instrumentation specific to cancer and its psychological components. Briefly, the objectives for the design and construction of the IMAGE-CA instrument were it should form a closer communication link between physician and cancer patient; it should assist a cancer patient to participate in her/his rehabilitative process, and it should allow a cancer patient's physician to anticipate the course of disease, better predicted by psychological variables than medical measures (Achterberg, Lawlis, Simonton, &

Simonton, 1977, in Achterberg & Lawlis, 1984). The latter predict from a post hoc dimension in that physical measures are primarily reactive to disease state. With predictive measurement, on the other hand, the physician can provide treatment protocols for future disease complications, as well as engage psychological intervention methods, if needed. Although I believe that Achterberg and Lawlis were successful in creating the IMAGE-CA instrument which is capable of fulfilling their objectives, implementing its use is a totally different issue dependent upon the receptivity (and will) of others, including physicians as well as patients

Achterberg and Lawlis' three-part process begins with the patient achieving a relaxed state, so as to be able to focus and imagine aspects of her/his disease. Next, the same relaxation and guided imagery instructional audio tape recording briefly educates the patient (as should the therapist be) on the immune system, the disease process, and how treatment might work. Such information is said to significantly aid image formation. Lastly, s/he is given the opportunity to imagine these factors in operation and then instructed to draw a picture of how the aforementioned three factors pertain to her/him (i.e., what did her/his imagined tumor(s) (disease or cancer) look like in her/his mind once s/he had relaxed?, what about the body's defenses against the tumor, represented by white blood cells?, and whatever medical treatment s/he chose to portray?). Achterberg and Lawlis' procedure differs here from that of the Simontons. Wanting to keep their imagery study simple, subjects are supplied with reproduction pens or pencils only--therefore, no colors are provided. These researchers endorse the extended development of the IMAGE-CA to include the variable of a colored palette. Also, rather than specific guided imagery suggestions being given for visualizing the disease, treatment, and immune system components, the cancer patient is allowed considerable choice in imagery. It is my opinion that one of these approaches may have more personal suitability to the individual patient and therefore be a more effective treatment technique to use with her/him.

In the ensuing highly structured interview both the patient's drawings and her/his verbal explanations of the above drawn factors are evaluated, for standardization and quantification purposes, on fourteen scoreable dimensions, using 5-point scales ((1) considered weak or ineffective and (5) considered as strong or most desirable) The first three of these dimensions--the vividness, activity, and strength of the cancer cells fall into the category of the disease (cancer) imagery The next division of dimensions have to do with the body's defenses or immunity (white blood cells). These are the vividness, and activity of the white blood cells; the relative comparison of numbers and size of cancer cells to white blood cells; and the strength of the white blood cells Treatment (radiation, chemotherapy, immunotherapy, surgery, or a combination of these) categorizes the third dimensions division--the vividness of the medical treatment, and the effectiveness of the medical treatment. The concreteness versus the degree of symbolism in the imagery is the next dimension. Another distinction from the Simontons' work, Achterberg and Lawlis (1984) believe that the key to a cancer patient having a better recovery chance is for her/him to get the imagery into symbolic form, as opposed to that which is realistic or anatomically correct. Another source of debate in the field of imagery centers on which of these techniques is more powerful than the other (Lerner, 1994) Most clinicians are inclined to believe that the former representations can be just as powerful or more powerful for some patients than the latter (Rossman, 1987, in Lerner, 1994) The overall strength of the imagery; the emotional investment that the patient projects to his drawing is the next scored dimension The regularity of the number of times per day the patient thinks of her/his disease in the described way is then estimated

In the fourth and last division in the analysis of imagery, an overall clinical judgment is made by the examiner related to prognosis, based on the above combined imagery factors being rated in much the same way as the criteria by Simonton et al (1978). Subtle cues imparted by the patient to the therapist or researcher, indicating her/his ability and willingness to participate in disease management, and the significance

and meaning s/he attaches to the images are important influential factors included here as well. Achterberg and Lawlis (1984) advise that interviewer -evaluators with less experience than fifty IMAGE-CA technique administrations omit this subjective fourteenth dimension, as high variability would be expected.

To clarify the meaning of these fourteen imagery variables, Achterberg and Lawlis (1984) conducted an intercorrelation analysis with other psychodiagnostic measures. It was found that the dimensions involving imaging the cancer, by and large, seem to be reflective of the more permanent and enduring "traits" of the cancer patient. The white blood cell imagery was related to a number of mood or "state" characteristics, suggesting their high variability and high dependency on current factors. Cancer imaging was found to be a more constant phenomenon and "did not relate to short-term disease progress to the extent that the white blood cell factors did" (p. 131).

From a clinical standpoint, the examination of a cancer patient's choice of imagery symbol(s) seems appropriate for taxonomy, in that various symbols can be related to stabilization or remission, or associated with physical decline. Many of the symbols identified are either ancient archetypal figures or traditional representations of figures of good and evil. Cancer patients who use knights, vikings, or large, powerful animals, especially dogs and bears, in their imagery typically respond well in the treatment process. These symbols are associated with a healthy attitude and have a positive connotation, that is, are predictors of favorable disease process management. Small insects--ants especially, crabs, scorpions, lobsters, and octopi, on the other hand, from a statistically predictive standpoint, are a poor sign as they are not associated with good disease outcome. Mechanical devices such as vacuum cleaners, automatic sprinklers, shovels, or picks are additional negative symbols. Achterberg and Lawlis (1984) believe that this is, in part, because they do not have their own natural source of energy. Also not associated with cancer patients' overall "good" imagery are fire, poison, or acids--highly destructive elements which apparently relate to the degree of a patient's discomfort and pain.

Achterberg and Lawlis (1984) have noted, as well, that the majority of unhealthy cancer patients tend to describe their disease element symbolically, while their white blood cells are more realistic in their portrayals; much more energy is spent on symbolizing cancer cells by patients with the poorest prognoses, while patients with favorable prognoses invest more energy in their projection of immunological mechanisms

Using imagery as a therapeutic tool, Achterberg and Lawlis (1984) do not impose on a client, as do Simonton, Simonton, and Creighton (1978), a change in her/his personal metaphor, rather they work with her/him to strengthen it for example, so that it is more likely to help her/him fight the cancer. They do believe, however, that it is important that a patient's images be in agreement with fact and for this to be ensured disease education may be required. Imagery can then be changed so that it conforms with what is known about the human body. The individual is helped to go beyond what Simonton et al. do, in learning how to live with, work on, her/his illness

Achterberg and Lawlis (1984) write, much to my surprise, that "working with a patient to alter imagery so that it reflects a more positive expectancy is frequently readily accomplished. [However, more as I would expect] at other times it is a task fraught with trauma and difficulty" (p. 110). In the latter cases, they recommend that a patient's resistance must be sensitively examined. "Any attempts at intervention or convincing the patient to fight to alter the course of the disease may be highly disrespectful of [her/his] inner desires" (p. 110). The Simontons express a similar sentiment "since patients could direct the course of their recovery, we also had to admit that they could--and should--direct the course of their dying, if that was the direction in which they wish to move" (Simonton et al., 1978, p. 220-221)

Achterberg and Lawlis (1984) provide a solid, in-depth empirical methodology description of their IMAGE-CA technique. This includes its administration, which is simplified with the help of a carefully designed and thorough Interview Record and Scoring Sheet booklet, which includes a summary of the data collection and has

straightforward, easy to comprehend instructions. The evaluations of both thirteen and fourteen imagery dimensions (that is the scoring systems), the procedures used to determine a cancer patient's overall score, and the interpretation of score results in terms of disease processes are also clearly explained.

In order to determine its reliability and validity, these researchers conducted two normalization studies on two diverse samples of the cancer population utilizing their IMAGE-CA technique. During its initial development Achterberg and Lawlis worked with patients of the Simontons. Ranging in age from 20 to 61⁺, these fifty-eight individuals having cancer are described as white, middle-class, highly articulate, well-educated, and insightful. Many were physicians, biologists, psychologists, allied health professionals-- "an elite group of psychologically oriented patients" (1984, p. 2). All were familiar with relaxation, meditation, and imagery technique. The criterion of this group was disease status, the degree of tumor involvement. Each subject had the diagnosis of Stage IV metastasized cancer, with a five percent chance of five-year survival. Interesting to note, this sample was said to be representative of people who seek psychological services following diagnosis of serious disease, with a 62% female - 38% male ratio.

The second normative group studied consisted of twenty-one low-income, racially mixed cancer patients. Many of them were indigent, and economically dependent upon government resources. Some were veterans with a history of alcoholism. Very few of these subjects would have considered utilizing imagery or going to a psychotherapist to gain help with their disease. These were primarily post surgery mastectomy patients whose disease process varied from "no known disease" through widespread metastasis. The criterion of this group was the degree of patient functionality.

For both of these study groups Achterberg and Lawlis (1984) provide a sufficient description of the methods by which reliability and validity of their technique was measured, and the results. In the first study, both interdimensional correlation and interrater correlation reliability analyses were statistically significant. Also, the concurrent

physiological validity, as well as the predictive validity, of this instrument was upheld. One related limitation was acknowledged by these investigators. In the combined dimensions scoring, both with and without the clinical judgment item, no disease process prediction can be made for scores between the top and bottom scores. In the second normative study, which is not a replication or a cross validation, the consistency of analyses of interrater reliability and the concurrent validity of the IMAGE-CA with disease process were again substantiated. Unlike in the previous study, a long-term follow-up is not conducted, eliminating the predictability variable. According to Achterberg and Lawlis (1984) their research has been replicated, as well as clinically validated by contacts from around the world.

A controversy surrounding the use of imagery as a therapeutic tool remains. The question is

“whether the images of cancer, as measured by the IMAGE-CA, are correlative factors reflecting a sort of ‘body wisdom’, [like what Bach refers to] or whether they could also be causative in terms of inducing physical change...The fact that [this technical instrument] was predictive of subsequent disease change as well as the literature reviewed, which demonstrated the potency of imagery in altering physiological function would suggest an element of causality. In order for imagery to have any effect on cancer remission, though, it would logically have to impact upon and, in some unknown way, direct the functioning of the immune system” (Achterberg & Lawlis, 1984, p. 141)

Graves

Graves (1982) believed that approaches to counseling children with cancer would be more effective if they were consonant with the child's level of understanding about her/his physical condition. Interested in developing a relatively simple means of ascertaining this, in a preliminary report she proposed to conduct a pilot study of the prognostic value of the drawings of thirty children diagnosed with malignancies, aged 5 to 19 years. The subjects would be divided, by a physician, into low, average, and high risk

groups (with their respective survival rate percentages identified). Graves hypothesized that if children do have an awareness of their bodily state, as previous investigations have suggested, and if that intelligence is manifest in their graphic expression, then their drawings of a battle between their cancer and their defense system should be able to differentiate among their creators' varying prognostic groups. Concerning the nature of the sample, whether the patients would be long-term or recently diagnosed at the time of their selection for the study was not specified. In addition, neither the number of subjects in each risk group nor the distribution of the range of their ages within each group were discussed. These details are necessary to know in order for another investigator to be able to replicate the study, and, in my opinion, alone or in combination they could seriously bias the applied statistical testing from which the study conclusions are drawn.

Using a modification of the Achterberg (1984) instructions, individually and privately these clinic outpatient respondents would be asked to draw a picture, any way they wished, of the "battle" between their cancer and their defense system. An essential study component, it is not clear if, and what, standardized preliminary explanatory description of the defense system is given to subjects. This would have to be mental-age-specific considering the range of their ages. A clarification of this would be necessary for replication of this experiment. Graves developed a scoring system of the battle, consisting of six dimensions to be evaluated on a five-point scale. A (1) would indicate that the cancer is winning the battle and a (5) is the most positive imagery assessment, of the defense. The six items to be judged are the relative size of objects drawn for cancer and defense; the relative number of objects drawn for cancer and the defense system; the powerfulness (as typified by the depicted symbol, strength of lines, definition of form, and color) of the defense imagery in relation to the cancer; the actual area covered on the page in portraying the battle (measured with a grid); the appearance of aggressiveness of the objects drawn for cancer and defense (as typified by activeness and kinesthetic method of drawing); and effectiveness of the battle between the disease and defenses based on the

interaction between these objects. In addition, the colors subjects use would be noted to determine any significant use of color in either the cancer or defense.

Two additional non-graphic testings would be consecutively administered to the study subjects. The entire battery would take about one to one and a half hours. First, to determine her/his approximate level of cognitive functioning, in the Peabody Picture Vocabulary Test the child would be asked to choose from a picture series the picture which best represents the answer to a question. This test should be administered during the same visit in which the drawing will be completed, or in a session following shortly thereafter. Next administered is a semantic differential scale, which Graves designed to help the subjects verbally describe their condition. The children respond to two series of pictures of "space-invaders", one to do with cancer and the other with sickness, each with six pictures. These six pictures each contain five separate images. The child is to identify within each picture, which polar adjective of its five images, best represents her/his feelings about the disease and the illness. Both of these tests do not seem age-appropriate for teenage subjects in the study. This is not discussed by the investigator.

The battle drawings would be judged by two art therapy graduate students, who are not familiar with the children or the study. They would be trained by the investigator in the use of a battle rating scale. Interrater reliability of these individuals would be attained. Scores obtained on the six items of the battle scale, the semantic differential scale, and the IQ derived from the Peabody Picture Vocabulary Test would be subjected to a Multivariate Discriminate Function Analysis. "This statistical procedure will ascertain which items and combinations of items discriminate among the three risk groups" (Graves, 1982, p. 93).

The results of Graves' study, according to Achterberg and Lawlis (1984), were as follows. The battle rating scale dimension of powerfulness (of the defense imagery relative to that of the cancer) was revealed by the stepwise discriminate function analyses as the best discriminator between high and low medical risk groups of children with cancer.

The upper end of the scale evaluation of the area of the page used to depict the battle was also found to discriminate independently between extreme risk groups of twelve children with leukemia as were four additional characteristics: mental age, chronological age, and originating from the semantic differential scale, the meaning of cancer as large to small, and the meaning of cancer as dying or living. Actual data collected and the statistical test procedure from which these results were derived were not presented by Achterberg and Lawlis (1984). Graves concluded that data suggest that the life-threatening nature of these children's illness is conveyed in their drawings as is their awareness of their condition. As a measure of children's understanding of the seriousness of their illness, then, the drawings are clinically very useful. These images also serve as a record of these individuals' ability to cope and their execution, as a type of play, may facilitate the same, helping the children's verbalizing of concerns and clearing up any misconceptions they may have about the disease and its treatment.

CONCLUSION

In review, it was revealed in the introduction of this research paper that the experience of my mother's suffering and death from the disease of cancer is a primary motivation behind both my exploring academically herein and, next, professionally as a practitioner, the viability of art therapy as an adjunctive intervention within the treatment plan of adults diagnosed with cancer.

Initially, the practice of art therapy as an adjunctive intervention for individuals suffering from this disease was appropriately situated within the context of "Medical art therapy"--the branch of this profession which is being practiced with medical, as opposed to traditionally psychiatric, populations, and within medical settings. Possible explanations given for this ever-expanding field are the development of liaison psychiatry and/or the discipline of psychoneuroimmunology, as well as increasing popular and professional interest in mind/body connections. Serving as an introduction to the field of specialization with which this paper is concerned, as well as to the more in-depth examination of my area of inquiry, is the ensuing overview of various aspects of the contemporary practice of art therapy and art as therapy with cancer clientele, as derived from a literature review. This represents the accomplishment of my self-imposed academic goal of finding out if such clinical work is being done, and is being written about in what kind of sites, where on-site, within what context, with what oncology diagnostic populations, utilizing what art therapy approaches/interventions, and media, for what clientele, and with what frequency. The fact that this clinical practice has been, and is currently being, done strongly supports the credibility of this paper's thesis.

Indicating an acute need and a field wide open for research in the future, the Methodology section of this research paper made it abundantly clear that literature resources which document, in any depth, specifically the practical application of art therapy with adult oncology clients are almost non-existent. Consequently, identified as being prominent realities of this medical population from my past personal experience

as well as their repeat references within the literature, oncology clients' important psychosocial issues/tasks of coping with physical pain, loss, and (for some) terminal illness are then consecutively presented within the current theoretical perspectives, obtained from a second literature search for relevant supplementary sources. Individually these serve as a foundational link to a respective discussion of the unique, valuable--if not vital--contributions the practical application of the art therapy modality can make in these areas of cancer treatment and care.

Having begun by establishing the position that a comprehensive pain management treatment plan must address both a patient's interrelated physiological and psychological states, the successfully proven adjunctive art therapy pain intervention models of Shapiro (1987), Landgarten (1981), and Halperin-Eaton (1987) were then described. Collectively these highlight the discipline's usefulness in this context as a tool for diagnosis, assessment, treatment, and (pain self-management) prognosis. Each of the approaches outlined is firmly grounded in mind/body connection, and includes a client insight-oriented component. These art therapy practitioners' common goal of decreasing, or eliminating, their patients' physical pain, as well as their dependency on medication(s), also serves as a preventative measure against drug addiction. From a purely economic standpoint, this could result in substantial savings to the health-care field. Given that documentation of the practical application of the art therapy modality within pain management treatment programs (and its benefits) is almost non-existent, it seems unfortunate that as they have presented them, neither Shapiro's nor Halperin-Eaton's technique procedures are sufficiently described to be able to be duplicated by art therapy practitioners who might wish to test their treatment effectiveness, for possible implementation within their cancer patients' intervention plans.

Next, numerous psychological, physical, social, and/or behavioral losses, which an individual having cancer may have to face, were identified. It was suggested that her/his recovery from these stressful experiences entails a process of grieving which must be fully

completed. Within the framework of three consecutive stages of art therapy bereavement intervention, which are correlated with the three stages of treatment for psychological trauma, reasons are given for why and how the art therapist, the therapeutic relationship, the therapeutic space, art process and products all can address the therapeutic needs of a bereaved oncology client and facilitate the desirable achievement of the ultimate resolution of her/his grief. Again, the modality of art therapy can be a form of preventative medicine for serious psychological, physiological, sociological, and behavioral problems which could otherwise develop from unresolved conflicts. Despite its creator's adequate theoretical and practical application descriptions, in my opinion, implementation of Simon's bereavement intervention could prove difficult for other art therapists.

In the Terminal Illness section of this research paper, medical and technological improvements, a longer life expectancy, and the institutionalization of dying were identified as contributing factors in an increase in the number of life-threatened individuals requiring health-care service. In a society where death and dying largely invoke the defense of denial, and medical caregivers are primarily trained to attend to the physical needs of their patients, the practice of art therapy was promoted as having a vital role to play in meeting the too often neglected psychological needs of these individuals facing impending death. Art therapy bereavement intervention is also of valuable service in facilitating these clients' passage through the five sequential stages of grieving being bereft of life: denial, anger (and isolation), bargaining, depression, and acceptance of death.

Several inherent qualities of the art therapy discipline which make it a unique treatment modality particularly suited for addressing the needs and deficits of the terminally ill population were then offered. These include being able to think in primordial images and thus acquire an instinctive understanding of death, not attainable through conscious thought, which, in turn, can help the dying process their situation, a non-verbal means of communication allowing more freedom in self-expression of fears, feelings, hopes, because the interdiction of death can thereby be overcome, and the opportunity to

express that which is verbally inexpressible, as well as, multiple and often ambivalent feelings in a single image. Also discussed, with reference to the case studies by Lichtenthal (1985), Rudloff (1985), and Kern-Pilch (1980), is the importance of the development and maintenance of a therapeutic alliance and its value to those who are terminally ill as a source of support, companionship, and an escort to, and witness of, dying. Patient transference--the taking on of the art therapist as her/his auxiliary ego is suggested as fulfilling the dying person's need for relatedness, and bonding.

As well, this population's tendency toward regression was discussed as being a natural, adaptive coping mechanism, possibly representing a client's attempt to complete an unresolved stage of development. It was proposed that a dignified death can be obtained by resolving Erikson's psycho-social phase of the life cycle, entitled "Integrity vs. Despair", by acceptance of one's own life cycle. The art therapy life review intervention was recommended as a means of achieving this through the process of reworking the events of one's life, examining one's past, present, and future, and integrating past unresolved conflicts. In general, the ability of the practical application of art therapy to ease an individual's process of dying, making it a less traumatic, isolative, feared experience and a more meaningful and accepted occurrence has been promoted. In the future, research on this specific oncology population could incorporate the area of palliative care, and hospice care more in-depth.

Overall, the research process of this first half of my research paper has provided an initiatory learning about medical settings, practice, beliefs, clinical objectives, and facilities--which in the introduction I deemed as being necessary in preparation for the successful promotion of the practice of art therapy's applicability within a medical context. As was my hope, in my opinion the presentations of the oncology population's psycho-social issues/tasks of coping with physical pain, loss, and (for some) terminal illness, within their respective theoretical and practical application of art therapy frameworks, in theory sufficiently support my hypothesis that art therapy is a viable adjunctive

intervention within the treatment plan of adults diagnosed with cancer (and in practice as is demonstrated in the three terminally ill cancer patient's case studies). The next step in research is to design and implement studies which evaluate the clinical efficacy of the art therapeutic approaches and techniques of these individual areas of intervention, with adult oncology subjects.

Another obvious direction for further theoretical and practical study is the examination of the viability of art therapy as an adjunctive intervention in the treatment of adult oncology clients suffering from depression. This secondary symptom of the disease of cancer is also repeatedly referred to in the review literature--but written about, in any depth, only by Dreifuss-Kattan (1990). With the wealth of art therapy literature which is devoted to this psychopathology, this area of inquiry alone could constitute a research paper.

In addition, research on the theory and practical application (and respective appeals) of group versus individual art therapy with adults diagnosed with cancer could be a very useful resource for art therapists in clinical practice with this population. My literature search produced only one article, written by an art therapist, which focuses on group work with adults facing this life-threatening illness. Baron (1985) describes the group program she developed for cancer patients as "a synthesis of modalities from the fields of holistic health, art therapy, and psychotherapy" (p. 29). Balancing its educational and psychologically-oriented components, in a twelve session format this group leader alternated bi-weekly relaxation and guided imagery exercise techniques from the Simonton approach, followed by a drawing component, with group exploration of uncovered information, or time for open discussion. Clinical material of the imagery and artwork, as well as members' interactions, taken from the author's experience, are presented to show how various group themes and issues emerged.

Taking into consideration the findings of a research study by Spiegel, Bloom, Kraemer and Gottheil (1989), it may be that art therapy with cancer patients in a group

setting could have a beneficial effect on participants' physical state of health. Interested in examining the effect of psychological and social supports on oncology patients' survival, Spiegel et al completed a randomized prospective psycho-social support trial for metastatic breast cancer patients. The randomly assigned control group subjects received standard medical treatment alone, the other group received this as well as a year of weekly ninety minute support group sessions. Within these sessions, the cancer patients were encouraged to express the complete range of feelings about their illness and its effect on their lives, to discuss ways of coping with their disease and living life as fully as possible; to improve communication with doctors and strengthen family relations; to build a strong sense of mutual support; to face fears of death and dying and master them, to face and to grieve losses within the group; and control their pain and other symptoms--all of which this research paper suggests art therapy intervention can facilitate. At the end of the year the women within this treatment group had experienced significantly less mood disturbances, less phobic responses and half the pain of the control subjects. This may indicate that psycho-social intervention can improve these cancer patients' quality of life.

The ten-year follow-up study of the breast cancer patients revealed that the subjects who participated in Spiegel et al's intensive psycho-social support groups lived, on the average, twice as long as the women assigned to the control group--a difference which was statistically and clinically significant. According to these researches, this fact may indicate that psycho-social intervention is the key element in prolonging the lifespan of those patients with metastatic breast cancer. Although aware of the need for further research, more long-term outcome studies, and validation of their findings, Spiegel (1990) writes that he and his colleagues believe that whatever the mechanism of the difference they observed, for the first time they had accrued "evidence that comprehensive cancer treatment involves not only aggressive surgical, radiotherapeutic, and chemotherapeutic intervention, but intensive psychosocial support as well" (p. 365), which, in my opinion, the art therapy modality can provide.

The final section of this research paper is a departure from what preceded it, however, an important area of study, having relevance to this investigation of the viability of art therapy as an adjunctive intervention within the treatment plan of adults diagnosed with cancer. Examined herein was primarily the research of practitioners outside the field of art therapy--Bach (1966, 1975, 1990), Simonton, Simonton, and Creighton (1978), and Achterberg and Lawlis (1984) respectively, which laid the foundation of the examination of evidence of the somatic aspects of a patient's physical condition and her/his disease prognosis within the art expression product. Following Bach's and Achterberg and Lawlis' hypothetical theoretical frameworks the concurring findings/conclusions of art therapists Perkins (1977) (and Cotton (1985)), and Graves (1982) respectively were featured. Some research similarities and distinctions, criticisms, and related controversies were discussed throughout.

In review, according to Bach who empirically studied thousands of the spontaneous drawings by children terminally ill with cancer, conveyed within the artwork are both the creator's psychological and somatic conditions, indicative of the fundamental interrelationship between psyche and soma. Collectively, the systematic analysis of the choice of particular colors--values, archetypal motifs, symbols, page composition and direction of movement (as determined by her quadrant assessment theory of drawing analysis described herein) within these patients' art expressions can evaluate their unconsciously reflected body conditions, physical illness, treatment, even disease prognosis. These life-threatened children's unspoken wants, needs, and anxieties, are documented therein as well. Overall, this suggests that patients' artworks have value as a tool for assessment, diagnosis, treatment, and prognosis.

Within Simonton, Simonton, and Creighton's (1978) cognitive-behavioural based cancer treatment program, to be used in conjunction with traditional medical treatment of this disease, a key role is played by the dual process of a relaxation exercise succeeded by the guided mental imagery protocol which they developed specifically for individuals with

cancer. The former technique fosters patients' belief that they are capable of exerting some influence or power over their body and can work with it toward regaining health. The purpose of combining this with the mental imagery activity, an effective motivational tool, is to create in the cancer patient positive beliefs and expectations of disease outcome. The Simontons believe that s/he can thus effect physical changes (which should strengthen the belief that s/he can use her/his mind in support of her/his body) and beneficially influence the body's natural defenses (the immune system) to become more active in fighting against the disease of cancer, perhaps even alter the course of a malignancy. This component of the Simontons' psychological cancer treatment approach is recommended to be practiced three times per day for a 10 to 15 minute duration each time

Every three months their program participants are requested to draw a sketch of their created mental imagery and to verbally describe it to them. Believing that the mental imagery being practiced has a determining effect on a cancer patient's state of health, that is, can enhance or impede the treatment of her/his illness, analyzing its specific content in tangible form is a means of identifying current underlying attitudes, beliefs toward her/his immune system, disease, and its treatment, as well as recovery expectancy. Based on the Simontons' experience, in collaboration with Dr. J. Achterberg-Lawlis, they developed a list of imagery criteria, composed of eight significant features or symbolic qualities, generally believed to be predictive of a cancer patient's favorable response to treatment of their disease. Using this as a guide to a patient's psychological and somatic states, any desirable alterations in her/his imagery and symbols are suggested, thereby changing her/his beliefs and attitudes to be more compatible with health recovery, with the purpose of positively effecting immune function and altering the course of her/his disease.

Achterberg and Lawlis (1984) refined the Simontons' (1978) theory and developed the practice of the IMAGE-CA technique, an instrument specific to cancer and its psychological components, which is used for analyzing the content of cancer patients' imagery as a reflection of their attitudes about their disease, and treatment, as well as any

belief toward self-healing ability. A diagnostic assessment tool, the IMAGE-CA technique can be used to evaluate the effectiveness of a patient's imagery, predict future development of her/his disease, and devise a cancer treatment plan.

The three-part process begins with the patient achieving a relaxed state, followed by her/his brief education on the immune system, the disease process, and how treatment might work--both from listening to an instructional audio tape recording. The above three factors are next to be imagined in operation within the patient her/himself and then recorded in a drawing. An ensuing structured interview results in this picture and the cancer patient's verbal explanations of it being evaluated on thirteen (if a novice interviewer-evaluator) or fourteen (if s/he has conducted more than fifty technique administrations) scorable protocol dimensions, using 5-point scales. These are predictive measurements of the patients' recovery expectancies and attitudes toward disease and treatment factors.

Intercorrelated with other diagnostic measures, each of the fourteen imagery variables was found to be related to the psychological functioning of the cancer patient--some being reflective of her/his personality "traits", and, others, of her/his mood or "state", the latter believed to have a direct affect upon, and interact with, immunological enhancement or deficiencies.

From an additional clinical standpoint, examination of a cancer patient's imagery symbols is seen as appropriate for taxonomy, in that various symbols can be related to stabilization or remission, or associated with physical decline. The presence of certain symbols in imagery, associated with a healthy attitude, has a positive connotation and is predictive of good response in the treatment process, that is, favorable disease process management. Conversely, from a statistically predictive standpoint, other symbols are a negative sign, as they are not associated with good disease outcome.

Using imagery as a therapeutic tool, Achterberg and Lawlis work with the cancer patient to alter her/his imagery and symbols so that they conform to what is known about the human body and, also, reflect a more positive recovery expectancy.

The two normalization studies which these researchers conducted on two diverse samples of the cancer population, and the methods by which the reliability and the validity of the IMAGE-CA technique was determined in each, are also described.

In conclusion, this research paper is not intended to be a comprehensive, definitive examination of my hypothesis that art therapy is a viable adjunctive intervention within the treatment plan of adults diagnosed with cancer. The theoretical and clinical issues involved in practicing this discipline with the adult oncology population is a complex, multidimensional subject--the discussion of which is limited by the scope of one research paper. However, using a primary literature review as its methodology, and within the parameters I gave myself, I feel confident that I have accomplished what I academically set out to do. This specific area of art therapy study is largely uncharted territory, therefore, this research paper, including its extensive bibliography, represents, as was my heartfelt desire, a significant student contribution to the body of research informing the continuing promotion and growth of the theory and practice of the field of art therapy. It will prove a valuable preparatory foundation from which to expand upon this investigation. I also hope that it will be successful in stimulating a broader interest in, and encouraging an appreciation for, the practice of art therapy with adult oncology clientele. There have been indications that local, national, and international art therapists' interest in the clinical application of this profession with the oncology population is growing. On display at the Fall of 1995 Association des art-thérapeutes du Québec (AATQ) annual conference in Hull, was an exhibition of artwork created by the pediatric cancer clients of a regional colleague; Slakov (1995), who practices with persons who have cancer and their families, presented on the powerful process of healing through the arts at the Fall of 1995 Canadian Art Therapy Association conference entitled "Art Therapy--a Creative Way of Healing",

which was held in Vancouver; and in addition to the previously mentioned 1995 AATA annual conference's art therapy-oncology presentations (descriptions of which follow), this association's Research Committee announced its granting of that year's research award to several Canadian art therapists doing research on image production of pediatric oncology patients in London, Ontario. They proposed an investigation of the influence of types of cancer and treatment protocols on the images of drawings created by children diagnosed with cancer.

A description of the 1995 AATA annual conference's special lecture--given by Dreifuss-Kattan (1995) will not be provided as her work was previously elaborated upon within the Art Therapy in the Context of Medical Settings section of this paper

The conference course offered by Malchiodi (1995) explored how art making can complement traditional medical intervention in health enhancement and assist in the healing process with reference to the fields of psychoneuroimmunology, allopathic medicine, and transpersonal medicine. The natural, unique connection which exists between the disciplines of art, art therapy, and medicine was demonstrated. A theoretical and practical overview of art therapy with medical populations was provided, emphasizing new paradigms for this discipline as a complement to health and wellness programs. The applications of these to individuals experiencing physical illnesses, such as cancer, were also presented. Additional topics examined included current research on somatic messages that may be present in art expression, and strategies for understanding and deciphering these, and relationships between imaginal techniques and wellness. Emphasis was also placed on the possible collaborations between art therapy and medicine to provide an integral (mind/body/spirit) model of health care to patients with serious and life-threatening physical illnesses.

The focus of Ain'ay Anand's and Anand's (1995) conference presentation was the role of an art therapist involved in the management of patients with laryngeal cancer. The application of medical art therapy to this population has not been emphasized in the

literature Intervention goals based on these patients' physical and psychological characteristics, in each stage of treatment, beginning during the preoperative period while they are able to verbally communicate, and continuing through postoperative and rehabilitation periods, were described With loss of speech often a result of surgical treatment, nonverbal therapy such as art therapy was presented as an important diagnostic and therapeutic adjunct

Lusebrink and Scifres (1995) presented a study which investigated the imagery processes encountered in brief supportive therapy with mastectomy patients using directed and undirected sandtray therapy techniques Topics touched upon included the use of imagery to enhance patients' active participation in the healing process and to facilitate through its psychophysiological concomitants the expression of one's emotional and physical functioning, relaxation as an important means of reducing cancer patients' stress and contributing to increases in functioning of their immune system, and peaceful imagery which, like relaxation, has been helpful in overcoming adverse effects in chemotherapy and radiation, and reducing pain The main issues the study addressed were the patients' psychosocial issues, and their self-expression of present needs, relaxation enhanced by the tactile manipulation of the sand and the construction of scenes representing peaceful imagery, and current concerns Subjects' spirituality and faith were found to be strong healing components These individuals' self-perceptions of the strength and activity of their immune system, cancer cells and treatment interaction were said to be reflected in their representations of such These images provided visual stimuli for daily imagery exercises The patients' portrayal of dream images was identified as a very important part of the interventions, revealing their intuitive feelings and bodily reactions to their illness The unstructured approach of free expression in sandtray was found to be helpful to emotionally repressed and noncommunicative cancer patients, aiding in their coping with overwhelming emotions and the frustration of the current circumstances being out of their control

Engelen's (1995) lecture at the AATA conference served as an introduction to her method of using the symbol of the wall in the psychotherapeutic treatment of cancer patients. She expanded on the methodology of symbol drama, or Guided Affective Imagery, as developed by Leuner 1969-1989, and explained its appeal as a means of quickly gaining access to the core of a cancer patient's psychological problems. It was stated that the techniques for the guiding and transformation of imagery lead to desirable changes in a client's emotions and attitudes toward life situations. The use of the flower--the classic diagnostic symbol drama, when initially determining if a patient is sensitive to symbols, and whether guided imagery is indicated or not, was described. Engelen discussed some aspects of the symbol of the wall which have been relevant in her treatment of this clientele--the etymology of the word 'wall', the importance of the wall in history, its presence in art, the use of its concept in language, and its use as a symbol in art, for example, and also the application of the wall symbol when working with cancer patients. She presented a brief description of a research group of adult cancer patients and a control group of adults without symptoms to whom she had offered the symbol 'wall'. In order to explain her practice, Engelen described a typical session. A number of drawings of 'wall dreams' made by subjects in both of these groups were shown and an account was given of the results of the use of these drawings as diagnostic and projective material in art therapy treatment of cancer patients. Engelen explained how clients working with the image of the wall and the drawings made of it will begin to understand and contain their often overpowering feelings. Then these can be carefully and safely explored, with the patient able to gain a sense of control--an absence of which is felt in regards to her/his physical process. Largely the reflection of the foci of this paper, Engelen stated that art therapy intervention offers cancer patients a means through which they can deal with their disease and make an improvement in their physical, emotional, and spiritual elements.

Ending this research paper on a personal note, just as I began this phase of my ongoing journey toward self-healing, following my bliss has proven to be an emotionally and intellectually challenging and demanding, yet fascinating, rich, and rewarding--ultimately necessary--existential task. Indeed, this heuristic act of love has not always been comfortable. Bringing my research work to light has been a profound, and individuating and initiatory labour, during which I have experienced encompassingly dark moments, which may be fittingly analogous to McIntyre's (1990) description of the move from the sense of darkness to light which is the essence of art therapy for children who are bereaved.

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