

**Healing Through Art:  
An Exploration of the Efficacy of  
Art Therapy With Children With Cancer**

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of  
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## **ABSTRACT**

### **Healing Through Art: An Exploration of the Efficacy of Art Therapy with Children With Cancer**

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This paper is an exploration of the efficacy of art therapy interventions with children with cancer. Some of the issues to be addressed are: the history and causes of cancer; the physical and psychological effects of cancer on children; the various treatments available; the current literature on using art therapy with this population; and the factors which contribute to the efficacy of art therapy. The research indicates that art therapy is mainly used to help children cope with their illness; however, together with visualisation strategies, drawings are also used to facilitate the physical healing process. Due to the exploratory nature of this paper, conclusions are formulated in terms of further work to be accomplished in order to better understand the role of art therapy in helping children with cancer.

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## INTRODUCTION

The verb "to heal" is derived from the Anglo-Saxon root "hal" meaning "sound," "healthy," and "whole", the English word "hale" is derived from the same root. In arriving at my definition of healing, I refer less to the process through which physical health is restored and more on the adoption of a healthy psychological attitude towards illness. While a disease may not necessarily be cured, suffering can be alleviated. It is this definition of psychological well-being in the face of a life-threatening illness that I will apply to the following examination of the efficacy of art therapy interventions with children with cancer.

\* \* \* \* \*

Tinnin (1990a, 1990b) and Lusebrink (1990) explored the relationship of cognition and emotion in right and left brain theory. According to Tinnin (1990a, 1990b) language (verbal symbolisation) lies in the left brain, and the nonverbal (visual symbolisation) lies in the right brain. In the left brain, thinking is linear and sequential, whereas in the right brain, thinking is circular, simultaneous, and parallel, similar in quality to dreams. Conscious material, seated in the left, is opposed by unconscious material in the right. Similarly, the primary process function of the right hemisphere of the brain (i.e. the nonverbal) opposes the secondary process function of the left (i.e. language).

Tinnin stated that the left side of the brain is dominant, censoring material from the nonverbal mind when translating the material into words so that the content is socially acceptable. The left brain material is externalised through words, whereas the right brain's emotional material is externalised through the autonomic nervous system, as found by change in heart rate, for example, by the physical expression found in gestures; and the symbolic expression found in art.

Lusebrink (1990) places what she terms "negative emotions" (anger, depression, and anxiety) in the right hemisphere, and the positive feelings in the left brain. The locus of psychic pain can be found in the negative feeling realm of the right brain; therefore, an approach that allows for interaction between cognition and emotions seems most appropriate in alleviating this pain.

One way of gaining entry into and dealing with the world of negative feelings in the right brain is through empathy. Art therapists are relatively at ease with fantasy and the primary process, and in light of this they may have a special capacity for empathy.

It appears that the most effective means of helping children who are in psychologic distress due to illness is by addressing the negative and disorganised feelings of the unconscious right brain, for it is there that the true emotional plight of a child can be found. The art therapist is well-equipped to intervene because of his or

her abilities to accept raw, primary process material and to help externalise and organise it through artistic expression. Relieved by this expression, the child is better able to deal with the emotional sequelae of the illness.

Following this introduction, in Part One, I will examine the history of cancer, its causes, and the current treatments available for cancer -- including some unconventional treatments -- with an explanation of the psychosomatic approach to healing.

In Part Two, I will examine the epidemiology of the illness, the psychological and psychosocial impact of this disease and its treatment on the child and the family. An in-depth exploration of what cancer means to a child, and common methods of coping will follow. The major developmental stages in terms of attitudes toward death will also be examined. Finally, in caring for the child with cancer, the goals of individual psychotherapy and group therapy will be explored.

Part Three will look first at the Jungian and Humanistic-Existential approaches to art therapy. This will be followed by a review of literature of case studies in which art therapy interventions have been successfully used with children with cancer. Finally, the relationship of the effective factors of art therapy process and products will be discussed.

## PART ONE

### **HISTORY OF CANCER**

Cancer, the disease, was first named in the fourth century B.C. by Greek physicians (Levy 1985). The Greek word *Karkinos*, which meant "crab", was the image selected by Hippocrates to describe cancer because certain cancers resemble a crab with claw-like tentacles buried deep within the flesh. The word was also a description of the pain experienced, which was similar to a crab's bite. The image might also portray the disease's crab-like spread through the body.

Cancer is a disease that is characterized by abnormal and excessive cell division; an alternate term is "malignant disease". Cancers are categorized into major classes by the type of cell they consist of and the part of the body where they begin.

The most common cancer is "carcinoma" - a cancer arising from the epithelial tissue which lines body surfaces (skin, digestive tract, lungs, cervix, breast, pancreas, thyroid). Another type of cancer, which is less common, is "sarcoma", or cancer of the supporting tissue of the body; i.e. connective tissue structures like muscle or bone. "Leukaemia" is a cancer that originates in the bone marrow and affects the blood, and is characterized by abnormal proliferation and development of white blood cells and their precursors in the blood and bone marrow. Another type of cancer is

"lymphoma", which originates in lymphoid tissue, in the cells of the immune system (U S Congress, 1990)

Most cancer begins with a tumour in the tissue of origin (which produces a primary growth). If treatment is not successful at this stage, cancer cells spread via the bloodstream and lymphatic system to other parts of the body, giving rise to secondary tumour deposits.

According to the Canadian Cancer Society, one in three people will develop cancer (Pope, 1991). All ages are affected. Half of the people who die of cancer are over 55, but, alarmingly, cancer is now the most common death by disease among children.

## **CAUSES OF CANCER**

Cancer is a disease that has a "multifactorial aetiology", that is, several factors need to operate together in the same person to bring about the disease (Breitbart and Holland, 1993). Research has not been able to pinpoint any one single cause. It is known that the risk of cancer developing is increased by exposure to numerous environmental factors, called "carcinogenic agents." These include cigarette smoke, certain industrial chemicals, dietary substances, radiation and viruses. Some forms of cancer can be attributed to inherited (genetic) differences.

Apart from the physical factors for the causes of cancer, it is also believed that cancer is the result of some emotional imbalance within the individual (Hughes, 1987, p. 4). Psychological factors such as personality type, (mood, depression, attitude) experience of stressful events, etc., do contribute to the strength of the body's "immune defense".

Bahnson (1980) surveyed the relationship between stress and cancer. Along with the general consensus that affect is an important factor causing cancer, it is also felt that there is a common background and personality make-up in many cancer patients -- normally feelings of loneliness and hopelessness originating from the lack of a protected and loving childhood. Levy (1985, p. 148, 149) suggested that the development of a personality marked by self-containment, inhibition, rigidity, repression and regression, often precedes cancer. Sometimes, this may involve somatic or cellular "regression" as well.

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

## **TREATMENTS FOR CANCER**

According to U S Congress Report (1990) current mainstream treatments for cancer are surgery, radiation therapy, chemotherapy (drug therapy), and immunotherapy.

### **Surgery**

Surgery is the oldest and still most effective mainstream treatment for solid tumours, which involves cutting into the body and removing the cancerous tumour and often the surrounding tissue. Surgery is frequently used with chemotherapy, radiation, or both, in order to remove as many tumour cells as possible without disabling the patient, so that there will be a greater chance of successfully eliminating the remaining tumour cells with the other treatments. In advanced stages of cancer, surgery is sometimes used for palliative purposes, to alleviate the physical interference of a cancer with other organs.

### **Radiation Therapy**

Radiation therapy consists of powerful x-rays which are directed at the cancer causing it to be destroyed. Radiation therapy may be used before or after surgery, or as a palliative measure to reduce the pain of malignancies in the bone and to shrink

tumours in other parts of the body. In administering radiation therapy, the dosage used has to be modulated to achieve the greatest antitumour effect while attempting to minimize effects on surrounding normal tissue.

## **Chemotherapy**

Chemotherapy or chemical therapy is a form of treatment in which drugs, often in combination, are injected into the blood stream and thus come in contact with the cancer cells. Chemotherapy and radiation therapy are used as primary treatments for some leukaemias and lymphomas, and are used in addition to surgery for solid tumours that have advanced or spread from their original site.

The highest dose tolerated is used in chemotherapy, with multiple drugs in combination. This, together with the systematic administration and the toxic properties of many anti-cancer drugs, gives rise to the severe side effects of cancer treatment.

## **Immunotherapy**

Immunotherapy arises from the most recent approach in conventional cancer treatment -- biologic therapy. In this form of treatment, antitumour effects are produced mainly through the action of natural host defense mechanism, i.e. the

immune system which has developed to protect against "foreign tissue" can be manipulated to destroy cancer cells, which are immunologically different from normal cells.

## **UNCONVENTIONAL CANCER TREATMENTS**

There are several other treatments being tried on cancer patients outside of mainstream medicine such as psychological and behavioural; nutritional; herbal; pharmacologic; and biologic. This paper focuses on the behavioural and psychological approaches to cancer treatment, which are used adjunctively to relieve the pain and distress associated with cancer and its treatment, and generally to improve a patient's psychological outlook.

## **PSYCHOSOMATIC APPROACH TO CANCER**

The term "psychosomatic" comes from the Greek words *psyche* and *soma*. Psyche means soul or mind "as a functional entity governing the total organism and its interactions with the environment." (Schneider, 1977, p. 12). Soma refers to the physical organism: the body.

Lachman (1972) defines psychosomatic in terms of relationships between psychological processes and bodily organs, denoting the wholeness of an organism

and conveying the idea that the psychological and the biological represent a unity. The term can also imply that although an organism is unitary, psychological and somatic aspects can be studied separately and considered by means of relationships between them.

The awareness that a distinction exists between mind and body and the realization that it might be possible to approach them as a unity appears to have been present for a long time. Today, physical and mental diseases are still largely considered separate entities and a person with symptoms in one area often is treated for that part alone. However, there does exist some insight and understanding of the importance of the mind-body balance in the form of a holistic outlook on life, health and disease.

These findings draw attention to the connection between mind and body. It follows that there is a need for people to be able to express at the non-verbal and thus psychologically defended level as well as verbally, so as to uncover images and symbols that may give clues to the inner meaning of their lives and therefore of their illnesses. If conflicts can be resolved, it is suggested that energy can be diverted for use in healing (Garner 1966, p. 23). Under the same assumption, according to Wittkower and Warnes (1977), if psychological traits can be instrumental in causing one's illness, then other inherent traits can be awakened and developed to enhance one's healing process.

## **Guided Imagery**

Mental imagery, a method which involves the creation and interpretation of mental images, was popularised by O. Carl Simonton. The Simontons (1978) used imagery and relaxation in the treatment of cancer. In addition to imagery exercises and the patient's regular cancer medication, they also conducted intensive psychotherapy to explore emotional issues surrounding the onset and course of the disease.

The first success was a sixty-one year old man who was diagnosed with cancer of the throat. A program of imagery and relaxation was developed for this patient to practice three times a day. He was instructed to first concentrate on relaxing his muscles from his head down to his feet. Next, he was to visualise being in a calm, pleasant place, such as the woods. Then he was to vividly picture the cancer in his body and to visualise his radiation treatment as "millions of tiny bullets of energy" (1978, p. 15) striking all the cells in his body, both the normal and the cancerous cells. The cancer cells were seen as being "weaker and more confused" than normal cells, and thus they would die from radiation, whereas the healthy cells would be capable of repairing the damage. Then the patient was asked to imagine his white blood cells carrying away the dead cancer cells through his kidneys and liver. Finally, he was able to picture his body as healthy and normal, with the cancer tumours decreasing in size.

This first case had remarkable results, as halfway through the treatment the cancer began to disappear and the patient started to eat and gain weight. In addition, there were few negative side effects experienced from the radiation treatment. After two months of continued improvement, there were no signs of cancer.

The Simontons clinically tested this imagery/relaxation procedure with 159 highly selected patients diagnosed to have medically incurable cancer and given one year to live, and got some remarkable results (Sheikh 1984, p. 133, 134). Sixty-three patients were alive two years after their diagnosis. Of these, 22.2 per cent demonstrated no evidence of cancer, 19.1 per cent showed tumour regression, while 27.1 per cent had stabilized, and there was some new tumour growth for 31.8 per cent. This approach to treating cancer patients provides a means of actively involving patients in their own treatment. The Simontons suggested that the imagery/relaxation component of their program leads to an enhancement of the patient's immune system, but they never directly tested this hypothesis.

The Simontons (1978, p. 52) identified eight features that they felt were important in altering the course of cancer.

1. The cancer cells are imagined as weak, confused, soft and easily broken down. Imagining cancer cells to resemble hamburger meat or fish eggs is an easier image than imagining them as tenacious ants, crabs, or rats.
2. The treatment is viewed as "strong and powerful" and able to interact with and destroy the cancer

3. In the imagery, the healthy cells easily repair any treatment-related damage. The cancer cells, on the other hand, being "weak and confused", are not able to recover and consequently are destroyed.
4. The body's immune system or army of white blood cells are imagined to greatly outnumber and overwhelm the cancer cells.
5. The white blood cells are viewed as aggressive and eager to destroy the cancer cells, and their victory seems inevitable.
6. It was important to visualise the dead cancer cells being flushed out of the body in a biologically natural way.
7. Patients should see themselves as healthy and disease free.
8. Patients are to imagine themselves fulfilling their life's goals.

The Simontons were unable to produce similar dramatic results consistently with other individuals. This could be because they neglected the role that psychological factors play in illness. According to Baron (1989), in order for an individual to think positively about the possibility of overcoming cancer and getting well, the patient's life outside the illness has to be taken into consideration. The imagery and drawing of a cancer patient does not exist in a vacuum, nor can it be changed through mere suggestion. The colours an individual chooses, where symbols are placed on the page, and the intensity with which the illness is drawn have roots deep in the individual's psyche.

However, through the use of guided imagery and art we may be able to influence the body's physical state through the mind. Guided imagery allows individuals to create a set of images in their minds that can hopefully establish the climate for these images to grow in reality. Baron (1989) states that, unfortunately, while individuals may wish to harness their imagination for healing purposes, often

unconscious attitudes can undermine these attempts, leaving a sense of helplessness that pervades their entire mental state. Art therapy can be a valuable tool in providing an avenue for exploration of the attitudes that may be blocking the healing process. Baron sees art as a means of capturing and recreating the images seen in one's mind, thus providing a concrete picture that often reaches beyond the images originally envisioned to express the patient's feelings towards illness, treatment, self and life.

Guided imagery and art can be used together as a reflection of an individual's existing psychological and somatic state, as well as a source of encouragement for patients to experiment with a new attitude toward their immune systems and illness in general. This paper will now consider some of the psychological and practical issues facing children with cancer, before moving on to the role art therapy can play in healing.

## **PART TWO**

### **EPIDEMIOLOGY**

Cancer remains the most common illness causing death in children aged between one and fourteen years (Councill, 1993). Children from birth to adolescence may be affected and they suffer from a range of malignancies, of which leukaemia is the most common. Most tumours are responsive to some type of chemotherapy and this forms the mainstay of treatment, with surgery and radiotherapy as appropriate for some patients.

Side effects, both medical and psychological, are inevitable in cancer therapy. Most drugs and many investigations entail intravenous injections, so anxiety and needle phobia may develop. Nausea and vomiting are common to many agents and periods of serious infection are not infrequent. Variable amounts of time in hospital and off school occur for all the children, and family life is disrupted.

The outlook for children with cancer is significantly better when they are treated at a paediatric oncology centre, where a multi-disciplinary team will have the experience and facilities not only for intensive medical care but also for extensive psychological support.

## **PSYCHOSOCIAL ASPECTS**

Childhood malignancies are a heterogeneous group of diseases and have varying etiologies attributed to genetic, immunological and environmental events, psychological factors, and even stress. There are two approaches in communicating to a child about the diagnosis of cancer: an open approach versus a protective approach (Lansdown and Goldman, 1988, p. 555).

Treatment for a diagnosed malignancy is aimed at inducing a remission, characterized by the absence of signs and symptoms of the disease. During treatment the child is faced with serious threats which will be the area of discussion now.

The most striking aspect of cancer is the life-threatening nature of the disease. Awareness of the seriousness of the disease is associated with an increase of anxiety and fear of death and separation. The modern methods of cancer treatment are not without side effects. A major complication is the physical discomfort caused by the treatment such as pain, weakness and illness.

Cancer treatment involves a high degree of acute distress, generally caused by (1) anxiety and pain associated with medical procedures, such as bone marrow aspirations, lumbar and venous punctures and injections with chemotherapeutic agents, and (2) nausea and vomiting resulting from chemotherapy and from conditioned

anxiety associated with treatment. These may manifest in a variety of symptoms such as insomnia, nightmares, anorexia, withdrawal and depression (Lansdown and Goldman, 1988, p 556).

Children undergoing cancer treatment experience a number of bodily changes. These side effects of treatment may be reversible, such as weight gains or losses, loss of hair, mouth ulcers and even acute psychosis. The side effects of treatment continually change the child's body image and this is consequently experienced as the potential loss of self-esteem induced by changes in body image. A lack of self confidence results from withdrawal from peers and a fear of going to school, thus affecting emotional and social adjustments and academic performance. Usually children with cancer are hospitalized many times during their illness. Hospitalizations are not only experienced as temporary separation but also as a reminder of the final separation (death). Clinging, signs of distress, despair, withdrawal and depression are associated with this separation anxiety.

## **THE MEANING OF CANCER TO THE CHILD**

The life threatening nature of the disease implies a separation from, and loss of, loved ones. Not only does the separation from important people induce loss but also the illness itself, such as a loss of health, a loss of body parts through surgery and a loss of contributing to family life. The child's new role of being sick or being

different involves a change in nearly every aspect of the child's life: he or she will experience a change in relations to other people and in the perception of him or herself. The illness deprives the child of control of daily routine, privacy, relationships with family and friends, and control of life itself. In addition, the greater dependency on others, the restrictions in mobility and activity, the invasion of treatment and the constant medical attention all affects the child's sense of control and competence (Schowalter, 1970).

## **PATTERNS OF COPING**

The term "coping" is used to denote how children adapt to their disease and treatment, the process which is activated when threat is perceived, intervening between threat and observed outcome, and aimed at regulating emotional distress and eliminating the threat. Dunkel-Schetter, Feinstein, Taylor and Falke (1992) identified five patterns of coping with cancer: seeking or using social support, focusing on the positive; distancing; cognitive escape-avoidance; and behavioral escape-avoidance

Dunkel-Schetter *et al.* (1992) found that younger age was associated with more support-seeking, more focusing on the positive, and more behavioural escape-avoidance.

Cancer includes a wide range of situations with which to cope -- such as painful or frightening symptoms, ambiguity about the prognosis, and changes in social relationships. According to Van Dongen-Melman and Sanders-Woudstra (1986), open communication and honesty are important strategies related to positive coping outcomes, as are maintaining hope and the effective use of defense mechanisms, in particular denial.

Denial, once considered as a destructive defense mechanism in the case of illness, is now regarded as playing a crucial role in facing day-to-day reality and maintaining a positive outlook for the future. Detwiler (1981) stated that like hope, denial may be an adaptive manoeuvre for dealing with loss, a response that persists in a patient or family until there is a readiness or need for another response.

Zeltzer, Kellerman, Ellenberg, Dash and Rigler (1980) found that successful coping strategies vary in effectiveness along with the type of stress, situational context and the characteristics the individual brings into the situation -- such as the child's adaptation to cancer, characteristics related to the disease, the child's developmental level and social environment.

The child's adaptation to cancer may be translated into behavioral problems and emotional disturbances, such as anxiety, fear, depression, extreme dependency on the parents, sleep disturbances, regression, anger and withdrawal. The basic

developmental processes still proceed under stressful conditions such as cancer, although these processes might be altered by the cancer experience, resulting in an atypical course of development.

## **ATTITUDES TOWARDS DEATH**

A child's response to his or her death is based on his or her understanding of death and on the reactions of the people around the child. Schowalter (1970) discussed four developmental periods based on the evolution of a child's understanding of death.

### **The Infant and Toddler**

Under the age of three, death is not yet a fact, but separation is, and the child's reaction is exquisitely sensitive to the calibre of parenting he or she receives.

### **The Preschool Child**

The dying preschool child recognizes the fact of death but does not understand it. Although the child may express less death anxiety than children in other age groups, and no longer responds to his or her illness purely with separation anxiety, the child commonly believes this illness is a retribution for bad thoughts or actions.

A child who accepts this guilt often becomes passive and withdrawn. A child who denies guilt and projects it onto others may become angry and rebellious. This complex interaction between guilt, denial, projection, passivity and aggressiveness is seen at all ages.

### **The Early School-Aged Child**

During the early primary school years, the child begins to comprehend the permanency of death. The concept of terminal illness first makes its impact, and death anxiety is greatest during this period. The severity of the recently formed superego and its self-punishing characteristics increase the child's fear of physical procedures, and he or she conceptualizes death as an external force which will malevolently stop his or her life. Religion begins to play a more important role, positively or negatively, with this age group, and although some children realize they are dying, they may be reluctant to voice these fears to their parents.

### **Pre-adolescence and Adolescence**

After age ten or eleven most children intellectually understand the universality and permanence of death. This is also the time of life when physical and sexual maturation, self-identity, and independence begin to develop. Most terminally ill adolescents know they are dying and may be overwhelmed by the despair and

resentment of unfulfillment: shame, guilt, anticipatory mourning for oneself, and depressive symptoms are not uncommonly seen

Along with the child's understanding of death, the other most important influence on the child's attitude and response toward death comes from those around him or her. Staff as well as parents sometimes feel guilty and uncomfortable in the presence of a dying child because the child's condition -- and often, attitude -- rebuke their failure and impotency. The wish to withdraw is omnipresent, but human presence and communication must not be withheld. One has to listen to hear and this is both taxing and painful; but the parents' positive involvement with the child facilitates their and the child's response to the latter's condition. The competence, constancy, and availability of the staff are paramount in supporting these efforts.

## **CARING FOR THE CHILD WITH CANCER**

In caring for the child with cancer it is important to supply direct emotional support by persons important to the child, namely the family and the health care team. It is also important to promote optimal developmental growth. This is reflected in the encouragement of treating the patient as normally as possible and of having the child resume normal activities. Emotional support by the family is provided by talking about feelings, fears and hope, and sharing concerns related to the disease. Open communication can facilitate effective coping and give access to the

intrafamilial sources of support. When the child is hospitalized open communication can be aided by using age-related methods of communication through play programs, art therapy, group sessions, drawings and counselling.

There are several treatment approaches in working with children with cancer and their parents. Behavioral methods, in which behavioral techniques like relaxation or visualization, are sometimes used with children in order to help them cope with painful procedures, or with anxiety or pain.

Supportive counselling or casework, including practical help, is offered to parents, usually in conjunction with services offered to the child by a social worker. Family therapy for the parents and siblings is another important treatment approach. Lansdown and Goldman (1988) found that when a family is directly involved in the treatment of their child they have a greater sense of control and also an opportunity to prepare themselves and their child appropriately for each stage of the child's disease. An effective support network in the community, such as a parent or group of parents of paediatric oncology patients, can make a great difference practically and emotionally to a family coping with childhood cancer.

Siblings suffer psychologically when a child has a long, life threatening illness. It takes time and commitment to be a good parent; when a child is first diagnosed even the best parents find that demands on both their time and commitment are

excessive. The whole family system is upset: there is physical disruption because parents spend so much time in hospital or visiting, there is emotional disruption because the attention of the parents is focused on the sick child to the exclusion of the others. Parents may become disproportionately indulgent to the patient. Irritability, social withdrawal, jealousy, academic under-achievement, enuresis and acting out are some of the behavioral problems that have been observed in siblings of children with a malignant disease (Walker, 1988).

## **INDIVIDUAL PSYCHOTHERAPY**

Emanuel, Colloms, Mendelsohn, Muller and Testa (1990) identified several issues which can be dealt with through individual psychotherapy with paediatric oncology patients: control, denial, isolation, dependency issues, contamination, abnormality, uncertainty and cultural issues.

### **Control**

Children with cancer often react to the loss of control in their lives and bodies that their illness and hospitalisation has meant for them by trying to find some aspects they can control in the situations they find themselves in, i.e. ruthlessly controlling their parents by refusing to allow them to leave or enter their rooms. Others react by

becoming non-compliant, either by refusing to take their medication or refusing to follow ward routines.

## **Denial**

Denial is closely related to the issue of control. Some forms of denial seem connected to staying on the side of life and holding onto hope and good objects, the mobilisation of the "fighting spirit" and a determination not to let the illness "win".

## **Isolation**

The feeling of being isolated and deprived of contact with the outside world is felt acutely by all children with cancer. This forced separation makes them feel depressed and lonely, or even persecuted and angry. Isolation and imprisonment are equated and the question of their illness as a punishment occupies much of their thinking. Parents too wonder why their child became ill: was it something they had done? Both parents and child might feel guilty for other reasons: the child is depriving its siblings of their mother or father as she or he stays with the child during isolation; the parents are agonizing how to apportion their time between the needs of the child in the hospital and the family at home.

## **Dependency Issues**

The increased dependency needs enforced by the illness and treatment are difficult to bear for children and parents. The dependency can feel humiliating and degrading, especially when related to incontinence or vomiting, even if the child also acknowledges the life-giving necessity of the treatment.

## **Contamination**

Children sometimes feel contaminated by something very bad which they feel has invaded their bodies. The sense of containing a bad internalized persecutor in their bodies makes some children afraid of going to sleep. Sleep and the implied loss of vigilance and control is often equated with death, and many of the children and parents suffer from disturbed sleep.

## **Abnormality**

Children feel abnormal in relation to an altered self-image brought about by the side effects of the treatment. These include hair loss, bloated appearance, loss of articulate speech and sterility. Many children feel that they are profoundly changed by the experience of having a life threatening illness. It makes them appreciate being

alive more, but it also makes them feel different and removed from the everyday concerns of their peers.

### **Uncertainty**

All children and parents express fear for the future. Parents become most protective of their children during the illness and after discharge, particularly when any infection may signal relapse.

### **Cultural Issues**

Some children have left their home countries in order to obtain medical treatment. There are different views about the role of emotions and the value of emotional expression depending on cultural and religious backgrounds.

## **GROUP PSYCHOTHERAPY**

Cancer patients involved in a hospital support group share an immediate sense of connectedness, because the group is composed of members going through similar life experiences. Members can problem-solve together and create a resource for each other. A support group provides a framework to touch upon those areas avoided in regular one-to-one therapy. Baron (1985) suggests that the group has the potential of

becoming the patient's extended family without the repercussion of feeling that one might overload an already strained spouse or child. A support group can be a stable force for individuals to re-energize themselves and combat feelings of alienation.

Having identified how psychological and psychosocial aspects of cancer can be addressed within the context of individual and/or group psychotherapy, this paper will now explore how the theories of art therapy can promote a further understanding of the issues that children with cancer face. This will be followed by a review of art therapy case studies in which successful interventions have been made with children with cancer. Finally, the art material produced by children with cancer will be analyzed for content and themes.

## **PART THREE**

### **ART THERAPY THEORY**

Carl Jung regarded imagination and creativity as healing forces in themselves when "feelings can be followed beyond words and manifested in painting, sculpture and movement." Jung (1968) believed that in times of stress one can turn inward toward the unconscious for psychological direction and for symbolic healing. To Jung, the conscious mind is only a small part of the human psyche, and other unconscious components (archetypes) carry within them healing potential. Painting and drawing can activate growth and change; that is, the images and symbols a person uses are both safe "containers" and "transformers" of emotions and feelings. Once painful images have been expressed this way, new growth occurs both in the conscious and the unconscious.

Another critical ingredient to Jung in the process of change is the nature of the transference relationship between the client and the therapist. For change to occur, the therapist needs to accept and understand the client (including the emotions symbolised in the drawings), and the client needs to feel accepted and understood by the therapist. McMurray (1988, p. 2) followed Jung's school of thought and proposed that image-making and the development of one's inner artist is a powerful tool for restructuring the ego.

The existential-humanistic approach to art therapy emphasises holistic personality integration. The ancient principle *mens sana in corpore sano in spiritu sano in mundo sano* parallels the humanistic-holistic approach to art therapy, whose ideal is "a healthy mind in a healthy body in a healthy spirit in a healthy world." (Garai, 1974, p. 205). The goal of therapy is not to get rid of fear, unhappiness, and anxiety, but instead to transform these feelings into honest expressions in some creative modality, "in order to experience the joy and exhilaration flowing from the accomplishment of such authentic expression." (Garai, 1974, p. 191).

The importance of mental imagery in the healing process was described by Simonton (1980). Imagery and relaxation are frequently employed in holistic healing, which tends to emphasise the belief that healing and transformation are determined mainly by the individual's ability to listen to the messages emanating from his or her own mind.

## **ART THERAPY WITH CHILDREN**

A child's drawings have inherent symbolic communications. As Rubin (1978) says, "there are direct as well as disguised messages." (p. 63). Therefore, pictures must be looked at from a gestalt viewpoint to see what is going on in the child. Symbols are containers of feelings. According to Thompson and Allan (1987) "symbols represent a certain nuance of psychological life and current emotion." (p.

27). Symbols mirror the child's unconscious or emotional mind. They can give both a statement of what is happening as well as reflecting emotional needs and wishes.

Children often find it difficult to talk about their fears, yet will portray them quite visibly in drawings. These can then be used as a bridge for discussion to help adults understand some of the inner-world issues of the child. The approaches used can vary. Some pictures can be spontaneous with no specific stimulus, others can be impromptu with specific directions. Still others can be concrete representations of guided imagery activities.

Bertoia and Allan (1988) state that for children in a crisis situation, using relaxation techniques or guided imagery before drawing helps release both stress and the creativity of the unconscious.

Allan and Clark (1984) describe an approach in which the counsellor is receptive to the child's imagery but sometimes is more focused and directive. Simply stated, the counsellor may ask a child to draw or redraw a particular image or symbol if that image seems to have symbolic relevance to the child. Their technique, called the "directed art counselling technique", is an effective vehicle for growth and change among children. Once rapport and trust have been established, the counsellor can help the child focus on key symbolic areas of pain and growth. The method also provides a pictorial account of activities in the child's unconscious and the process of

growth and change. Allan and Clark (1984, p. 124) believe that the major advantages of the directed drawing approach are that it seems to tap directly into the symbolic mind and improvement occurs through this pictorial modality, often without the need for verbal elaboration by the counsellor.

A pioneer in the use of spontaneous drawings with dying children is the London Jungian psychologist Susan Bach. Bach (1966, p. 20) saw spontaneous drawings as reflecting the child's inner or psychological world and noticed that the drawings also revealed physiological information extracted by the child from the unconscious level of existence. Bach (1975, p. 7) believed that the process of creative expression alone, in the presence of the counsellor, with no interpretation, will help children symbolically release some of the powerful emotions and symbols at a critical time in their lives. Children can also work through the psychological process of serious illness and dying this way. Simply being with the child and talking about the content of the picture in the third person also helps alleviate some of the loneliness and isolation such children feel.

Kubler-Ross (1983) indicated that the common grieving stages children experience are similar to those experienced by adults: denial, anger, bargaining, depression and acceptance. Acceptance refers to an awareness of the situation and a determination to live fully in the remaining days. These stages may occur in any order, and some may not be experienced at all. Some individuals may function

primarily within one emotional stage through most of the dying process, yet they too are aware of the prognosis at an unconscious level (p. 36). Hope is often present: at some times hope for cure, at others, hope for unfinished business to be completed before death. Fear about many things will also be a part of the child's experience. Kubler-Ross found that through creative work, either written or artistic, children are attuned to events in their lives and express this knowledge, often symbolically, to those who will hear them.

"Children, if they try to talk to you about dying, they will not have words for that and they very often use drawings. Drawings to me are the most beautiful way of expressing, of talking with children about their own dying. This is a universal language." (Kubler-Ross, 1983, p. 22).

Kubler-Ross started her work with death and dying in Maidenek in a concentration camp after the war, where she was very impressed with how very young children in that place were not only aware of their impending death but used drawings and poetry to talk about what it is like to be so young and have to die.

Bluebond-Langer (1978, p. 97) also studied critically ill children in hospitals and found that they move along a continuum of changes in self-concept. The child moves from thinking of the self as being well, to thinking of the self as being seriously ill. This change to Stage One (seriously ill) is Bluebond-Langer's first phase in the continuum. As the disease progresses, the child moves to Stage Two (seriously ill and will get better), then to Stage Three (always ill and will get better), to Stage Four (always ill and will never get better), to Stage Five (dying). This

changing awareness is sequential. Specific events must be integrated with past information before the child moves to the next phase. As the children arrive at each new phase of awareness, they would likely react with denial, anger, and so forth, as identified by Kubler-Ross.

Art therapy with paediatric cancer patients addresses the emotional and developmental needs of a population which is undergoing extreme stress. The child needs not only to resolve internal conflicts, but also has to negotiate physical illness and/or disability so that she or he can continue to grow and develop as a person. Art therapy is used as an adjunctive treatment in the medical setting. There are several potential applications of art therapy interventions with medically ill children. Art therapy can be used to reduce symptoms of depression and anxiety, to increase the child's sense of control and autonomy and to facilitate communication with the family and the health care team. Art therapy can promote effective coping strategies outside the hospital and therapeutic session, including relief of pain through distraction (Prager, 1993, p. 3)

## **ART THERAPY CASE STUDIES**

Baron (1989) presents her work with individuals in a cancer support group in which she combined structured relaxation and guided imagery techniques -- as previously presented by the Simontons -- with artwork. Some of the individuals in

her group used imagery and art as a way to experiment and reinforce beliefs about self-healing that were new to them. They first created an image in their minds about surgery and the immune system, and then made drawings to reinforce that imagery.

Baron noticed that what was envisioned in one's mind and on paper had an impact on unconscious feelings that might run contrary to the images presented. These individuals were able to confront their negative beliefs towards their illness and recovery. The imagery and art process, which was centred on eliminating their cancer, was an important tool that the individuals could use daily to participate in, and possibly take control of, physical functions previously thought to be out of conscious control.

Bertoia (1993), an expressive therapist, presents the case of a young girl, named Rachel, who was terminally ill with leukaemia. Over a period of twelve months, Rachel made a series of drawings which revealed her inner experience of death and dying. Bertoia incorporated guided imagery and relaxation exercises for relaxation and pain management. She extended these with several other activities, especially drawing, to dramatically illustrate the relationship between psyche and soma.

According to Bertoia (1993), another way of using imagery is in active imagination. "Many children find visualisations or guided imagery useful to 'see'

themselves doing something or being somewhere they enjoy, for releasing distressing emotions, and for experiencing positive, loving scenarios." There seems to be a great value in having the mind create a desired situation within the individual.

Crowl (1980) describes how art therapy can be used to help a child master his or her anxiety regarding impending surgery. Her client was a nine year old boy admitted to the hospital with a hernia that would have to be surgically operated on. He received comfort and emotional support from many people but continued to fear the forthcoming operation. Through art therapy, however, he was able to project his inner anxiety in a visual form, as he was unable to express it verbally. He was aware of the details of the impending surgical procedure and of the environment. Through a series of four drawings he graphically expressed his fear and was able to put it to rest momentarily. Having been given permission and encouragement to draw what was on his mind, he was able to allay the infinite threat of the unknown by giving it form and thus bringing it under a measure of control.

Paine, Alves, and Tubino (1985) used human figure drawings with paediatric oncology patients as an assessment tool and found that the reduced size of human figure drawings is related to the anxiety which their illness generates and also to the lowered self-esteem experienced as a result of physical disfigurement and the social stigma of cancer.

The distinct fears that children commonly experience during hospitalization are of separation or abandonment, mutilation or castration, loss of control, helplessness, alteration of body image or disfigurement, pain, needles and death. If not allowed to express these fears a child may regress or withdraw. Themes of helplessness, anxiety, isolation, and body-image emerge in Geraghty's (1985) work with a hospitalized Alaskan girl. The ten year old girl was able to express visually feelings that were frightening for her to verbalise. Drawing was a safe vehicle by which she could communicate how she was feeling to the therapist and others around her. Without art as an emotional outlet, the girl might have suppressed these feelings, causing further regression and stress and intensified fears. The sense of control that the girl experienced in art therapy was badly needed at a time when she was exposed to frightening and painful experiences beyond her control.

Kern-Pilch (1980) emphasized the value of choice and control in doing art therapy with terminally ill children, and showed that therapeutic intervention can do a lot in improving the quality of a patient's last days by helping them prepare to meet death peacefully rather than struggling in terror against it. Kern-Pilch was able to provide her patients with on-the-spot support and assistance in maintaining self-esteem and identity at a time when friends and family could respond to the patients' needs only from a distance.

Rudloff (1985) described the therapeutic process with a twenty-three year old man with cancer on the final journey of his illness. An art therapist can be of help even after a client can no longer work with art materials, either because they are so physically debilitated or too emotionally withdrawn, by just being there attending to the needs of the patient. Through art the client was able to express very deeply felt emotions of isolation, anger, horror, fear and sadness and resolve these issues by verbally processing the images with the therapist.

Lichtenthal (1985), herself a chronic cancer patient, described the experience of art therapy with a twenty-one year old woman dying of cancer. Art therapy served as a healing process for the patient to strengthen her ego and to cope with her illness. The patient was able to deal with her depression and guilt feelings through art. Art therapy functioned as a way of pulling inner life experiences together to reflect upon what was once pleasant and comforting. According to the Kubler-Ross (1969) stages, the patient had passed through denial, anger, bargaining and depression and was in the process of acceptance. Art therapy gave the patient a sense of control and provided her with guidance and support in an environment in which she could express herself safely and with permission.

Simon (1974) noted a dramatic improvement in the physical health of a patient with tuberculosis shortly after a change in his mental attitude that was achieved in part through painting. Simon (1981) described bereavement art as an attempt to work

through the conflict of death and dying in three overlapping stages. The first stage consists of expression of the conflict. In the second stage the art provides an image that enables the suffering of the expressive stage to find containment as it is slowly converted to mourning. The third stage brings resolution, the patient comes to view death tranquilly as the natural end to life and is able to use initiative to better effect in his life -- whereas earlier it was either lacking or misapplied. Kubler-Ross (1969) has shown how important it is for a patient to have a sufficiently intimate companionship while working through the anger and fear of being bereft of life. Bereavement art arises spontaneously and can be used to resolve itself only within a secure situation where the patient's needs are supported.

Prager (1993) shared case studies in which empathic support was used to enable hospitalised children to express powerful feelings about illness and to release feelings about perceived body image and to come to terms with illness. Prager stated that the expressive outlet from which potent emotions were released served to ease the children's psychic pain more effectively than did intellectual explanations.

Bush (1994) explored the use of computers and creativity software as a new modality for art therapy with chronically ill children in paediatric settings. The chronically ill child is faced with enormous psychosocial challenges during illness and hospitalization. Children regardless of their age encounter both real and imagined fears related to their prognosis and the pain experienced during procedures and

treatment. Children's feelings of loss of control and lack of choice during treatment can be experienced as punishment and bodily mutilation. Therefore, the hospitalized child can react by either becoming especially withdrawn and ceasing to communicate with the world or by becoming excessively needy and unable to satisfy the desire to feel safe and protected. Self-esteem often suffers as children lose a sense of mastery of the environment.

For the chronically ill child who is experiencing loss of control, the computer can provide a powerful mastery experience in which numerous choices can be made within the tight boundaries of the screen. Another important aspect of using computers with this population is to allow the child to interact with "machines" in a different role as when receiving cancer treatments.

Tartakoff (1994) believes that children who face their mortality due to childhood illness wish to leave a legacy, a record that they were indeed here. Black and white photographs have been used by children and siblings as a canvas, a means of creating a story to show their world to others as well as a means of taking back control in a world very much out of control. Children are invited to colour on, cut, place objects and weave the photographs. This allows them to own the images and further personalize the story as a concrete and safe tool for communication which can ultimately be instrumental in the healing process. By using photographs which clearly show the children as they are and giving them permission to alter the photographs in

any way they wish, the therapist can discover many truths about how children see -- or wish to see -- themselves.

Baron (1985) developed a group program for cancer patients to provide a safe environment for individuals to share their feelings and fears around their illness using deep relaxation techniques, guided imagery and drawing. These exercises had a theoretical basis in the relationship between emotions, stress and cancer and it was hoped that group participants could use these sessions to become active in their own healing process.

Themes of separation anxiety, alienation, anger, aggression and fear, body-image and self-concept, beliefs about disease and treatment, and images that may represent concepts of death itself are commonly observed in artwork of children with cancer.

Councill (1993) employed art therapy in the beginning phase of diagnosis and treatment, during which cancer treatment assaults children's body image, identity and self-esteem. Embarrassment, anger and social withdrawal may accompany the child's sudden loss of self. Children may try internally based coping strategies, resulting in depression, withdrawal, self-blame and alienation. Psychological support is made available by the active presence of the art therapist and the relative safety of art materials for displaced expression.

In the middle phase of treatment, Councill (1993) states that intervention is around supporting the patient through the long-term stress of treatment. Denial may be an important ingredient of the patient's defense. During this phase, the patient is helped to restore his or her sense of self. Art therapy provides a valuable outlet for reflection of feelings about loss and self within a supportive environment.

During relapse or palliative care, heightened uncertainty replaces the now-familiar routines of treatment. Anger and isolation may resurface, and communication with family members and staff may break down (Kubler-Ross, 1969). Art therapy can be especially helpful in facilitating communication during this difficult period. Parents and staff members may feel their decisions about treatment are responsible for the patient's imminent death. Often the patient is the first person to sense that death is imminent and that isolation becomes painful if it cannot be expressed somehow. Art has a powerful way of giving expression to profound existential themes and the relationship of an art therapist can be a strong support to the patient when words are too difficult to say or to hear.

Allan and Crandall (1986) conducted a study to compare the visual imagery (i.e. the drawings) and the metaphorical statements (i.e. the words used to describe the pictures) of coping and non-coping children. A coping child was defined as one who gets on well with the teacher and peers and shows average developmental mastery of learning skills. Noncoping was defined as the converse: failure to get

along with the teacher and peers and failure to master the work skills necessary at the child's grade level.

The purpose was to determine whether the pictures and words of coping children reflect emotional health, whereas those of non-coping children signify inner turmoil. The treatment consisted of three phases (p. 45):

- 1) Relaxation and imagery -- in which the children were guided visually on the imagery of a rosebush. It was assumed that the children would project into the image of the rosebush, the various facets of their personalities.
- 2) Drawing -- in which the children were asked to draw a picture of what they imagined during the guided visualisation.
- 3) Post drawing inquiry -- in which the children were asked eleven questions about the experience. For example: "What do you look like? Tell me about your flowers... your leaves... your roots.... Who takes care of you?"

Allan and Crandall found that the pictures of non-copers showed more signs of disintegration and rigidity than did those of copers. Children's drawings and the words they use to describe them can give a therapist a view into their inner world of feelings. The image provides a safe vehicle for children to project some of their own thoughts and feelings, later paving the way to talk more directly about their own issues (Allan and Clark, 1984).

Projective techniques such as the rosebush strategy often yield useful information, but in working with children with cancer the use of spontaneous

drawings could be more revealing because children can then direct adult interactions in a way which will be most helpful to the former. Children find it easier to communicate, especially those things they will not or cannot share verbally, through drawing. Spontaneous drawings, like dreams, indicate the projected content of our unconscious conflicts.

### **IMAGERY USED BY CHILDREN WITH CANCER**

There are several patterns and themes that emerge in the artwork produced by children with cancer which will be the focus of the following discussion. Furth (1973) conducted a research study to compare the content of drawings by leukaemic children with those of other children, some of whom were hospitalised but not with life-threatening situations, and some of whom were healthy. In his study, forty-five children drew three pictures each over a three month period. Furth was unable to obtain statistically significant findings; however, he noticed some distinct trends.

Children with leukaemia tended to draw indoor scenes, not to fill in their main objects, preferring to outline forms and not to draw suns -- but when they did draw them the suns tended to be positioned differently. They tended to place the suns in the upper right quadrant. Moreover, healthy children tended to draw faces on their suns, while hospitalised children did not.

There was no clear use in the specific pattern of colours, but according to Furth (1988), a light yellow often used for coloured hair may indicate a precarious life situation. Furth also noted that light blue, which may indicate fading away or withdrawing, was the most common colour used for some or part of the central image. Bach (1990) suggested that in the drawings of leukaemic children, the absence of the colour red may represent the profusion of white cells within their blood.

Abstract drawings were sometimes made by the hospitalised children. Furth (1988, p. 82) writes, "An abstract portion of a drawing or a whole abstract drawing usually represents either something that is hard to understand, difficult or obtuse, or an avoidance."

In Bertoia's (1993) work with a terminally ill leukaemic girl, she noted some common symbols in her client's artwork, such as: placing the sun on the left, representing the west; drawing rainbow images suggestive of hope and rebirth; and using traditional symbols such as travel and light, common in dreams of the dying. The common emotional themes represented were fear, sadness, anger, emotional contradiction and ambivalence, and facial expressions.

Bertoia (1993) and Council (1993) found several content themes in the drawings of children with cancer. First was the repeated appearance of a series of numbers. Bach (1969) often found significance in repeated numbers as units of time

in the child's work. The most frequent image in Rachel's series of drawings was that of a girl, whom she often identified with, either by appearance or by having done that activity. Monsters and predators in some form also appeared frequently in the drawings of children with cancer. Bertoia (1993, p.83) writes, "These images can be seen to represent the fearsome, destructive nature of the disease, impending death and knowledge of separation."

Rachel's apprehension towards her illness was indicated by the theme of trickery, dreaming and hiding. There was also a shift in Rachel's drawings from solid objects to fading and floating images over the series. This shift was interpreted by Bertoia as Rachel's understanding that she would die at the point where tricks and dreams stopped and move on to distancing herself from this world, fading away physically and floating free of physical attachments.

Other themes that were contained in Rachel's art work were: Intuition -- an indication that the intuitive or unconscious self already knows the outcome of the disease; Eyes -- especially on figures, indicated whether these figures were facing the situation directly or avoiding it, or focusing on the situation attentively; Home -- the houses drawn were often in poor physical condition, perhaps to represent the deterioration of physical being; Journey -- represented by a drawing about having or travelling to a new home, expressing the temporary nature of life and the anticipation

of leaving for a new place of existence; Transformation -- through the use of symbols representing optimism, hope, metamorphosis, death, and re-creation.

### **SPECIAL QUALITIES OF ART THERAPY PROCESS AND PRODUCT**

The efficacy of art therapy intervention with children with cancer has several therapeutic benefits. Children can control their own choices of art materials, in addition to choosing the subject and verbalization of their artwork, thereby enabling them to experience themselves as active creators. The therapeutic alliance between the art therapist and the child in a hospital setting can be strengthened by giving the child a measure of choices in the session. Doing so could counterbalance the innumerable hospital procedures over which the child has no choice.

Children can maintain communication with family and medical staff through art expressions when their relationships are strained by anger, withdrawal, fatigue and feelings that are too emotionally charged to be expressed verbally. Art therapy can be used to reduce symptoms of depression and anxiety, increase the child's sense of control and autonomy, and facilitate communication with the family and health care team. Art therapy can enable children to trust adult caregivers.

Children can continue the process of development through visual communication, thereby supporting social and mental growth and mitigating the

isolation of the hospital experience. Art therapy can also promote effective coping strategies outside the hospital and therapeutic sessions, including relief of pain through distraction. The active presence of an art therapist and the relative safety of art materials for displaced expression can afford valuable psychosocial support.

Children can also gain a sense of mastery over feelings about illness and treatment through rehearsing troubling events and working out concepts of self in art expression. When an art therapist is part of the overall treatment team, he or she can provide a uniquely humanising influence in the midst of an experience that threatens the child's sense of self and trust in the world.

In working with children with cancer, an art therapist needs to employ a client-centred approach which allows him or her to sensitively follow the client's lead to allow feelings to emerge without overwhelming fragile defenses. Also, by finding a material with which a child enjoys working, the chance to interact without talking unless the child so chooses -- is provided.

Lastly, the art therapist's sensitivity to children's graphic messages, and trust in the value of open-ended creativity, allow for art therapy to be an extremely valuable support to children who are physically ill.

## CONCLUSION

There seem to be two different approaches to using art therapy interventions with children with cancer -- therapy as helping patients cope, and therapy helping people heal, i.e. in a very physical way. Most of the literature on art therapy and children with cancer follows the former approach, with therapists taking the coping track in implementing art therapy. More research needs to be done on the use of guided imagery, relaxation techniques, and drawings in creating positive defensive, mental, and visual imagery which could ultimately have an impact on the body's physical functioning.

There are several difficulties an art therapist could encounter when working with this population. An inability to comprehend cancer personally is just one. The therapist's own attitude towards death and dying, the desire to make life extend, and the optimistic hope that the child will get better are some of the others. However, by making post-session countertransference drawings, the therapist could deal with personal feelings that arise when working with this population.

In medical centres, where science and technology bring about the miracles of modern medicine, image making along with careful listening can support the work of healing. According to Baron (1989), the field of helping professionals is placing a great deal of value on an individual's imagery and art as a means of evaluating and

re-evaluating the physical conditions present in the patient's body. Therefore, the art therapist, trained to speak the language of art, will be a valuable source in channelling these messages, influencing attitudes that may be blocking the healing process.

Researchers in the new area of psychoneuroimmunology indicate that there is a deep and extensive connection between the body and the mind. The use of art therapy to alter an individual's imagery to the extent that physical healing results -- i.e. the course of the illness is concretely altered -- seems to be the ultimate challenge. Until then art therapy can be used to allow individuals to explore their attitudes towards illness, the immune system, medical treatment interventions, and healing.

Eventually, I would like to explore the possibility of art therapy intervention with children with cancer by incorporating the holistic approach toward mind-body balance in healing illness through art. Only then, through personal experiences and observations with individual and group art therapy interventions, would I be able to elaborate further on the role of imagery in healing illness.

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