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**The use of Art Therapy
With Children in Hospitals
Case Study**

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A Research Paper

in

The Department

of

Art Education and Creative Arts Therapies

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Abstract

Not until recently have specialists begun to look at the effects of hospitalization and surgery on children and adolescents. Hrutkay and Eilert (1990), for example, describe the psychosocial effects of pediatric surgery and subsequent hospitalization on children. The authors identify reactions varying from increased anxiety and adjustment disorders to depression. They also observed that children in hospital often show increased dependence and regression, which cause considerable problems with rehabilitation and recovery. Moreover, children and adolescents, in the process of development, already deal with many difficult tasks as they are in constant change. This paper is a case study describing an adolescent girl's experience of art therapy while in hospital over a period of several months. Art therapy provided this patient with the opportunity to work through several issues pertaining to her development, including individuation and identity formation. It also allowed expression and reparation of her hospital experience, providing her with a sense of control.

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Introduction

For some time now, researchers have been studying the psychological effects of hospitalization on children, attempting to identify the consequences of hospitalization. In the past, researchers described the consequences of the experience on children (regression, disorganization of spatial perspective-taking skills...) yet were not in agreement whether these effects were serious or widespread. There is still some debate over the seriousness of the effects of hospitalization, as well as the causes, but few specialists today argue that children are affected by such an experience. Dimock (1959) writes that it is important to offer special attention to all children in hospitals. He stresses that children who are homesick, shy, quiet and retiring need as much attention as the children who are overtly demonstrating adjustment problems do. This is an important distinction for these children, Dimock continues, who are often overlooked as their actions do not command attention. They seem well adjusted. These however may be the children who would profit the most from individual attention. Thompson and Stanford (1981) write about a child that was so incapacitated by fear that he seemed to be coping wonderfully, being described as a "model patient" when in fact he was afraid of being subjected to even worse terrors as he did not comply with treatment.

Prugh, Staub, Sands, Kirschbaum and Lenihan (Gaynard et al, 1990) refer to studies by Cerreto, 1986; Douglas, 1975; Goslin, 1978; Lambert, 1985; Meijer, 1985; Quinton & Rutter, 1976; Folland, 1984, 1987; Spitz, 1945; R.J. Thompson, 1985, which point to the fact that illness, injury, and hospitalization can directly effect a child's cognitive, physical, perceptual, emotional, and social development: "A stressful event or chronically stressful situation produces both a physiological and emotional response"

(Frydenberg, 1997, 15). Yet the effects of stress on the body have not been clearly defined as physical illness and stress have only been correlated. However Dimock (1960) believes that hospitalization and illness have an important effect on an individual's whole being. He quotes Plato who, over two thousand years ago, said: "The greatest mistake a physician makes is to attempt to cure the body without attempting to cure the mind; yet the mind and the body are one and should not be treated separately." (Dimock, 1960, p.10) Dimock believes that this is surely as true today.

Gayard et al (1990) write that professionals in child development, mental health, and other health care professionals have suspected for a long time that children's emotional health can be negatively affected by hospitalization. According to Thompson (1985), hospitalization produces unfamiliar, often painful stimuli, disruption of routines, and separation from supportive persons. These elements combined with the personal characteristics of an individual create varying degrees of upset.

Fromm (1974) questioned our knowledge and understanding of human beings. He argued that true knowledge could only be gained of things as only these can be dissected without being destroyed. Things he continued, can be manipulated without damage to their nature, they can be reproduced. Man, he reminds us, is not a thing. Bugental (1974) believes that in clinical psychology, we have gained far more knowledge from the practitioners of psychology than we have from the researcher or investigators. I believe that his opinion may be based on the quality of information gathered by practitioners. This quality of information is what attracted me to qualitative methods of study. It was important to me to maintain the richness of my experience at the hospital

and this is why I have chosen to write a case study based upon a young hospitalized teenage girl whom we shall call Jessica.

As a young adolescent Jessica had many issues to deal with other than those already mentioned. Adolescents struggle to find their identity, which leads them to become concerned with their moral, physical and social development (Thompson & Stanford, 1981). Hofmann, Becker and Gabriel (1976) write that anxieties about body image, self and socialization are at their peak in adolescence. They believe that mid-adolescence, which ranges from 14 to 17 or 18 years, is the most difficult time for adolescents to be in hospital. The authors write: "Illness and hospitalization, which directly challenge the struggle for independence and raise doubts about sexual functioning, while limiting the crucial access to peers seriously threaten the adolescent during this volatile time" (Hoffman, Gabriel & Becker, p.35).

Today, many hospitals have become more sensitive to adolescents' needs and offer different programs and longer visiting hours. However, Prugh, Staub, Sands, Kirschbaum and Lenihan (Gaynard et al., 1990) found that even with psychological preparation, frequent parental visitation, and play opportunities, 68 percent of the children studied had "significant difficulties" in coping with the stress of the hospital setting. As an art therapist, I believe therapy offers an individualized support, which can help patients address their feelings about their bodies, treatment and their hospital stay. Art therapy can allow hospital patients to better adjust to all the aspects of their lives while in hospital and also prepare them for discharge and life outside the hospital. In order to gain a better understanding of this topic, I have chosen to describe many issues pertaining to children in hospitals and more specifically to Jessica. To begin I will

review the literature on children in hospitals also addressing such issues as pain, stress and control. Then I will continue with developmental issues describing adolescence, self image and the development of it, separation and individuation and socialization. A review of art therapy in hospitals will follow, as well as a discussion of the value of self expression, and the case description. In the discussion and conclusion at the end of this paper, I wish to examine the aforementioned issues, gaining an understanding of how these entered into Jessica's work in art therapy. I will also attempt to demonstrate how art therapy provided Jessica with an opportunity to express and repair much of her experiences as a young woman as well as a hospital patient.

CHAPTER 1

Children in hospitals

This section will attempt to illustrate children's lives in hospital through a description of the difficulties they encounter as they strive to satisfy their needs and understand their medical condition. Opinions concerning the effects of hospitalization on children have changed greatly in the past decades. Traditionally, although negative behaviors in hospitalized children were observed, emotional and psychological needs were seldom considered in treatment plans. For example, Dimock (1960) refers to hospital studies, which describe child patients experiencing night terrors, fears, obsessions, negativism, regressions, and hostility. The researchers concluded however that it is not all children that suffer in this manner. Other studies point to the consequences of hospitalization, emphasizing their variety, their importance as well as their prevalence. To begin, Schneider described children in hospitals as preoccupied with fantasies of body damage (Fisher, 1973). Rose (Thompson, 1985) observed that children in hospitals experience a decrease in pleasure, speech and attempts to control. She also observed increases in sadness, crying, emotionality, and affection. Thompson and Stanford (1981) observed eating, sleep and speech disturbances, mannerisms, tics, fears and regressive behaviors. Thomas and Stanford (1981) also found that in some cases, fear actually caused interference for childrens' medical treatment:

...thousands of...children who annually enter the hospital develop many secret fears and fantasies, often far too scary to share with other people. Some...fear punishment or abandonment by parents, while others are more concerned about physical limitations caused by disease, or about their own mortality. The

misconceptions generated by a young mind may be so ominous that they interfere with medical treatment. (p.5)

Researchers have thus, clearly been able to identify several effects of hospitalization on children. They now questions the prevalence and long-term effects of the phenomenon, it's specific causes, and the how these affect their treatment plan.

In a study, Prugh found that 92 percent of the children receiving the “traditional practices” (no psychological preparation, opportunities to play, nor regular visits from parents), experienced “significant difficulties”. As we can see, when hospitals limit their treatment uniquely to a medical treatment, children still suffer. In order to alleviate the negative effects of hospitalization, we must better understand their causes.

As children develop, their needs are changing constantly. In order to progress in their development, these needs must be met. Gaynard et al (1990) wrote that while in hospital, children's developmentally important needs may be thwarted, which result in developmental disturbances. The need for independence and accomplishment, which children of all ages experience, is very important as it helps children develop in many ways and allows them to gain self-esteem. Dimock (1960) found that it was very difficult for hospitalized children to be independent. This unmet need, Dimock hypothesizes, increases their need for autonomy and initiative, which of course, becomes even more difficult to satisfy while in hospital. Irwin and Kovacs (Thompson, 1985) found that in the days following surgery, children's self-esteem was lowered, and they were more dependent. In the case of adolescents, feelings of independence are very important.

Williams (Thompson, 1985) also wrote about the effects of hospitalization, as he observed varying degrees of aggressive and regressive reactions, ranging from severe

lethargy to restlessness or hyperactivity, to a full-blown rage-like reaction. This occurs as the restriction of a child's mobility forces the child to attempt to cope with the hampering of his instinctual drive, in any way possible. Gaynard et al write:

"Hospitalized children tend to have many anxieties and concerns about their body, their physical condition, and impending health care events. In addition, they must cope with the frustrations of confinement and decreased mobility inherent in hospital care"

(Gaynard et al., 1990, p.69). Body and self-image as well as self-esteem are certainly very important for children and adults alike. Children however, are more sensitive to outside influences as they are still developing. Schowalter (1977) suggests that illness negatively affects body image and self-esteem.

As children develop their sense of self, they must also define their boundaries. These ideas will be further discussed later, however I now wish to address the fact that while in hospital, it is very difficult for children to set their boundaries. Children in hospital must deal with this task very differently as non-hospitalized children as they often see their boundaries crossed during medical treatment. Fisher (1973) describes this intrusion: "The person who is suddenly faced with surgery...may react with the feeling that his borders are endangered and too weak to cope with the intrusions that are imminent" (p.40).

A child's developmental level also influences a child's understanding of his or her condition. As they grow older and discover death and explore what it is all about, many children begin looking at disturbances in their own body processes as miniature death situations (Fisher, 1973). Schowalter (1977) writes that fears of death associated with illness are reported to be prevalent, as are concerns over the loss of independence that

hospitalization or illness may entail (lack of privacy, limiting choices, existence of regulations). Children, according to Beverly, 1936; Richter, 1943; Gips, 1956; Gellert, 1961 (Thompson, 1985, p.60), Kister & Patterson, 1980; Cook, 1975 (Rutter, 1970), often experience illness as a product of their own behavior. Piaget described young children as believing in automatic punishment emanating from things themselves (Thompson 1985). Rutter (Thompson, 1985) found that children seemed to see themselves as responsible for negative events much more than for positive one. But according to Cook (Thompson, 1985), who studied children aged 5 to 15, this type of thinking is not exclusive to young children. Cook found that all of the children in his study (hospitalized or not), gave explanations of illness characterized by themes of self-causation and blame.

Thompson and Stanford (1981) write: “a significant proportion of all children who enter the hospital suffer some form of psychological upset. It is not just the unfortunate few, somehow constitutionally weaker than others, who encounter difficulties” (p.18). Thompson (1985) states that early studies such as Prugh’s, Staubs’, Sands’, Kirschbaum’s and Lenihan’s (1953), conclude that the upset that children in hospitals experience is prevalent. Thompson (1985) writes: “Any child is susceptible to the traumas of a hospital stay. If the difficulties brought on are of such importance within hospitalized children then we must investigate further” (p.18). It seems that this “investigation” should take place for all children as some children, as we have seen, are not very overt about their concerns. Looking at childrens’ emotional response to hospitalization can also allow professionals to prepare children for a well adjusted return home, as the effects of illness and hospitalization may be far reaching.

Researchers have also been examining children in order to define the lasting effects of the hospital experience on children, if any. Vernon, Foley, Sipowicz, and Schulman (Gaynard, et al., 1990) concluded in their 1965 study of children's responses to hospitalization that emotional distress is common while in hospital as well as following discharge. In the study by Thompson and Stanford (1981), the behaviors observed, in some cases, persisted several months and in others, several years. After hospitalization, patients must also cope with their illness and recovery.

Researchers have often looked at psychosomatic illness as a way of coping with life events. McQuade & Aikman (1976) talk about a case where an individual's illness is not psychosomatic in origin but rather in function. The case is of a young girl with a "clubfoot" who was hospitalized for its correction. While in recovery from the operation, she fractured her foot in a fall, and later broke it. Her foot had served her all her life as an explanation for things that went wrong in her life. Without the foot, what would become of her? This was, in Dr Dunbar's words, "an expression of the patient's unconscious need to keep the deformed extremity as a defense against and cover for her more fundamental personality conflicts" (McQuade & Aikman, 1976, p.119). The authors write that medical professionals warn against the dangers of "curing" certain patients of the physical symptoms they have come to depend on. "Unless this kind of patient receives psychiatric treatment or unless his life changes for the better, he almost always suffers a recurrence of the old symptoms, or else acquires new ones, or runs into emotional problems" (p.119).

Each individual develops their coping strategies in order to deal with life events. Resilience or good coping, according to Frydenberg (1997), depends on temperament,

high self-esteem, internal locus of control and autonomy, support from family group or other individuals, flexibility etc. However, not all children in the hospital setting have these resources. As we have seen in the last paragraph sometimes the ways people find to cope with life events such as illness become a problem rather than a solution.

Frydenberg also writes about other strategies that people use to deal with life's circumstances, as well as the effect of these: "...cognitive strategies, including information seeking, were related to positive affect, while emotional strategies, particularly those involving avoidance, blame and emotional ventilation, were related to negative affect, lowered self-esteem and poor adjustment to illness" (Frydenberg, 1997, p. 41). In the next two sections, we will take a look at two very important issues that children in hospitals must learn to cope with: pain and control.

Pain

All that you perceive, think, and believe occurs in the context of your body experiences. A relatively minor body sensation, like a headache, can radically change your immediate perspective on what is going on about you. The noblest of fantasies may be submerged by a nagging little pain. (Fisher, 1973, ix)

The experience of pain greatly influences one's perception of events and people around oneself. Pain is obviously part of everyone's life and influences our learning, perception and emotions. Sternbach (1984) believes that painful experiences markedly change our perception of the world, relationships with others, preoccupations, and activities. But before we examine the influences of pain, we must first better understand pain itself. How do we perceive pain? What meaning does the experience hold for us? Records have shown that the phenomenon of pain has been troubling philosophers and

scientists since the time of Aristotle (Fordyce, 1986). Kruger and Kroin (1978) remind us of Freud's work about pain. They write:

Freud's introduction of psychoanalytic theory not only revealed the role of pain in behavioral reinforcement in man...early experiences and learning are crucial determinants of an organism's response to a noxious stimulus (Melzack & Scott, 1957; Niessen, Chow & Semmes, 1951), and much of the modern clinical approach to pain control is directed toward an understanding of behavioral-reinforcement variables, rather than exclusively seeking an organic explanation of all pain pathology. The recency of this subfield of psychology precludes any historical perspective, but with the formation of modern pain clinics, clinical psychology and medicine have formed a new alliance that bodes well for the future of pain research and pain control in man. (Kruger & Kroin, 1978, pp.174-175)

Today, even though science is progressing rapidly in physiological and behavioral areas, the complexity of the experience of pain still makes defining and understanding it difficult (Chapman, 1978). Merskey (1986) writes that the Greeks and ancient Hebrews believed that a link existed between the sensation of pain and the emotions. This is still reflected today in our use of the word pain, which applies both to physical and emotional discomfort, as Fordyce points out. Fordyce writes that although we know that pain is a sensation that usually makes us feel uncomfortable, we often are unable to distinguish or define pain, which it seems may be due to the entanglement of physical and emotional factors. Chapman (1986) emphasizes the complex nature of the experience of pain as he writes:

Pain is surely one of the most complex phenomena in human perception. At the sensory level it involves the integration of neural transmission from the skin, muscles, joints, organs, and vasculature with neural signals that originate in environmental events impinging on the perceiver. In addition, brainstem and limbic structures respond to noxious stimulation, producing an aversive feeling state that has the quality of emotion, particularly fear. (Chapman, 1986)

Despite the difficulties with defining pain, the International Association for the Study of Pain has accepted the following definition for the word: "Pain is an unpleasant experience which we primarily associate with tissue damage or describe in terms of tissue damage or both" (Merskey, 1986, p.176).

But then, where does pain actually come from? Chapman defines pain as "an unpleasant sensory and emotional experience associated with actual or potential damage, or described in terms of such damage" (Merskey, 1986, p.115). Of course we must not forget the physical or tissue damage which Chapman writes of and that we all recognize as the trigger for pain; yet is it the perception of it or the actual damage that create pain? Studies demonstrate (Fordyce, 1986), that there is no consistent pattern between reports of pain and the actual state inside the body. He believes that it is the anticipation of pain as well as a variety of emotions that trigger feelings of pain. The anticipation of a change in the body even if no change actually occurs may produce feelings of pain. Fordyce believes that it is the perception of pending threat to the person that creates pain. Similarly, Merskey (1986) explains that muscle tension which is created and controlled by emotions such as pain fear, greatly contribute to the perception of pain. However, it has been shown that we learn to perceive events as painful through our education and

culturally determined attitudes. Much as with everyday behavior, we learn how to deal with pain from our family, friends and so our culture. Modeling from those in our environment, provide us with coping strategies. Culture usually dictates how much one must express or inhibit pain, deny or avoid dealing with pain (Craig, 1986, Pilowsky, 1986).

Pilowsky (1986, 181) writes that the shaping of one's personality has a strong relationship to pain. From birth we learn to function as we are constantly attempting to find a balance between satisfying inner drives, as we also must deal with environmental realities. So, in many ways pain shapes our personalities. Parents sometimes use pain in order to shape their children's behaviors. They may use the threat of pain or actually inflict pain (Pilowsky, 1985).

Craig (1986) believes that cognitive processes also contribute to the perception of pain. When in pain, people interpret its source and react according to their personal meaning, their personal history, and future implications of the disease or injury. But what meaning do children generally attach to pain? Pilowsky (1986) writes that pain may be perceived much like an attack from another person, but emanating rather, from one's own body. Often, as previously mentioned, children and teenagers especially, tend to feel as if health problems are related to their behavior. Fisher (1973) illustrates how children often see pain as a negative consequence or punishment:

The superstitious way in which we come to interpret body events is unhappily illustrated by what has been found in studies of children who suffer serious body disability. A basic reaction in such children is one of guilt. A young child who had a leg amputated clearly verbalized the idea that he must have some something

bad to have such a terrible thing happen to him. This is true not only of children.

Adults who have suffered gross body damage reveal, if one wins their confidence, similar guilty thoughts. (Fisher, 1973, p.6)

How then, can we reduce pain? The ancient Egyptians relief their pain by wearing an amulet of the eye of Horus, a child-god, on an ankle or wrist (Fairley). This would not work in our present day society, however the idea that one's faith can reduce pain still applies. Merskey (1986), Sternbach (Craig, 1986) and numerous other researchers believe that anxiety increases pain. Their studies demonstrate that anxiety enhance one's sensitivity to pain, or increases pain responsiveness. It would then be expected that anything that diminishes anxiety also diminishes pain. Merskey and Beecher (1960) and Shapiro (Chapman, 1978) write about findings, which demonstrate that placebos have relieved pain in individuals. Evans (Chapman) has attributed this phenomenon to anxiety reduction. Merskey adds that the same results came from offering patients psychotherapy, hypnosis, behavioral treatments, and overt suggestion. Beecher (1960), like Merskey attributes these findings to the participants' state of mind. He explains that when individuals are positive, they have faith in their treatment, the perception of pain actually does decrease regardless of the treatment (Craig, 1986, p.73).

In conclusion, it is important to remember that all individuals express themselves differently. This means that although we may easily recognize the expressions that resemble our own, we must be very observant in order to understand those who express themselves differently. Sternbach (1986) writes: "In simpler times, it was assumed that there was a 1:1 relationship between the perception of pain and the expression of it...The

problem, rather, seems to be one of lack of appreciation of differences in style of communication.” (p.224)

Stress

Stress refers to an ongoing transaction between a person and the environment that results in an emotional appraisal that the situation is threatening or harmful to some important aspect of well-being. In “stressful situations, people usually feel little of no control over the situation, or feel unable to change the situation in order to remove the threat or harm. (Gaynard et al., 1990, p.16)

Stress is an important part of a child’s life in hospitals. The fear of an unknown condition and treatment, a new environment filled with new people, and separation of a child from their care givers all contribute to a stressful situation. This stress as we have seen in the last section for instance, influences hospitalized children’s condition, increasing the perception of pain.

Frydenberg (1997) sees the root of stress in our concerns about everyday life events. This of course entails that what each individual perceives as stressful is different. When a task is anticipated as being stressful Frydenberg continues, the experience is more likely to be stressful. Clough (Thompson, 1979) wrote: “Children who tended to define themselves as being ill were more compliant during hospitalization. Those who found medical treatment to be stressful... exhibited more anxiety behavior” (p.50).

However, as Olbrich (1990) writes, people are not simply the inactive recipients of stress. Rather, we all bring into play our productive capacities, in order to deal with the demanding, challenging or threatening situation. As a result of stressful situations,

change is the likely outcome as one can not always use their usual patterns or action or reaction as these may not be useful. Adaptive change or failure to adapt can result.

Meichenbaum (1983) and Frydenberg (1997) explain that there are two main ways of looking at stress. One of the ways is to see it as a condition of the environment. The other way to see it is as individuals' reactions to threatening or challenging situations. Meichenbaum continues to say that we can also adopt a transactional view of stress, integrating both views. Gaynard et al. (1990) as well as Meichenbaum believes that stress is influenced both by the individual and the environment and thus believes that the perception and interpretation of a situation determine whether it produces a stress response. Responding behavior also influences one's stress level as it either maintains or escalates it. Lazarus (Olbrich, 1990) believes that different forms of coping also have an effect on stress. He believes that one's way of coping determines whether stress will have a facilitative or impairing effect. Selye (Frydenberg, 1997) adopts the integrated view of stress. She defines stress as the biological and psychological response of the individual to environmental demands (Frydenberg, 1997).

In response to stress, Meichenbaum (1983) believes, the individual under stress must either change the environment, alter the situation that is causing the stress or, for those who cannot change the environment, they must regulate their emotions, reduce their emotional distress. As little can be done to change the hospital routine and treatment, they must find ways of dealing with their situation. Lazarus (Olbrich, 1990) sees coping as an active way of organizing and responding to stressful events. With this perspective he sees the individual having an influence on the stressor, just as the stressor itself has an influence on the individual. Lazarus believes that in a first step, individuals evaluate and

judge what is being demanded of him or her. Then, he or she must figure out how personal resources can be used to fill the demand, developing a “plan of action”. Lastly, individuals look at the results of his or her actions re-appraising the behavior used.

Lazarus (Jackson & Bosma, 1990) thus chooses to see stress as challenging, believing that stress is the starting point of development. The author believes that events that are perceived as stressful, such as environmental changes, illness, critical life-events, biological and psychological changes allow behavioral changes, as an individual’s habitual responses may not be sufficient to deal with the situation. Olbrich (1990) writes:

A panel report on psychological assets and modifiers of stress – presented by the Institute of Medicine and the National Academy of Science – states that individuals who have faced severe life stressors may also find that they have increased self-esteem, are able to perform better in similar situations at a later time, learn empathy, or can take advantage of new opportunities. (Olbrich, 1990, p.39)

Individuals perceive new situation as stressful because they do not know how to deal with the new demands. Olbrich (1990) writes that the factors determining whether stressful events will encourage growth, difficulty or trauma in individuals are, the pervasiveness and persistence of the stressor, the timing of the event, the individual’s personal resources available for dealing with the stressor, the opportunities available to act on the environment and to receive social support (Dunkel-Schetter & Wortman, 1981) and the meaning given to the experience (Benner, Roskies & Lazarus, 1980). He tells us: “Scientists and practitioners in the fields of personality and clinical psychology have reached the conclusion that how people cope with stress is more important for their

adaptation, their health and their development, than is the stressful impact itself. (Coelho, Hamburg & Adansm 1974; Godfried, 1977; Meichenbaum, 1977' Murphy & Moriarty, 1976; Filipp, 1981; Moos, 1976, 1977; Kaplan, 1983)" (Olbrich, 1990, p.40).

Gaynard et al. (1990) write about children's vulnerability to stress as well as the indicators of a child's capacity to deal with the stresses associated with hospitalization. Each individual, they explain, depending on various elements such as developmental age, abilities to communicate, coping skills and resources fears, cultural background, recent and current life stressors, etc., deal more or less successfully with the hospital situation. Jackson and Bosma (1990) see the goal of coping as acceptance, tolerance and the avoidance or minimization of the stress arising from the demands and the mastery of the difficulty. But how can we help children to attain this process? Tyszkowa (Bosma & Jackson, 1990), concludes that in order to develop appropriate coping strategies for life, it is important to develop an appropriate cognitive approach to oneself and to life situations, and to develop a relatively high level of self-esteem. Frydenberg (1997) asks whether we must help children cope by enhancing self-esteem or rather, help them to develop coping strategies, which will in turn influence self-esteem? Thompson (1985) believes that play offers children an excellent way of coping with stress. He writes: "A parallel body of research postulates a relationship between play and stress operating in the opposite direction. That is, play is believed to be used by children as a means of reducing anxiety produced by stressful conditions" (p.213). Gilmore (Thompson, 1985) observed that when children experiences strong affects, they chose to play with objects relevant to the perceived source of anxiety. These play situations offer appropriate ways for children to cope, also influencing patients' sense of control.

Control

Much of what children are asked to do in the hospital requires them to be passive.

They must hold still for examinations, procedures, and injections. Often they are restricted to bedrest or told to remain in their rooms... Unless the child is extremely ill, the passive nature of this role will be difficult to accept.

Frustrations generated by this condition can be alleviated through the child's play activities, as the passive recipient turns active. (Thompson & Stanford, 1981, 81)

Children's attempts to control tend to decrease while in hospital according to Rose (Thompson, 1985). Yet, Gaynard et al (1990) believe that the loss of control much like the loss of parental support, relative autonomy, self-esteem or sense of security can upset a child's psychological well-being.

Control is a very important element in the development of a person, allowing for example great opportunities for learning. Rogers (1977) reminds us that the organism is self-controlled. He writes: "In its normal state it moves toward its own enhancement and toward an independence from external control" (p.240).

Fisher (1973) writes: "Each person battles day and night to maintain his borders. The struggle to maintain control over a separate chunk of the world's space does not, in some respects, seem very different from the strategies of the one-celled organism protecting itself behind its enclosing membrane" (p.40). Dimock (1960) writes about the need children have to be autonomous as well as to express a sense of initiative. In hospitals he explains, this need is probably made more intense by the fact that children are not often put into a position of control.

Meichenbaum (1983) writes that when people believe that they have some influence over unpleasant experiences, they do better in the situation. On the other hand those who do not believe they have control over their circumstances show greater stress reaction. To show the extent of this reaction, Meichenbaum writes about studies where individuals are given the means to control the flow of negative stimuli (a loud noise) that is being exerted over them. At the same time, the participants are asked a series of questions. Those who had control not only performed better during the questionnaire, but did not even feel the need to end the loud noises.

Rogers (1977) found that when people have some sense of power, and support, constructive behavior changes occur, and they exhibit more strength, power and responsibility. Rogers also observed teachers that shared their power with students. This sense of power increased self-directed learning for students and also accelerated their rate of learning. As we can see, personal performance can be greatly influenced from individuals gaining a greater sense of control. Frydenberg (1997) questioned adolescents and found that in order to cope with a situation, they felt it was necessary to be strong and in control.

Gaynard et al. (1990) write about the greater sense of control that children can acquire from decision making in the hospital:

...simply being able to come and go from the playroom at will enhanced their sense of control over separations issues. The ability to control some of their comings and goings contrasts with the passive role typically played by pediatric patients continually watch parents, family, and staff come and go from their hospital rooms, and feel little ability to affect others' arrivals or departures. (p.86)

According to Gaynard et al., (1990) expressive play allows children to “gain increasing control over their feelings and behavior and to express themselves in acceptable, constructive, enjoyable ways. In turn, parents and health team members benefited from more compliant, less disruptive patients” (p.69).

CHAPTER 2

Developmental issues

Adolescence

“Throughout the history of civilization, adolescence seems to have been understood as a period of disturbance” (Olbrich, 1990, p.35). Victor Hugo described adolescence as the mix of twilight and dusk, the beginning of a woman and the end of a child (Dolto, 1988). Dolto (1988) writes that dreams about killing and being killed are common at the beginning of adolescence for as a new individual is born, a child also dies. Allerbeck & Hoag (1985) believe that “Contemporary characterization of the younger generation in the mass media, in public or private discussions continue to advance the notion of disturbance” (Olbrich, 1990, p.35). Olbrich states that adolescence is best understood as a period of change during which increased demands often lead to crises and conflicting patterns of behavior. Dolto (1988) described adolescents as introverted, secret, easily hurt and disappointed, wanting to succeed and afraid of social situations. She says that adolescents at 13 are looking for themselves, their internal life is important, they like being alone; they are anxious to grow up, they wish peace and well-being for others and are interested in their career and marriage. They become less close in their relationships with their parents and distance themselves from family, except with siblings that are much older or much younger. Although some disaccord exists concerning the importance of this life period, it is generally seen as a period of change.

Erikson (Van der Werff, 1990) believed that the development of self and self-understanding are issues that belong to adolescents. His life span developmental theory focuses heavily on adolescence. According to the theory, the crises that arise in the pre-adolescent years lead to the establishment of the ego, qualities of hope, will, purpose,

competence and ultimately, a sense of self. During adolescence, he explains, one acquires a good knowledge of this self, which does not mean the end of human development but the end of this task.

“As soon as capacities of self-reflection and social cognition permit, the individual wants to acquire a clear and true conception of himself” (Van der Werff, p. 30). This often becomes overwhelming as adolescents begin to question all aspects of themselves. Moreover, they become hypersensitive as their awareness of others increases. Adolescents begin to wonder what they themselves, as well as others think them. In order to define and establish their identity, they must consider who they want to become, who they were and what is expected of them. Dusek and Flaherty (1981) give an example of this type of questioning: “I am not the person I was, so many changes occur, who am I becoming...” (p.1). The authors write that as adolescence is a period such of rapid and dramatic change, individuals are sometimes overwhelmed.

During this time of life, bodily changes are nearing completion, the final stage of cognitive development has been reached and important changes occur in terms of an individual's social and societal position (Van der Werff). Peterson, Adams and Gullota (Buhrmester & Prager, 1995) believe that of the developmentally predictable stressors, pubertal changes are the most far-reaching. These changes take place quite rapidly and produce stress-inducing concerns about bodily appearance. The problem of self-conception, Van der Werff writes, is in full bloom. Dolto (1988) sees these changes as a mutation phase, a transition to adulthood from childhood, much like the mutation of the fetus becoming a baby. She compares the rapidly changing adolescents to crustaceans. Dolto explains that as a crustacean grows to large for its shell, it must develop a new one.

Until it has developed a new one, it must seek protection, as it is very vulnerable to all that surrounds it. Similarly, as adolescents develop, they must leave behind their old identities and bodies in search of new ones, disturbing their sense of security as they do so. Van der Werff (1990) explains: "...the individual, having lost the self-evident identity of his childhood, is now in search of another new image of himself" (p.24). Until this is done however, Dolto believes that if either the crustacean or the adolescent suffer wounds, they will be forever marked as a new shell will eventually cover up this wound but never erase it. Adolescents' attention to their bodies is thus increased and Thompson observed that this attention was further intensified, especially at the beginning of the hospital stay (Thompson, 1985). Van der Werff (1990) refers to others' descriptions of the diverse changes that occur during adolescence:

Bozhovick (1980) ...a Soviet psychologist, suggests that the adolescent has to acquire a new self-definition and that, in searching for it he has to cope with "intrapsychic contradictions"...Broughton's (1981) work on "the divided self in adolescence"...found a variety of problems and worrying ...referred especially to contrasts between essence and outer appearance; reality and illusion; the spirituality and the material. He summarizes this and interprets these "dialectical categories" as the dualism between the "true inner self" and the "false, outer appearance", thus borrowing expressions from the Riegelian as well as the humanistic tradition. (p.24)

It is evident however, that the creation one's own personality is no simple and unambiguous cognitive process of concept formation (Van de Werff, p.17). Marcia (Van der Werff, 1990, p.28) believed that only after a period of exploration, can adolescents

build a sense of self, adopting certain values, goals, norms, roles, self-images. Coleman & Todt and Seiffge-Krenke explain that adolescents deal with all the changes that occur within adolescence through coping. This period of transition, which generally leads to development encourages new forms of adaptation (Olbrich, 1981).

Each individual's first experiences with the world are perceived through bodily sensations. Freud believed that body image was imperative to the development of an ego: "...the ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body. It may thus be regarded as a mental projection of the surface of the body..." (Fisher, 1968, p.42). Van der Werff writes that it is actually the transforming body experienced in adolescence that lead transient self-concept contrasts, like being a child and at the same time as no longer a child. Adler maintains this idea as he also believes in the dependence of the ego on one's body: "Is Adler not really saying that when an individual perceives an aspect of his body as inferior, he generalizes this inferiority to his total concept of himself?" (Fisher, 1968, p.46).

Development of self/ self image

An individual's self-concept is the product of a process of self-conceiving. In this process, the individual attempts to acquire a clear and true image of himself, in order to meet his cognitive need of such a picture... The individual, on his way to such an image of his personal identity, may encounter various problems. These may be concerned with the integration of contrasting ideas about himself, for example, or with questions about his true nature, his destination or the meaning and purposes of his life. (Van der Werff, 1990, p.13)

Erikson (Dusek and Flaherty, 1981) believes that in order to develop, adolescents must assess their competencies as they revise their self-concept, personal philosophy and identity. Erikson links changes in self-concept to cognition. In Piaget's thinking, the new demands that come with new cognitive skills cause dis-equilibriums. As the restructuring of adolescents' self-concept begins, re-equilibrations also occur. Mead and Erikson write: "Transitions can also help can also help initiate identity development" (Olbrich, 1990, p. 36).

Seiffge-Krenke (1990) describes adolescents as preoccupied with the restructuring of their identity. Arnold (1989) has studied the ego-ideal formation in adolescence. He suggests "that some influences on the adolescent ego-ideal stem from the period of primary narcissism, i.e. from the time when the child is not yet aware of being separate from the parents and strongly identifies with their strength and perfection.... Adolescents may flexibly disregard some of the internalized parental demands, accept others and incorporate new ones by identification with idealized persons outside their family" (Olbrich, p.39, Jackson). Seen in these terms, the adolescent's ego-ideal appears to be "an outcome of his/her manifest separation from the parents and the psychic loosening of earlier identifications" (p.39).

Self-concept was linked to physical appearance and the perception of physical attractiveness in adolescents (Frydenberg, 1997). This perhaps originates in the fact that in society, especially for women, one's body is in most instances an important part of the definition of her status (Fisher, 1973). Fisher and Cleveland (1968, p.351) suggest that the body in many ways is experienced as certain parts of the self are (internalized systems). The authors further explain that as children we learn to experience the world

and communicate with those around us based on our bodily sensations. They show how the body is so closely linked to the internalized self as it acts as the container for it, acting as a visual representation of the self. Fisher and Cleveland (1968) link definite boundaries with the ability to be an independent person with definite standards, goals, and forceful striving way of approaching tasks. The authors continue in stating that the individual with definite boundaries adjust better to the stress of a serious illness than does the individual with relatively indefinite boundaries: "Some illnesses may make a child feel different from his peer group, particularly if they change his appearance in any way. The meaning of the illness to the child influences his reaction to it and to hospitalization" (Dimock, 1960, p.147).

Youniss & Smollar (1990) explain that although private self-reflection is imperative, the self is also constructed through relationships. Much like the young child that learns through the reflection of him or her self in the mother, the adolescent sees his or her views reflected in others. Adolescents often describe themselves in relation to others (Youniss & Smollar, 1990). An important element in the development of a sense of self and self-esteem is social approval. With this approval, Buhrmester & Prager (1995) write that individuals can obtain reassurance about themselves from their friends: "Through self-disclosing interactions, youth engage in self-reflective discussions that help them better understand who they are and what they will become in the future" (p.36).

Separation/individuation

"...the adolescent's ego-ideal appears to be an outcome of his/her manifest separation from the parents and the psychic loosening of earlier identifications." (Olbrich, 1990,

p.39). The process of separation/individuation occurs out of the physical and emotional maturation of a child much like the first phase experienced earlier in life, when young children become aware that they are separate from their caregivers. Adolescents begin to handle new problems themselves as integration allows them to handle these new situations in a more independent, more responsible, less confused, better organized way (Rogers, 1977). In early adolescence, socialization becomes very important and children begin to define themselves in a different way, as individuals, without their families. Olbrich (1990) writes about this process, describing the adolescent's move from the family into the society. As adolescents move away from their parents, they begin to create relationships in which exchanges are more egalitarian in nature. This, according to Buhrmester & Prager (1995), changes adolescents' relationship to their parents, which provokes a decrease in dialogue between the two. This decrease does not mean however, that adolescents no longer value or need their parents' input on various issues (Youniss & Smollar, 1985; Fend, 1990; Buhrmester & Prager, 1995). Buhrmester & Prager (1995) write that parent-adolescent exchanges are still instrumental in the process of identity exploration. Fend (1990) and Youniss & Smollar (1985) similarly describe the change in the parent-child relationship as adolescents' increasing independence forces parents to recognize their children as individuals. They also contend however, that parents still remain important, as regardless of the increasing distance that exists between the two, adolescents still need acceptance and respect for the new individuals they are becoming, from their parents. A good illustration of this reliance is that adolescents still are found to turn their parents for advice especially in critical moments (Youniss &

Smollar, 1985), such as, for example, when the decisions made will affect their future lives. Youniss and Smollar (1990) write:

Adolescents still seek validation as well as advice from their parents because they realize that parents are interested in and able to help them...adolescents are able to accept their parents' perspectives because they understand them more as persons than they did previously. (p.142)

Socialization

The central thesis is that concepts of persons are constructed within the context on interpersonal relationships which structure interactions and, hence, bias experiences of self and others...there are at least two distinct conceptions of the self during these age periods. One is founded on relationships with parents and the other is based in relationships with close friends. (Youniss & Smollar, 1990, p.145)

As we can see, social situations serve a very important purpose in the development of individuals. Erikson (1950) emphasizes the importance of socialization for adolescents as he describes this period as a psychosocial identity crisis (Olbrick, 1990). Youniss and Smollar (1990) write that in their descriptions of friends, adolescents have compared their friends to personal therapists. This obviously tells us a great deal about the role of friends, but also about the importance adolescents attach to them. Thus with friends, according to Youniss and Smollar (1990), it is possible to explore many difficult or confusing issues, defining and clarifying our opinions and in so doing, also defining and clarifying our selves. The authors write: "The amount of talking which friends do almost guarantees that they will learn about each other and see themselves reflected in one another's rephrasing" (p.145). Derlega and Grzelak explain that the

disclosure between friends allows for the exchange of feedback that helps one define the appropriateness and correctness of attitudes, beliefs and values (Buhrmester & Prager, 1995). Also, revealing personal information to others in self-disclosure, is believed by Jourard (1971) and Raphael & Dohrenwend (1987), to be critical to mental health (Rotenberg, 1995).

Olbrich (1990) describes how adolescents look to friends for models of what they themselves would like to be. Youniss and Smollar (1990) discuss the fact that during this period, adolescents no longer chose friends because of their similarities but rather, choose friends that are different from themselves. Perhaps this interest in differences can be seen as an exploration of different aspects of oneself, with the guarantee of feedback from a sympathetic critic.

In conclusion, socialization is necessary for learning in many ways, but is also an important source of support for adolescents, especially when they need support as they do in times of illness. Morrow, Hoagland & Carnike, Pearlin, Lieberman, Menaghan & Mullan state that “social support can modify the impact of stressful circumstances such as illness and health care experiences” (Gaynard et al., 1990, p.8).

CHAPTER 3

Art therapy

Overview of expressive arts therapies in hospital settings

In my research, I have not been able to obtain any literature pertaining to art therapy in hospitals specifically. Rather the literature dealt with play, which, it must be stated, was traditionally used to define many activities including art. Play, defined by the study of an experimental child life program, carried out by Gaynard et al., (1990) are activities that are pleasurable and enjoyable, are spontaneous and/or voluntary, involve engagement and are a form of communication. The word play in this section could therefore be used interchangeably, with the word art.

Conflicts which are common in the normal growth of the child are even more prevalent among hospitalized children who must deal with pain, separation, and much that is unfamiliar. The need to express these feelings and attain mastery over them through play experiences, so necessary for all children reaches critical importance in the life of the hospitalized child. (Thompson & Stanford, 1981, p.77)

Although some recognize the therapeutic value of play, it seems however, to be commonly regarded simply as a diagnostic tools. Gaynard et al. (1990) for example, stress the assessment value of self-expression (as seen in play). Thompson and Stanford (1981) write that by observing a child's play, one will be able to gather clues about the possible sources of the child's conflict. Dimock (1959) believes that the tension that is released, and the needs and wishes that are symbolically expressed in play can allow professionals to gain many insights into a child's behavior. Two of the most widely used

forms of play used for analyses, he specifies have been painting and dramatic play.

Dimock writes:

Play can be used effectively as a projective technique for helping to diagnose the problems of children. Many aspects of play are so free and unstructured that it is simple for the child to project himself and his feelings and problems into it. This is especially true of such things as painting; playing with clay, sand or water; dramatic make-believe play; and making up stories. (Dimock, 1959, p.130)

Fisher (1973) writes about the fact that individuals express their body feelings in whatever they create. He continues to say that researchers and artists alike have recognized the projective quality of art as those who create are able to identify representations of themselves in their work.

Dimock does however continue to describe the other values of play as he writes about children working out feelings such as fear, insecurity, frustration bewilderment, confusion, as well as the ambivalence of love and hate through play. He believes that children benefit from this type activity, as they are able to clear their minds, relax and see their problems more clearly. This, he says, allows them to take more positive steps toward the solution or their problem. Dimock (1959) believes that children are ready to communicate deeper and more basic feelings to therapists when they have reached this state. Dimock writes: "It is through this communication the real values of play therapy are achieved" (p.133-134).

Gaynard et al., (1990) established an experimental child life program in hospitals in order to verify whether the program allowed children to cope and gain a sense of mastery or competence in the hospital. The researchers observed the children

participating in the program and found that, as children's emotional needs were considered, stress was reduced and children's coping was aided. This, in turn, positively impacted their psychosocial welfare and physical recovery.

It was anticipated that this would not only minimize the stress of hospitalization, but actually make it a positive, growth-promoting experience. Unfortunately, there are no hospital studies and no controlled longitudinal studies of children that have determined whether such effects could be maintained over time. (Gaynard et al., 1990, p.18)

Play therapists, as observed by Thompson and Stanford (1981), are not prevalent in the hospital system. As the authors put it, many hospitals cannot imagine having staff hired "just to play with the kids" (p.63). In 1985, Lindquist wrote that play therapists were a new category of specialists who were still rarely admitted in the hospital setting. Thompson and Stanford point out that this indicates an unfortunate misconception regarding the essential role of play in the life of children.

Value of self-expression

When facing any difficult situations, individuals can choose to cope with them or try to ignore them. Kroeber (1963) and Haan (1963) wrote about the difference between coping and defensiveness:

Coping involves purpose, choice, and flexible shift, adheres to inter-subjective reality and logic, and allows and enhances proportionate affective expression; defensiveness is compelled, negative, rigid, distorting of inter-subject reality and logic, allows convert impulse expression, and embodies the expectancy that anxiety can be relieved without directly addressing the problem... (Olbrich, p.38)

It is apparent that people should cope with their situation rather than resist it, however this is not always easy, as some do not know how. Art therapy offers a wonderful opportunity to cope, fulfilling many of the elements mentioned in the quote above such as, purpose, choice, flexibility etc. The power to choose and be active, which art therapy provides, are crucial elements in order to help one cope. Rogers (1977) expresses the necessity of these elements: "Therapy is not a matter of doing something *to* the individual, or of inducing him to do something about himself. Instead a matter of freeing him for normal growth and development, or removing obstacles so that he can again move forward" (p.6).

McQuade and Aikman (1976) wrote about the surprising effects of the expression of hostility in wartime: "...people in war time are physically healthier than they are in peacetime – seemingly because war provides an acceptable outlet for hostility feelings. During the Six Day War in Israel in 1967, the death rate from disease fell even in homes for the aged" (p.119). Of course this does not mean that every individual that is ill should engage in war activities, but rather that the expression of emotions is beneficial and thus individuals must find an outlet for all types of feelings. Dimock (1960) writes that 'more mature' behaviors must be used in order to satisfy the emotional needs. Only then can permanent change in a desirable direction be achieved. Rotenberg (1995) refers to the widespread belief held by clinicians that revealing personal information is imperative to mental health (Jourard, 1971; Taphael & Dohrenwend, 1987) as well as to the success of therapy (Rogers, 1951; Truax & Carkhuff, 1967).

Art play includes the different kinds of painting and drawing, and the use of pliable substances such as clay. Like dramatic play, art has good potentialities for

self-expression along creative and imaginative lines. Many kinds of art are unstructured and the children are able to use them to meet their needs. The arts provide media, which can easily be used to express and release aggression and anxiety. Art play is more individualistic than dramatic play but it promotes parallel play and co-operative art projects do lend themselves to use by groups. (Dimock, 1960, p.112)

According to Dimock (1960), non-verbal expression is natural to children, as he believes they express their emotions through the actions that make up play. Art, as a non-verbal form of expression, is a very useful tool for hospitalized children who do not always have the words to express what they are feeling. Lindquist (1985) writes that many hospitalized children can not express their needs and desires verbally and stresses that they must be given the opportunity to express these. She also believes that these children have a right to the presence of someone who can be both their interpreter and advocate, such as a play therapist. Dolto (1984) believes that children must be respected in their choices, which may not include verbal communication. This is especially true of children and adolescents who, according to Dolto (1988), simply do not have the words to express themselves especially when discussing feelings. She believes that when children are confronted by unknown individuals, who press them to share by asking questions, they often see these persons as intrusive, as violators.

“Nonexpressivity under stress has been found to be related to heightened autonomic arousal (Notorius & Levenson, 1979); in addition, coping styles based on repression and denial have been associated with heightened physiological responsiveness to stress” (Weinberger, Schwartz, & Davidson, 1979; Eisenberg & Fabes from

Rotenberg, p.130, 1995). McQuade and Aikman believe that emotion must be expressed in some way or another. They believe that when we can not express ourselves in words or actions, we express ourselves physiologically. The White House Conference on Children and Youth indicates that initiative and imagination are essential for a healthy personality (Dimock, 1960). Dimock continues to say that for children who have difficulty using their imagination and expressing their feelings, play provides a natural outlet. Thompson and Stanford (1981) write that “play” is not only the way children learn, but also the way they cope with the unfamiliar and express their concerns: “...in the context of a supportive relationship, children can use expressive play as a means of releasing feelings associated with illness, injury, and healthcare that have accumulated as a result of their circumstances (Erikson, 1963; Freud, 1952; Waelder, 1933)” (Thompson & Stanford, 1981, p.7).

“One of the foremost problems children have in adjusting to the hospital is satisfying their desire to be an individual person who has some independence. They want to be able to make certain decisions, and have an important role to play in what is going on” (Dimock, 1960, p.64). Self-expression through various types of play can offer a sense of control through free self-expression according to Dimock (1959), as it allows participants to choose their subject matter, material etc. Thompson and Stanford (1981) believe that play (including art activities) facilitates self-expression and provides a mechanism for coping by allowing children to become active participants, rather than the passive receiver so often the norm in a hospital experience. Art therapy in an undirected manner resembles Roger’s client centered therapy, which allows clients to maintain power in the therapy. “...client centered, experiential, person-centered approach,

consistently stressing the capacity and autonomy of the person, her right to choose the directions she will move in her behavior, and her ultimate responsibility for herself in the therapeutic relationship, with the therapist's person playing a real but primarily catalytic art in that relationship" (Rogers, 1977, p.21). When a therapist, according to Rogers (1977), does not try to control the therapy situation, the therapy relationship becomes egalitarian, and each participant takes responsibility for himself in the relationship.

Rogers explains that in these circumstances, growth is much more rapid. As Dolto points out, it is important to respect children's silences. McQuade and Aikman (1976) point out that it is also important to respect the rate at which people choose to share. The authors write that if patients are pressed to release feelings, which they may find dangerous or threatening, the result can be a mental breakdown.

In finishing, we must remember to trust children's instinct and help them express their needs and develop within stressful situations such as hospitalization. This it seems, may require a major shift in attitude for our society which, as reflected in our schools, industrial and military organizations view individuals as unable to be trusted and so must be guided, rewarded, punished, and controlled by those who are wiser or higher in status (Rogers, 1977). Dimock (1959) also writes about the many professionals in the health care system prefer to reassure children, often playing down situations, adopting a 'you're getting much better' attitude. As Dimock points out, not only is this procedure unsuccessful but it is also repressive, preventing a patient to really look at his or her situation, or gain insight from it. Advice is another tactic intended to help children. Adults as well as children are very resistant to change when they are unwilling. Children

will often reject these ideas in order to maintain his or her own integrity and independence.

CHAPTER 4

Case description

*It must be noted that because of the length of this paper, I will be describing only certain sessions with Jessica, mostly those at the beginning of her process.

Family and personal history.

Jessica is a thirteen-year-old girl from the West Indies. She is living with her uncle, one of her older sisters as well as her uncle's children. Jessica wishes that her mother would live with her but her mother refuses to move (suggesting rather that Jessica move) and visits instead, once in a while. There are several other children in the house, her cousins, which she enjoys taking care of. She has many other siblings (including half brothers and sisters, approximately 14 she reports). Her father and at least one brother have passed away recently and her mother lives in another town. Jessica was diagnosed with Blount's disease, a degenerative bone disease, which in the last few years has kept her in a wheel chair, although she had walked before (on her knees, because of the deformity of her legs). She was examined by a doctor at three years of age for her condition and is now receiving corrective surgery in Canada. This is her first time out of her country, and she has traveled to the hospital alone. An aunt from Toronto came to visit, for two weeks, at the beginning of her stay and, since, Jessica has visited her in Toronto. It was explained in Jessica's chart, that she had not been to school since the age of 9 or 10 (since grade 5, about three year ago), because, the chart explained, her environment was not "conducive to the use of aids such as a wheelchair".

Diagnosis.

Jessica's diagnosis is not a psychiatric one but rather a physical one. She has been suffering from Blount's disease, a degenerative bone disease, as mentioned earlier.

In a young child, this disease presents a “bow leggedness” and progresses until (usually both) femur are dramatically curved, the pressure (because of weight bearing from the body) on the curved bones is too great and the bones too weak. She is in the hospital for major corrective surgery (which lasts 2 ½ to 5 hours), during which the outer layer of her leg bones are cut, and held in a stretched position, in a straight line with a brace. This brace, developed by Dr. Ilizarov (also the name of the technique), includes a series of metallic circural rings that encircle the patient's limb. Attached to these rings are the spokes that actually hold the bone in the desired position, as they are installed through the patient's bone. These allow the limb to either be lengthened or straightened. The procedure forces the body to fill in the gaps between the bone, re-building a straight bone. Jessica has been in the hospital since early December and has had one of her leg done (the other must also be corrected).

Reasons for art therapy.

Although all patients are prepared for their intervention as it is explained and even demonstrated with a doll, what the procedure actually is, Jessica had great difficulty at the beginning of her hospital stay. She was obviously in a lot of pain, but she also seemed to be suffering from a great deal of fear. It is expected that patients receiving this type of treatment follow a strict exercise routine, actually beginning the day following surgery. Daily exercises must be done in order to stretch muscles and maintain strength and walking is also suggested to increase bone density, accelerating the healing. She often complained of pain right before physical therapy, physical exercise or before anyone touched her. She was non-compliant with her routine and when medicated, her pain seldom decreased. It was noted in Jessica's chart that she needed a great deal of

“verbal reassurance and comforting”. Hrutkay (1990) wrote an article about the psychological effects of the technique. He points to the fact that the long hospitalization and multiple operative procedures create “significant psychological impact”. The article explains that many patients suffered from severe anxiety to mild depression as a result of the intervention. Other reactions included non-compliance, dependence and regression. This often resulted in confrontations with the nursing staff as the patient refused to follow the rules of regular exercise and pin care (the patients must clean the area where the pins penetrate the limb daily). Hrutkay also writes that some patients actually had feelings of abandonment, some turning to violence, suicidal ideation, self-destructive behavior, or adjustment disorder. These were the worst yet the rarest reactions. The author also points out that this procedure is usually performed during adolescence, a period which according to the author is “characterized by psychological turmoil”. He concludes that psychological or emotional problems can and should be anticipated.

Aims and goals of therapy.

I hoped that some of Jessica’s anxiety and fear of the hospital and her treatment be alleviated which would increase her well being and also help her participate with treatment. An exploration of her identity (who she used to be, who would become) has been an important part of her sessions. Jessica needed to address her feelings, in order to cope with them. She was very guarded and usually avoided her feelings, as she seemed to fear them. She did not address the issues at hand and chose to make jokes and act in a cheery manner regardless of her feelings. I hoped that this process would offer her support during her hospitalization and also that it would allow her to form an identity, as she would learn about the various aspects of herself.

Length and frequency of art therapy.

“Clinicians and investigators report that one potential source of stress for children is the absence of a trusting relationship with at least one care provider who is frequently and regularly available (Broadhead et al., 1983; Cobb, 1976; Drotar & Bush, 1985; Magrab, 1985; Perlin et al., 1981; Turner, 1981; Wolfer & Visintainer, 1975). This is particularly true when parents cannot be with their children and when children are exposed to many different care providers.” (Gaynard et al., 1990, 23). Jessica and I have been meeting three times weekly, since her arrival. During the sessions, she has the choice of paint, pastels, wax crayons, wood pencils, plastecine, markers, etc... As Dimock (1959, 106) writes, individuals get far more satisfaction when activities are self-originated. When these activities are flexible and offer the individual the opportunity for self-expression, one can use the opportunity to satisfy one’s own needs. She usually draws and then fills out with colour (paint or pencil).

December 7TH 1998, 1st session.

Today was my first meeting with Jessica. I presented the various materials to her and she decided to work with collage. She said that she wanted to use images of flowers, explaining her love for them. She chose a few pictures in different magazines, then happened upon a story about gold. Her eyes opened wide with amazement as she commented on the large amount of gold in the pictures. She asked me if it was real. Before I could answer, she declared that she would read the article to find out. The gold in the photographs was indeed real. The women in the photographs were each covered in gold jewellery, which Jessica felt was a lot for just one person to own. She then told me that if they sold the gold, they would be rich... I asked her, which would be better: the

A COZIER FAMILY ROOM.

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Figure 3

gold or the money? “The money”, she answered. She asked me for my opinion. She did not choose any of the photographs and continued to look through the magazine. Next, she found images of bee hunters and asked about them. She was quite repulsed. She asked to look at a different magazine, specifying that she wanted one with people and flowers in it. She next chose a picture of two little Russian girls (figure 1) surrounded by flowers. I asked about flowers, and she told me about her garden at home. Everyone worked in the garden together she explained, her family and the children from the neighbourhood. Although working in the garden was a lot of work, Jessica explained, it did not really seem like it. As she continued, she told me about the waterfall that she included and how it reminded her of home. She finished two more collages (figures 2, 3) and the session ended.

Jessica was quite reserved, understandably, as this was our first meeting. The images that she chose were mainly about comfort: food, homes, a mother holding her little girl. Jessica was quite calm throughout the session and answered my questions politely. She seemed however to be sad as she longed for the comforts of home. She reacted quite strongly to the articles about the gold and the honeybees. When she saw these articles, it seemed important for Jessica to make her independence clear as she asked me a question and then quickly sought out to find the answer herself. She questioned the reality of both these articles, as they seemed strange to her. At the time she had just been thrust in a new and strange reality herself and thus opted for the comfort she found in familiar things such as flowers, waterfalls etc. I was intrigued by the image on the top left of a woman near a cemetery and asked her about it. She simply answered that she often played near one.

January 5TH 1999, 5th session.

Today, Jessica worked with paint for the first time (figure 4). She made a rainbow, then a sun. Next, Jessica asked for a pencil and drew the rest of her image. She began with a boat, then figures and then filled in with colour. As she worked, she told me that the figure on the right was her (even though she does not have yellow hair she said). Then she asked me for a “blonde” colour as she worked on the figure on the far left’s hair. She painted the water line and went back to her pencil in order to trace the under-water elements. She produced the shape on the lower left-hand corner, not really knowing what it was but supposed that it was a shell or something. Then as she painted the rock (the brown shape at the bottom), she remarked that it looked like a man’s head, but said no more. She then commented on the resemblance between the seaweed in her painting and the seaweed from home, with its long, skinny, spaghetti like shape. She asked me about the seaweed here. Throughout the session, she commented about the colours she used and how she loved their brightness.

Today, Jessica was as she had been in our last sessions. She was quite reserved and not very expressive verbally. She did share a bit more information, than during the previous session. She worked in a very careful, meticulous manner, as she had previously, which surprised me as she had chosen paint to work with this time. This reflected her self-control (as well as her ability) and guardedness even more. I asked her about her fish’s destination, as they all pointed in the same direction. She did not know where they travelled to, but knew that it was together. She was able to enter into the narrative of her image a little bit as she answered questions about the fish and the people in the boat, yet did not elaborate. I found it interesting that although Jessica traced out



Figure 4

six sections to her boat, she made only five sections with paint (a number also reflected in the fish). I was also interested by the “under world” that she created in her drawing, below the water. It seems that Jessica’s blonde self-portrait could have been a sign of a struggle for identity on her part. It also seemed that this could have been the beginning of transference (my hair is blond).

January 6TH 1999, 6th session.

Today Jessica wondered out loud what to do. She finally decided to draw a house, telling me how big it would be (figure 5). She became disappointed, as her drawing was not satisfactory, yet she continued, saying that it was O.K. She told me what the various windows she traced corresponded to: the hall, the kitchen, the bathroom, her sister’s room and hers as well. As she coloured the roof, she became displeased, telling me that she should have used another colour. She told me about the sister she lives with and the fact that house steps in her country, are often red. I asked about her family. She told me that she had many siblings, seven of each in fact. She began enumerating them and soon flipped her sheet over in order to write them down, including her half brothers and sisters. As she spoke, she checked some of these with a mark. She then returned to her drawing. Again she became displeased and erased lines several times. When she was done, we looked at her drawing. I asked her if there was anyone in the house. She told me that no one was, they had all gone to work.

Interestingly the house that Jessica drew looked a lot like the hospital she was staying at, with it’s red roof, and white walls. I asked Jessica if she knew who lived in the house. She told me that she and her sister did. It seems that she was taking the inventory of her family members, remembering her roots. I wondered why she checked

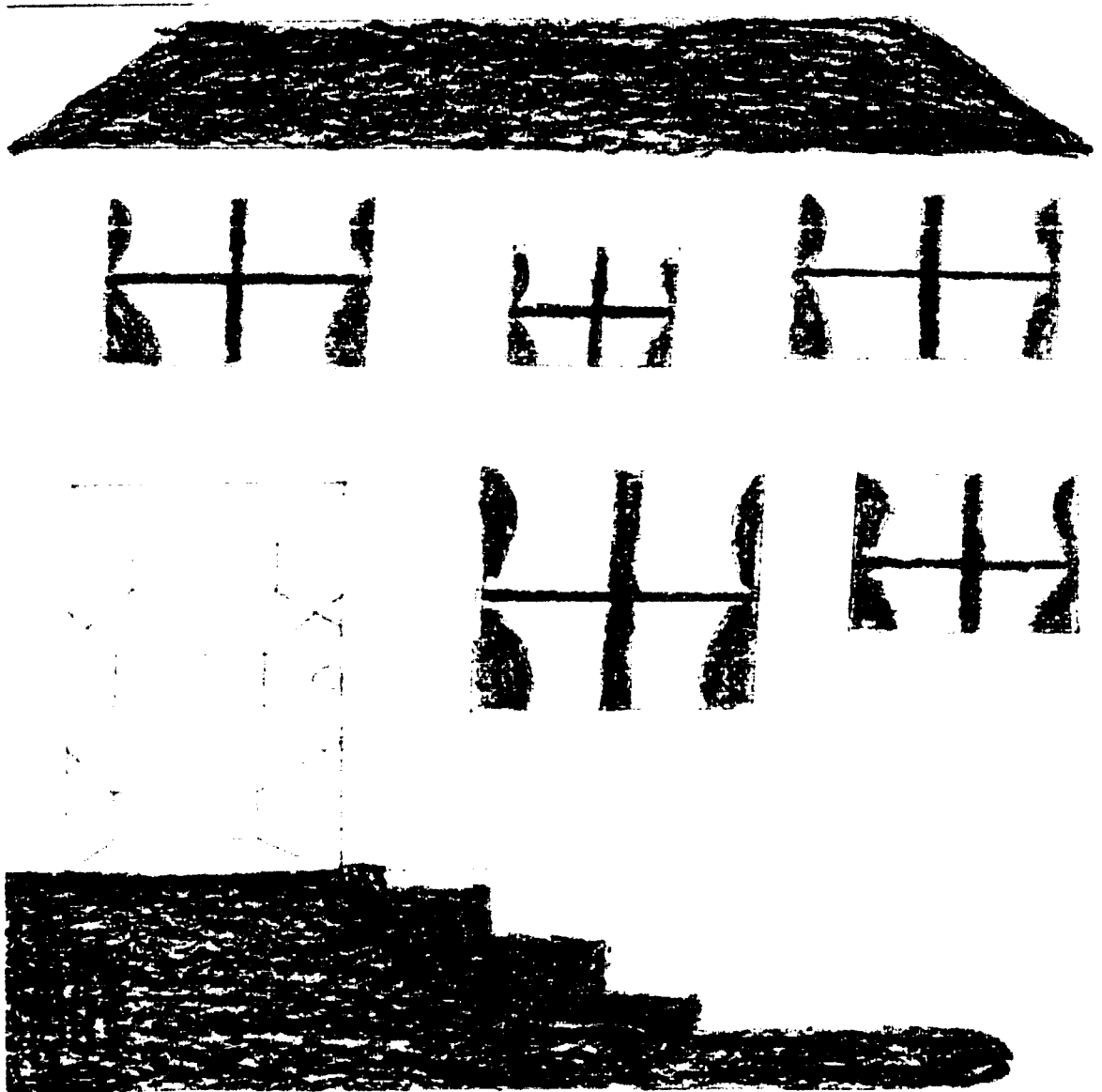


Figure 5

out certain of the names on her list, but she did not provide me with an explanation. Several times during the session, Jessica seemed to be displeased with her drawing. She never seemed discouraged or frustrated, simply accepting or correcting her work. She paid great attention to the door handle, which seemed to be quite important

Freud (Fisher, 1968) believed that houses were a symbol for the body. Fisher (1973) explains that one's choice of shelter represents one of the ways in which we reinforce or compensate for our feelings of body boundaries. Fisher (1968) links the ability to be an independent person who has definite standards, definite goals and forceful striving ways of approaching tasks. He sees the individual with definite boundaries as not easy to diverted by stress. Fisher also believes that certain situations are likely to increase one's anxiety about losing one's body boundaries, thus, one's sense of security within one's own body. These situations include those in which there is a literal threat to the integrity of the body such as surgery for example: "If a person finds that he is going to be exposed to things that can penetrate his molecular structure he gets anxious about his boundary holding up...Whenever anything mechanical is inserted into the body it causes boundary disturbance, no matter how reassuring the conditions under which it is done" (Fisher, 1968, p.29). Jessica, in the hospital setting was placed in a very vulnerable position and I feel that her need for protection was reflected in her choice of large, strong houses.

Fisher (1968) wrote about various ideas on refuge:

...Jung referred to the idea that the troubled person may become very introverted in order to seek refuge and protection within himself. He thought of this process as a way of reanimating the mother figure and obtaining her protection. That is,

introversion could at one level be thought of as an attempt to convert one's own body and personality into a container analogous to the mother container. (p.47)

Rank believes that the depiction of vessels in art represent the artist's conception of his body (Fisher, 1968). Fisher also observed the fact that the more elaborate and details a house was, the more ornamental decorative (including landscape), the higher the personal barriers (indicating firm body boundaries).

Fisher (1968) writes about the theme of houses from another viewpoint: "...that the individual can ascribe to people and things feelings that simply mirror how he perceives his body. Thus, a person who doubts the strength and integrity of his body may express this feeling by being chronically afraid that intruders will break into his house..." (p.xiii)

January 11TH 1999, 7th session.

Jessica drew today on the left-hand side of the page. She drew a tree (figure 6) and had great difficulty with her branches and so cut off the ends. She then moved toward the right side of the page, making a second tree. As she put leaves on these branches, I commented on their similarity with the first ones. She smiled as she agreed. I commented on the fact that although this new tree was different, it also looked something like the first one. She agreed. After these, she added the flowers between the trees, saying that they needed company. I asked her if the trees had been feeling lonely and she said that they just liked the smell of the flowers.

It was interesting that the tree branches in Jessica's painting and even the flowers had a spoke like quality to them. They reminded me of the metal rods that were actually holding Jessica's leg into place, allowing it to grow straight. As she worked, she told me



Figure 6

that she was having difficulty with the limbs (she drew, erased and re-drew, erased...), which she then said had been cut off. I asked who had cut them off, to which she responded, “the saw man”. She quickly told me that it was okay as the old limbs were no good anymore, plus there were many new sprouts on the tree. She filled the space between the branches with leaves very carefully, drawing each leaf one by one. I was intrigued by the fact that the second tree in her drawing seemed to be a “hybrid” of some sort. It is clearly different from the first one, yet it has also grown the same leaves. The cut limbs reminded me of Jessica and her own limbs. Her message seemed full of hope as she depicted the new sprouts, a symbol of her body to come.

January 12th 1999, 8th session.

Today, Jessica painted without an outline. She told me that she was making a swing (figure 7), but as she worked, she became puzzled at the construction of it. She stopped, examined it and became disappointed, as there were too many lines. She covered some of these up but then decided to start again with a new painting, concerned that “people” would not know what her painting was. I reflected that it seemed to be important for her to be understood by others. She agreed as she asked for another sheet. She began to draw (figure 8), and spoke about her dogs (“Dropsy” and “Cut Throat”). She told me how Dropsy got his name (he was found at the bottom of a hole) but could not explain the second dog’s name. She told me that in her country, people feed their dogs spice if they want to make it “bad”. She answered that dogs were bad for their owner’s protection. She then worked on the flowers as she remembered who had shown her to draw them. Then, she stopped to look at her drawing and found the top to be too

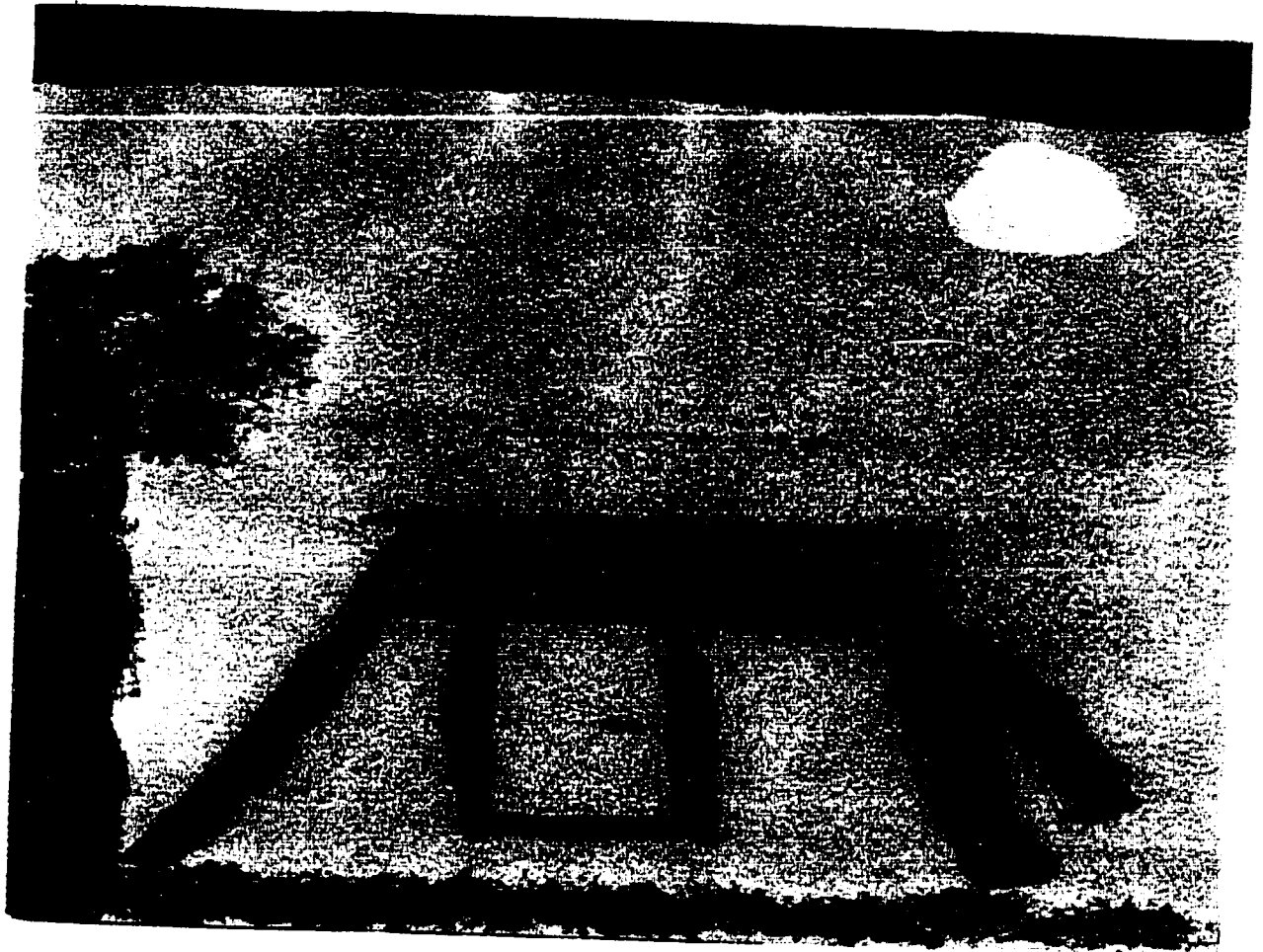


Figure 7



Figure 8

empty. She wondered what to fill it with and drew some mountains. When she'd finished, I asked her about the drawing and where she would go if she was there. She told me that she would not go between the mountains. I questioned her further and she told me that it was a very dangerous place. It was dangerous but she did not know why.

Today, Jessica seemed to be speaking of danger and the need for protection. This is interesting as she began the session with a free-hand painting, which she could not finish. This had never happened with Jessica and I wonder what displeased her about the experience and what caused her to protect herself in her next drawing with a dog. Was she afraid of the lack of structure? She told me about how dogs are made to become bad for the protection of their owners. The hospital staff reports that Jessica did not follow her treatment plan in the beginning of her stay at the hospital. Was this her way of "being bad" in order to protect herself? The swing that she painted (figure 7), did not seem very sturdy. Was she afraid of displaying any "weaknesses"? Perhaps she did not feel in control and was not able to produce an image as she usually does. She was concerned about what others would think of her painting although she knew that painting was not going to be seen by anyone. Was she concerned about my view of it?

January 13TH 1999, 9th session.

Today, Jessica came in wanting to make a collage. She wanted to draw and then cut out her images. She cut out trees, flowers, fruit and butterflies. As she cut the fruit out, she asked me to guess what she was making. I reflected, as I did in the last session, that it was important for her that I understood what she was doing. She said that she just wanted to know if her cut out looked as it should. I answered that it may be fruit. She responded positively, adding that the fruit were mango. She continued with some

papaya, which had fallen from the tree and told me about this happening at home. She told me that everyone around would run to catch the falling fruit and that the little children often got to the fruit first. I said that the fruit must be quite good to deserve such a response. She agreed saying how wonderful they were.

Jessica shared a very bright and exciting moment of her everyday life at home. She spoke about running with the children after the fruit, which made me wonder, as she did not exclude herself in the retelling of the experience. Was she bringing together her past and her future? Was Jessica painting the portrait of a “normal” child, looking forward to the day she would be able to be one of them?

January 19TH 1999, 11th session.

Today, Jessica was uncertain about what to do. She asked to see one of the books from the library behind me and decided to copy some flowers from it (figure 9). She spoke of colour mixing, as she was quite pleased with her results, painting the flowers. She told me how she loved to mix her own colours. She painted the flowers and leaves with great care.

It seemed that perhaps Jessica was feeling quite anxious today as she was unable to draw from her imagination. Instead she enjoyed mixing colours which, she agreed with a smile, were unique. Perhaps Jessica was not feeling quite secure and so, needed some structure within which she could explore with colour. I wondered about the cause of this feelings of insecurity. The previous session, Jessica had shared many details about her life at home. Did she need some sense of security as she had exposed herself to me? Did she long for home and the security she felt there?

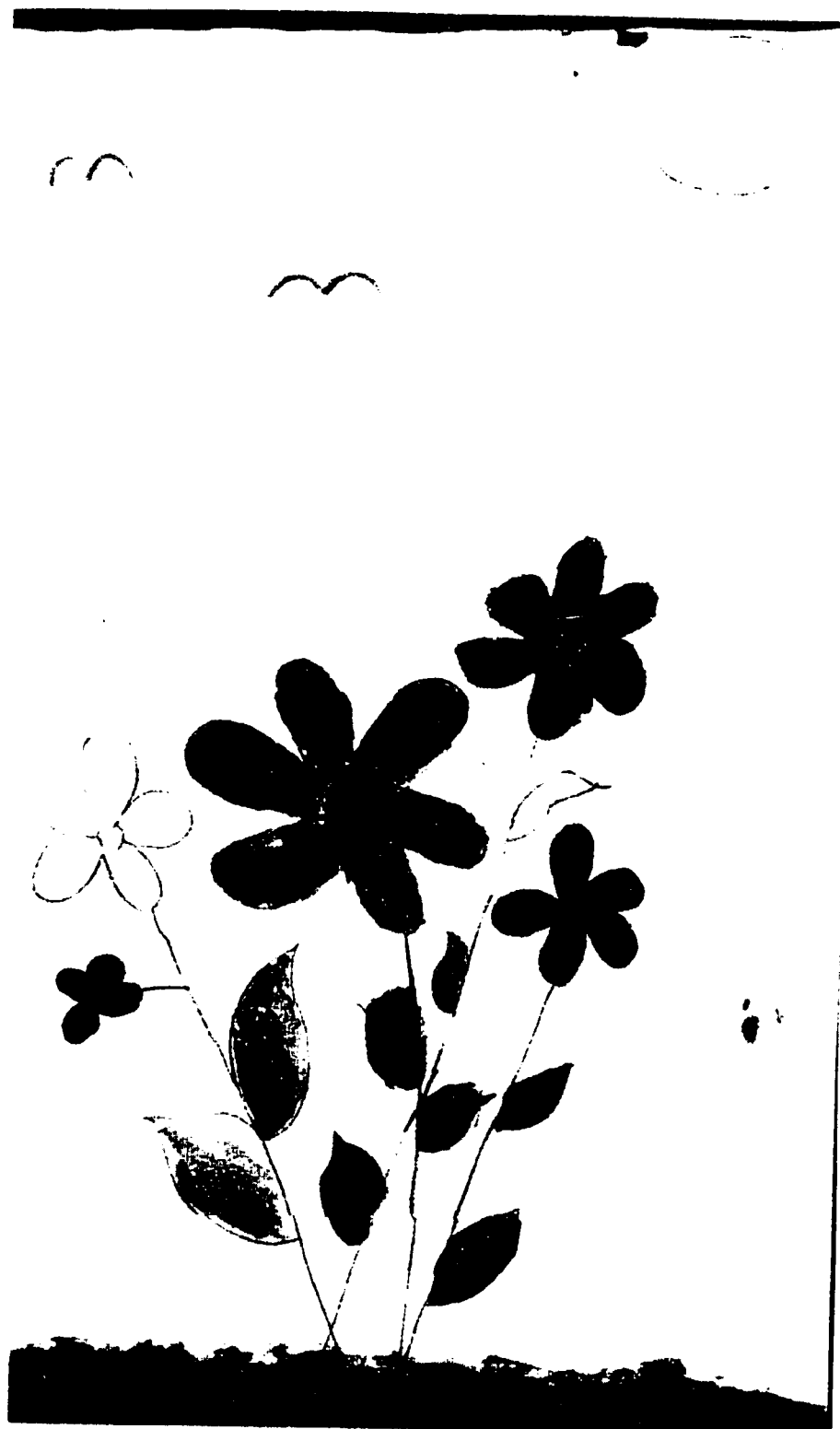


Figure 9

January 20TH 1999, 12th session.

Today, Jessica made a drawing (figure 10). During the session a nurse came in to see her, as she needed to give her some medicine. This nurse talked to Jessica about her drawing, commenting on the blue flowers she had made. She asked her where there were blue flowers, as she'd never seen any. Jessica told her that it was her painting and so she could decide on the colour of the flowers. Later on in the session, she seemed unsure about the appearance of something and asked me about it. I reminded her of response to the nurse: it was her painting, so she could decide. She smiled but said nothing. As she painted, she told me that she was really happy with the pitcher she had painted. I told her that the girl would now be able to share with someone. She agreed.

I was quite pleased with Jessica's reaction to the nurse, as she was usually concerned about what others would think. She seemed to be feeling a bit stronger as she was able to stand for her blue flowers. There also seemed to be an invitation in the drawing, as two glasses are set out.

January 25TH 1999, 13th session.

Today Jessica decided to paint, and began making a house starting with the roof (figure 11). She was pleased with the colour mix as she painted the blue doors over the red walls. She continued with the tree and asked me about a colour mix. She was however, disappointed at the result. She worked at it some more and found a satisfactory mix. She told me how she loved to mix her colours and agreed that no one else could have the same colours. Jessica finished her painting and decided to paint some more. She worked without tracing an outline, telling me that she would be "just making a shape" (figure 12). She worked quickly and decided to make something else. I asked her



Figure 10

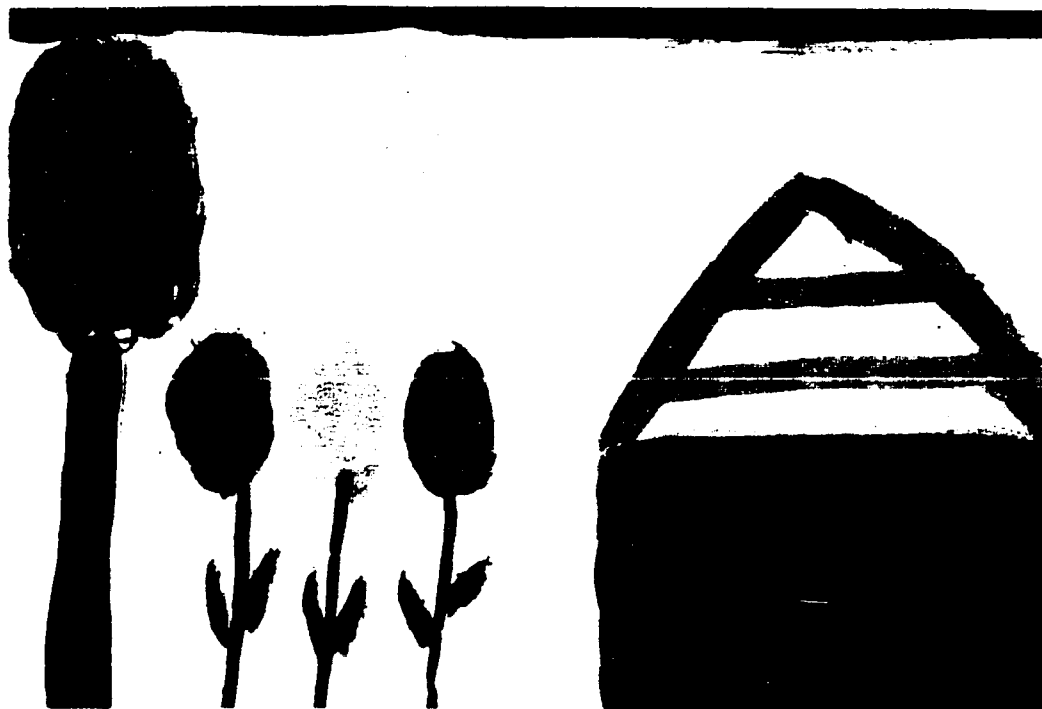


Figure 11



Figure 12

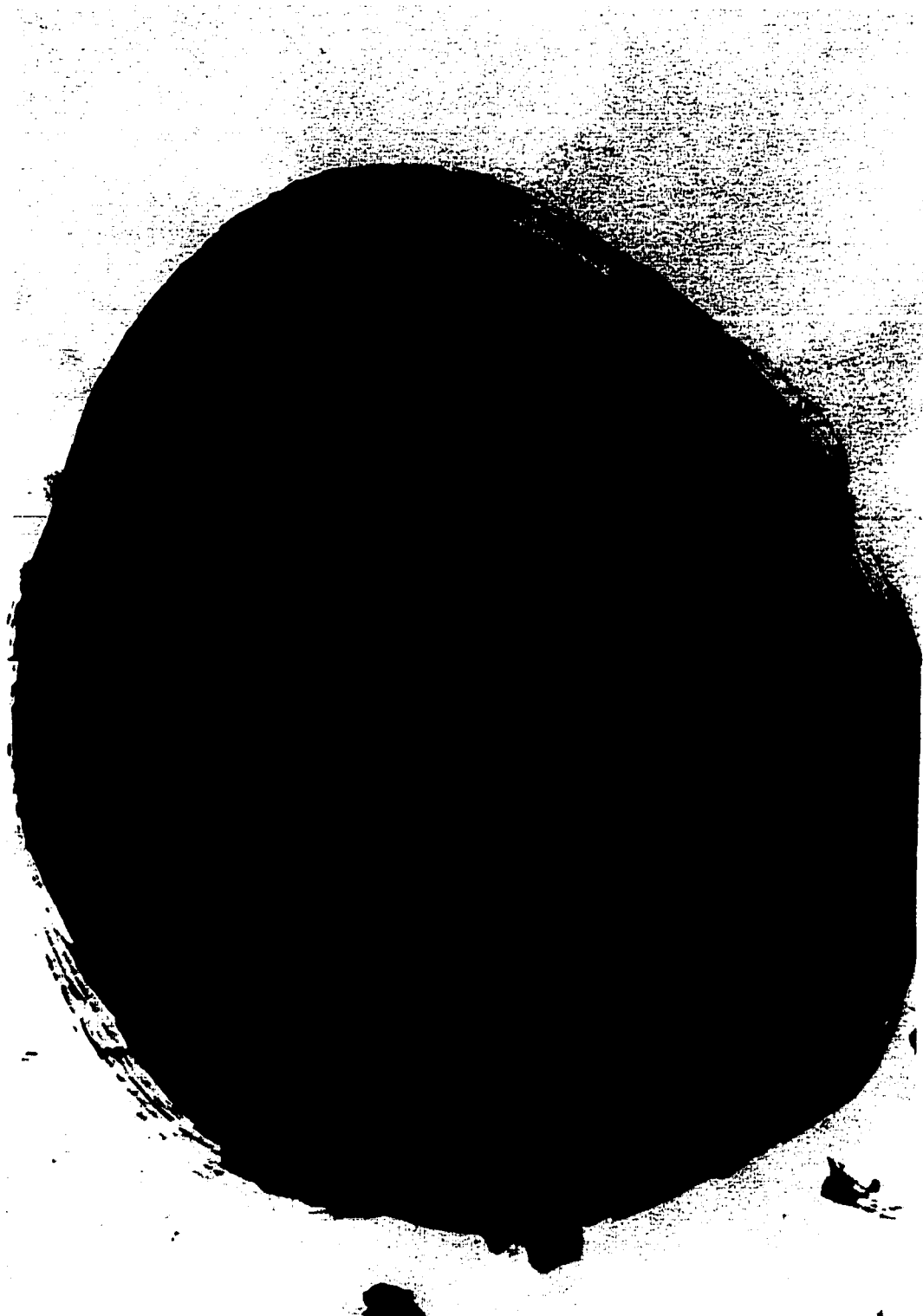


Figure 13

if she could tell me a little about the shape she had just made, but she could not. For her last piece, Jessica began to paint directly onto her sheet again (figure 13), adding more and more paint, until it all became a large mass of mixed colours, ending in brown. She filled most of the page with her brown sphere.

Jessica really enjoyed the colour mixing once again and spoke about it a lot today. She seemed to be having fun and did not seem to feel distress or anxiety. There definitely seemed to be regression in her work today as she made a large mess of brown paint on her page. She was, for the first time however, able to free herself and work directly and freely with the paint.

January 26TH 1999, 14th session.

Jessica drew today. Her branches (figure 14) were consistent with her past ones. She made a flower as she had on our first meeting, which I reminded her of. She was quite surprised, asking me if I really remembered. I asked her if she ever remembered things from her past. She told me that she did and, when I asked, told me that it was just stuff. She made more flowers and told me how one of these flowers was special because of its colours. Before we ended the session, she asked to see her painting of the brown sphere from the previous session. I showed it to her and asked for her impressions. She told me that she just wanted to see it dry.

This is the first time that Jessica left something to be finished in a later session as she has always worked very hard to finish in the session, often hurrying. I was pleased, as it seemed that she felt more secure, knowing that I would be there the following day. Was this a result of our last session together? Was Jessica able to trust me more as she regressed to an early time in her life, “messing” her paper? Did she gain confidence



Figure 14

because I contained her mess, and offered her some constancy (which she could see as I remembered other sessions, as I kept her painting)? She continued to work on this painting in the next session.

February 1st 1999, 16th session.

Today, Jessica wondered, as she often did, what to do. She said that she was out of ideas. I made some suggestions, as she was quite indecisive. She decided to make a portrait (figure 15). She wondered out loud about the construction of the features and was disappointed at the eyes, which she re-worked several times. She examined her drawing and told me how she'd never seen anyone with such a strangely shaped face. She re-worked the contour. As she drew, she asked me if I was an artist. When I answered, she was very surprised and said that she liked looking at art but not making it. I asked her why. She told me that she did actually like making art but she felt that it was not very good. She told me about her difficulties with drawing. She said under her breath that she would like to see some of my art, without looking up. I reflected that she was curious about me. She agreed and continued to say that the face she had drawn had a big mouth. I asked her if the girl she had drawn had a lot to say. She told me that she didn't. She then asked for a blue pencil and coloured in the eyes, which she later brought to my attention. She then made green eyelashes and neon yellow eyebrows. "How weird she looks", she said. I reflected this but she changed her mind, the girl no longer looked weird. Jessica then asked for "peach colour" and then asked me what colour I was. I asked her if she meant my skin colour and said that it was probably pretty close to peach. She coloured her portrait a little and compared it to the colour of my hand. As she continued, she told me that in the West Indies, "they" call peach coloured people like me



Figure 15

brown. She said however that I was not really brown, but she was. Then, she told me that she did not know what she had looked like as a baby; she had no pictures. She wanted to know. She asked me what my thoughts were before I was born and answered, saying that I couldn't know. She then asked me about blushing as she picked up a pink pencil, and coloured the cheeks. She told me that how we (Caucasians) sometimes turned red out of shyness. She'd seen it happen in the hospital. I asked her if it ever showed when she was shy. She told me that you could tell from people's body language. She agreed that in both situations people show their emotions with their bodies. She asked me what I thought her country looked like. I told her that I thought that there were many green trees and colourful houses. She smiled and agreed. I asked her what she thought it looked like here, before she came. White, she said. She told me about her two sisters and her preference for one of them. She quickly changed her mind, as she was unsure. At some point, she seemed to become self-conscious asking me if I was watching her. I asked her if she felt uncomfortable. She answered that no, she was used to me. When she had finished her painting I asked her if the girl had something to say. She asked me to wait a minute and added words to her drawing. She then held out the paper for me to see. She'd written an exchange down between the girl and her mother. The mother was telling her daughter that she had freaked out, which Jessica explained, meant someone went wild, doing lots of bad stuff like the girl in the picture. When I asked her what kind of bad stuff she had done, she told me that she had dyed her hair and eyebrows and painted her lips. She then began to make a rainbow in a new painting. The session ended, she would finish her painting the following day.

Jessica shared a lot with me today. She seemed to be struggling with her identity, as she seemed to have many contradicting feelings. She made many comparisons between countries, cultures and people. She told me today that I reminded her of her sister as I looked like her. I felt that I was slowly gaining her trust. Her drawing seemed to integrate many different characteristics within one portrait. Certain elements reminded me of Jessica, others such as the skin and eye colour didn't. This portrait seemed to be a cross between two people. The words that Jessica added to her portrait seemed to reflect her concerns about physical appearance. This was very appropriate for her age. Could these words have also been an indication of guilty feelings of some sort? Did she feel that she had been bad and that her mother had disapproved and left her? Today it seemed like Jessica gave me a better look at her, as she shared a "close up". She seemed to feeling uncomfortable during the session, which may have been because she'd chosen to share more than usual.

February 8TH 1999, 18th session.

Jessica drew a picture of a forest at the top of a series of hills (figure 16). She expressed her love for forests as she found them very peaceful. She did not speak much as she drew but told me, as she added some birds, that these trees were the birds' homes. I mentioned how they all lived close together. She agreed but told me that they each had their own tree. I mentioned that this seemed to be important. She agreed and showed me "her" tree in the center of the paper, where she lived alone but welcomed visitors. She commented on how peaceful the scene was. Our session ended as Jessica noticed the time and wheeled herself out.

It seemed that Jessica spoke of belonging in her drawings today. She drew homes, a place for each of the birds. Was Jessica talking about support as she made their homes so close together or was she speaking of a sense of isolation among others?

February 9TH, 10th 1999, 19th & 20th sessions.

During these two sessions, Jessica still seemed to be searching for a sense of belonging. On the 9th, she drew a bird called the “doctor bird” (figure 17) and asked if there was such a bird in Canada. On the 10th, she drew a girl with no surroundings along with her belongings (figure 18). She seems to be defining her identity with her clothes, yet she just floats about, as she has no place to be. Jessica seemed to be searching for her place, her home.

March 1ST 1999, 21st session.

Our sessions resumed after a two-week break, as she was away for one week and I was away for the following week. Jessica seemed happy to resume her regular routine at the hospital. She began drawing a girl dressed up for a party during the session. She seemed to be quite concerned with the girl’s appearance, including dress, accessories as well as body shape, as she paid great attention to these details. Dissatisfied, Jessica drew her figure’s extremities, especially the arms, over several times. She carefully added jewelry, which was as important as the makeup she also added. I asked her about her drawing, and she added words in bubbles. I asked Jessica if she liked dressing like the girl she’d drawn. She told me that she was too young but that her sister dressed as the girl in the drawing did. She told me that when she would be older, she would dress like her.

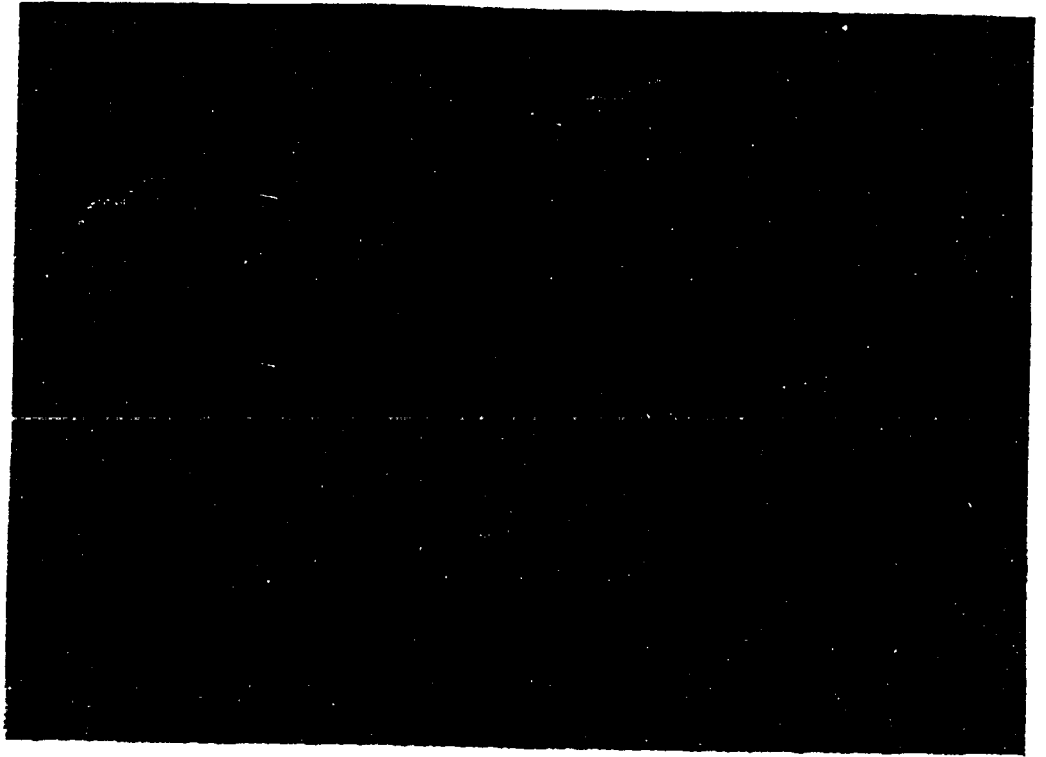


Figure 16

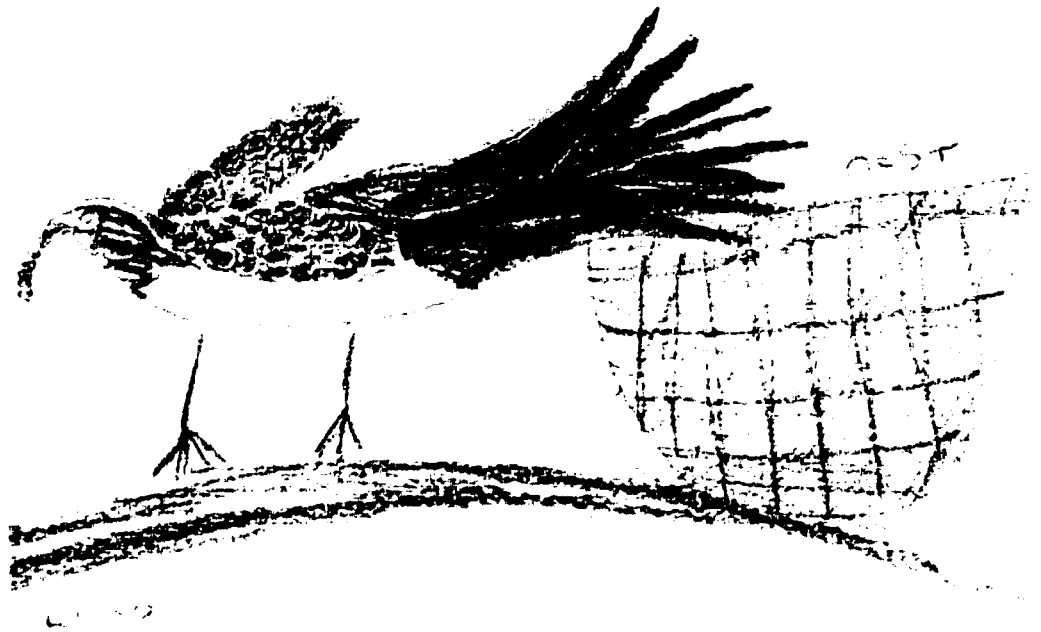


Figure 17

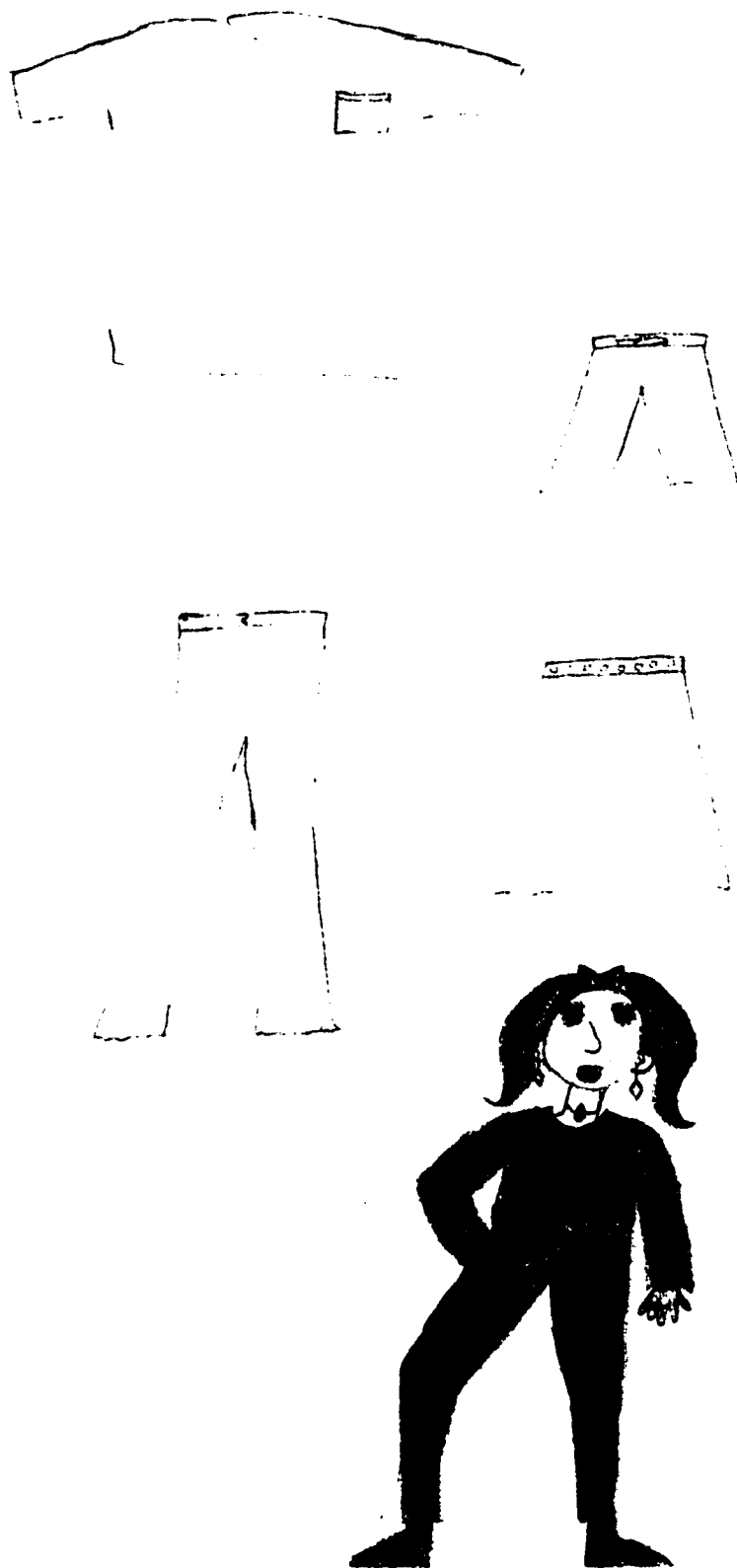


Figure 18

This was Jessica's first session after a week spent out of the hospital. The concerns that were displayed in her drawing, about physical appearance, having the right clothes and jewelry are typical in adolescent years, as we know: "Adolescence is generally regarded as a 'phase of heightened self-awareness' " (Inge Seiffge-Krenke, p.49). I wondered if these feelings had not been emphasized as she had just spent time outside the hospital. Outside the hospital, Jessica was surely in contact with a greater number of people, where her need for socialization may have been stronger. Fisher (1973) writes about our concerns with appearance:

You can't reconstruct your body but you can, by means of clothes, exercise choice in the type of façade you attach to it. There is no doubt that we are all fascinated by the process of clothing ourselves...As we decorate and clothe ourselves, we are, in a sense, doing a self-portrait. (p.86)

Fisher (1973) continues, as he recognized the developing individual defining him or her self through choices concerning themselves, including their clothes: "Girls regard the putting on of makeup and certain clothes...as definite badges of their grownup status...The fascination of women with clothing may represent, in part, the fact that it has provided one of their few means for advertising status" (p.97-99).

This drawing also seemed to reflect Jessica's need for acceptance. Was Jessica perhaps dreaming of her future life at home? Would she be the beautiful, popular and go to parties with her new appearance?

March 2nd 1999, 22nd session.

Jessica wondered what to do out loud. After a few moments, she quickly picked up a brush and painted a red heart encircled by a thick black line (figure 19). She looked

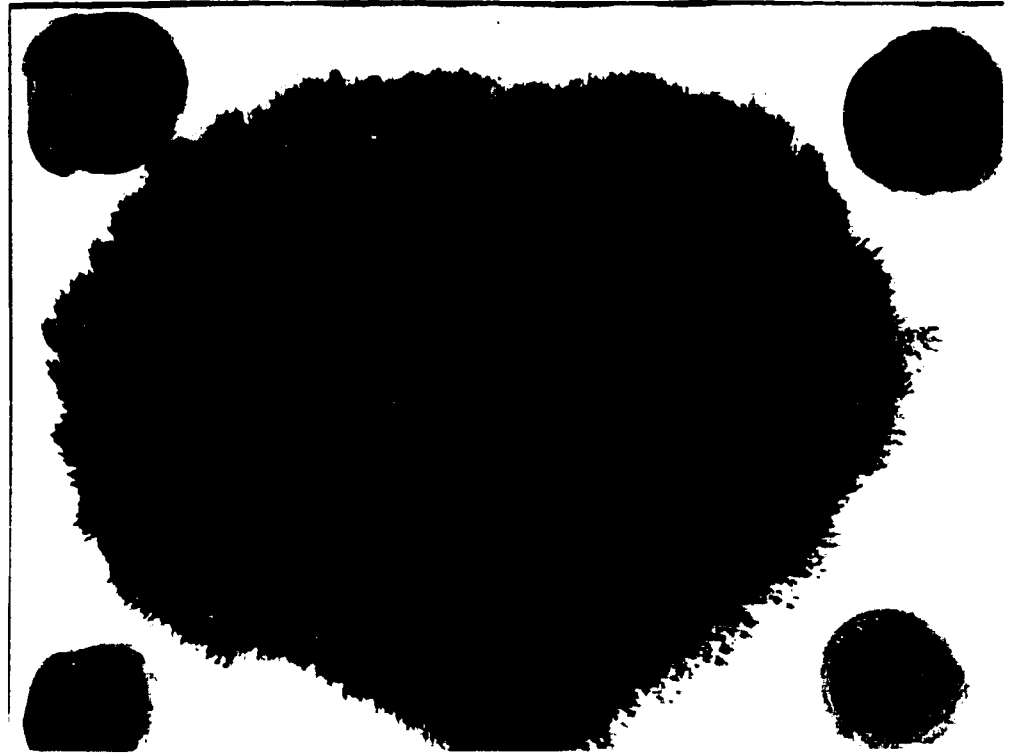


Figure 19

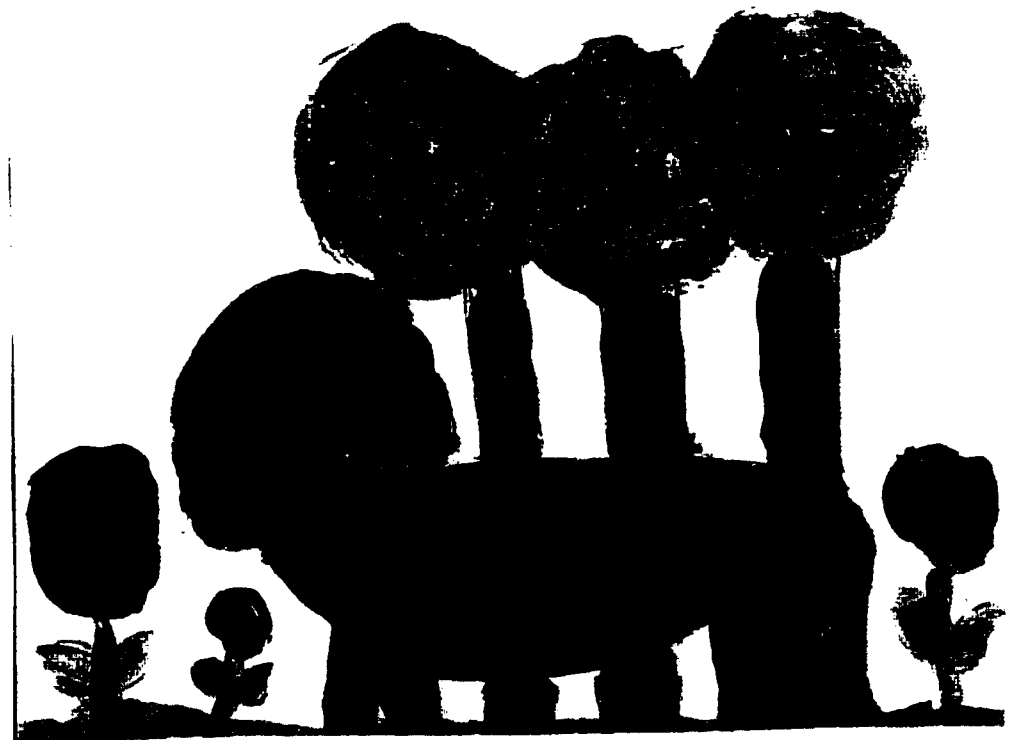


Figure 20

at it a moment and then added red coloured rays, emanating from the large heart. When she finished, she told me that these rays represented the love that came out of the heart. I asked her about the thick black line that surrounded the heart, mentioning that it looked like a protective device. She agreed, saying that nothing could attain the heart, yet love could come out of it. Then she pushed her painting aside and chose another white sheet of paper. After a short hesitation, she decidedly picked up her pencil and began drawing. She erased and re-drew, starting her drawing off with the outline of a tail (figure 20). During this time, she changed her mind about the animal she was to draw, as she examined it. She decided to draw a lion after rejecting her previous idea of an elephant. She commented with surprise how the lion looked like a girl, as she put it. She asked me if a lion could be a girl. She worked some more and then painted the animal's face, covering its features. She later explained that the lion was back from the wild. She did not know where it had been, but it was now back.

Jessica produced what seemed to be the perfect illustration of the ambivalence she experiences as a changing person in both her works today. Lindquist (1985) believes that this ambivalence is characteristic of adolescents' developmental stage.

In her second painting, she was uncertain whether the figure she had begun to draw was an elephant or a lion. In this same painting, Jessica demonstrated signs of aggressiveness as the lioness both shows her teeth while also demonstrating fear as the animal's tail is down. When she finally chose the lion, she was perplexed, as she was not sure if it could be a "girl". Jessica seemed to be struggling with feelings of aggression, which she may have felt were inappropriate for her, as a girl. Girls are not often encouraged to express anger, and this may have been part of the reason for her dilemma

with a female animal aggressively showing her teeth. Jessica was uncomfortable with these negative feelings and this is perhaps why she decided to hide the animal's face. Fisher (1973) writes about an artist that revealed his anxieties through his art. The artist, Fisher explained, covered up the body parts he felt anxious about with various objects in his paintings such as the newspaper a figure held in a painting of his: "I could speculate that his preoccupation with defending the integrity of his own body was repeatedly mirrored in the symbolic forms of body armoring he provided for the figures in his artistic images" (p.129). As adolescents develop their identity, they must figure out what is expected of them and who they want to be. When their feelings conflict with who they are supposed to be, confusion and uncertainty may arise. According to Erikson (Munitz), the task or crisis at this stage of development is identity vs identity diffusion. Identity, Erikson explains, is formed out of the combination of one's identifications (past and present), attributes, wishes and orientation. Identity becomes a way to organize these and represents the individual as best it can.

Her ambivalent feelings may have also been due to the contradictions she was encountering in the hospital. In the hospital, Jessica had many negative as well as positive experiences. She had for example, experienced great pain while being allowed to attend school, which she wasn't at home. At the hospital, Jessica was constantly surrounded (which she was not at home) yet she was restricted in her choices.

Jessica seemed to be having difficulty integrating the negative feelings she possessed with the other positive feelings she more easily recognized. This difficulty reminded me of new borns which, according to Klein (Mitchell & Black, 1986) split their experiences into good and bad ones. This split allows them to relate to the outer world.

Jessica also seems to be denying her negative feelings, much like in Klein's description, as these may have been too confusing or simply unbearable.

The lioness that Jessica depicted looked out of the corner of her eye, which gave her a fearful look. During the session, I was placed where the lioness was looking to, at Jessica's left. Was this a demonstration of fear and suspicions regarding our relationship? Was this what the lioness was guarding against as she exposed her teeth? This again, seemed to be a demonstration of her ambivalent state of being, as Jessica was close to me, yet was also fearful and felt the need to protect her self. This theme also seemed to be present itself in her painting of a heart as she offered love yet was unwilling to open up her heart to others, needing to protect it.

March 9TH, 10TH 1999, 25th & 26th sessions.

In the session before these, Jessica went back to drawing flowers as she had done in the beginning of our sessions together. It seemed that she had been moving forward but now was somehow resistant. Was she feeling stuck? Was she afraid? During these sessions, I suggested that Jessica illustrate a story. She accepted the idea and worked on the first page for two sessions.

March 16th, 22nd 1999, 28th & 30th sessions.

Jessica added two more drawings to her story after taking a break last session. These were of a party and a girl coming home from the party. In the second drawing, she told me that the girl had to be careful, as she was afraid of waking her mother. I asked Jessica about the fact that she described herself as sometimes difficult because she was always joking (she compared herself to the girl in the drawing as she also was difficult). I asked her why she always told jokes to which she responded it was necessary in order

for her to remain happy. I asked her about this. She told me that when you tell jokes, people pay attention to you, they like you. I asked her if she was afraid of people not liking her. She said no. I asked her if she thought that people only like funny people. She told me that she did not believe that, she knew that some people like those who are serious.

March 23rd 1999, 31st session.

Today, Jessica was not feeling very well, she felt “funny”. I asked her to describe this “funny” feeling and she told me that she felt like she does when she is about to get a cold. She was unable to describe the feeling in any more detail...

Jessica was very quiet today. She was not very expressive at all and seemed to be a bit depressed. She could not however describe this feeling and I felt that perhaps she was confused by her emotions, as she could not understand them. It seemed that her way to express these was to feel them in her body as a cold (as she seemed to do in the beginning of her stay, feeling pain perhaps instead of fear and anxiety).

CHAPTER 5

Discussion

This discussion will focus on the themes, images and issues which Jessica seemed to be dealing with, in order to better understand her process as a growing individual as well as a medical patient. To begin, I will be addressing the developmental issues, those pertaining to adolescence, as they are reflected in her art work. Several reoccurring themes will then be examined, and a brief discussion of cultural influences will be addressed followed by concluding comments. Each of these components was a part of Jessica's experience while in hospital and, through this discussion, we will better be able to understand each's influence on her experience and what role art therapy played in the equation.

Adolescence

Jessica was an adolescent, which according to Klein is the second phase of individuation in one's life. As such, she was going through a transition period in her life. The difficulties that arose from this passage from childhood to adulthood were, in Jessica's case, certainly heightened by the fact that she had been on her own in the hospital for five months, much as an adult would. The need for independence in adolescence is important. Jessica however, had this independence forced upon her during her hospital stay. It seems that this may have led to a precipitated identity search, but it also seems that without support, her needs to individuate may have may have been stifled. Throughout our sessions, I believe that Jessica has begun to ask herself questions about her identity. It seems that this questioning began as she was confronted with a different culture, which she examined closely through comparisons with her own. Being confronted with this new culture, new independence, I believe that Jessica began to

define herself through her cultural identity, finding characteristics that apply to her.

Erikson (Munitz) describes how each individual's identity is made up of his or her feelings about his or her past, present and future (as with the realization of what kind of person one wishes to become). Jessica not only reflected upon her cultural identity but also began to compare herself mainly to her father, naming the qualities she had in common with him.

Jessica probably felt the need for support, much like the young child who looks back at mom, in order to make sure she is still there, in the "back and forth" motion of individuation (pushing forward toward independence yet feeling the need for a little more nurturing as reassurance). I think that this is perhaps one of the causes of the ambivalence coming through in her art. Some examples of this ambivalence may be seen in the large comfortable looking nest sitting precariously at the end of the branch (figure 17), the large heart that gives out love but that is isolated with a thick black line (figure 19), followed by the aggressive yet fearful looking lioness (figure 20), etc. Jessica may have felt that she needed support, yet she also wanted to grow up and be one of the cool girls she depicted in her drawings. Moreover, this time in Jessica's life was not only a transition period developmentally, as she was also changing in a very concrete physical way. There was of course the normal growth process that occurs at her age but there was also the dramatic corrective surgery that she had undergone which changed her appearance. Not only would this correction change her image but it would also put her into a different role, as she would soon be mobile, would no longer have a disability and would also look very different appearance.

Erikson (Munitz) writes that the crisis preceding identity versus identity diffusion is industry versus inferiority. This is a period of crisis during which, according to Erikson, children develop a sense of competency based on school and occupational skills. This is a time during which children acquire a sense of confidence from which they can then go on to deal with the next crisis, forming a personal identity. Jessica had often expressed, especially at the beginning of her stay, a sense of incompetence, as she often questioned her capabilities. This may have been due, in part to the fact that she did not seem to have acquired much confidence in school, as she was removed from its walls... But I believe that this could have also been amplified by the stressful situation in which she found herself at the hospital (during which children often live through some form of regression). Since her arrival, Jessica had been working hard in school, as she attended daily, at the hospital program. I think that this allowed her to grow a great deal, as I believe she gained a great deal of self confidence.

Hrutkay and Eilert (1992) write that femoral and tibial lengthening, combined with a lengthy hospital stay (the longer the stay, the more problems according to the authors) and multiple operative procedures create a significant psychological impact. Distress, they continue, should be anticipated. Patients receiving this correction are usually young, possibly in their teenage years, as was Jessica. As a young person, she did not necessarily have the emotional experience on which to rely for this surgery and subsequent treatment. Moreover, the teenage years are, according to Eilert and Hrutkay, "a period characterized by turmoil". The authors describe the patient's distress as mostly adjustment disorders but also mention depression and anxiety as other possible outcomes. Adjustment disorder is defined by the DSM-IV as impairment in occupational, social or

interpersonal functioning. At the hospital, Jessica's adjustment was impaired, as she was non-compliant with her treatment. The authors also mention dependence and regression as a regular occurrence with the patients.

Themes

Starting with Freud...psychologists have called attention to what is known as the repetition compulsion – the need to re-enact major personal problems in the small and large occasions of daily living. In the words of Erik Erikson, “the individual unconsciously arranges for variations of an original theme which he has not learned either to overcome or to live with; he tries to master a situation which in its original form had been too much for him by meeting it repeatedly and of his own accord” (p.120).

Jessica certainly had re-occurring themes in her work, which included nature, houses and physical appearance. According to the quote above, these themes must be regarded as very important as they are re-enactments of personal problems, and according to Gaynard et al. (1990), allows processes such as assimilation. The authors explain: “(themes)...may be repeatedly enacted until the child is thoroughly familiar and comfortable with the information. Since the assimilation of information often requires repetition, multiple opportunities for play relevant to the material presented may be necessary” (p.20).

The need for protection seems to have been present with her houses (figures 5, 11) as well as with the protected heart (figure 19), menacing lioness (figure 20) and dog named Cut throat (figure 8). Jessica's need for protection and nurturing also seemed to be reflected in the nurturing pictures from her first session (figures 1, 2, 3). These needs were surely enhanced by the fact that she was far away from home, in a strange country

without any family members, going through major surgery. Was Jessica attempting to protect herself from the individuals around her by exhibiting aggressiveness, for example, or was she attempting to protect these others from the anger she contained? It seemed that Jessica was afraid of people's reactions, especially as she needed their support.

If the artistic creation has a sizeable body-image component, what impact does it have on its creator? ...there may be some (gains) that involve mastering and reveling in body experiences... The creative product that mirrors back self-representations may be a way to get self-affirmation... An artist may see in each of his canvases images that tell him: "yes you do exist. Your body is significant and alive and a solid thing." This sort of reassurance might be important if an individual has grown up in an environment in which there was great body insecurity... In his output the creative person may seek to heal his anxiety about a specific part of his body. There are painters and sculptors who seem preoccupied with certain body areas more than with others.... In his repeated encounter with a specific body part in his work the artist has a chance to ponder it and to desensitize himself to its threatening implications. (Fisher, p.144)

Jessica certainly often repeated certain themes that seemed to be a reflection of her body. Near the beginning of her sessions, she drew three girls in a boat (figure 4) thus covering their legs. Later she covered the bottom of her lioness' legs (figure 20). In this image she even covered the lioness' face, covering it up with a semitransparent coat of paint. In this last instance it did not seem as if Jessica was uncomfortable with her face but rather with the expression on it, as discussed earlier.

Culture

Adolescence is undoubtedly perceived differently in different cultures... Each society has its own norms and attitudes relating to modes of coping with internal and external demands, which influence the normative patterns of behaviour of its members. Thus, although many developmental tasks are universal, we may assume that they have different connotations for young people from culture to culture. (Seiffge-Krenke, 1990, p.63)

Although I will not discuss culture in great detail or specificity, I think that it is important to consider and acknowledge the differences between cultures as well as the adjustment difficulties that may arise while in an unknown culture as it is such a great influence on every aspect of us all. Sensitivity to different attitudes can greatly enhance one's understanding of individuals from unfamiliar cultures. One must be extremely cautious about assumptions as concepts may vary immensely from one culture to another. Concepts such as boundary setting and self definition, for example (which certainly played a role in Jessica's experience), must be looked at carefully as they are non-existent in certain cultures such as those from non-industrialized countries (which is reflected in the absence of a word for the self) (Fisher & Cleveland, 1968). Attitudes about the role of the family also influence one's self-concept as different societies hold very different opinions about independence.

Culture is certainly reflected in interpersonal relationships and coping styles as we learn these from our family and friends. Jessica did not express herself verbally with ease. It seemed that this type of expression was not greatly encouraged at home, as no family members from home communicated (by phone or letters) before the fifth month of

Jessica's hospitalization. Some of the ambivalence she seemed to experience toward me may have been due to the fact that she was not accustomed to this type of support.

Jessica seemed to avoid issues and feelings. This may have been influenced by her culture as cross-cultural studies (Diaz-Guerrero, 1973; Emmite & Diaz-Guerrero, 1983) have shown how certain cultures encourage more active modes of coping whereas others encourage more passive modes. It is also important to consider, Meichenbaum points out, the added stress that acculturation adds.

Jessica, according to the hospital's medical staff, was non-compliant at the beginning of her hospital stay. She has adjusted considerably and began participating with her treatment plan. Since the beginning of her sessions, Jessica seemed to be afraid of her feelings, as she was unable to name any of these. This would have been difficult it seemed, as she was often faced with conflicting feelings, which promoted confusion within her. Jessica's inability to express or describe these feelings seemed to be reflected in the way she explained these feelings to me as well as herself, equating them with being on the verge of a cold (which in fact never materialized itself) or describing them as "bad" or "funny". Toward the end of her sessions, she actually began to untangle her feelings and recognize her state of being, naming and describing many clear feelings. She has also opened up some more on the personal level, sharing more intimate details about her life. For individuals undergoing major physical corrections and dramatic body alterations, self-esteem and body image are important issues. I believe that a client in this instance necessitates much support as this change (amplified by adolescence) propels these clients into the unknown, which can be greatly unsettling. Much like the individuation phased seen in childhood, the teenager on his or her way to a different self,

needs help to understand experiences as well as support and comfort in order to have the courage to go forward.

Conclusion

In conclusion, I feel that Jessica was able to express many issues that she was dealing with. I believe that our sessions together allowed her to work through, repair and assimilate many of these issues and also offered her support and attention. I think that she was able to gain the sense of control that is important for everyone and even more important as a hospitalized teenager as it allowed her to explore her own identity and feelings. Art Therapy gave Jessica the opportunity to make concrete choices in terms of subject matter materials etc., as well as to work at her own rate. Through these choices, she was provided with the opportunity for control over her sessions as well as her own process within these sessions. I believe that the reflection that Jessica's art provided her encouraged and allowed exploration and assimilation.

As termination neared, I think that Jessica was confronted with past experiences of loss (such as her deceased father, she began telling me about). Her experience in the hospital had been a difficult one and the difficulties would not necessarily end at discharge. She would be going back home with a new body and would have to adjust, to this new identity. In the future, Jessica will have to find new ways of relating to others, as she becomes re-aquainted to those around her. She had demonstrated her resourcefulness and strength (which included flexibility) in her working, which was very rich in many ways and she also proved to be quite resourceful. She was never stifled by the lack of materials and often was flexible enough to modify these or even her work if

she was displeased with it. Hopefully she will be able to use art in the future as many issues are yet to come.

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Consent Form

Art therapy Research Paper
Valérie Neufeld, Student
Master's in Creative Arts Therapies Programme
Concordia University

I, _____, undersigned, give permission to Valérie Neufeld to photograph the pieces of art work that have been produced during the art therapy sessions that took place during her 1998-99 practicum, for inclusion in her Master's Research Paper in the Creative Arts Therapy Program at Concordia University.

I also give Valérie Neufeld permission to have access to my medical files for a period of one year for the purpose of writing her research paper.

I understand that both myself and the setting where my art therapy sessions took place will be kept strictly anonymous and that no identifying information will be given in the research paper. I also understand that I may withdraw my consent at any time before the research paper is completed, without explanation, simply by contacting Valérie Neufeld or her supervisor, Leland Peterson. This decision will have no effect whatsoever on my art therapy or any other aspect of my medical treatment.

I have had an opportunity to ask any questions about the implications of this consent, and I am satisfied with the answers I received.

I have read and understood the contents of this form and I give my consent as described above.

Signature of patient or guardian

Date

Witness to Signature

Date