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## Dialectical Tensions Experienced During Pediatric Chronic Illness: Analyzing Art Therapy Conversations from a Relational Dialectics Perspective

Katherine A. Rafferty  
*Iowa State University, rafferty@iastate.edu*

Erin Parcell  
*University of Wisconsin-Milwaukee, eparcell@uwm.edu*

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## **Dialectical Tensions Experienced During Pediatric Chronic Illness: Analyzing Art Therapy Conversations from a Relational Dialectics Perspective**

### **Cover Page Footnote**

We would like to thank the children and families who allowed us the opportunity to be a part of their story. We would also like to acknowledge the two art therapists for their professional guidance and assistance throughout the data collection and analysis period.

### Abstract

Relational dialectics theory (RDT) provides a framework for understanding the dialectical tensions families experience when talking about pediatric chronic illness. One place where families may express these tensions is during clinical art therapy sessions, where therapists encourage child patients and their family members to use the creative process of art to tell stories while engaged in art making. Subsequently, we studied one clinical art therapy program for families with chronically ill hospitalized children. We examined the naturally occurring conversations during the art making process. Family members' talk enumerated three primary dialectical tensions describing the pediatric illness experience. Findings and implications are discussed to explain how RDT may inform art therapists' sensitivity to addressing these specific dualities verbally expressed by families.

*Keywords:* relational dialectics theory, pediatric chronic illness, verbal communication, clinical art therapy

## Dialectical Tensions Experienced During Pediatric Chronic Illness: Analyzing Art Therapy Conversations from a Relational Dialectics Perspective

Chronic illness is a contextual family experience in which one family member's illness influences the entire family system (Roy, 2006). The work required of families during the management of chronic illness is magnified when a child is diagnosed because of the dependent nature of children on family caregivers and the likelihood of severe illness episodes occurring that require high-intensity acute care (Darcy, Björk, Enskär, & Knutsson, 2014). The term "pediatric chronic illness" refers to a medical condition with the following criteria: (a) the onset occurs between the ages of 0 and 18; (b) the diagnosis is based on medical scientific knowledge; (c) the illness is not (yet) curable; and (d) the illness exists for a minimum of three months, or three episodes have occurred within the last year (van der Lee, Mookink, Grootenhuys, Heymans, & Offringa, 2007). Common pediatric chronic diagnoses that fit within this definition include asthma, diabetes mellitus, congenital heart disease, juvenile rheumatoid arthritis, cystic fibrosis, and mental illness (e.g., eating disorders). Approximately 20% of North American children ages 0 to 17 years live with chronic health conditions; co-morbidity is common, with 29.1% of children displaying three or more conditions (Children and Adolescent Health Measurement Initiative, n.d.).

Due to the likelihood of severe illness episodes occurring that require high-intensity acute care, the management of many pediatric chronic conditions includes frequent hospitalizations (Darcy et al., 2014). A child's hospitalization can be traumatic and stressful for the entire family. Researchers have found that many families must balance maintaining hope for the future while also accepting the reality of a bleak outcome (Jones, 2012; Roy, 2006). In addition, this period requires children and their families to attend to the medical condition alongside a child's

emotional, behavioral, and developmental issues (Fritsch, Overton, & Robbins, 2011; Mussatto, 2006). Thus, a child's hospitalization is wrought with tensions due to the need for major life adjustments that attempt to balance treatment regimens and medical appointments with the rigors of daily life.

Although limited research exists, therapy sessions are one environment where these dialectical tensions about pediatric chronic illness are likely to be discussed. For example, Davis, Mayo, Piccora, and Wimberley (2013) found that case managers, parents, and children often wrestled with using both strengths language (i.e., acknowledging something positive to move forward in a positive direction) and deficit language (i.e., stating something negative that hinders moving forward in a positive direction) when talking about a child's future with mental illness during counseling sessions. With a growing number of healthcare institutions in the United States creating arts programming for patients and their family caregivers, therapeutic art interventions conducted within clinical settings are another environment where family members may discuss dialectical tensions. Scholars know that participating in art-making can be transformative as families tell stories *through* art, tell stories *about* art, and tell stories *while engaged in* art-making (Harter, Quinlan, & Ruhl, 2013). After recognizing that families naturally told stories that included dialectical tensions *while engaged in* art-making at one clinical site, we selected relational dialectics theory (RDT) (Baxter & Montgomery, 1996) as a sensitizing framework to inductively analyze the verbal communication occurring during the art making process. As family health communication scholars, our focus was on families' conversations about the dialectical tensions surrounding their children's chronic illnesses and current hospitalizations. We describe the presence of three dialectical tensions discussed in this environment. In light of these dialectical tensions, we believe that art therapists would benefit

from including RDT in their interpretive toolkit when working with child patients and their families.

### **RDT and Family Health Communication Scholarship**

RDT is a communication theory about dialectical tensions, or contradictions, that are verbally expressed and negotiated within personal relationships such as families (Baxter & Montgomery, 1996). Dialectical tensions are dynamics between two opposing yet unified forces, needs, or desires in relationships, such as the need for connection yet also independence. Most relational partners want and need these aspects in their relationships, but they often experience them as working against one another (e.g., too much autonomy takes away from feelings of connectedness) and manage them accordingly (e.g., spending more time together versus apart). Dialectical tensions may occur across the lifespan of a relationship; however, they are most evident during moments of heightened awareness such as the management of a family member's chronic illness. For example, a chronically ill child and her family may experience a range of dialectical tensions when navigating the ups and downs of the treatment period. During this time, the family may struggle between wanting to know more information about the condition and prognosis while simultaneously desiring uncertainty.

Family health communication scholars have used RDT to study several health contexts (Baxter, Braithwaite, Golish, & Olson, 2002; Fisher, 2011; Golden, 2010; Kvigne & Kirkevold, 2003; Mirivel & Thombre, 2010) and report family members often frame dialectical tensions as opposites (e.g., autonomy versus connection) exposing the struggles family members encounter during the illness experience. However, few scholars have analyzed dialectical tensions when a child is the patient. Davis et al. (2013) examined children's mental health team meetings and the emergence of the strengths-deficit contradiction as case managers, parents, and children

discussed a child's future prognosis. Other researchers have identified parents' joy-grief contradiction due to a premature birth (Golish & Powell, 2003), as well as autonomy-connection and openness-closedness while grieving the death of a child (Toller & Braithwaite, 2009). Thus, dialectical tensions are clearly felt and expressed when a child is sick or has passed away, but how families discuss them during a child's hospitalization for his or her chronic condition remains unknown, despite the growing number of North American children living with chronic illness (Children and Adolescent Health Measurement Initiative, n.d.).

### **Family Talk during Clinical Art Therapy Sessions**

Clinical art therapy is an "intervention based on the belief that the creative process involved in making the art is healing and life enhancing" (Nainis et al., 2006, p. 162). Therapists encourage patients and their family members to creatively express their thoughts during therapeutic art interventions through verbal and nonverbal expression by using various modalities—pencil and paper, paint, photography, clay, music—for diagnostic, recreational, and/or palliative purposes (see Malchiodi, 2003). Through the creative use of these different modalities, art provides a conduit for individual expression (both verbal and nonverbal) of thoughts and feelings as well as the management of uncertainties, developments, and changes regarding the illness experience. Thus, art is both a process and product of communication that facilitates post-traumatic growth (Beebe, Gelfand, & Bender, 2010; Parisian, 2015). Change and coping occur during art-making as individuals assign meaning to experience, develop a stronger life purpose, increase self-awareness, and allow themselves to move forward (Mohr, 2014) and feel hope (Appleton, 2001). In particular, therapeutic art interventions provide an extraordinary range of clinical possibilities that assist patients and their family caregivers who are affected by a diverse range of health issues (e.g., post-traumatic stress disorder, autism, mental illness,

pediatric oncology, neurological disorders) (State of the Field Committee, 2009). Given these conclusions it is not surprising that nearly half of the healthcare institutions in the United States report offering arts programming (Harter et al., 2013).

Most research on these clinical art programs, and in particular those programs within pediatric medical settings, involves patient case analysis and experimental designs to test the effectiveness of art in relieving pain (Nainis et al., 2006) or reducing psychological symptoms (Chapman, Morabito, Ladakakos, Schreier, & Knudson, 2001). This body of research tends to focus on the examination of the art piece or modality (e.g., photography, painting, pencil and paper). The focus on the artwork is significant because art is not only a context to be studied but also a powerful vehicle for self-expression and narrative sense-making where patients and families not only tell stories *through* art and *about* art, but also tell stories *while engaged in* art making (Harter et al., 2013). Thus, a significant component to therapeutic art interventions is the interaction that occurs between the individuals (e.g., patient, family caregivers) and the art therapist, whether in one-on-one or group art therapy sessions.

Given the absence of research specifically analyzing the *stories while engaged in art making*, we decided to focus on how art work serves as an object of dialogue about dialectical tensions. We believe that focusing on verbal communication during art making is relevant because within art psychotherapy research art expressions are often used to enhance verbal exchanges between the therapist and client, particularly when patients cope with difficult illness experiences (Sholt & Gavron, 2006) such as hospitalizations. Studying talk during the art-making process may provide additional insight into how conversations serve as an indirect means for exposing dominant narratives, empowering change, and illuminating channels of influence (Huss, 2013). In analyzing individuals' talk, we focused on *how* child patients and their



family members utilize clinical art therapy sessions to verbally communicate about the illness experience. Examining the possible presence of dialectical tensions within art therapy conversations has practical implications for art therapists because conflict, failed health messages, and poor health are likely outcomes when family and health professionals (e.g., clinical art therapists) fail to recognize the existence of dialectical tensions surrounding the illness experience (Pecchioni & Keeley, 2011).

## **Method**

### **Research Design**

Over the course of nine months, the first author conducted participant observations at one clinical art therapy program for families with chronically ill hospitalized children. This program was affiliated with a non-profit organization in the Midwest United States. We conducted participant observations because this method allows researchers to examine the content and process of family communication (du Pré & Crandall, 2011). Across the nine-month period, the first author observed 24 two-hour sessions of art therapy. The non-profit organization and head art therapist facilitating the program granted consent to the observations, and verbal assent and written consent forms were individually administered to child patients, siblings, and their adult parental caregivers before each session began. Individuals who arrived late completed consent and assent forms as they entered the room; no one denied assent or consent. During and after each art making session the first author took extensive field notes. In addition, the first author regularly met with the two art therapists who facilitated the program to discuss their observations and obtain additional information based on their professional expertise.

### **Participants and the Art Therapy Program**

Clinical art therapy sessions were offered to child patients and their families twice a week for a two-hour time frame. The structure of each session was flexible in nature; child patients and their family members could attend the session at any time during the two-hour period. Each session had a predetermined art therapy project selected by the therapists (e.g., drawing, painting, making worry dolls, collage making, clay-work). Most individuals who attended the sessions participated in the creation of these directed art projects. However, there were times when individuals wanted to work independently on completing a previous project or make cards and write letters to their loved ones in the hospital. Thus, the purpose of the group was to provide a safe space for child patients and their families to process their hospitalization experiences through the creation of artwork.

Sessions had no more than ten individuals, with most involving five people. Primarily parents (mainly mothers) of hospitalized children attended the sessions, followed by siblings (between 4-12 years old) of the sick child, and then teenagers receiving outpatient treatment for different mental health diagnoses (e.g., eating disorders, depression, obsessive compulsive disorder). Most attendees were White/Caucasian, but other race/ethnicities also attended. Based on the therapists and first author's observations, common diagnoses of the hospitalized child patients included cancer, eating disorders, obsessive-compulsive disorder, cerebral palsy, scoliosis, anxiety disorders, and cystic fibrosis.

### **Analysis**

Observation notes were transcribed immediately after each observed session. The first author read the field notes several times with the goal of identifying themes that described the salient dialectical tensions evident in families' verbal communication to the therapist as well as conversations with other individuals attending the art sessions. Thus, the analysis was focused on

verbal communication, as analyzing spoken tensions and discourse is the purpose of RDT (Baxter & Montgomery, 1996). The first author reviewed each field note at least twice using the constant comparative method (Glaser & Strauss, 1967). The concept of contradiction as outlined in RDT served as the sensitizing concept (Blumer, 1954), but we allowed the creation of specific themes to inductively emerge from the data. After reading through the field notes, the first author used open coding to generate a list of initial codes for dialectical tensions that the participants discussed during art making. She then compared this list to her field notes to refine and add new codes. For codes to emerge as themes, recurrence, repetition, and forcefulness had to occur (Owen, 1984). She shared these findings with the second author, a family communication expert in RDT, who then read through the field notes to confirm relevance and saturation of initial themes. Upon agreement, both authors completed a second-order analysis by reviewing the emerging themes. At this stage, codes and themes were compared to reduce the data and increase precision. The first author further confirmed the salience and relevance of the emerging themes by conducting member checks with eight parents who had participated in the clinical art therapy program. During the interviews, the first author asked them: (a) if each tension resonated with their personal experiences, and (b) how they personally experienced each tension. She also used peer debriefing sessions with the two therapists to confirm the salience and relevance of the themes. Theoretical saturation was achieved when no new dialectical tensions emerged from the observations, parents' interviews, and peer debriefings (Lincoln & Guba, 1985).

### **Findings**

The art therapy room provided a safe and creative space for personal expression that stimulated conversations about the families' pediatric chronic illness experiences. Across the observed clinical art therapy sessions, directed and non-directed art making fostered verbal

communication. For example, during one of the observed sessions, a mother and her young daughter created a “get well card” for her other daughter who was receiving chemotherapy. The creation of this card fostered dialogue between the daughter and mother about the other child’s prognosis. In other instances no conversations occurred until the art therapist posed direct questions to the individual about his or her artwork. For instance, during a different clinical session one of the art therapists had two teenage girls attending a three-month in-patient treatment program for eating disorders draw pictures of their favorite places. As the girls drew their pictures, the art therapist asked questions about how the drawings reflected their current feelings and states in life. Conversations about the creation of art provided a conduit for patients to share personal narratives and verbally express dialectical tensions (e.g., tensions between desiring independence but also wanting to feel connected to family and friends) to the art therapist. During sessions with multiple people in attendance, the art therapist approached individuals as they worked independently; however, the environment was set up so that individuals could also talk with other people; group processing occurred between individuals and the art therapist as well as between attendees. Regardless of the structure or group composition, the verbal processing of dialectical tensions was evident and was something that was naturally discussed during the creation of artwork.

### **Managing Hospital Life – Attending to Life Outside the Hospital**

The most prominent tension verbally expressed by family members attending the clinical art therapy sessions was *managing hospital life – attending to life outside the hospital*. Parents and siblings discussed the challenges with balancing their family alongside the demands of a child’s hospitalization (e.g., extended in-patient treatments). For instance, one mother verbally expressed this tension as she worked with the art therapist to make miniature worry dolls. Over

the course of several sessions, the creation of the worry dolls fostered multiple conversations where she described her son's frequent hospitalizations and the strain placed on her family:

And just like that, we were packing bags, adjusting plans, and calling in family reinforcements. We know the drill. We've done this before. Today I felt particular bitterness, however, because today is Ashley's 7th birthday. As if this girl hasn't already taken the back seat enough times this year, all of a sudden her birthday becomes all about Dave again. All about Cancer. Stupid Cancer.

Being at the hospital was a difficult experience for many parents. Having the ability to paint, write, and draw during the art therapy sessions allowed parents to state these tensions as they worked through feelings of guilt, betrayal, and frustration for not always sitting at their child's hospital bed. One mother who recently delivered her daughter who had a heart condition that was diagnosed at 20 weeks gestation used different colors and strokes of paint to form a backdrop to a personal letter that she painted and wrote. All of the text was written using black and gray marker, except for the words "hardest," "betrayal," "24 hours," and "love," which were written in blue (see Figure 1). Part of her letter denoted this dialectical tension when she wrote: "forgive yourself for not being able to spend 24 hours a day at the hospital...forgive others for their insensitive comments and questions." Artwork such as this illustrated the contradictory feelings and chaotic hardships parents experienced.

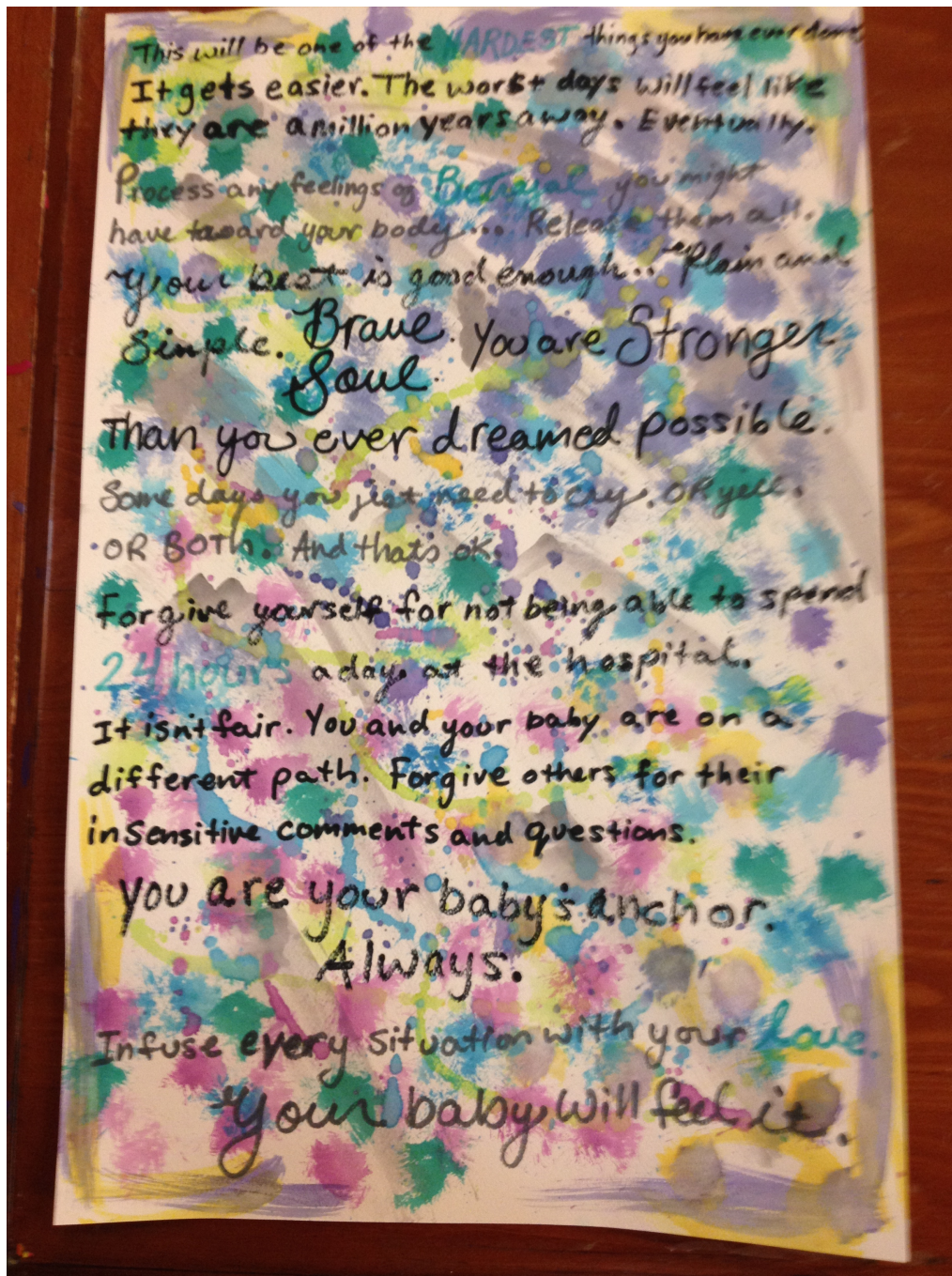


Figure 1. Art serves as a backdrop to a personal letter, holding contradictable feelings.

Other parents discussed this tension when describing how their children's hospitalizations required some family members to be displaced from their homes for a period of time. For example, one mother who frequently used the art therapy room enumerated the challenges of

seeking medical attention for her daughter in the Midwest while her husband and other children were at home on the East Coast. She often talked about wanting to “be here” with her hospitalized daughter while also wanting to be at home caring for her other children and husband. The art therapist typically had mothers like her create an origami heart where they wrote about other challenges pertaining to this tension. As the mothers individually constructed their origami hearts, they discussed the hardships associated with attending to their sick children while managing other family relationships, long-distances, careers, and finances. During one of the observed group sessions a mother shared her frustrations with the art therapist and other mothers present:

And we're trying to maintain careers while we're dealing with health risks... There have been several parents walking around with Bluetooth and we are trying to maintain a life outside of being here. So you have to make sure that life happens outside of here because this is not supposed to be forever.

Siblings of sick children also talked about experiencing the tension between *managing hospital life – attending to life outside the hospital*. For example, a 10-year-old brother to a hospitalized boy awaiting a kidney transplant described to the art therapist his love of baseball and not being able to attend summer camp this year. He further stated that although he desired to be at baseball camp, he also loved his mom and wanted to support her while his brother was in the hospital. As he talked about this tension with the art therapist, he created a “worry envelope” where his mother could store all of her worries about his brother. In a different session, another sibling created an ornament to be displayed on the wish tree outside of the art room. On the ornament the girl wrote: “I know my brother needs medicine, but I wish for our family to be

together.” The creation of artwork such as this enumerated the challenges families experienced with balancing the rigors associated with hospital life and life outside of it.

### **Maintaining Certainty – Experiencing Constant Uncertainty**

A second tension reflected the struggle of *maintaining certainty – experiencing constant uncertainty*. When talking about this tension, family members of the hospitalized child discussed the difficulties with planning for the future and also living in the present moment. Many parents described living in a constant state of uncertainty where they paradoxically felt they had to make challenging decisions. During one art therapy session, one mother with a daughter diagnosed with cancer shared with the art therapist:

You don’t know if you’re going to have to plan for a funeral, or you don’t know if you’re going to be just dealing with complications the whole way through. And there are a lot of them. I mean they talk about the heart failure, the liver failure, the kidney failure, the transplants...I have just come to realize that it’s really just a day by day. And you can’t worry about the future... But, I still have questions about the future. I don’t know how are her organs going to hold up, or how are they going to hold up in life?

During art sessions, parents, such as this mother, constantly commented on questioning the future. Uncertainty about the future left some parents to focus on the day-to-day in an attempt to maintain some degree of certainty. However, a child’s health setbacks or the delivery of bad news from medical providers would create additional uncertainties for families that exacerbated this tension. During one art therapy session, one mother with a daughter who had epilepsy described the presence of *maintaining certainty – experiencing constant uncertainty* dialectical tension because of complications with her daughter’s medications. She shared these feelings with the art therapist and others in attendance as she painted a picture of a sunrise:



It had been four months without [a seizure]. I was like, “yes, maybe we’ve finally got these medications.” And then nope. [She has a seizure] So there’s a lot of uncertainty. It is trying to stay ahead of the game as she continues to grow and her medications and dosages change.

Parents attending the clinical art therapy sessions had to adapt to frequent changes with ongoing treatment programs and extended hospital stays. Continuous fluctuations in their schedule left parents in a state of constant uncertainty while desiring more certainty with day-to-day living and the future. For example, during one of the art sessions a mother whose daughter had been hospitalized for almost a year due to her fatal leukemia diagnosis disclosed to the art therapist that she was looking for apartments in the area. Her daughter’s prognosis was bleak, which left her wrestling with how to plan for the future. As she was painting a picture of a giraffe (her daughter’s favorite animal) to be displayed in her daughter’s hospital room, she posed a question to the art therapist detailing the existence of this dialectical tension: “Does the entire family move or just me? What about my other daughter’s school or my husband’s job? We thought that we had it figured out, but then things got worse. Now we just don’t know.”

Child patients also talked about wrestling with the dialectical tension of *maintaining certainty – experiencing constant uncertainty*. For example, one of the female teenagers with an eating disorder spent several clinical art therapy sessions talking about her imminent transition out of the treatment program. Over the course of two months she disclosed to the art therapist that she was feeling safe and certain in the hospital alongside feeling stressed and uncertain from the simultaneous certainty of having to return home after her treatments ended. Her anxious talk about this dialectical tension monopolized the art therapist’s time across several sessions. The therapist later revealed to the researcher that there were a few times when she was unable to

work with others in attendance because of this girl's need for one-on-one processing. The girl would whine and monopolize the group conversation whenever the therapist would attempt working with other people. During one session, in particular, the art therapist had to pull the girl out of the room to talk with her privately about her behaviors. In this conversation, she acknowledged the hardships that the girl was experiencing and offered reassurance and some reconciliation of the dialectical tension by encouraging the girl to use her art creations as a means to express her fears and anxieties. After this incident, the girl spent the course of several weeks drawing and painting about her feelings. She often painted dark scenes of abstract objects or drew pictures of places she loved to visit (e.g., sitting on a swing by the water next to a willow tree).

### **Maintaining Privacy – Expressing Oneself**

A third tension expressed during the art sessions was *maintaining privacy – expressing oneself*. One common art project where parents verbally expressed this tension was when mothers, in particular, weaved their own strings of fabric into the community “Friendly Loom.” The loom sat in the corner of the art room next to a basket of yarn and strips of fabric where families could write a message and weave strips of fabric as a way to share their hospitalization story (see Figure 2). Most of the messages on the fabric were anonymous and did not contain names or specific information about a child's condition, thus signifying one's privacy. However, the public display of the loom in the art room and the opportunity for individuals to write a personal message and weave strings of yarn about their own story provided families with the opportunity to engage in self-expression, even if they did not have the “right words” to say or wanted to remain private about their thoughts and feelings.

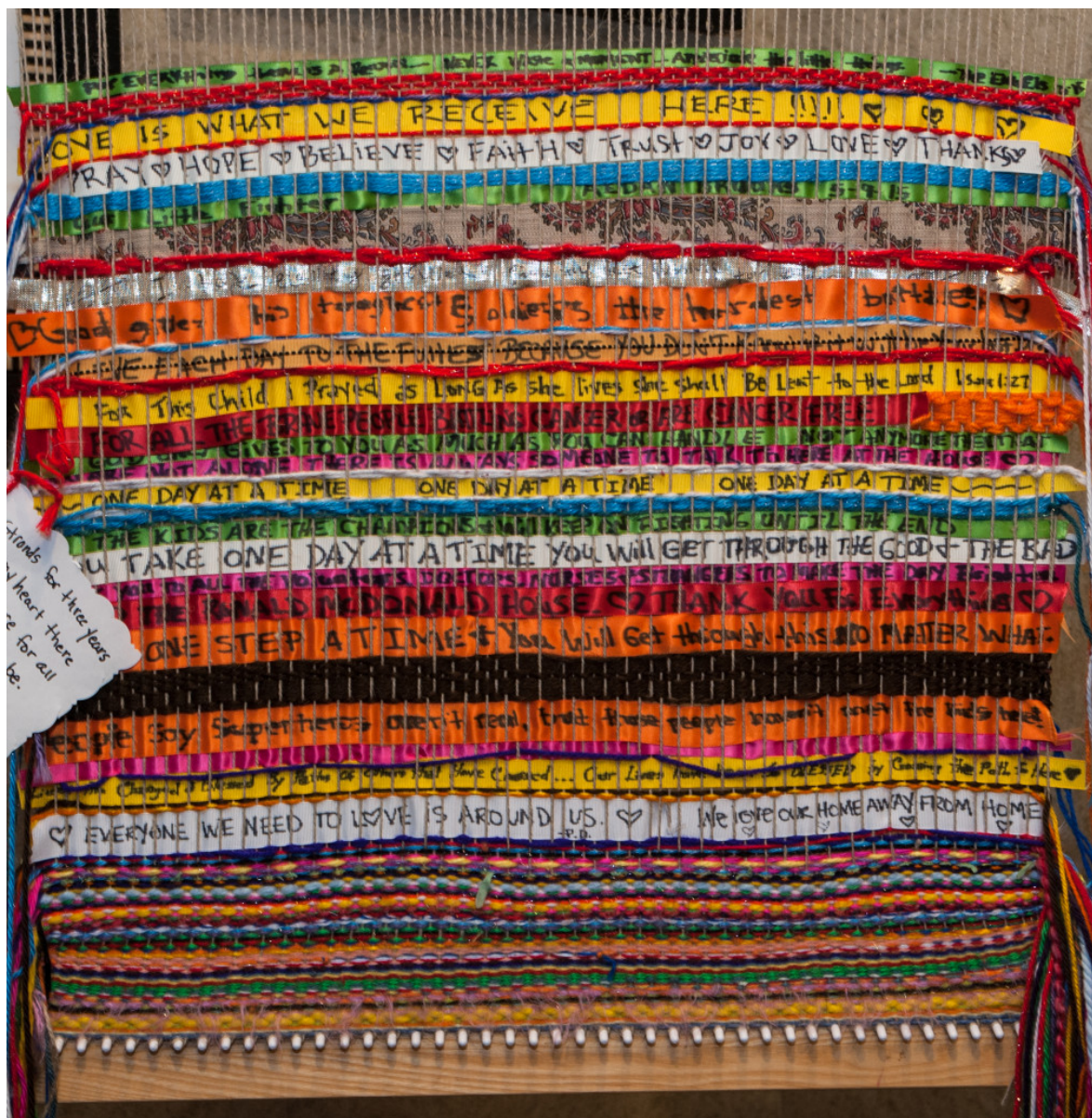


Figure 2. Art serves to maintain privacy while expressing intimate feelings.

Another way that this tension was expressed was when siblings acknowledged their sick brother or sister in conversation but remained silent about their own feelings and emotions as they created artwork. For example, during one session the art therapist asked a girl to talk about her younger brother who had cancer. Rather than answering the therapist's questions the girl quietly drew a picture of an elf and wrote a message where she included the statements:



When you see me, I am mostly helping out with my brother. My brother has a disability that I don't want to get into, but I know that he is safe. All I come to talk to you about was to NEVER EVER GIVE UP! NO ONE can tell you to give up something if you love it! Remember that statement! (see Figure 3)

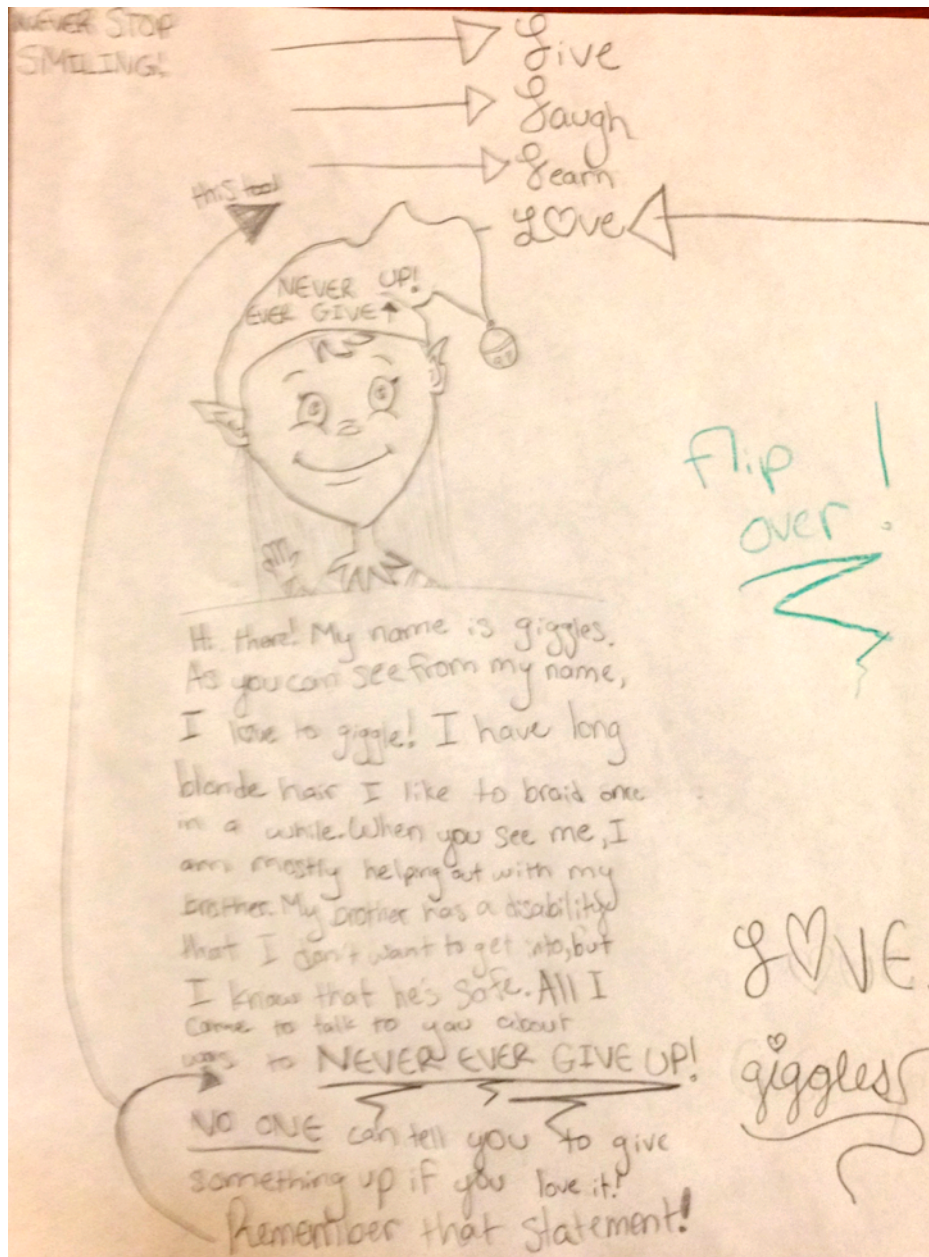


Figure 3. Art serves to communicate what the client is not ready to share verbally.

This message conveyed to the art therapist that this girl had a story to share, even if she wanted to remain private and refrain from verbally expressing it to the art therapist. During a different therapy session, the art therapist asked a nine-year-old girl about her brother's health condition. She responded, "My brother is in the hospital and that is that." She did not answer any other questions even though her parents told the therapist that she was aware of her brother's cancer prognosis. Instead she silently painted a picture of a rainbow for her brother and wrote, "I love you. Please get better! I am sad you are sick." In cases such as these two instances, the children limited their role in conversations or remained silent. The construction of their artwork provided an outlet for writing out thoughts and feelings they could not or would not explicitly discuss. While a child's developmental status may have hindered conversations (e.g., they are not old enough to articulate feelings at that level), several parents with multiple children felt that their other children became the unintentional "forgotten ones" who struggled with the dialectical tension *maintaining privacy – expressing oneself*. During an interview about how this tension was experienced by her "forgotten child," one mother shared:

[My son] was ignored for a lot of his life in the beginning. And you just don't even know you're doing it because the other [child with cerebral palsy] takes up so much of your time and attention. It was always like, "Go get this. Do this. Hurry up. Move. Help. Help." And then it turned out that he didn't really want to rock the boat. I think I noticed it around third, fourth grade when he was completely withdrawn... He felt like he couldn't even state an opinion even though he had so much to say.

A final example of this tension was made salient in observing a seven-year-old boy's artwork over the course of several months. He refused to talk about his sister's severe mental

illness despite visiting her every other day and being relocated to the Midwest because of her inpatient treatment program. Whenever the art therapists directly asked him questions about his sister, he typically responded with single word answers (e.g., “fine”). However, when constructing different pieces of artwork, he frequently desired to create dragons, worry dolls, or space ships. In analyzing his artwork, the art therapists and his mother attributed these creations as his way of processing his sister’s condition and managing his own concerns about keeping himself safe. During an interview the mother stated:

His sister is the person that he loves the most, but she is also the person that scares him the most. He won’t tell you this, but he shows it through his artwork... [The art therapists] were able to pick up his real need to feel safe just through the art that he made. All of it had to do with safety, the need for safety guarding, guarding the art room and keeping it a safe place... And [the art therapists] just let him express himself how he’s needed to and encouraged his artistic expression.

Like this mother said, dialectical tensions existed because of the burdens placed upon families from their child’s treatments and hospitalizations for pediatric chronic illness.

### Discussion

A child’s hospitalization can be a source of distress to the child and the family as they negotiate and survive in spatial domains that, by design, are organized around technology and sterility (Harter et al., 2013). Participating in art-making can transform patients’ and their family members’ understandings of place and sense of self by helping them express and manage their dialectical tensions. We used relational dialectics theory (Baxter & Montgomery, 1996) as a framework to study individuals’ conversations while participating in clinical art therapy sessions. We focused on the dialectical tensions discussed *while engaged in* art making. We acknowledge

some individuals prefer to express themselves through nonverbal modalities while others open up and engage actively in verbal conversation. The focus of this study was on how the art-making process facilitates conversations about dialectical tensions that are experienced across the pediatric illness experience. This insight is relevant to clinical art therapists because verbal communication is one of the therapeutic outcomes produced from art making (Sholt & Gavron, 2006), and verbal communication also exposes personal narratives about the illness experience (Huss, 2013). Clinical art therapists should consider developing directed and non-directed art projects that encourage patients and family members to express and manage their dialectical experiences through the creation of artwork.

Art therapy in medical settings is complementary therapy that relieves pain and suffering as well as facilitates the emotional health for patients and family caregivers (Beebe et al., 2010; Chapman et al., 2001; Nainis et al., 2006; Stafstrom, Havlena, & Krezinski, 2012). We observed many child patients and their families utilizing the art therapy program to process the illness experience. In fact, one mother stated during an interview:

How could you not be positive coming into this environment? It's the bright spot amidst all the darkness. You can get all of the negative energy out and talk about how you're feeling.

As this mother verbalized, art making fostered a safe and creative space where families could discuss the dialectical tensions to the therapists or other individuals present (e.g., other family members, other parents with sick children) (Stafstrom et al., 2012). For example, during the art making process mothers discussed the challenges of raising their other healthy children who were not hospitalized while simultaneously caring for their ill child and attending to his or her hospitalization; teenagers suffering from mental illness discussed the tensions between leaving

treatment centers and returning home; and siblings of sick children remained silent about their feelings related to their brother or sister's future health, while they also expressed their concerns by creating "get well" cards and personal reminders of comfort (e.g., letters of self-encouragement, worry dolls) for their brother or sister in the hospital. As these examples illustrate, art making can open up dialogue that otherwise might remain dormant, and this environment often fosters a matrix of supportive relationships. Other scholars have referred to this process as "leading with art," which is a process where the art materials and the invitation to be creative creates and sustains an environment that enables conversation but does not demand it (Harter et al., 2013).

Our findings suggest that the production of art and the concomitant conversations may provide one avenue for children and their families to talk about their dialectical tensions. For example, even though the therapy sessions were voluntary, the same individuals would frequently attend the sessions and share their positive experiences about having this program amidst the hardships of hospitalizations and pediatric chronic illness. In addition, many of the publicly displayed art projects contained messages of gratitude to the art therapists for providing a positive, supportive, and welcoming environment. Other art expressions that were publicly displayed included letters of advice or words of encouragement to other families going through similar experiences. The artful expressions created within clinical art therapy settings helped foster interpersonal relationships and engagement with others at a time when individuals may be separated physically and/or emotionally from their typical surroundings and primary social networks. Like Harter et al. (2013) we believe that artful encounters are generative processes that foster new and enriching potentials through human communication. Art is a way to engage with others and spur moments of dialogue between patients, therapists, and family members. We



acknowledge that not all art needs to be interactive; however, therapeutic interventions that foster the potential for shared experiences to be verbally expressed may be beneficial for some patients and their families who feel isolated or muted, and desire a safe space to work through and state their dialectical tensions.

### **Limitations and Future Research**

As with any research, our study contains some limitations that need to be considered. First, while we worked with two art therapists to discuss their formal assessments about the art created during the sessions, it is important to note that we are communication scholars and so our focus remained on dialogue and conversation about how dialectical tensions were discussed *while engaged in art making*. Second, all of the observations and interviews occurred at one non-profit organization that also provided families with housing and other services (e.g., meals) during a child's hospitalization. Families without access to these resources may experience additional stressors and potentially different dialectical tensions; therefore, scholars should also study these contexts. We also see potential for the latest iteration of RDT for future research. While we used the original RDT framework (Baxter & Montgomery, 1996) to examine dialectical tensions verbally expressed by family members, we could also examine how their talk reflects *dominant discourses* (Baxter, 2011). In our study, mothers struggled with being “good mothers and wives” (i.e., in the home taking care of the family), and children talked about wanting to feel “normal” (i.e., not have an illness or a sibling with an illness).

Future scholars would make positive contributions to RDT and clinical art therapy research by attending to the specific ways dialectical tensions are discussed and managed through the art therapist-patient relationship. In doing so, we acknowledge that art-making often does not warrant the need for verbal expression, and some individuals prefer nonverbal

modalities as avenues for self-expression. Future researchers studying dialectical tensions should focus on nonverbal behaviors and the created artwork to advance further explanations about *why* individuals receive health benefits from art making, which include lowering anxiety as well as improving quality of life, self-concept, mental health and overall well-being (e.g., Nainis et al., 2006; Parisian, 2015; Stafstrom et al., 2012). Future scholars might need to incorporate additional frameworks to examine these health benefits achieved through the art making process. One way to do this would be to assess how maintaining privacy and expressing oneself could potentially change over the course of several therapy sessions. The expressive writing paradigm, which has been found to decrease inhibitions and lead to positive health benefits (e.g., less stress) (Smyth & Pennebaker, 2001), would be one suitable framework for this examination. Given the written gratitude expressed by the children and families who wrote letters of advice and words of encouragement to others using the art room, it is likely that the art making process may be another avenue for decreasing negative inhibitions. In fact, Pizarro (2004) suggests that a combined approach of writing and art therapy may produce positive health outcomes, although his hypotheses have not yet been tested.

The narrative capacity of art is especially significant for patients and families whose lives have been altered by severe chronic disease and disability. Our study provides an initial set of dialectical tensions that families with children hospitalized for chronic illness may experience and discuss during clinical art therapy sessions. Clinical art therapists should consider using RDT as an entrance point and interpretive tool for assisting families in creatively expressing and negotiating the dialectical tensions they experience during these challenging life periods. In particular, we found that RDT is a useful perspective for understanding how artwork and the art

making process become objects of dialogue and verbal self-expression about dialectical tensions surrounding the illness experience.

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